North Carolina

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 10/05/2017 9.13.46 PM)

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 2018

End Year 2019

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 Jason

Last Name Vogler

Agency Name DMHDDSAS, NC DHHS

Mailing Address 3001 Mail Service Center

City Raleigh

Zip Code 27699-3001

Telephone 919-733-7013

Fax 919-508-0951

Email Address jason.vogler@dhhs.nc.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date 10/2/2017 6:12:49 PM

Revision Date 10/5/2017 9:12:46 PM

V. Contact Person Responsible for Application Submission

First Name DeDe

Last Name Severino

Telephone 919-733-4670

Fax 919-508-0951

Email Address dede.severino@dhhs.nc.gov

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,

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

February 13, 2017

Memorandum

From: Mandy Cohen, MD, MPH
Secretary

Re: Delegation of Authority

As of this date, I am delegating my signature authority to Christen Young, Deputy Secretary for Policy and Operations; Dale Armstrong, Deputy Secretary for Facility Based Behavioral Health and Developmental Disabilities Services; Rod Davis, Chief Financial Officer; Dave Richard, Deputy Secretary for Medical Assistance; and Mark Benton, Deputy Secretary for Health, for the Department of Health and Human Services. During such times as I designate, Ms. Young, Mr. Armstrong, Mr. Davis, Mr. Richard or Mr. Benton may have the authority to sign official Departmental documents for which my signature is required.

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 OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

October 2, 2017

MANDY COHEN, MD, MPH
SECRETARY

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857
virginia.simmons@samhsa.hhs.gov

Dear Ms. Simmons:

Please accept North Carolina's 2018-2019 application for the Substance Abuse Prevention and Treatment Block Grant from the North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

This two-year plan outlines the Division's strategies and activities to meet the federal block grant requirements and its implementation. It allows our state to develop, implement and maintain a more robust recovery-oriented system of care, which includes prevention and early intervention services for youth and adults experiencing or at-risk of substance use disorders, as well as treatment services at various levels of care and recovery supports.

As with many states, addressing the opioid epidemic is a top priority for North Carolina. We intend to continue our efforts and propose that additional SABG funds will be set aside to be used at the discretion of the Department of Health and Human Services to address this issue. We 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. We will utilize the funds to further implement the comprehensive strategies identified in the Action Plan to reduce opioid addiction and overdose death.

Again, thank you for the opportunity to submit this application and bring much needed resources to serve those in need in our state.

Sincerely,

Mark T. Benton

for Mandy Cohen, MD, MPH
Secretary

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State Information

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

Fiscal Year 2018

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
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Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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 (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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, day care, 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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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 Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Mandy Cohen, MD, MPH

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

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

Fiscal Year 2018

U.S. Department of Health and Human Services
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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
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2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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 Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Mandy Cohen, MD, MPH

Signature of CEO or Designee[1]: Mark T. Benton for MC

Title: Secretary

Date Signed: 10/2/17
mm/dd/yyyy

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

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

Mandy Cohen, MD, MPH

Title

Secretary

Organization

NC Department of Health and Human Services

Signature: Date:

Footnotes:

No lobbying activities

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

Mandy Cohen, MD, MPH

Title

Secretary

Organization

NC Department of Health and Human Services

Signature: Mark T. Benton Date: 10/2/17

Footnotes:

No lobbying activities

Planning Steps

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

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health 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 behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health 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 gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

Department of Health and Human Services
Division of Mental Health/Developmental Disabilities/and Substance Abuse Services

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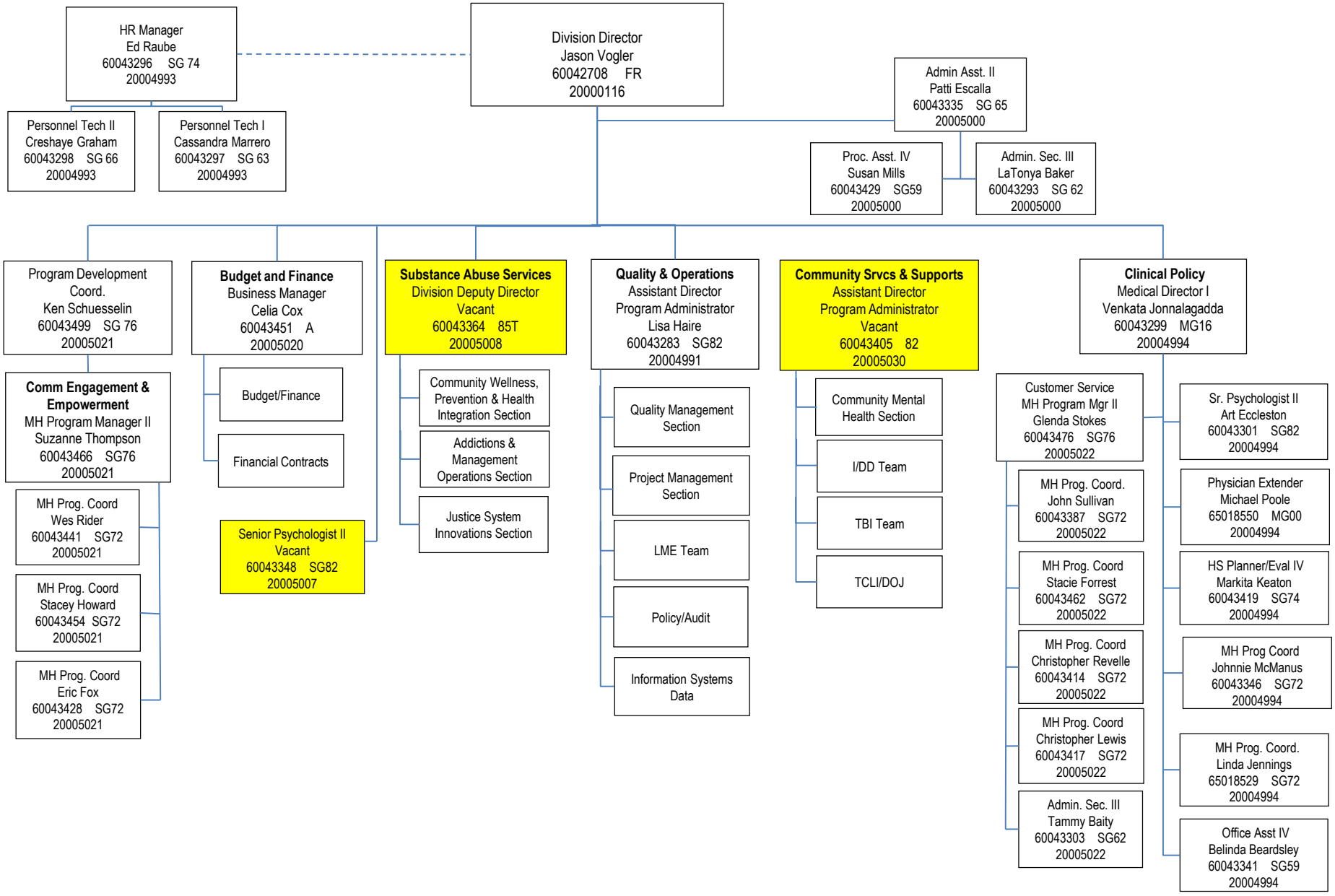
DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES



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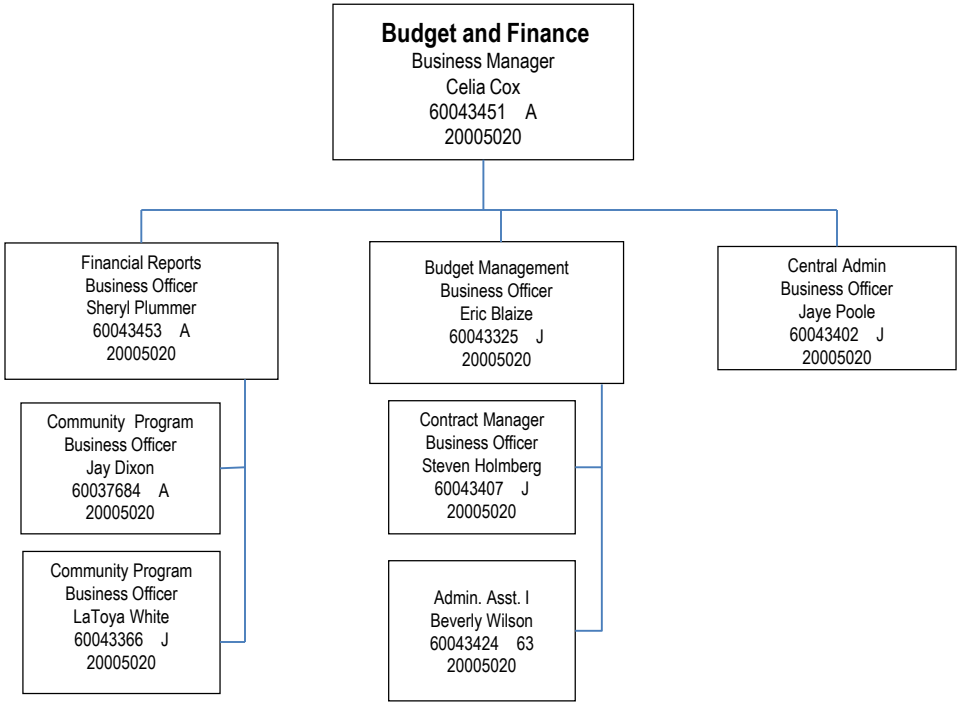

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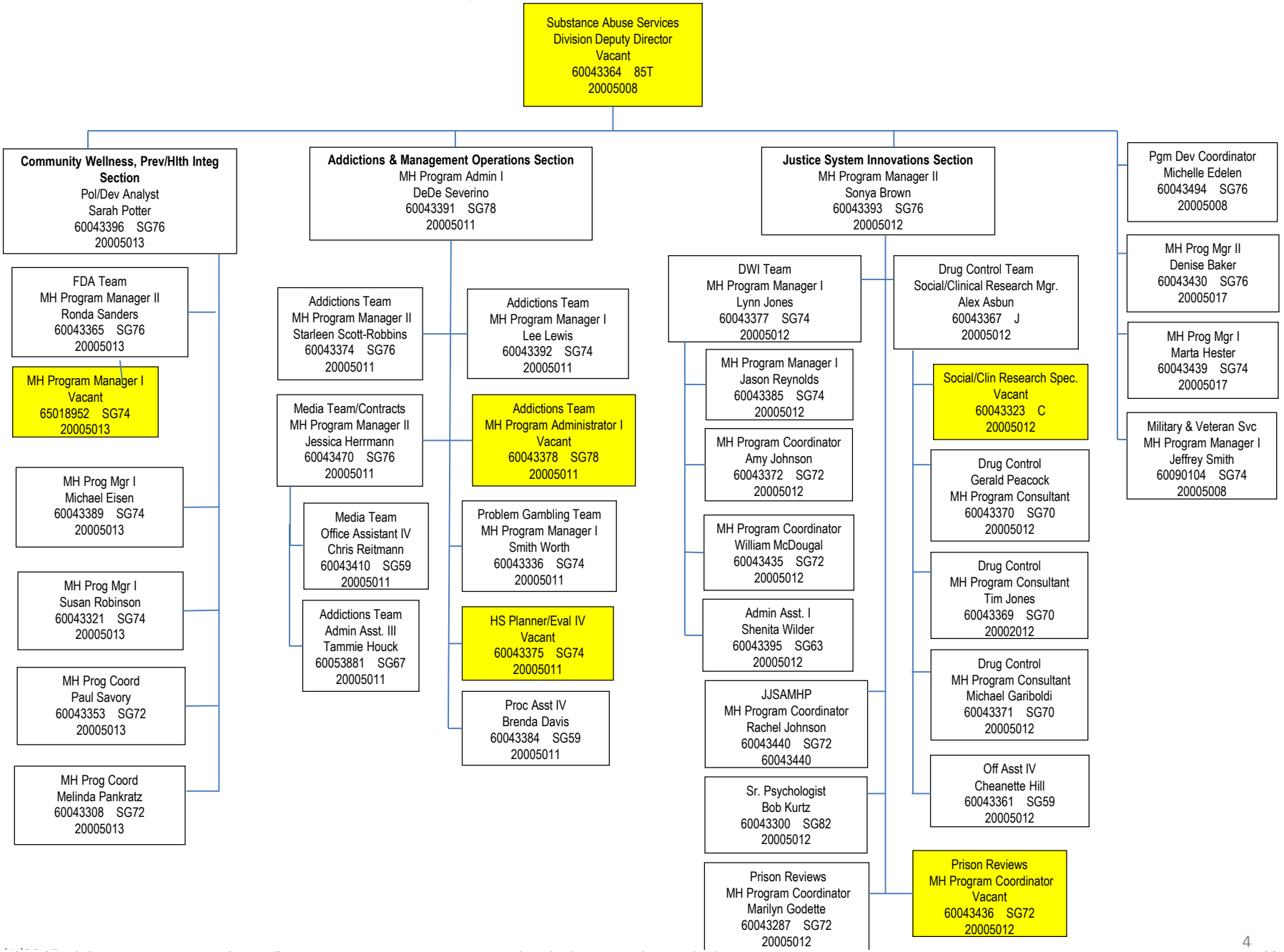

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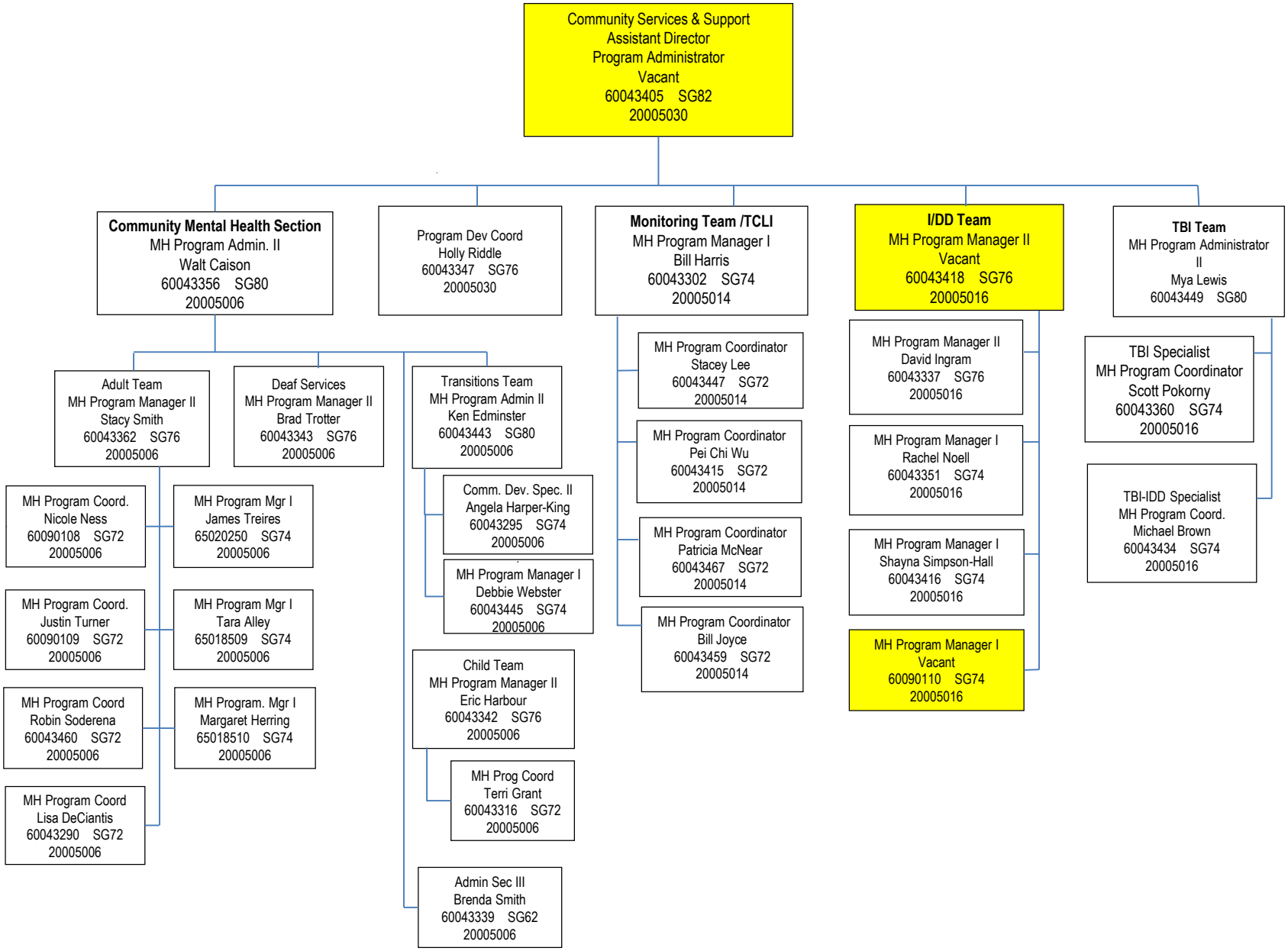

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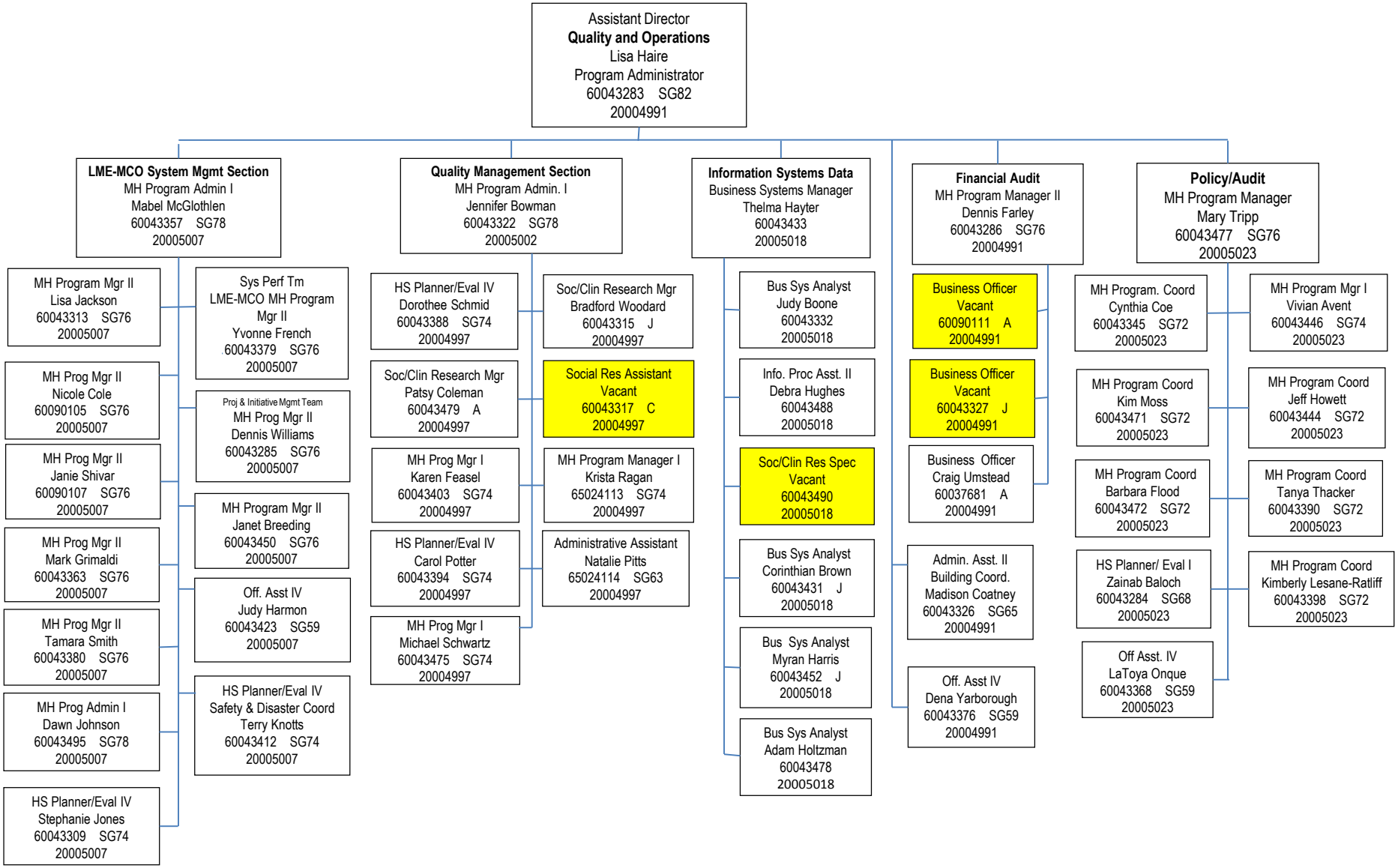

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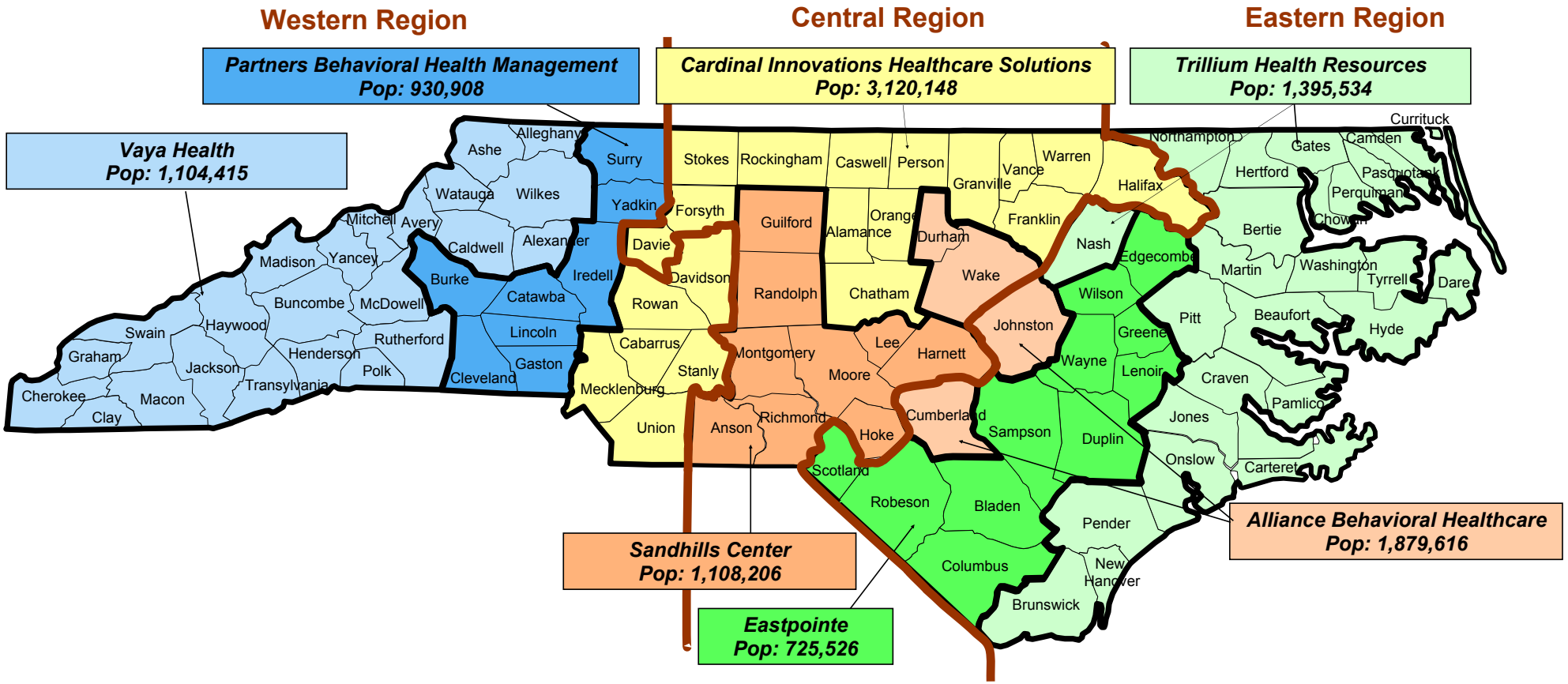

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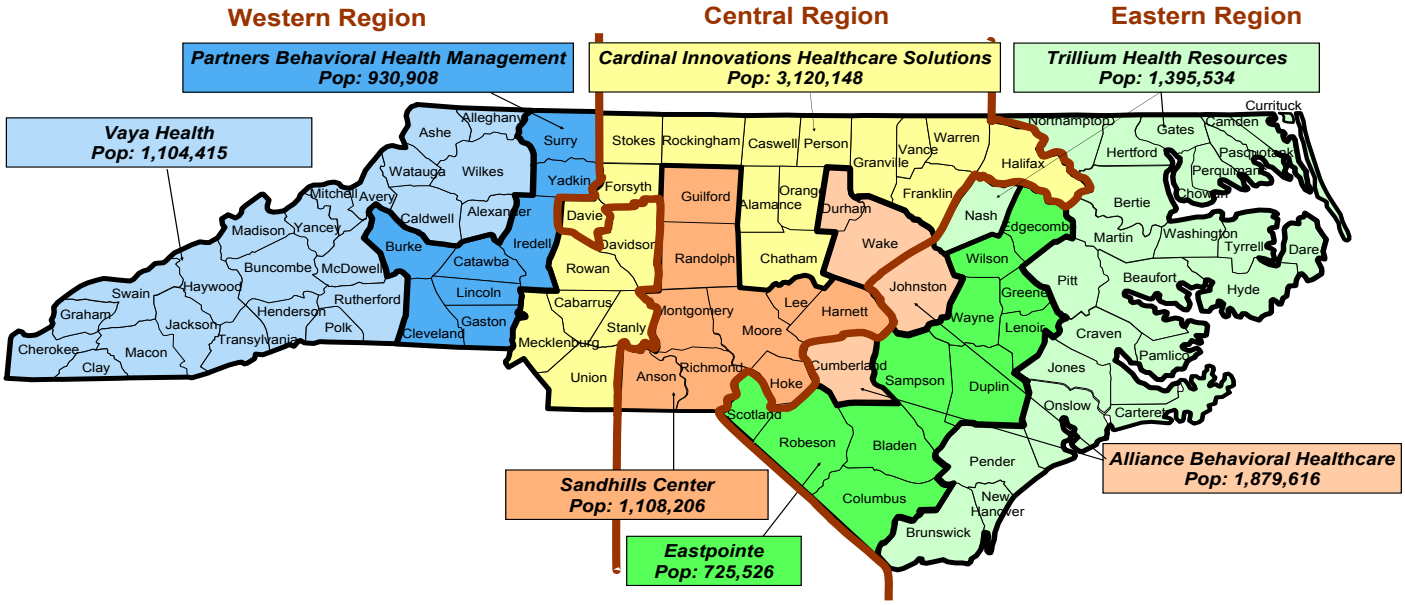

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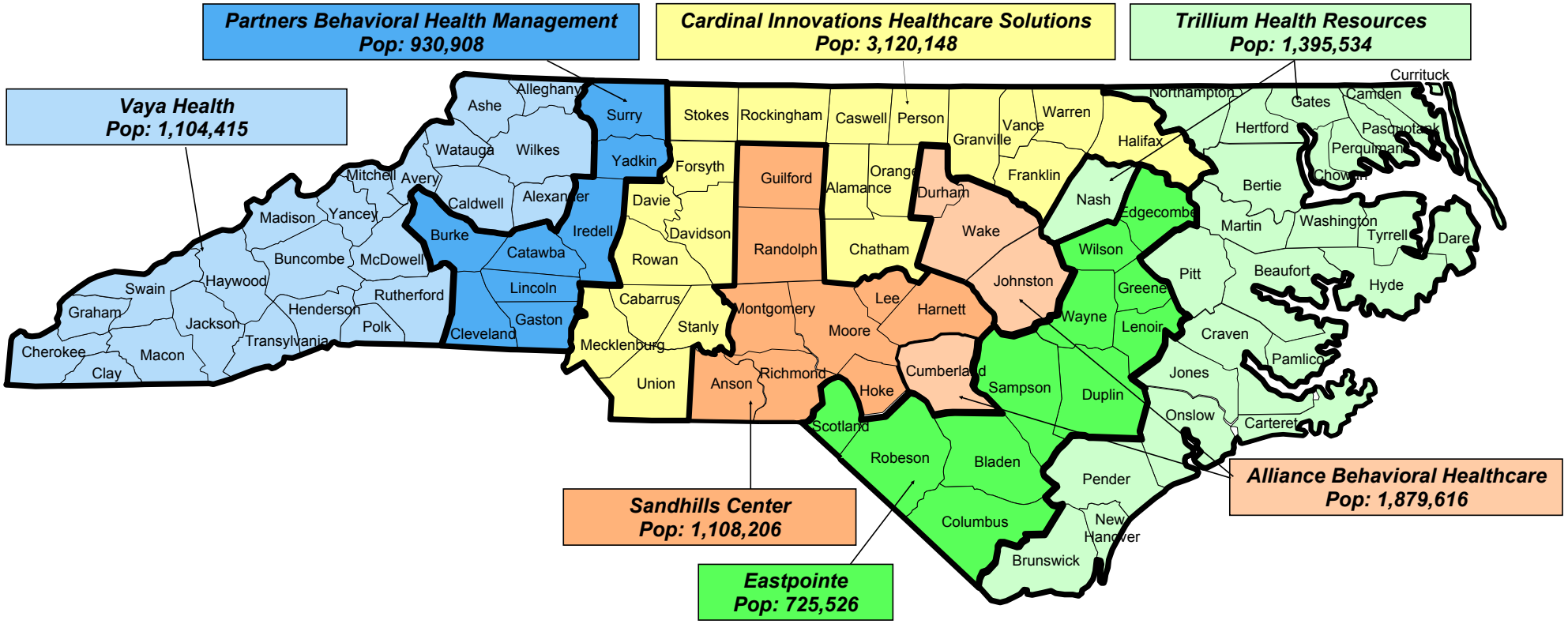

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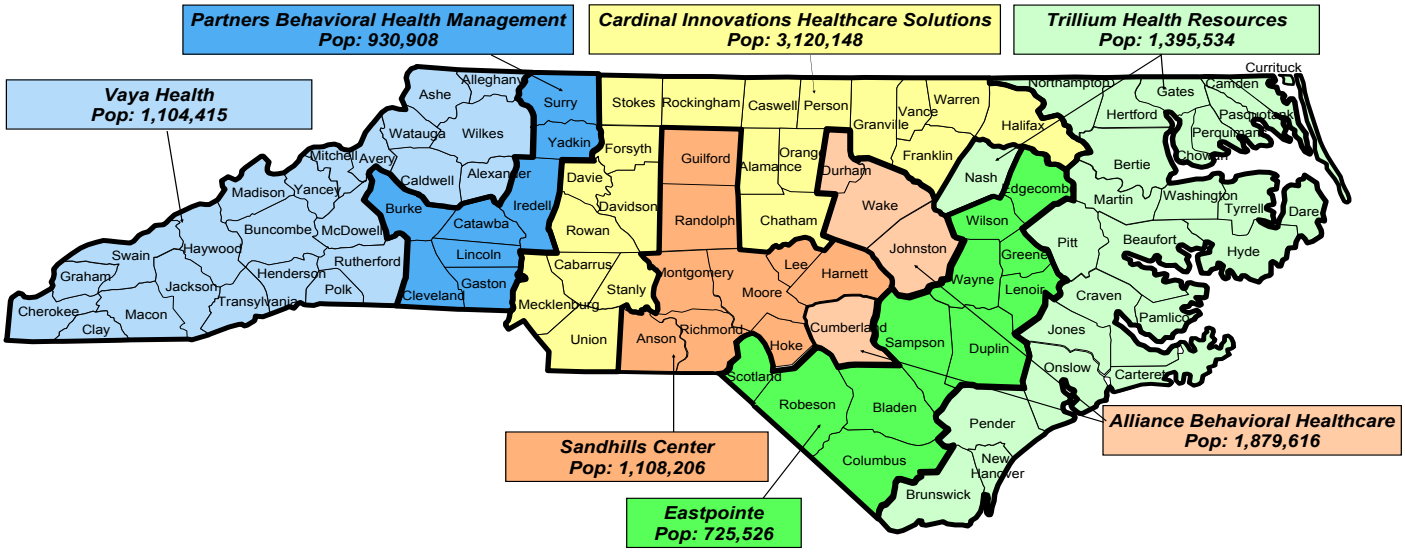

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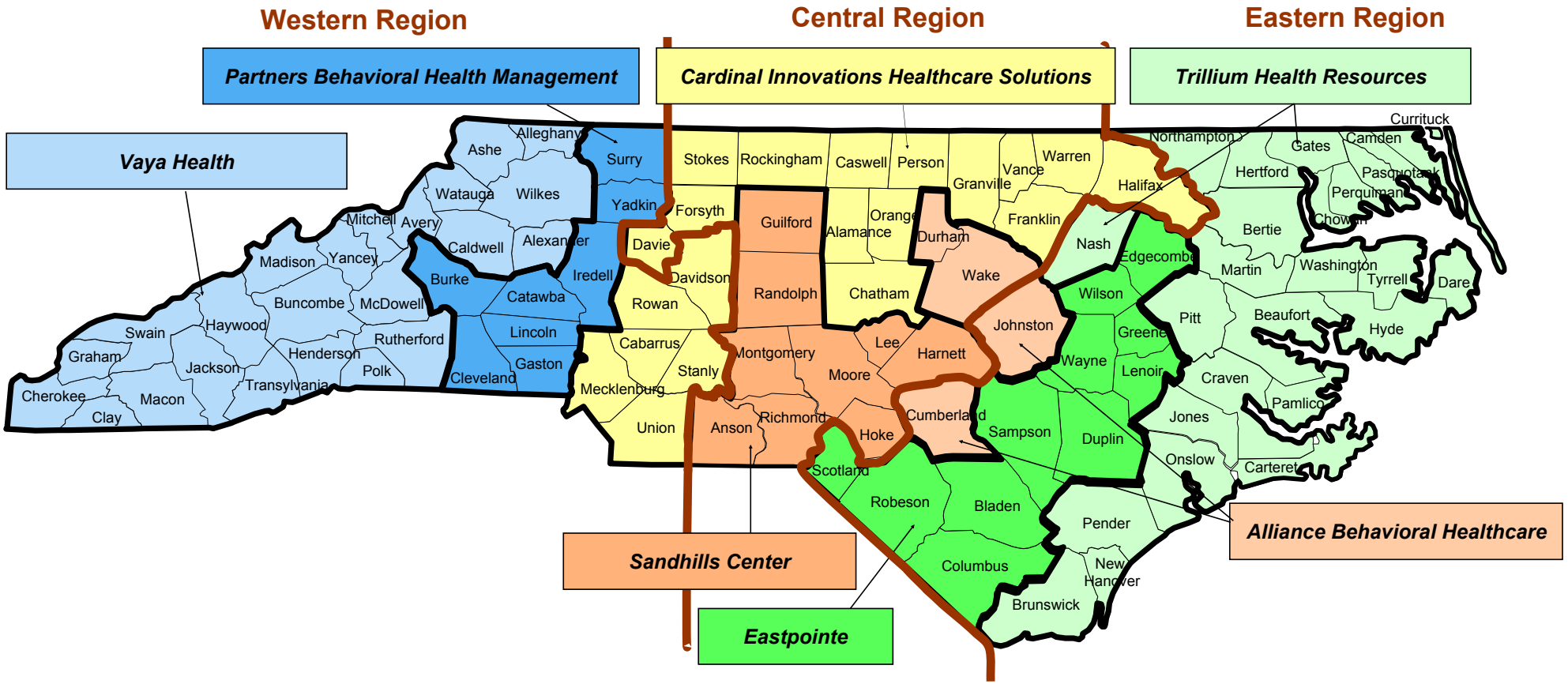

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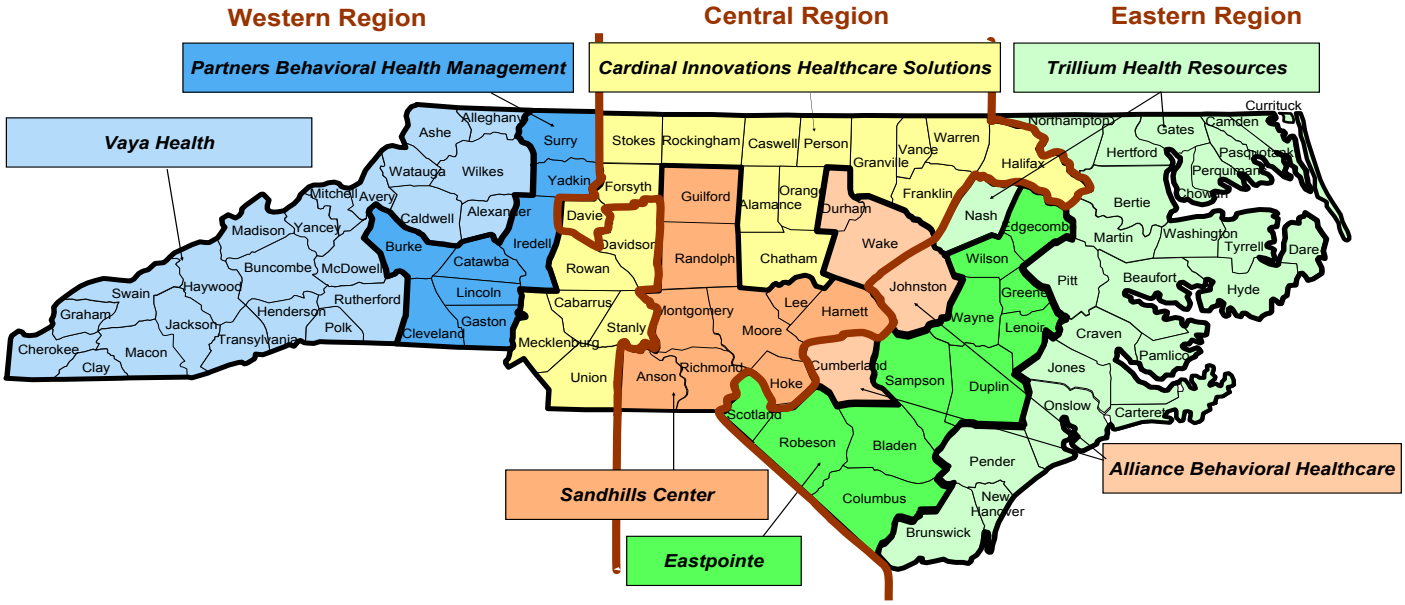

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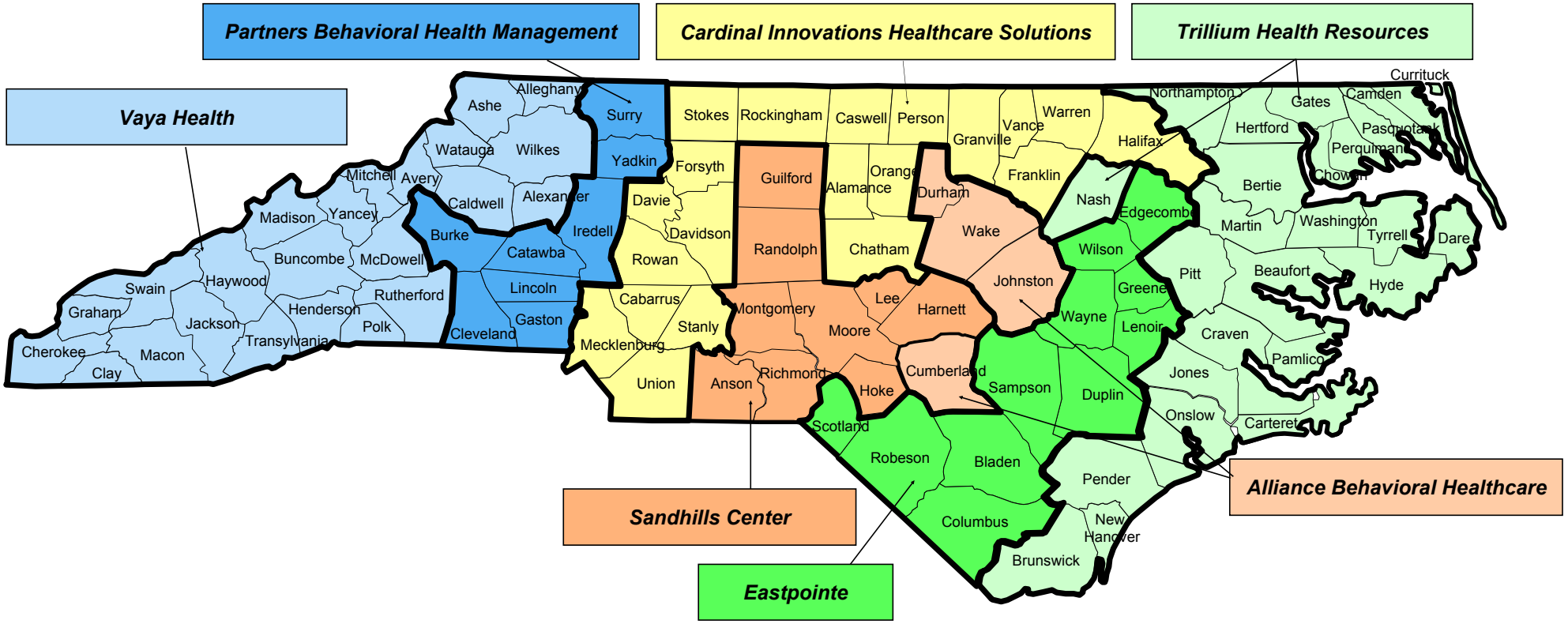

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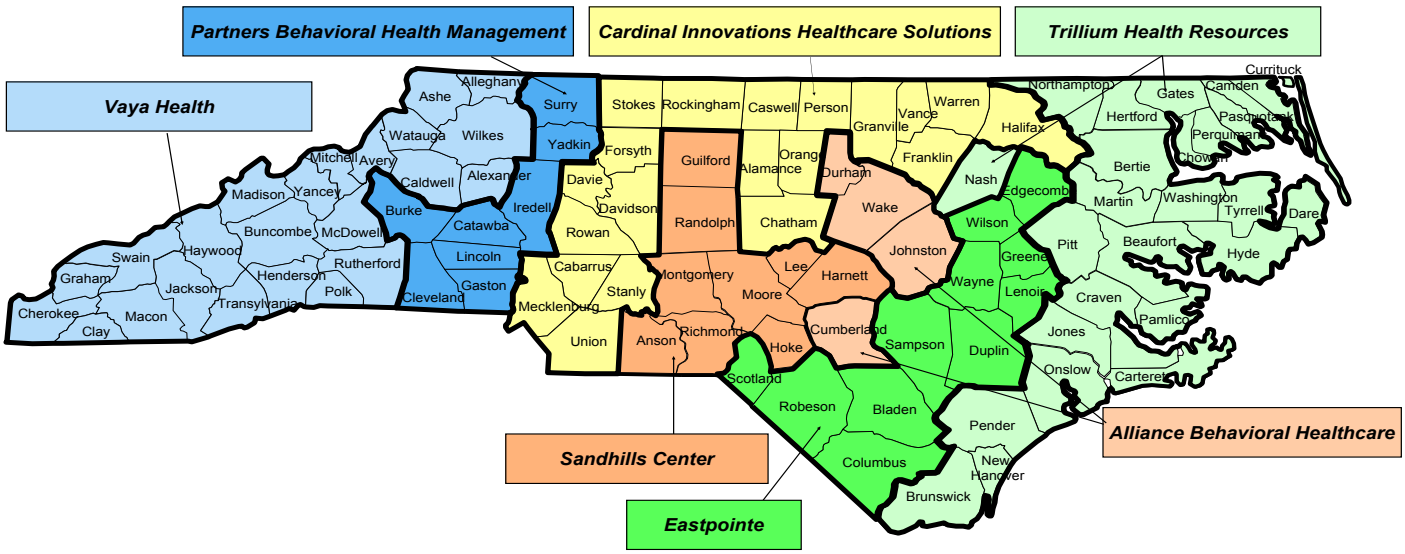

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The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) of the North Carolina Department of Health and Human Services is the Single State Agency for the Substance Abuse Prevention and Treatment (SAPT) Block 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 six sections, each of which contains one or more teams. The structure is slightly more functional in nature, although there are disability-specific teams/sections as well.

Please see the **DMH/DD/SAS organizational chart** in the Attachments section.

The Deputy Director's office, currently being recruited for after the long time Deputy Director Flo Stein retired in June 2017, is responsible for the three sections primarily involved in prevention, early intervention, and treatment and recovery services for individuals with or at risk of a substance use disorder. Those sections consist of the Addictions and Management Operations team, the Community Wellness, Prevention and Health Integration team and the Justice Systems Innovations team.

The Community Services and Supports section is headed by an Assistant Director who provides oversight to the Community Mental Health team, the Intellectual/Developmental Disabilities and Traumatic Brain Injuries team and the Transitions to Community Living Initiative (Department of Justice settlement agreement) team.

The Assistant Director of Quality and Operations section oversees the Quality Management team, the Project Management section, the LME/MCO team and the Policy and Audit team.

The Division's Medical Director heads the Clinical Policy and Customer Services sections.

The Consumer Empowerment section provides consumer advocacy leadership and ensures that state-operated healthcare facilities and community-based systems are in compliance with rights protection for individuals served through the system. This section and the Financial Operations section both report directly to the Division Director. The Financial Operations section is responsible for fiscal monitoring, accountability and regulatory compliance, support of information technology

and contracts management. It is made up of the Information Systems/Data Team, Finance and Budget team and the Financial Contracts team.

The Community Mental Health, Addictions and Management Operations, Clinical Policy and Intellectual/Developmental Disabilities sections have staff with expertise in each of the populations of focus, who are further specialized along the developmental stages of early childhood (0-5), later childhood (6-12), youth (13-17) and adulthood. The section also has a designated Housing Specialist who provides oversight to Housing Specialists at each LME/MCO, in addition to staff with expertise in evidence-based practices and peer support.

Within DMH/DD/SAS, the substance abuse primary prevention services is currently housed in the Community Wellness, Prevention and Health Integration Team. This team is comprised of the Section Chief, and 10 staff that are responsible for substance abuse prevention including underage drinking, the Partnership for Success 2013 grant focusing on prescription drug use/misuse, prevention components of the Opioid STR grant, Strategic Prevention Framework – Prescription Drugs, Tobacco Prevention and Cessation/FDA compliance and Mental Health Promotion/Early Intervention including Suicide Prevention. The Substance Abuse Prevention Block Grant Manager is responsible for overseeing the overall management of the Substance Abuse Prevention Block Grant including programmatic and financial compliance, monitoring and reporting, training and technical assistance, interagency relationships, coordination and planning, needs assessment and the utilization of evidenced based programs, policies and practices.

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 and two field staff who provide technical assistance and monitoring of the more than 60 opioid treatment programs in North Carolina, a recovery-oriented systems of care specialist and an adolescent services specialist. Additional staff function as Project Director's for several federal discretionary grants, such as Access to Recovery, Medication Assisted Treatment-Prescription Drug and Opioid Abuse and the Opioid State Targeted Response/Cures grant.

The Justice Systems Innovations Team is responsible for DWI services, the Controlled Substances Reporting System, North Carolina's prescription drug monitoring program, and criminal and juvenile justice programming, such as TASC and the Juvenile Justice Substance Abuse and Mental Health Partnership (JJSAMHP).

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

occurred since then, resulting to date in seven (7) LME/MCOs covering all 100 counties. DMH/DD/SAS and the Division of Medical Assistance (the state Medicaid agency) jointly administer the LME/MCOs. The Division is primarily responsible for the oversight of services delivered by Local Management Entities/Managed Care Organizations (LME/MCOs), as they are the Division's intermediaries at the local level.

Please see the map in the Attachments section for the counties covered by each LME/MCO.

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 therapies, 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 a recovery community organization that works with several funded and grass-roots recovery community centers and collegiate recovery programs. Utilization of peer supports, recovery coaching and mentoring are becoming more embedded in services as integral components of treatment and recovery success.

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. We will utilize the funds to further implement the comprehensive strategies identified in the Action Plan to reduce opioid addiction and overdose death.

The continuum further includes evidence-based practices included in the state's Medicaid-reimbursable service definitions, such as Therapeutic Foster Care, Multi-Systemic Therapy and Family Functional Therapy for children and youth and Assertive Community Treatment, Supported Housing and Supported Employment. Other evidence-based practices are provided via existing service definitions by some LME/MCOs. For example, an ACT team may implement an integrated dual disorders treatment model to better serve individuals with co-occurring mental illness and addiction. Seeking Safety or trauma-informed cognitive behavioral therapies may be utilized under the SAIOP or SACOT service definition for those individuals who have experienced trauma in their lives. LME/MCOs have also developed and implemented, with DMH/DD/SAS approval, alternate service definitions such as peer and recovery supports, transition services, and wellness and living skills, to create a more robust continuum of care. Telehealth/telemedicine is utilized in areas that have shortages of therapists and/or psychiatrists. The Division also supports recovery supports services through several discretionary grants such as Access to Recovery, Medication-Assisted Treatment – Prescription Drug and Opioid Addiction and the Opioid STR grants.

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.

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, initiatives for preventing underage drinking, etc.

DMH/DD/SAS receives funds from the General Assembly, and utilizes block grant funds, for crisis services (mobile crisis teams, walk-in crisis and psychiatric after-care and crisis intervention teams) geared towards the reduction of hospitalizations, use of emergency department services and jail diversion for people with substance use and mental health disorders.

The United States Department of Commerce (2015) reports that North Carolina is home to the third largest active military population in the country. This population is comprised of each branch of the military: Army, Marines, Navy, Air Force and Coast Guard. An additional 45,000 soldiers, marines, and airmen and women live in all 100 counties of North Carolina and serve in the National Guard or Reserves. North Carolina's veteran population is even larger, consisting of nearly 800,000 veterans, placing the state eighth in veteran population in the country. 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).*

North Carolina DHHS, Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) through the Governor's Working Group on Veterans, Servicemembers and their Families (www.ncgwg.org), which is housed in the Governors Institute on Substance Abuse, coordinates on various initiatives that address Veterans, Servicemembers and their families. This monthly working group, held at the NC National Guard Joint Force Headquarters, 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.

In 2008, SAMHSA invited representatives of state mental health and substance abuse agencies to join with the Department of Defense (DOD) and the Department of Veterans Affairs (VA) to begin to construct a behavioral health response for combat veterans returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). Upon returning from this initial national summit, DMH/DD/SAS, with the approval of the NC DHHS, initiated work utilizing a strategic plan that strengthens collaboration, coordination and resource sharing between the State of North Carolina, federal military partners and service members and their families.

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, legal and financial services and benefits for veterans. In 2014, then Governor Pat McCrory charged the Working Group "with facilitating collaboration and coordination among ALL federal, state and local agency partners that touch a veteran's life in the state of North Carolina."

The Working Group promotes evidence-based practices in the screening, assessment and treatment of active and reserve components, veterans and military family members in North Carolina, including traumatic brain injury (TBI). It successfully competed to participate in three national policy academies supported by SAMHSA where the team works with national leaders to continually refine the North Carolina Plan. The North Carolina process to support veterans has received national recognition and has provided technical assistance to many other states.

Collaborative efforts include *Operation Home: Ending Veterans Homelessness Task Force*, NC Student Transitional Resource Initiative for Veterans Education (NC STRIVE) and the upcoming NC Practice Improvement Collaborative (NC PIC) on reducing Veterans Suicide.

Through town hall meetings, focus groups and Regional Networking meetings, the state determined the need for a more accurate, consistent and efficient reporting and monitoring system that will assist us with more accurate reporting on consumers served and services delivered. We have contracted with Prospectus Group to utilize their ECCO system for capturing implementation plans and reporting. We are also in the process of making sure that policies and procedures for the delivery of primary prevention services are communicated consistently, have been published and have support through the North Carolina Training and Technical Assistance Center (NCTTA). NCTTA was formed in 2016 to replace the Centers for Prevention Resources (CPRs), which provided funds to four prevention providers to support substance use prevention training across the state. NCTTA is independent of provider agencies and provides coordinated training and technical assistance across the state.

Strengths of the state' s substance abuse prevention program include long and strong relationships with the NC Commission on Indian Affairs, NC Department of Public Instruction, NC Office of Juvenile Justice and Delinquency Prevention, NC Teen Pregnancy Prevention Program, NC Department of Social Services, NC Office of Youth Advocacy, NC Highway Safety Program , Wake Forest University, East Carolina University, Research Triangle Institute, Pacific Institute for Research and Evaluation Southeast CAPT, CADCA and statewide substance abuse prevention partnerships, alliances, collaboratives and coalitions who have contributed time, resources, effort, and passion to ensure the

delivery of quality and effective substance abuse prevention services to youth, their families and communities.

We in North Carolina are transitioning our system from one that primarily serves selective and indicated North youth populations through prevention education to one that utilizes the Strategic Prevention Framework to assess local needs, build community capacity, plan strategically, and implement evidence-based strategies for the prevention of alcohol, tobacco, and other drugs, with a majority of funds expended for universal, population-based strategies. To that end we have recently developed a data dashboard, providing administrative data for all 100 counties, and also administered a statewide youth prevention survey. For FY2018 we have newly issued a contract for evaluation services.

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

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

- ***Governor's Institute on Substance Abuse*** – the primary objective of this contract is to increase access to and improve the quality of services provided in the state by: (1) expanding the use of evidence-based/best practices; (2) promoting the integration of behavioral healthcare with primary healthcare in two regions of North Carolina and the rest of the state; (3) improving physician understanding of addictions; and (4) enhancing the quality of the workforce and provider agencies in the state, with a special emphasis on service members, veterans and their families. Of note, the Governor's Institute focuses on training and education of physicians and other medical staff providing SUD treatment services, particularly in opioid treatment programs. It hosts the annual Addiction Medicine Conference with an attendance of over 300 participants each year, some from as far away as Canada.

- ***Oxford House, Inc.*** – this contract allows for the continuation of substance use recovery home management services by opening new houses, administering loans and serving and

mentoring re-entering substance users in their transition from incarceration. There are currently over 240 homes in North Carolina with more than 1800 beds. This past year, 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 (NC TOPPS) which allows Local Management Entities/Managed Care Organizations (LME/MCOs) and their contracted network service providers to submit initial and periodic updates, as well as episode completion interview information for all consumers within specified substance abuse and mental health populations. Data entered into the system is then used in developing accountability measures for both the Mental Health and Substance Abuse Block Grants.

- ***University of North Carolina, School of Social Work, Springboard*** - the primary goal of this contract is to increase access to and improve the quality of prevention, treatment and recovery support services by: (1) expanding the use of prevention, treatment and recovery support services for substance abuse that demonstrate success in improving outcomes and/or supporting recovery; (2) enhancing the quality of the workforce providing prevention, treatment and recovery support services; (3) enhancing the ability of provider agencies to determine the ongoing effectiveness of substance abuse 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 provides monitoring and oversight of HIV-Early Intervention Services provided through contractual agreements with the LME/MCOs and the Division of Public Health.

- ***NC Substance Abuse Professional Practice Board*** – The NC Substance Abuse Professional Practice Board (NCSAPPB) will continue to register, certify, approve and issue associate-level licensed clinical addictions specialists and credentialed substance abuse professionals in accordance with state and federal requirements to improve substance abuse related services for consumers throughout North Carolina.

- ***NC Division of Public Health*** – this multi-year inter-departmental agreement augments HIV/Early Intervention Services provided through contracts with the LME/MCOs and is integral to North Carolina's adherence to the requirements for HIV designated states. The Division of Public Health provided testing, counseling services and therapeutic interventions to nearly 5000 individuals in SFY15.

- ***Alcohol/Drug Council of North Carolina*** – this contract provides information and referral services, as well as public education related to substance use and addiction across the entire state. This agency is also responsible for the Perinatal Substance Use Project, which includes

screening, telephone hot-line, information and appropriate referrals for women throughout North Carolina who are pregnant or parenting and using substances. The project provides information on bed availability for substance use services in the NC Perinatal/Maternal and CASAWORKS Initiative 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.

Recovery Communities of North Carolina (RCNC) – this is a relatively new contract for the Division which was initiated to increase the availability of, and access to, recovery support services for individuals pursuing their recovery. RCNC provides assistance and "mentoring" to other communities and groups that have expressed a desire to create their own recovery community center. They currently function as an umbrella recovery community organization to four recovery community centers across the state. Other areas of focus include recovery messaging training and delivery of the CCAR peer support curriculum for individuals pursuing certification as a peer support specialist.

- ***UNC – General Administration*** – this vendor provides fiscal oversight to six (6) universities that receive funding for collegiate recovery programs and services. This initiative was established by then Governor McCrory in 2015 due to concerns over alcohol consumption by college students and the need to provide a college atmosphere that is not "recovery hostile." Collegiate recovery programs have been developed at the following schools: UNC-Charlotte, UNC-Chapel Hill, UNC-Greensboro, UNC-Wilmington, East Carolina University and NC A&T.

- ***Addiction Professionals of North Carolina (APNC)*** – this contract was executed to advance policy, services, and professional development that reflect the highest standards of the prevention and treatment profession, strengthen its value to the community and promote the values of its members. This agency also employs a Collegiate Recovery Program Coordinator that works directly with the above six campuses on collegiate recovery programming and sustainability, as well as other grass roots collegiate recovery programs in several other universities, colleges and community colleges across North Carolina.

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 behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state?s behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state?s unique data system (including community-level data), as well as SAMHSA?s data sets including, but not limited to, the **National Survey on Drug Use and Health** (NSDUH), the **Treatment Episode Data Set** (TEDS), the **National Facilities Surveys on Drug Abuse and Mental Health Services**, the annual **State and National Behavioral Health Barometers**, and the **Uniform Reporting System** (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorderprevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the **National Survey of Substance Abuse Treatment Services** (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the **Behavioral Health Barometers**. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the **Healthy People Initiative**[1] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[1] **http://www.healthypeople.gov/2020/default.aspx**

Footnotes:

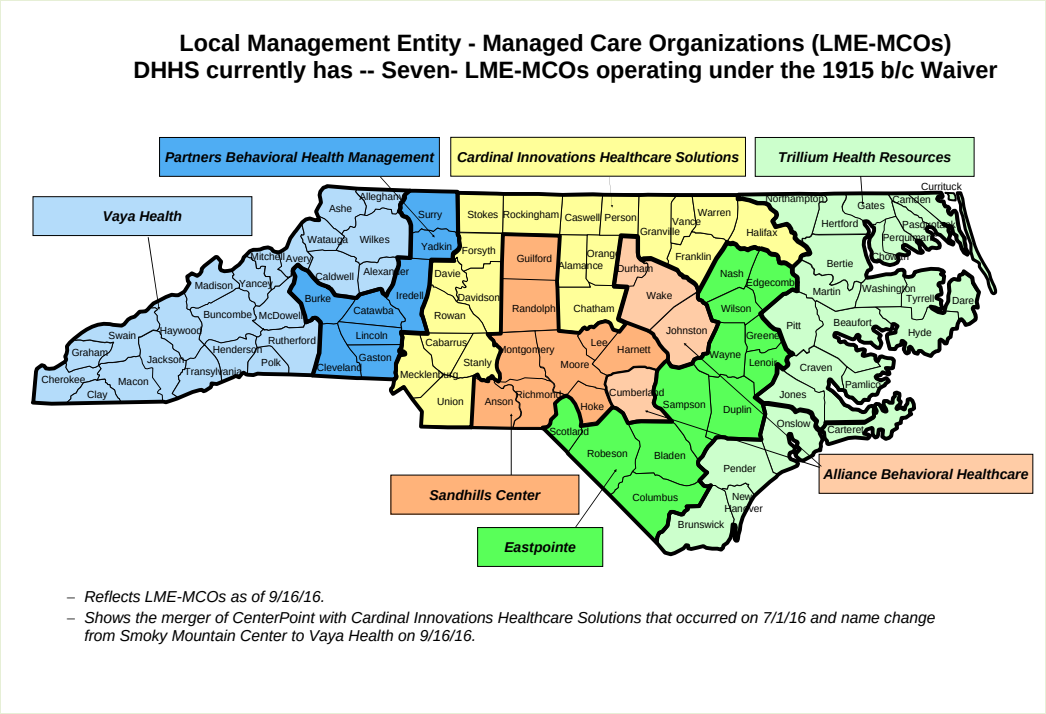
2016 Community Mental Health, Substance Use and Developmental Disabilities Services Needs and Gaps Analysis

Nothing Compares
NORTH CAROLINA

Carol G. Potter, DMH/DD/SAS, Quality Management Section

Why do Annual Gaps Analysis?

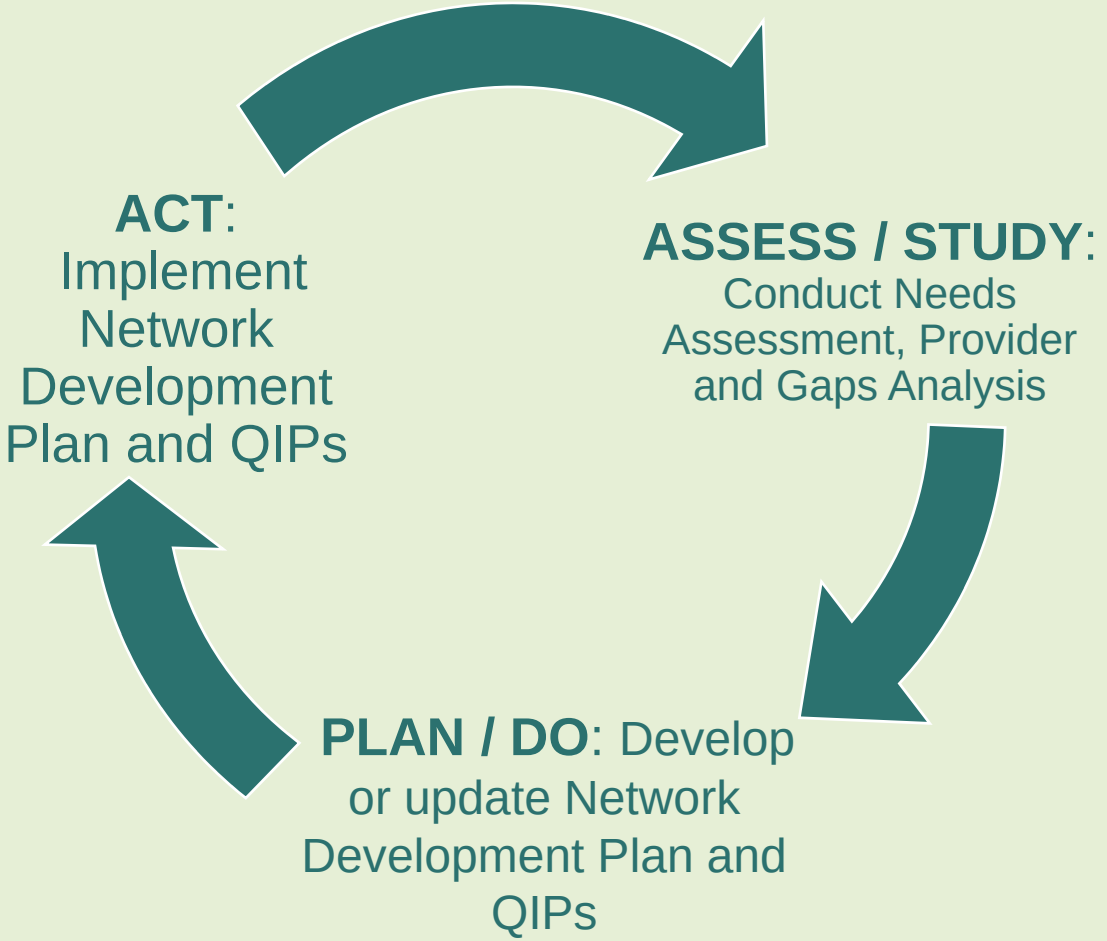
Centers for Medicare & Medicaid Services – CMS - mandates it



LME/MCOs responsible for

- DMA and DMH/DD/SAS contractual requirements about publicly-funded behavioral health services;
- ensuring service coverage for catchment area;
- ensuring services are accessible;
- ensuring individuals have choices;
- addressing needs of underserved and special populations; and
- meeting community stakeholders' needs.

Part of LME/MCO Strategic Planning and Quality Improvement Cycle



Process for SFY 2016 LME/MCO Gaps Analyses

- Joint annual initiative between Division of Medical Assistance (DMA) and Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS)
- DMA requires gaps analyses consistent with Centers for Medicare & Medicaid Services (CMS)
- LME/MCOs gathered input from consumers, family members, providers and stakeholders about community and service needs and priorities

Service Categories for SFY 2016 Gaps Requirements

- Outpatient services
- Location-based services
- Community/ mobile services
- Crisis
- Inpatient services
- Specialized services

Outpatient Services

Can include

- psychiatric and biopsychosocial assessment
- medication management
- individual, group, and family therapies, psychotherapy for crisis
- psychological testing

Location-based Services

- Psychosocial Rehabilitation
- Child and Adolescent Day Treatment
- SA Comprehensive Outpatient Treatment Program
- SA Intensive Outpatient Program
- Opioid Treatment
- Day Supports
- Adult Developmental Vocational Program

Community/ Mobile Services

- Assertive Community Treatment Team
- Community Support Team
- Intensive In-Home
- Mobile Crisis
- Multi-systemic Therapy
- Home-based I/DD Services
- (b)(3) MH/I/DD Supported Employment Services
- (b)(3) Waiver Community Guide
- (b)(3) Waiver Individual Support (Personal Care)
- (b)(3) Waiver Peer Support
- (b)(3) Waiver Respite
- I/DD Supported Employment Services (Innovations)
- I/DD Supported Employment Services (State-funded)
- MH/SA Supported Employment Services (IPS-SE) (State-funded)
- Developmental Therapies (State-funded)

Inpatient Services

- Inpatient Hospital -- Adult
- Inpatient Hospital – Adolescent/Child

Crisis Services

- Facility-Based Crisis
- Respite
- Detoxification (non-hospital)

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Specialized Services

- Partial Hospitalization
- MH Group Homes
- Psychiatric Residential Treatment Facility
- Residential Treatment Levels 1-4
- Child MH Out-of-home respite
- SA Non-Medical Community Residential Treatment
- SA Medically Monitored Community Residential Treatment
- SA Halfway Houses
- I/DD Group Homes and AFLs
- I/DD Out-of-home respite
- I/DD Facility-based respite
- Intermediate Care Facility/IDD

Who Travels?

Individual travels to provider site for

- Outpatient services
- Location-based services
- Crisis services
- Inpatient services
- Specialized services

Provider travels to community or individual's home for Community and Mobile services

2016 Access and Choice Standards

- Outpatient services
  - DMA and DMH/DD/SAS: 100% of enrollees have choice of two providers within 30/45 miles of their residences
- Location-based services
  - DMA: 100% of enrollees have choice of two providers within 30/45 miles of their residences
  - DMH/DD/SAS: 100% of consumers have at least one provider within 30/45 miles of their residences
- Community/ mobile services
  - DMA: 100% of enrollees have choice of two provider agencies within the LME-MCO catchment area
  - DMH/DD/SAS: 100% of consumers have access to at least one provider agency within the LME-MCO catchment area

2016 Access and Choice Standards

- Crisis
  - Medicaid and State-funded standards: 100% have access to at least one provider for each crisis service within the catchment area.
- Inpatient services
  - Medicaid and State-funded standards: 100% have access to at least one provider for each service within the catchment area.
- Specialized services
  - Medicaid and State-funded standards: 100% have access to at least one provider for each service.

SFY 2016 Access to and Choice of Providers for Outpatient Mental Health, Substance Use Disorder or Developmental Disabilities Services

Service by Rural/ Urban and Age Group	Medicaid Enrollees with Choice of Two in 30/45 Miles	DMA Total Enrollees	DMA Percent	DMH/DD/SAS Consumers with Choice of Two in 30/45 Miles	DMH/DD/ SAS Total Consumers	DMH/DD/ SAS Percent
Outpatient-reside in urban counties	910,825	910,906		100,194	100,296	
Outpatient-reside in rural counties	224,156	234,188		33,965	34,177	
Outpatient-adults	520,418	525,727		124,761	125,062	
Outpatient-children	614,558	619,367		9,400	9,413	
Total for Outpatient Services	1,134,976	1,145,094	**99.12%**	134,161	134,475	**99.77%**

SFY 2016 Access to and Choice of Providers of Location-Based Mental Health, Substance Use Disorder or Developmental Disabilities Services

Services	Medicaid Enrollees with Choice of Two in 30/45 Miles	DMA Total Enrollees	DMA Percent	DMH/DD/SAS Consumers with One in 30/45 Miles	DMH/DD/ SAS Total Consumers	DMH/DD/ SAS Percent
Psychosocial Rehabilitation	575,700	601,624	**95.69%**	89,798	95,629	**93.90%**
Child and Adolescent Day Treatment	647,210	691,156	**93.64%**	41,910	42,406	**98.83%**
SA Comprehensive Outpatient Treatment Program	875,715	1,145,093	**76.48%**	52,118	68,102	**76.53%**
SA Intensive Outpatient Program	1,112,748	1,145,093	**97.18%**	67,823	68,102	**99.59%**
Opioid Treatment	311,718	601,623	**51.81%**	22,332	67,851	**32.91%**
Day Supports	1,138,069	1,145,093	**99.39%**	42,760	43,218	**98.94%**
Adult Developmental Vocational Program (not a Medicaid service)	N/A	N/A	N/A	44,733	44,746	**99.97%**

SFY 2016 Location-Based Services, continued

NOTE: Data was submitted by LME/MCOs in their 4/1/2016 gaps analysis reports and percentages calculated according to instructions provided by DMA and DMH/DD/SAS. For Medicaid, the denominator was the number of adult, child or total enrollees for the reporting period (7/1/2014-6/30/2015) who were age-appropriate for each location-based service according to the chart to the right. The numerator was the number of adult, child or total Medicaid enrollees during the reporting period with choice of two providers of each service within 30 (urban) or 45 (rural)miles of their residences. For each state-funded location-based service in the chart to the right, the denominator was the total number of people in the same age-disability group(s) who received any state-funded service during the reporting period (7/1/2014-6/30/2015). The numerator was the number of consumers from the denominator with access to at least one provider for each location-based service within 30/45 miles of their residences.

Location-based Services	DMA		DMHDDSAS					
	Adult ≥ 18	Child <18	Adult ≥18 MH	Child <18 MH	Adult ≥18 SUD	Child <18 SUD	Adult ≥18 I/DD	Child <18 I/DD
Psychosocial Rehabilitation	✓		✓					
Child and Adolescent Day Treatment		✓		✓		✓		
SA Comprehensive Outpatient Treatment Program	✓	✓			✓	✓		
SA Intensive Outpatient Program	✓	✓			✓	✓		
Opioid Treatment	✓				✓			
Day Supports	✓	✓					✓	✓
Adult Developmental Vocational Program							✓	✓

SFY 2016 Access to and Choice of Providers of Community/Mobile Mental Health, Substance Use Disorder or Developmental Disabilities Services

Service	Medicaid Enrollees with Choice of Two in Catchment	Medicaid Total Enrollees	Medicaid Percent	DMH/DD/SAS Consumers with One in Catchment	DMH Total Consumers	DMH/DD /SAS Percent
Assertive Community Treatment Team	601,624	601,624	**100%**	95,629	95,629	**100%**
Community Support Team	601,624	601,624	**100%**	117,955	117,955	**100%**
Intensive In-Home	691,155	691,155	**100%**	42,470	42,470	**100%**
Mobile Crisis	1,066,653	1,145,094	**93%**	129,726	129,726	**100%**
Multi-systemic Therapy	546,304	691,155	**79%**	42,470	42,470	**100%**
Home-based I/DD Services	1,145,093	1,145,093	**100%**	44,746	44,746	**100%**
(b)(3) MH/SA Supported Employment Services	221,145	221,145	**100%**	Medicaid only	Medicaid only	Medicaid only
(b)(3) I/DD MH/SA Supported Employment Services	299,586	299,586	**100%**	Medicaid only	Medicaid only	Medicaid only

SFY 2016 Community/Mobile Services, continued

Service	Medicaid Enrollees with Choice of Two in Catchment	Medicaid Total Enrollees	Medicaid Percent	DMH/DD/SAS Consumers with One in Catchment	DMH Total Consumers	DMH/DD /SAS Percent
(b)(3) MH Supported Employment Services	30,448	30,448	**100%**	Medicaid only	Medicaid only	Medicaid only
(b)(3) I/DD Supported Employment Services	30,448	30,448	**100%**	Medicaid only	Medicaid only	Medicaid only
(b)(3) MH/I/DD Supported Employment Services	815,060	815,060	**100%**	Medicaid only	Medicaid only	Medicaid only
(b)(3) Waiver Community Guide	1,145,094	1,145,094	**100%**	Medicaid only	Medicaid only	Medicaid only
(b)(3) Waiver Individual Support (Personal Care)	1,145,094	1,145,094	**100%**	Medicaid only	Medicaid only	Medicaid only
(b)(3) Waiver Peer Support	1,145,094	1,145,094	**100%**	Medicaid only	Medicaid only	Medicaid only
(b)(3) Waiver Respite	1,145,094	1,145,094	**100%**	Medicaid only	Medicaid only	Medicaid only
I/DD Supported Employment Services (Innovations)	1,145,094	1,145,094	**100%**	Medicaid only	Medicaid only	Medicaid only

SFY 2016 Community/Mobile Services, continued

Service	Medicaid Enrollees with Choice of Two in Catchment	Medicaid Total Enrollees	Medicaid Percent	DMH/DD/SAS Consumers with One in Catchment	DMH Total Consumers	DMH/DD /SAS Percent
I/DD Supported Employment Services (State-funded)	State-funded	State-funded	State-funded	44,746	44,746	**100%**
MH/SA Supported Employment Services (IPSSE) (State-funded)	State-funded	State-funded	State-funded	117,955	117,955	**100%**
Developmental Therapies (State-funded)	State-funded	State-funded	State-funded	43,653	44,746	**98%**

NOTE: Data was submitted by LME/MCOs in their 4/1/2016 gaps analysis reports and percentages calculated according to instructions provided by DMA and DMH/DD/SAS. For Medicaid for the reporting period (7/1/2014-6/30/2015), use as the denominator the number of adult, child or total enrollees age-appropriate for each specific service according to the chart below for community/mobile services. The numerator is the number of adult, child or total Medicaid enrollees during the reporting period with choice of two providers within the LME/MCO catchment area for each specific service. For each state-funded community/mobile service (see chart below), use as the denominator the total number of people in the same age-disability group(s) who received any state-funded service during the reporting period (7/1/2014-6/30/2015). The numerator is the number of consumers from the denominator with access to at least one provider within the LME/MCO catchment area.

SFY 2016 Community/Mobile Services, continued

Community/Mobile Services	DMA		DMHDDSAS					
	Adult ≥18	Child <18	Adult ≥18 MH	Child <18 MH	Adult ≥18 SUD	Child <18 SUD	Adult ≥18 I/DD	Child <18 I/DD
Assertive Community Treatment Team	✓		✓					
Community Support Team	✓		✓		✓			
Intensive In-Home		✓		✓		✓		
Mobile Crisis	✓	✓	✓	✓	✓	✓	✓	✓
Multi-systemic Therapy		✓		✓		✓		
Home-based I/DD Services	✓	✓					✓	✓
(b)(3) MH/I/DD Supported Employment Services	✓	✓						
(b)(3) Waiver Community Guide	✓	✓						
(b)(3) Waiver Individual Support (Personal Care)	✓	✓						
(b)(3) Waiver Peer Support	✓	✓						
(b)(3) Waiver Respite	✓	✓						
I/DD Supported Employment Services (Innovations Waiver)	✓	✓						
I/DD Supported Employment Services (state-funded)							✓	✓
MH/SA Supported Employment Services (IP-SE; state-funded)			✓		✓			
Developmental Therapies (state-funded)							✓	✓

SFY 2016 Access to and Choice of Providers

- Crisis services
  - When LME/MCOs reported having a contract with at least one facility in the catchment area for each service, they met the standard
  - Facility Based Crisis
  - Respite
  - Detoxification (non-hospital)

- Inpatient services
  - Adolescent/child
  - Adult

- Specialized services

SFY 2016 Needs and Gaps Identified by Consumers, Family Members and Other Stakeholders

- LME/MCOs used a variety of methods to get input from consumers, family members and other stakeholders about needs and service gaps, then they reported on results of surveys and summarized the feedback.
- Reviewed consumer, family member and other stakeholder input found in the LME/MCO gaps analysis reports
- Grouped it by topic or concern
- Five primary categories emerged:
  - Access to care
  - Resources
  - Quality
  - Awareness
  - Other

Questions?

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NORTH CAROLINA OPIOID STR GRANT

TI080257

NEEDS ASSESSMENT

JULY 30, 2017

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NEEDS ASSESSMENT

NORTH CAROLINA OPIOID STR GRANT - TI080257

JULY 31, 2017

Introduction

Over the past several years, North Carolina 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 grant provides 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. The Secretary has appointed Dr. Susan Kansagra, Section Chief of the North Carolina Division of Public Health, Chronic Disease and Injury Section, to oversee and coordinate all activities within the DHHS related to the opioid crisis. 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 Medical Assistance (DMA), the Office of Rural Health (ORH) and the Office of Emergency Medical Services (OEMS). The Attorney General's office is also highly involved. Epidemiologic data available from the Injury and Violence Prevention Branch, Injury Epidemiology and Surveillance Unit (NC DPH) show that prescription opioid poisoning deaths increased by 256 percent between 2000 and 2015 while deaths from heroin overdoses increased by 800 percent, indicating that the state, like the rest of the country, is facing a problem of epidemic proportions.

North Carolina is comprised of 100 counties. Each county is covered by a local management entity-managed care organization (LME-MCO) that acts as the Division's intermediary for the management of public funds for substance use, mental health and intellectual and developmental disability needs. Each of the seven (7) LME-MCO receives state and federal block grant dollars, as well as federal discretionary funds, which are distributed via contract to community agencies that have been credentialed by the LME-MCO. Each LME-MCO is responsible for completing an annual needs and gaps analysis that, in conjunction with gaps identified by DMHDDSAS, functions as a guide for targeting areas in need of services and supports.

I. Summarize the most recent annual data obtained from the state's Prescription Drug Monitoring Program (PDMP)

North Carolina has been cited as one of the more progressive states in the nation for the laws it has enacted in response to the opioid crisis. It has a Prescription Drug Monitoring Program known as the North Carolina Controlled Substances Reporting System (CSRS) that keeps electronic records on controlled substances dispensed by pharmacies and other prescribers. Mandated by the state in 2005, the PDMP law was revised in 2013 to allow unsolicited alerts to physicians, pharmacists and the NC Medical Board. In 2015, the CSRS reported the dispensing of 9,383,417 prescription drugs to 2,166,634 patients across the state. More than 25,000 practitioners in the state have registered with the NC CSRS.

In late June 2017, Governor Roy Cooper signed House Bill 243, the STOP Act, into law in a ceremony at the North Carolina State Capitol. The STOP Act, which stands for Strengthen Opioid Misuse Prevention Act, seeks to help curb epidemic levels of opioid drug addiction and overdose in North Carolina through several key provisions. Those specific to PDMP include:

- Strengthening oversight and tightening supervision on opioid prescriptions;
- Requiring prescribers and pharmacies to check the prescription database before prescribing opioids to patients; and
- Instituting a five-day limit on initial prescriptions for acute pain, with exemptions for chronic pain, cancer care, palliative care, hospice care, or medication-assisted treatment for substance use disorders.

Most recent data from the NC CSRS specific to the numbers of opioid and benzodiazepines prescriptions are shown below:

North Carolina				
Number of Counties	**Sum of Opioid Rx**	**Sum of Benzo Rx**	**Sum of Opioid Rx Per 100,000**	**Sum of Benzo Rx Per 100,000**
100	8,212,108	4,662,085	9,372	5,042

Attachment 1 illustrates the rates of opioid and benzodiazepine prescriptions by each North Carolina County per 100,000 persons. A synopsis of the top 10 counties per rates of opioid and benzodiazepine prescriptions per 100,000 people and the LME-MCO service area each county is located in is as follows:

Opioid Prescriptions

Ranking	**County**	**Sum of Opioid Rx**	**Sum of Opioid Rx Per 100,000**	**LME-MCO**
1	Columbus	89,225	158	Eastpointe
2	Swain	22,424	156	Vaya Health
3	Richmond	69,229	154	Sandhills Center
4	Scotland	52,056	148	Eastpointe
5	Robeson	185,439	139	Eastpointe
6	McDowell	60,139	133	Vaya Health
7	Rutherford	87,378	132	Vaya Health
7	Caldwell	107,707	132	Vaya Health
9	Rockingham	119,394	131	Cardinal Innovations
10	Mitchell	19,295	128	Vaya Health

Benzodiazepine Prescriptions

Ranking	**County**	**Sum of Benzo Rx**	**Sum of Benzo Rx Per 100,000**	**LME-MCO**
1	Rockingham	88,361	97	Cardinal Innovations
2	Stokes	41,576	90	Cardinal Innovations

3	Surry	63,213	88	Partners Behavioral Health Management
4	Yadkin	31,794	85	Partners Behavioral Health Management
5	Rutherford	54,238	82	Vaya Health
6	Mitchell	11,052	73	Vaya Health
7	Burke	63,490	72	Partners Behavioral Health Management
7	Graham	6,196	72	Vaya Health
9	Wilkes	48,407	70	Vaya Health
10	Alleghany	7,482	69	Vaya Health

The tables above illustrate that the highest rates of prescribed opioids are primarily in the western and southeastern parts of the state, while the highest rates of benzodiazepine prescriptions are in the western and north central areas of the state.

As stated earlier, the recently enacted STOP Act provides for more reporting requirements, as well as adds limitations to the length and number of opioid prescriptions, which we believe will have a positive impact on prescribing practices. Additionally, funding was designated in North Carolina's Opioid STR proposal to augment and expand some of the capacities of the CSRS, including the dissemination of CSRS data on a monthly basis to all 100 counties in the state.

II. Summarize the most recent annual data available for opioid-involved overdose deaths

The table below illustrates data obtained from the Medical Examiner's office through the Injury and Violence Prevention branch of DPH and includes deaths with any mention of opium, heroin, other opioids, methadone and/or other synthetic opioid and unintentional intent. It ranks these ten counties from highest to lowest based on the average number of deaths per 100,000 people in 2013, 2014 and 2105.

		Deaths			Population Per County			Death Rates Per 100,000			
Ranking	**County**	**2013**	**2014**	**2015**	**Jul 2013**	**Jul 2014**	**Jul 2015**	**2013**	**2014**	**2015**	**Ave 2013 - 2015**
1	Wilkes	17	26	23	70,076	69,817	69,784	24.3	37.2	33.0	31.5
2	Burke	17	17	28	89,604	89,184	88,786	19.0	19.1	31.5	23.2
3	Yadkin	7	11	5	38,160	38,023	37,885	18.3	28.9	13.2	20.2
4	Brunswick	26	18	23	114,882	118,634	121,744	22.6	15.2	18.9	18.9
5	Pamlico	0	3	4	13,320	13,071	13,067	0.0	23.0	30.6	17.7
6	Richmond	4	7	11	46,253	46,030	45,988	8.6	15.2	23.9	15.9
7	Stokes	6	3	13	46,859	46,409	46,059	12.8	6.5	28.2	15.8
8	Carteret	7	12	13	69,138	70,101	70,911	10.1	17.1	18.3	15.2
9	Yancey	0	3	5	17,877	17,940	17,962	0.0	16.7	27.8	14.9
10	Rowan	15	20	26	138,251	139,161	139,457	10.8	14.4	18.6	14.6

Please see **ATTACHMENT 2** for a complete listing of deaths in all counties.

The next table below shows the top ten counties ranked according the number of prescription opioid poisoning deaths in 2015. There is some correlation between population size and ranking as the most populous counties in the list, Mecklenburg County and Wake County, with 2015 populations of more than one million, ranked first and second in the number of deaths from prescription opioid poisoning. Guilford County with a population estimate of 517,600 ranked seventh. Forsyth County and Cumberland County with population sizes above 300,000 ranked third and fifth respectively. However, counties with relatively small populations such as New Hanover in southeastern North Carolina (population size = 220,358), Brunswick, (population size = 122,765), and Burke (population size = 88,842) are also in the top ten list. In a report published in 2016, Castlight Health, a healthcare information company based in San Francisco, (http://www.starnewsonline.com/news/20160421/study---wilmington-no-1-in-opioid-abuse) cited Wilmington, a popular tourist destination in New Hanover County, as the city with the highest rate of opioid abuse in the entire nation. Counties with the smallest populations on the list are rural, predominantly white counties with relatively high poverty levels. Brunswick County abuts New Hanover while Burke is located in the western part of the state.

Also shown in the table below are percent changes between the year 2000 (when prescription opioid medications began to be more widely prescribed) and 2015. The county with the largest percent change between the two time periods is Brunswick County with a percent change of 567 percent followed by Mecklenburg County, with a percent change of 550 percent.

Counties with the Highest Number of Prescription Opioid Poisoning Deaths in 2015 and Percent Change between 2000 and 2015

County	# of Deaths in 2000	# of Deaths in 2010	# of Deaths in 2015	% Change 2000 - 2015
Mecklenburg	6	41	39	550%
Wake	8	31	38	375%
Forsyth	10	15	33	230%
New Hanover	7	22	32	357%
Cumberland	6	22	31	417%
Burke	7	14	30	329%
Guilford	10	21	29	190%
Brunswick	3	18	20	567%
Buncombe	9	16	19	111%
Statewide	234	717	854	256%

Source: http://www.injuryfreenc.ncdhhs.gov/DataSurveillance/poisoning/AllPrescriptionOpioidPoisoningDeathsbyCounty-1999-2015.pdf

Counties with the highest number of prescription opioid poisoning deaths tended to have the highest number of heroin deaths as well, as shown in the table immediately below.

Counties with the Highest Number of Heroin Poisoning Deaths in 2015 and Percent Change between 2000 and 2015

County	# of Deaths in	# of Deaths in	# of Deaths in	% Change

	2000	2010	2015	2000 - 2015
Mecklenburg	8	3	31	289%
Wake	2	2	30	1400%
Forsyth	2	1	23	1050%
New Hanover	2	3	23	1050%
Guilford	2	4	23	1050%
Cumberland	1	0	22	2100%
Burke	0	1	14	1300%
Buncombe	1	1	14	1300%
Brunswick	0	1	14	1399%
Statewide	41	79	369	800%

Source: http://www.injuryfreenc.ncdhhs.gov/DataSurveillance/poisoning/AllPrescriptionOpioidPoisoningDeathsbyCounty-1999-2015.pdf

III. Summarize the current availability of medication-assisted treatment

North Carolina currently has 61 opioid treatment programs that have completed full certification processes with a capacity of over 22,000 slots, with daily dosing averaging around 17,000 per day. The table below has the most current data available, with census figures reported either in December 2016 or June 2017. It is sorted by county with the LME-MCO responsible for that county also listed.

	Program Name	Census	Buprenorphine	Methadone	Vivitrol	County	LME-MCO
1.	ATS of North Carolina, LLC	583	Y*	Y	Y	Cumberland	Alliance Behavioral Healthcare
2.	BAART Community HealthCare	374	N	Y	N	Durham	Alliance Behavioral Healthcare
3.	Johnston Recovery Services	228	Y	Y	N	Johnston	Alliance Behavioral Healthcare
4.	Metro Treatment of North Carolina - Fayetteville	317	Y	Y	N	Cumberland	Alliance Behavioral Healthcare
5.	Metro Treatment of North Carolina - Durham	360	Y	Y	N	Durham	Alliance Behavioral Healthcare
6.	Morse Clinic - Zebulon	31	Y	Y	Y	Wake	Alliance Behavioral Healthcare
7.	RMTC - Raleigh Methadone Treatment Center	183	N	Y	N	Wake	Alliance Behavioral Healthcare
8.	SouthLight Healthcare	406	Y	Y	Y	Wake	Alliance Behavioral Healthcare
9.	Morse Clinic - North Raleigh	95	Y	Y	Y	Wake	Alliance Behavioral Healthcare

10.	Western Wake Treatment Center	54	Y	Y	N	Wake	Alliance Behavioral Healthcare
11.	Chatham Recovery	130	Y	Y	Y	Chatham	Cardinal Innovations Healthcare Solutions
12.	Insight Human Services	431	N	Y	N	Forsyth	Cardinal Innovations Healthcare Solutions
13.	Lexington Treatment Associates	794	N	Y	N	Davidson	Cardinal Innovations Healthcare Solutions
14.	McLeod Addictive Disease Center - Monroe	227	Y	Y	Y	Union	Cardinal Innovations Healthcare Solutions
15.	McLeod Addictive Disease Center - Charlotte	405	Y	Y	Y	Mecklenburg	Cardinal Innovations Healthcare Solutions
16.	McLeod Addictive Disease Center - Concord	684	Y	Y	Y	Cabarrus	Cardinal Innovations Healthcare Solutions
17.	Metro Treatment of North Carolina -Charlotte	377	Y	Y	N	Mecklenburg	Cardinal Innovations Healthcare Solutions
18.	Morse Clinic - Hillsborough		Y	Y	Y	Orange	Cardinal Innovations Healthcare Solutions
19.	Queen City Treatment Center	339	N	Y	N	Mecklenburg	Cardinal Innovations Healthcare Solutions
20.	Rowan Treatment Associates	527	N	Y	N	Rowan	Cardinal Innovations Healthcare Solutions
21.	Vance Recovery	231	Y	Y	Y	Vance	Cardinal Innovations Healthcare Solutions
22.	Winston Salem CTC		Y	Y	Y	Forsyth	Cardinal Innovations Healthcare Solutions
23.	ATS of North Carolina - Goldsboro	199	Y	Y	Y	Wayne	Eastpointe
24.	Lumberton Treatment Center	212	Y	Y	N	Robeson	Eastpointe
25.	Rocky Mount Treatment Center, LLC	149	Y	Y	N	Nash	Eastpointe
26.	Wilson Professional Services Treatment Center	206	Y	Y	N	Wilson	Eastpointe
27.	Addiction Recovery Medical Services	219	Y	Y	Y	Iredell	Partners Behavioral Health Management
28.	McLeod Addictive Disease Center - Hickory	559	Y	Y	Y	Catawba	Partners Behavioral Health Management
29.	McLeod Addictive Disease Center - Statesville	371	Y	Y	Y	Iredell	Partners Behavioral Health Management
30.	McLeod Addictive Diseases Center - Gastonia	576	Y	Y	Y	Gaston	Partners Behavioral Health Management
31.	Metro Treatment of North Carolina - Hickory	341	Y	Y	N	Catawba	Partners Behavioral Health Management

32.	Metro Treatment of North Carolina - Gastonia		Y	Y	N	Gaston	Partners Behavioral Health Management
33.	Alcohol and Drug Services East (ADS)	183	N	Y	N	Guilford	Sandhills Center
34.	ATS of North Carolina - Pinehurst	300	Y	Y	Y	Moore	Sandhills Center
35.	Crossroads Treatment Center of Greensboro, PC	460	N	Y	N	Guilford	Sandhills Center
36.	Metro Treatment of North Carolina - Greensboro	418	Y	Y	N	Guilford	Sandhills Center
37.	Sanford Treatment Center	268	Y	Y	N	Lee	Sandhills Center
38.	Coastal Horizons Center, Inc.	220	Y	Y	Y	New Hanover	Trillium Health Resources
39.	Elizabeth City Treatment Center	32				Pasquotank	Trillium Health Resources
40.	Greenville OTP	164				Pitt	Trillium Health Resources
41.	Greenville Recovery Center	205	N	Y	N	Pitt	Trillium Health Resources
42.	Jacksonville Treatment Center	330	Y	Y	N	Onslow	Trillium Health Resources
43.	Metro Treatment of North Carolina - Wilmington	417	Y	Y	N	New Hanover	Trillium Health Resources
44.	PORT Human Services	173	N	Y	N	Pitt	Trillium Health Resources
45.	PORT Human Services - New Bern	172	N	Y	N	Craven	Trillium Health Resources
46.	Walter B Jones Alcohol and Drug Abuse Treatment Center (WBJ/ADATC)	10	Y	Y	Y	Pitt	Trillium Health Resources
47.	ATS of North Carolina (Mountain Health Solutions - N Wilkesboro)	533	Y	Y	Y	Wilkes	Vaya Health
48.	ATS of North Carolina (Mountain Health Solutions - Asheville)	233	Y	Y	Y	Buncombe	Vaya Health
49.	BHG XXXVI	286	Y	Y	N	Buncombe	Vaya Health
50.	BHG XXXVII	165	Y	Y	N	Haywood	Vaya Health
51.	Carolina Medical Wellness Services, PC					Henderson	Vaya Health
52.	Counseling Solutions of Murphy, LLP	73				Clay	Vaya Health
53.	Crossroads Treatment Center of Asheville	576	N	Y	N	Buncombe	Vaya Health

54.	Crossroads Treatment Center of Weaverville, PC	160	N	Y	N	Buncombe	Vaya Health
55.	Katharos Sanctuary					Buncombe	Vaya Health
56.	McLeod Addictive Disease Center - Boone	191	Y	Y	N	Watauga	Vaya Health
57.	McLeod Addictive Disease Center - Marion	270	Y	Y	Y	McDowell	Vaya Health
58.	McLeod Addictive Disease Center - Lenoir	372	Y	Y	Y	Caldwell	Vaya Health
59.	Premier Treatment Specialists, LLC.	223	N	Y	N	Henderson	Vaya Health
60.	Stepping Stones Wellness Center, LLC	172	Y	Y	N	Watauga	Vaya Health
61.	Western Carolina Treatment Center	726	Y	Y	N	Buncombe	Vaya Health
	TOTALS	**16940**	**42**	**56**	**23**		

***Y = medication is available for patients, N = not available, shaded area is unknown at this time

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 OTPs 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 Treatment Authority, DMHDDSAS and is responsible for program approval, for monitoring compliance with the regulations related to scope of staff, and operations (10A NCAC 27G.3604).

North Carolina's OTPs are operated as either for-profit businesses or nonprofit organizations, and also includes one operated at one of three state-run facilities (Walter B. Jones Alcohol and Drug Abuse Treatment Center located in Greenville, North Carolina). Additionally, the Secretary of the North Carolina DHHS has instructed the remaining two state-run facilities to pursue certification as an OTP and implement those services as soon as possible, both for patients in the facilities, as well as potentially for individuals in the communities in need of medication-assisted treatment. Approximately half of the OTPs in North Carolina receive state and federal dollars; however, most are cash pay.

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 is a large number of office-based opioid treatment providers (OBOTs) in our state as well. We are currently in the process of developing a strategy to become knowledgeable of these practices and have encouraged LME-MCOs to open their networks to these certified providers in areas where an OTP does not exist but a need has been identified. Funds are designated in our Opioid STR grant to implement an ECHO training model, to include interested OBOTs, in an effort to encourage and support their practices. Please see **Attachment 3** for a listing all of the DATA 2000 certified practitioners in North Carolina, as generated by the DEA.

IV. Current programmatic capacity

The Division is obtains data from NC Tracks, which is our multi-payor claims system that processes state, federal and Medicaid paid claims. We capture fee-for-service data for publicly funded patients through billing of CPT and H-codes. Each state or federally funded patient is assigned a benefit plan with allowable services. However, each LME-MCO has some discretion in what services they cover. For example, most LME-MCOs reimburse for the dispensing of medication (H0020), however, due to limited funds, some LME-MCOs may only cover the cost of formal clinical treatment services; i.e., individual or group counseling and not the actual dispensing of methadone or buprenorphine. As such, we believe our claims data does not accurately represent the number of persons with an OUD currently served through the OTPs. We attempted to collect data from each OTP; however, only approximately half had responded as of the time of submission of this assessment. We will continue to determine other methods for collecting such information. Results of the survey by county are as follows:

NC OTP Consumers by County and Payer Category as of 06.30.17			
	29%	**71%**	
County of Residence	**# of Publicly Funded (Medicaid, State, Local)**	**# Privately Funded (Self-pay, Private Insurance)**	**Total Census**
Alamance	27	19	46
Alexander	5	35	40
Alleghany	1	2	3
Ashe	26	36	62
Avery	15	47	62
Beaufort	13	17	30
Bertie	1	1	2
Brunswick	8	2	10

Buncombe	134	825	959
Burke	56	75	131
Cabarrus	0	41	41
Caldwell	6	22	28
Camden	0	5	5
Carteret	3	3	6
Caswell	7	1	8
Catawba	124	102	226
Chatham	40	34	74
Cherokee	0	46	46
Chowan	0	3	3
Clay	0	7	7
Craven	148	19	167
Cumberland	5	678	683
Currituck	0	4	4
Dare	0	2	2
Davidson	2	553	555
Davie	4	49	53
Duplin	1	1	2
Durham	182	56	238
Edgecombe	4	62	66
Forsyth	7	113	120
Franklin	35	17	52
Gates	0	1	1
Gaston	2	0	2
Graham	0	5	5
Granville	47	29	76
Greene	0	3	3
Guilford	121	58	179
Halifax	1	7	8
Harnett	16	47	63
Haywood	12	44	56
Henderson	79	270	349
Hertford	1	2	3
Iredell	85	81	166
Jackson	2	4	6
Johnston	94	109	203
Jones	4	0	4
Lee	11	3	14
Lenoir	4	2	6
Lincoln	5	2	7
Macon	3	6	9
Madison	11	40	51

Martin	2	3	5
McDowell	76	73	149
Mecklenburg	2	3	5
Missing	0	28	28
Mitchell	10	24	34
Montgomery	1	2	3
Moore	3	4	7
Nash	12	59	71
New Hanover	180	18	198
Northampton	1	0	1
Onslow	1	330	331
Orange	27	22	49
Out of State	0	471	471
Pamlico	2	0	2
Pasquotank	0	14	14
Pender	10	3	13
Perquimans	0	3	3
Person	9	8	17
Pitt	40	268	308
Polk	5	4	9
Randolph	35	76	111
Rockingham	8	2	10
Rowan	6	379	385
Rutherford	33	18	51
Sampson	3	35	38
Stanly	1	4	5
Stokes	0	8	8
Surry	14	11	25
Swain	1	5	6
Transylvania	4	24	28
Vance	90	58	148
Wake	334	366	700
Warren	10	8	18
Washington	1	0	1
Watauga	24	72	96
Wayne	15	4	19
Wilkes	229	281	510
Wilson	4	13	17
Yadkin	24	27	51
Yancey	6	36	42
Grand Total	**2575**	**6354**	**8929**

Source: Data collected directly from OTPs, compiled by the Quality Management section, DMHDDSAS

V. Locations of existing prevention and recovery initiatives

The North Carolina Harm Reduction Coalition (NCHRC) is a statewide grassroots organization dedicated to the implementation of harm reduction interventions, public health strategies, drug policy transformation and justice reform in North Carolina and throughout the American South. Since the Overdose Prevention Project (OPP) became operational August 1, 2013, NCHRC has dispensed **46,461** free overdose rescue kits that include naloxone (as of 07.24.17) and have received **7,516** confirmed reports that the life-saving medication was administered successfully by lay individuals. Currently, the OPP has over 170 volunteer contractors who dispense the overdose rescue kits throughout the state. NCHRC distributes directly to individuals using drugs, people prescribed methadone, people prescribed buprenorphine, people coming out of detox facilities, people being released from jail, sex workers and their family members/significant others through a medical standing order.

NCHRC also trains and equips law enforcement with naloxone and has provided the majority of the 164 departments who carry it with naloxone (approximately 68 counties). NCHRC has a special partnership with the Office of Emergency Management Services to work on promoting naloxone being carried by all first responders. EMS agencies across North Carolina administer naloxone daily and have seen an increase in such from 2014 to 2016:

- 10,092 administrations in 2014 (27.6 per day)
- 11,399 administrations in 2015 (31.2 per day)
- 13,069 administrations in 2016 (35.8 per day)

Other specific initiatives of the NCHRC include:

- Establishment of post law enforcement overdose reversal programs in Raleigh (Wake County), Wilmington (New Hanover County), Carolina Beach (New Hanover County) and Brunswick County;
- NCHRC has jail naloxone programs in Durham County and has one pending in New Hanover County;
- NCHRC distributes naloxone at all its syringe exchange programs (SEPs) around the state.

The Division has partnered with the NCHRC to provide state and SABG funds for the purchase and distribution of naloxone kits, with more planned for FY18 to especially target distribution to all of the OTPs. Additional funding is also set-aside in the Opioid STR grant.

Although not specifically funded through the Division, there are some organic rapid response teams in operation across the state. Some are connected with recovery community centers or organizations, such as Recovery Communities of North Carolina (RCNC). The Division currently provides funding assistance to approximately eight recovery community centers, including RCNC. RCNC has partnered with local law enforcement to respond to overdoses in the Raleigh area. Volunteers will visit individuals who have experienced an overdose reversal in the emergency department, at their home or other location as soon as possible after the reversal to attempt to engage, offer support and assist individuals in accessing and navigating treatment.

This past session, the North Carolina General Assembly awarded a special appropriation in the amount of $250,000 to Guilford County to develop and implement a rapid response team. Funds are also set-aside in our Opioid STR grant to develop more rapid response teams. Although these funds

have not been distributed yet, it is expected that we will release a "request for interest" and award funds, either through the LME-MCOs or through direct contract, to communities most in need with adequate infrastructure or support to implement a team relatively quickly.

VI. Policy and legislation proposed or enacted within your state related to the opioid overdose crisis including the overall socio-political environment that is supportive of MAT

The North Carolina **911 Good Samaritan/Access to Naloxone** bill protects an individual who seeks help from 911, the police or EMS if s/he or another person is experiencing a drug overdose. Also known as SB20, witnesses and victims of an overdose have limited criminal immunity from prosecution for small amounts of most drugs and paraphernalia that may be found as a result of calling for help. The immunity also applies to underage drinkers who seek help for alcohol poisoning, but the caller must give their real name and stay with the victim.

The law in North Carolina also protects individuals who administer naloxone to someone who is having an overdose. If, in good faith, they think the person is having a drug overdose and they use reasonable care to give the naloxone, they are protected from a lawsuit for administering the person naloxone.

The **911 Good Samaritan/Access to Naloxone** bill also allows for a standing order distribution, meaning that medical practitioners can dispense naloxone without the provider present. Since the law was passed in June 2016, over 1,300 pharmacies have signed on to dispense naloxone under the State Health Director's standing order. A resource website (www.naloxonesaves.org) was launched in collaboration with the UNC Injury Prevention Research Center to provide resource information for pharmacies and the public on naloxone and where to find a pharmacy selling naloxone.

As of July 11, 2016, North Carolina, through Session Law 3012-88, allows 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. Syringe exchange programs in North Carolina are required to provide the following services:

- Syringe disposal;
- Distribution of clean syringes and 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;
- Educational materials specific to prevention of disease transmission, overdose and addiction;
- Treatment options, including medication-assisted therapy (MAT) and referrals;
- Naloxone distribution and training, or referrals to these services;
- Consultations and/or referrals to substance use disorder (SUD) treatment and mental health treatment if indicated/desired; and

- 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 Division of Public Health (DPH), by completing and submitting a form and also submitting annual reports to the Division of Public Health. It should be noted that no agencies within the North Carolina Department of Health and Human Services operate syringe exchange programs or services.

In 2014, House Bill 97 was introduced with several sections directly addressing prescription drug abuse. While it did not pass, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, in collaboration with stakeholders from across the state, began the work of developing the North Carolina Strategic Plan to Reduce Prescription Drug Abuse, which was supported by the National Governor's Association and Substance Abuse and Mental Health Services Administration (SAMHSA) policy academies. The following year, Session Law 2015-241, mandated not only the development of the strategic plan, but also the creation of the Prescription Drug Abuse Advisory Committee (PDAAC), which is tasked with implementing activities guided by strategies within the plan. It is a collaboration among DMHDDSAS, DPH, LME-MCOs, treatment providers, healthcare systems, law enforcement, regulatory boards, local health departments, community coalitions and others to plan, implement and evaluate comprehensive strategies to prevent drug overdose and treat opioid use disorders. Over 200 agencies, organizations, and individuals participate in PDAAC work.

Governor Cooper signed the **STOP (Strengthen Opioid Misuse Prevention) Act** into law in June 2017. The STOP Act seeks to help curb epidemic levels of opioid drug addiction and overdose in North Carolina through several key provisions including the requirement for prescribers to check the CSRS prior to prescribing targeted controlled substances for the first time and then every 90 days thereafter if the prescription continues.

Governor Cooper was also named to participate on the President's Commission on Combating Drug Addiction and the Opioid Crisis, a bipartisan group of leaders that is chaired by Governor Chris Christie of New Jersey. This opportunity will allow North Carolina to share some of its strategies and policies specific to the opioid epidemic, as well as be part of a national effort to reduce discrimination and enact policies and long-term strategies that support access to care and recovery.

Governor Cooper is also supportive of and committed to the National Governor's Association's Compact to Fight Opioid Addition. The compact is a commitment by governors to build on current efforts to fight the opioid crisis.

VII. Provide a description of the current evidence-based, evidence-informed and promising practices in place for prevention efforts

North Carolina is expanding use of the Lock Your Meds media campaign to make this campaign available to high need communities that demonstrate high prescribing rates and high overdose deaths. This campaign is identified as a prevention priority in the North Carolina State Opioid Strategic Plan. The goal for the campaign is to raise community awareness and attain reductions in

social access. The campaign will address the following intervening variables among youth aged 12 to 18 years and young adults aged 19 to 25 years:

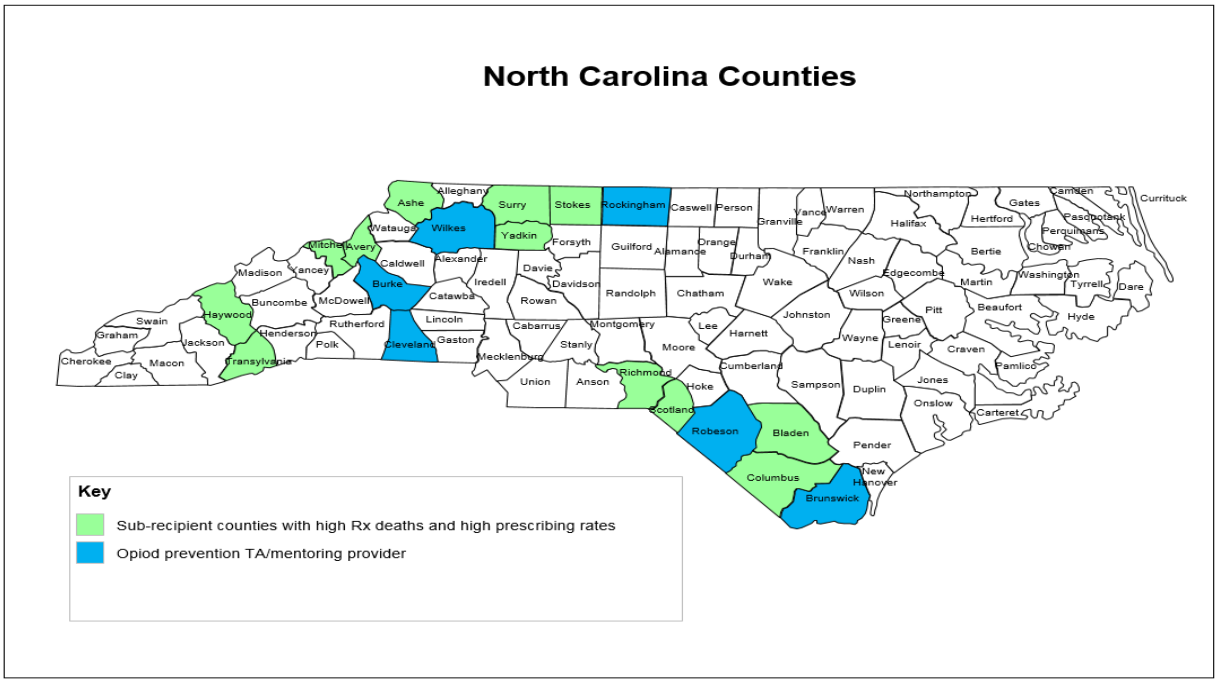
- parental/adult monitoring;
- access and availability; and
- proper storage and disposal of medications.

Other funded prevention programs that target the opioid crisis include: the Strategic Prevention Framework-Partnership for Success 2013, and the Strategic Prevention Framework – Rx programs. These programs are described and aligned with North Carolina's Opioid STR efforts below:

	SPF-PFS 2013	**SPF-Rx**	**STR**
Staff	PFS Project Coordinator PFS Outreach Coordinator	SPF-Rx Project Director .5 FTE PDMP/Epi .5 SPF-Rx Evaluator	Campaign Director Communications Specialist Outreach and Training Specialist .14 FTE Admin
Sub-Recipient Counties	13 counties: Rockingham, Cabarrus, Davidson, Rowan, Robeson, Burke, Cleveland, Iredell, Gaston, Randolph, Wilkes, Henderson, Brunswick	5 counties: Columbus, Dare, Mitchell, Nash, Stokes	15 counties: Haywood, Transylvania, Mitchell, Avery, Ashe, Surry, Yadkin, Columbus, Bladen, Scotland, Richmond, Stokes, Carteret, New Hanover
Key Activities	• NC Epidemiology Workgroup • LYM Campaign in SRCs • Expansion of EBPs in SRCs • Coalition Development/Capacity • SPF Process • Youth Survey Pilot in SRCs	• LYM Campaign in SRCs • Safe Prescribing Practice Training • Increase utilization and functionality of CSRS • Statewide Opioid Prevention Conference	• LYM Campaign in Statewide (excludes SPF-PFS and Rx Counties) • Lockboxes • Coalition Development/Capacity • SPF Process • Mentoring on successful strategies including: medical

			system policy changes, proper disposal, community engagement, proper storage, increased perception of harm, use of media campaigns to build local prevention capacity, EBP Selection and Implementation • Special population training (OTPs, OBOTs, and women's residential treatment programs) • Naloxone purchase and distribution

North Carolina is using the SPF to identify EBPs and continue to utilize the Lead and Seed program when this fits with community needs. The counties are: Haywood, Transylvania, Mitchell, Avery, Ashe, Surry, Yadkin, Columbus, Bladen, Scotland, Richmond, Stokes, Carteret and New Hanover. These were identified as highest need based on the combination of highest prescribing rates and highest overdose death rates.



VIII. Summarize the existing recovery support initiatives including a description of their current involvement and capacity for addressing the opioid crisis

With the signing of Executive Order 52 in May 2014, then Governor Pat McCrory established the Governor's Task Force on Substance Abuse and Underage Drinking Prevention and Treatment. This Executive Order, in addition to other things, called for the funding of collegiate recovery programs on six college campuses, as well as several recovery community centers. The Division also obtained an Access to Recovery grant in 2014 that, in collaboration with the above, set the stage for formal and deliberate focus on the development and expansion of recovery supports. This impetus aided its efforts to more fully implement a recovery-oriented system of care.

The Division currently utilizes block grant funds to support several recovery community centers, including Recovery Communities of North Carolina, a recovery community organization and center that provides technical assistance to other recovery community centers across the state in varying degrees of development. One of RCNC's contractual deliverables is the provision of recovery messaging training and the promotion of "multiple pathways to recovery." These trainings are meant to bridge gaps and educate philosophical differences between abstinence-based approaches and medication-assisted treatment. In addition, as mentioned previously, RCNC and other recovery community centers participate on rapid response teams to engage with individuals who have experienced an overdose reversal.

As of July 27, 2017, there were 2,473 NC Certified Peer Support Specialists in North Carolina, of which 1,111 were substance use disorder peer specialists. Eligibility criteria include:

- 18 years or older;
- lived experiences in recovery from a significant mental health or substance use disorder;
- in recovery for at least one year; and
- high school diploma or equivalent.

Through various discretionary grants such as the Access to Recovery and Medication-Assisted Treatment-Prescription Drug and Opioid Addiction grants, we have begun to offer peers more options for employment. The majority of the OTPs have not utilized peers to as much extent as other providers of SUD treatment, but the MAT-PDOA grant specifically calls for the integration of peer services on site at the two OTPs participating in this grant. Peers and recovery supports are also integral components of our Opioid STR grant.

There are a few providers across the state that specialize in re-entry services. In addition to having more than 230 Oxford Houses in North Carolina, Oxford House has also focused on re-entry initiatives for many years. Outreach and engagement of recently released incarcerated individuals, as well as participation in formal re-entry programs is an integral component of the North Carolina Oxford House. The Opioid STR grant also provides funding specifically for an outreach worker to identify, engage and coordinate services for individuals being released from jails and prisons who have an OUD.

Community Success Initiatives, a large Wake County provider, has offered various recovery support services to individuals leaving jails and prisons, and has been able to expand its reach through the Access to Recovery grant.

IX. Provide a summary of persons served with public and private funds in DATA 2000 Buprenorphine Waiver Provider Practices (including FQHCs) by state and county (from most recent annual data available)

North Carolina does not currently have access to any data specific to persons served in OBOTs with private funds. We are also not currently aware of any OBOTs formally under contract with any of our LME-MCOs, so therefore it is unlikely there are many, if any, individuals receiving publicly-funded care. As the LME-MCOs open their networks to provide better access to care in areas that cannot support an OTP, we expect to have data on publicly-funded care.

X. Estimated current treatment need – based on data collected via the National Survey on Drug Use and Health (NSDUH); CDC reports; N-SSATS; TEDS admission and discharge data; other sources

Data based on treatment episodes for substance use from the NC DMHDDSAS Client Data Warehouse (CDW) show that counties with the highest numbers of deaths from heroin and prescription opioids were also among the counties that served the largest number of individuals for opioid and heroin use as seen in the table below. The association between opioid related deaths and county ranking by numbers served for opioid use has at least two implications: first, there is a growing awareness in communities about the consequences of use in these counties; and, second, despite the increase in numbers served, overdose deaths have not abated, highlighting the need to assist providers in these counties with evidence-based prevention, treatment and recovery services.

Persons Served by DMHDDSAS in 2016 in Selected Counties for Opioids, Heroin and for Heroin and Opioids Combined and Persons Added in 2016*

County	Opioids	Heroin	Combined	Persons added in 2016
New Hanover	229	671	900	82
Wake	488	400	888	315
Guilford	330	536	866	248
Forsyth	437	407	844	154
Buncombe	429	210	639	278
Mecklenburg	184	432	616	324
Gaston	409	195	604	163
Cumberland	469	114	583	303
Pitt	263	298	561	178
Craven	366	189	555	114
Statewide	7,149	12,118	19,537	3,131

*Burke is not among the list of ten counties serving the most persons with heroin and opioid use in 2016. In that year, the county served 324 individuals with combined heroin and opioid use; 307 with opioid use; and 17 with heroin use.

The U.S. Department of Health and Human Services describes the rise in deaths from the use and misuse of opioids as an epidemic. Deaths involving opioid pain relievers and heroin increased by 200 percent between 2000 and 2014 (https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm?s_cid=mm6450a3_w). The surge was largely fueled by the promotion of prescription opioids to treat pain in the late 1990s and early 2000s and the subsequent transition to heroin as a substitute for opioid medications as prescribing practices improved.

North Carolina was one of 19 states that saw statistically significant increases in drug overdose death rates between 2014 and 2015. The prevalence estimate (age-adjusted death rate) from drug overdose deaths for the state was 15.8 per 100,000 in 2015. A total of 1,567 North Carolinians died from opioid overdoses in 2015 (https://www.cdc.gov/drugoverdose/data/statedeaths.html). The overdoses are driven largely by the nonmedical use of pain relievers, the prevalence of which was estimated at 4.27 for North Carolinians 12 years and older based on the 2013-2014 NSDUH surveys.

Only 11 percent received treatment for their illicit drug use for each year the survey was conducted from 2010-2014 (https://www.samhsa.gov/data/sites/default/files/2015_North-Carolina_BHBarometer.pdf). In an analysis conducted for the NC Substance Abuse Professional Practice Board in September 2016, the Quality Management Section of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) found an estimated 704,520 persons to be in need of substance use disorder services with only 6,675 clinicians available to treat them. The number of providers included 1,571 interns.

The human impact of opioid use is incalculable. The consequences are damaging and long-lasting for the individual, his or her family, and society in general. Opioid use also imposes a substantial economic burden, accounting for a large number of hospitalizations and Emergency Department visits. As seen in the table below, the number of people making hospital visits and Emergency Department (ED) visits in the state has been increasing, with the exception of ED visits for prescription opioids that decreased from around 11 percent between 2010 and 2014. The increase has been dramatic for visits associated with heroin use which increased more than fourfold within the same time period, with a percent change of 451.72 for hospitalization and 429.22 for ED visits (http://www.injuryfreenc.ncdhhs.gov/DataSurveillance/Poisoning.htm).

Hospital and ED Visits for Opiate and Heroin Poisoning for North Carolina

Hospital/ED Visits	2010	2014	% Change
Opiate poisoning hospitalizations	1,925	2,698	40.16
Prescription opioid hospitalizations	1,559	1,963	25.91
Heroin hospitalizations	58	320	451.72
Opiate poisoning ED visits	2,846	3,515	23.51

Prescription opioid ED visits	2,266	2,019	-10.99
Heroin ED visits	213	1,127	429.11

An analysis conducted in 2015 by Matrix Global Advisors allocated the national estimate of health care costs amounting to $25 billion as found by Birnbaum, et al. (2011) to 50 states and the District of Columbia to generate a state-by-state estimate that took into consideration state population, rates for services, and health care costs, among others (http://www.drugfree.org/wp-content/uploads/2015/04/Matrix_OpioidAbuse_040415.pdf).

The health care costs for North Carolina in 2007 were estimated to be $582,486,663 of which 95 percent was due to excess medical and drug costs. Five percent was attributed to costs associated with treatment, prevention, and research. In a study of Medicaid beneficiaries with continued eligibility of at least one year between 2002 and 2003, McAdam-Marx, Roland, Cleveland, and Oderda (https://www.researchgate.net/publication/42607928_Costs_of_Opioid_Abuse_and_Misuse_Determined_From_a_Medicaid_Database) compared the medical costs incurred in the past 12 months by patients diagnosed with opioid abuse or dependence with those who did not have the diagnosis and found the adjusted costs to be at $23,556 for the latter as compared to $8,436 for the former. The costs are even higher when one takes into account the total Medicaid population of the state estimated to be at 1,833,630 in July 2015, the prevalence estimate of past year abuse for opioid abuse and dependence ranging from 9.4 to 10.3 percent and the annual costs of $30,779 (adjusted for inflation) for treating an individual with an opioid use disorder.

Attachment 4 indicates the latest prevalence data based on population estimates by county as of July 2017. It includes separate estimates for individuals aged 12 or older for the use of prescription pain relievers non-medically and heroin use, in the past year. The prevalence rates were derived from SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014 and 2015. Based on a population estimate for North Carolina of 8,754,236 individuals aged 12 or older, the following totals indicate prevalence of prescription opioid misuse and heroin use, respectively:

		Rx Opioid Use		Heroin Use		
NORTH CAROLINA	**Population Ages 12+**	**Prevalence**	**Persons**	**Prevalence**	**Persons**	**Total Persons**
	8,754,236	**4.57%**	**399,795**	**0.20%**	**17,508**	**417,304**

It should be noted that these prevalence estimates do not take race, income or other socio-economic factors into consideration, which can and should influence or target areas of greater need for publicly-funded services. While we know where individuals with Medicaid benefits reside, accounting for indigent, uninsured or under-insured individuals is difficult at best.

We do believe that all of the data and information contained in this assessment provides a foundation for identifying areas of highest need. Existing contracts with LME-MCOs and other direct contractors will allow us to deploy funds expeditiously. Data collection through NCTracks (claims) and NCTOPPS (outcomes) will allow us to monitor the utilization of the funds, as well as begin

determining potential impact. We have collected baseline data on the number of unduplicated persons served with an OUD, as well as average costs per person per month by LME-MCO. This data has been utilized to determine approximately how many additional persons should be served through each LME-MCO with North Carolina's Opioid STR funds. A new benefit plan was also created in order to track new individuals admitted to services, along with an approved service array that includes individual, group and family therapies, enhanced services such as intensive outpatient and comprehensive outpatient, medication dispensing, etc. We have the flexibility to add additional services if requested by the LME-MCO through creation of "alternative service definitions." Alternative service definitions allow us to capture data on a fee-for-service basis, which greatly facilitates data collection, and will likely include various recovery supports, medication monitoring (H0033), etc.

We will continue to monitor data, including surveillance data, for new trends and adjust funds or targets as indicated. This information, along with existing documents such as the DMHDDSAS Strategic Plan and the PDAAC Opioid Action Plan will be the integral in the development of our plan for the Opioid STR funds over the next two years.

We appreciate the opportunity to present the needs of our state, and more importantly the work we are engaging in to meet those needs. We look forward to your review, comments and guidance as we come together to utilize these funds in the best possible manner for the most substantial impact. Please direct any questions or concerns to DeDe Severino, Section Chief, Addictions and Management Operations, DMHDDSAS, at dede.severino@dhhs.nc.gov or 919.733.4670.

ATTACHMENT 1

RATES OF OPIOID AND BENZODIAZEPINE PRESCRIPTIONS BY COUNTY PER 100 PERSONS

County	Sum of Opioid Rx	Sum of Benzo Rx	Sum of Opioid Rx Per 100	Sum of Benzo Rx Per 100
Alamance	124,749	79,608	78	50
Alexander	42,496	24,324	114	65
Alleghany	10,196	7,482	94	69
Anson	24,394	10,659	96	42
Ashe	28,329	15,500	105	58
Avery	15,123	8,962	86	51
Beaufort	57,120	28,266	120	60
Bertie	19,985	8,432	101	43
Bladen	41,718	14,777	124	44
Brunswick	138,565	78,427	109	62
Buncombe	210,561	139,340	82	54
Burke	110,881	63,490	125	72
Cabarrus	167,321	87,709	83	44
Caldwell	107,707	56,020	132	69
Camden	6,559	3,035	63	29
Carteret	72,306	45,738	105	66
Caswell	11,904	5,965	52	26
Catawba	172,875	102,861	111	66
Chatham	37,799	19,913	52	28
Cherokee	32,543	17,033	117	61
Chowan	12,456	5,243	87	37
Clay	11,942	6,598	109	60
Cleveland	117,207	64,529	121	66
Columbus	89,225	38,952	158	69
Craven	106,048	48,540	103	47
Cumberland	260,718	110,795	80	34
Currituck	14,439	7,661	56	30
Dare	28,639	22,400	80	62
Davidson	146,746	88,044	89	53
Davie	40,238	25,753	96	61
Duplin	45,986	23,840	78	40
Durham	149,441	79,710	49	26
Edgecombe	42,094	18,409	79	35
Forsyth	270,346	196,174	73	53
Franklin	49,188	24,063	76	37
Gaston	247,301	148,493	114	68
Gates	5,656	3,022	49	26
Graham	10,389	6,196	121	72
Granville	40,898	18,703	69	32
Greene	13,339	7,199	63	34
Guilford	344,991	224,434	66	43

Halifax	47,573	29,627	92	57
Harnett	113,845	52,130	87	40
Haywood	66,301	37,685	109	62
Henderson	101,439	66,335	89	58
Hertford	17,374	8,909	72	37
Hoke	31,523	10,408	59	20
Hyde	3,755	2,374	68	43
Iredell	155,259	95,029	90	55
Jackson	32,336	18,669	77	44
Johnston	140,214	75,653	73	40
Jones	7,137	3,341	73	34
Lee	62,231	23,309	104	39
Lenoir	51,417	27,635	90	48
Lincoln	89,139	50,921	110	63
Macon	33,573	16,896	98	49
Madison	20,660	12,209	97	57
Martin	27,058	12,943	117	56
McDowell	60,139	26,432	133	59
Mecklenburg	543,375	307,029	52	29
Mitchell	19,295	11,052	128	73
Montgomery	28,224	11,661	103	43
Moore	85,703	45,515	90	48
Nash	82,604	46,996	88	50
New Hanover	186,215	121,899	83	55
Northampton	15,801	7,882	79	39
Onslow	133,034	69,355	71	37
Orange	60,346	48,088	43	34
Pamlico	12,276	5,818	96	45
Pasquotank	32,090	13,644	81	34
Pender	55,467	29,530	94	50
Perquimans	10,609	4,698	80	35
Person	46,800	24,129	119	61
Pitt	130,939	71,046	74	40
Polk	15,734	10,593	77	52
Randolph	149,257	91,017	104	64
Richmond	69,229	30,047	154	67
Robeson	185,439	56,648	139	43
Rockingham	119,394	88,361	131	97
Rowan	139,052	69,652	99	50
Rutherford	87,378	54,238	132	82
Sampson	65,057	27,933	103	44
Scotland	52,056	15,584	148	44
Stanly	62,174	34,655	102	57
Stokes	52,629	41,576	114	90
Surry	86,109	63,213	119	88
Swain	22,424	9,202	156	64

Transylvania	29,856	19,903	89	59
Tyrrell	3,314	1,406	80	34
Union	142,187	88,640	63	39
Vance	45,539	17,242	103	39
Wake	541,137	352,230	52	34
Warren	13,886	4,977	70	25
Washington	12,065	5,793	99	48
Watauga	32,559	21,943	60	41
Wayne	94,848	51,210	76	41
Wilkes	77,839	48,407	113	70
Wilson	65,131	39,862	80	49
Yadkin	43,757	31,794	117	85
Yancey	19,889	10,813	113	61
Grand Total	**8,212,108**	**4,662,085**	**9,372**	**5,042**

Data Source: NC DHHS: DMHDDSAS, Justice Systems Section, Drug Control Unit

ATTACHMENT 2

OPIOID DEATH RATES IN NC PER 100,000 POPULATION BY COUNTY (SORTED BY RANK - HIGHEST TO LOWEST)

	Deaths				Population				Rates per 100K population				Rank
County	2013	2014	2015	Ave 2013-2015	Jul 2013	Jul 2014	Jul 2015	Ave 2013 - 2015	2013	2014	2015	Ave 2013-2015	1=high 99=low
Wilkes	17	26	23	22	70,076	69,817	69,784	69,892	24.3	37.2	33.0	31.5	1
Burke	17	17	28	21	89,604	89,184	88,786	89,191	19.0	19.1	31.5	23.2	2
Yadkin	7	11	5	8	38,160	38,023	37,885	38,023	18.3	28.9	13.2	20.2	3
Brunswick	26	18	23	22	114,882	118,634	121,744	118,420	22.6	15.2	18.9	18.9	4
Pamlico	0	3	4	2	13,320	13,071	13,067	13,153	0.0	23.0	30.6	17.7	5
Richmond	4	7	11	7	46,253	46,030	45,988	46,090	8.6	15.2	23.9	15.9	6
Stokes	6	3	13	7	46,859	46,409	46,059	46,442	12.8	6.5	28.2	15.8	7
Carteret	7	12	13	11	69,138	70,101	70,911	70,050	10.1	17.1	18.3	15.2	8
Yancey	0	3	5	3	17,877	17,940	17,962	17,926	0.0	16.7	27.8	14.9	9
Rowan	15	20	26	20	138,251	139,161	139,457	138,956	10.8	14.4	18.6	14.6	10
Gaston	32	32	27	30	209,652	210,980	212,238	210,957	15.3	15.2	12.7	14.4	11
Davidson	24	28	18	23	164,232	164,110	164,341	164,228	14.6	17.1	11.0	14.2	12
New Hanover	25	22	44	30	213,785	217,844	221,590	217,740	11.7	10.1	19.9	13.9	13
Caldwell	5	7	22	11	82,362	82,405	82,241	82,336	6.1	8.5	26.8	13.8	14
Alexander	6	3	6	5	37,209	37,429	37,383	37,340	16.1	8.0	16.1	13.4	15
Rutherford	8	6	13	9	68,892	67,535	67,359	67,929	11.6	8.9	19.3	13.2	16
Randolph	19	11	26	19	142,646	142,678	142,599	142,641	13.3	7.7	18.2	13.1	17
Mitchell	1	1	4	2	15,365	15,357	15,337	15,353	6.5	6.5	26.1	13.0	18
Madison	1	2	5	3	21,472	21,440	21,508	21,473	4.7	9.3	23.2	12.4	19
Ashe	6	3	1	3	27,468	27,425	27,444	27,446	21.8	10.9	3.6	12.1	20
Alleghany	1	1	2	1	10,874	11,033	11,156	11,021	9.2	9.1	17.9	12.1	21
Scotland	2	6	5	4	36,192	36,120	35,952	36,088	5.5	16.6	13.9	12.0	22
Pender	4	2	14	7	55,313	56,589	57,689	56,530	7.2	3.5	24.3	11.8	23
Bladen	1	6	5	4	35,226	35,250	35,245	35,240	2.8	17.0	14.2	11.4	24
Surry	6	13	6	8	73,898	73,368	73,341	73,536	8.1	17.7	8.2	11.3	25
Chowan	2	0	3	2	14,761	14,839	14,884	14,828	13.5	0.0	20.2	11.2	26
Dare	3	7	2	4	35,330	35,471	36,059	35,620	8.5	19.7	5.5	11.2	27
Lincoln	13	9	5	9	79,630	80,329	80,813	80,257	16.3	11.2	6.2	11.2	28

Transylvania	4	4	3	4	32,971	33,231	33,333	33,178	12.1	12.0	9.0	11.1	29
Sampson	3	14	4	7	64,673	64,553	64,717	64,648	4.6	21.7	6.2	10.8	30
Craven	12	8	14	11	105,373	104,288	104,521	104,727	11.4	7.7	13.4	10.8	31
Henderson	17	9	9	12	108,630	110,264	111,173	110,022	15.6	8.2	8.1	10.6	32
Columbus	3	7	8	6	57,846	57,376	57,732	57,651	5.2	12.2	13.9	10.4	33
Edgecombe	6	5	6	6	55,840	55,735	55,467	55,681	10.7	9.0	10.8	10.2	34
Haywood	8	2	8	6	59,765	59,955	60,218	59,979	13.4	3.3	13.3	10.0	35
Forsyth	26	37	46	36	361,710	363,211	365,397	363,439	7.2	10.2	12.6	10.0	36
Catawba	14	15	17	15	156,287	155,545	155,477	155,770	9.0	9.6	10.9	9.8	37
Macon	4	2	4	3	34,164	34,133	34,179	34,159	11.7	5.9	11.7	9.8	38
Cleveland	8	5	15	9	97,280	97,245	97,071	97,199	8.2	5.1	15.5	9.6	39
Iredell	14	21	13	16	164,883	167,078	169,005	166,989	8.5	12.6	7.7	9.6	40
Clay	2	1	0	1	10,559	10,621	11,007	10,729	18.9	9.4	0.0	9.3	41
Robeson	12	13	11	12	134,553	133,599	133,305	133,819	8.9	9.7	8.3	9.0	42
Vance	4	4	4	4	45,565	44,977	44,849	45,130	8.8	8.9	8.9	8.9	43
McDowell	2	3	7	4	45,359	45,298	45,317	45,325	4.4	6.6	15.4	8.8	44
Stanly	3	3	10	5	60,403	60,562	60,820	60,595	5.0	5.0	16.4	8.8	45
Watauga	4	3	7	5	52,953	52,959	53,219	53,044	7.6	5.7	13.2	8.8	46
Halifax	4	1	9	5	54,064	53,432	53,105	53,534	7.4	1.9	16.9	8.7	47
Granville	3	7	5	5	56,845	58,042	58,108	57,665	5.3	12.1	8.6	8.7	48
Cherokee	2	4	1	2	26,907	27,060	27,608	27,192	7.4	14.8	3.6	8.6	49
Cabarrus	18	17	13	16	186,531	189,528	192,434	189,498	9.6	9.0	6.8	8.4	50
Rockingham	8	5	10	8	92,494	91,775	91,316	91,862	8.6	5.4	11.0	8.3	51
Lee	5	3	7	5	59,857	60,314	60,962	60,378	8.4	5.0	11.5	8.3	52
Nash	8	7	8	8	94,722	94,459	94,056	94,412	8.4	7.4	8.5	8.1	53
Davie	2	4	4	3	41,453	41,647	41,729	41,610	4.8	9.6	9.6	8.0	54
Cumberland	16	28	36	27	334,126	334,466	336,304	334,965	4.8	8.4	10.7	8.0	55
Buncombe	7	21	29	19	248,578	251,995	255,008	251,860	2.8	8.3	11.4	7.5	56
Avery	1	1	2	1	17,842	17,868	17,879	17,863	5.6	5.6	11.2	7.5	57
Graham	0	0	2	1	8,994	8,979	9,057	9,010	0.0	0.0	22.1	7.4	58
Moore	3	7	10	7	91,879	93,144	94,254	93,092	3.3	7.5	10.6	7.2	59

Johnston	12	7	19	13	177,043	180,064	182,580	179,896	6.8	3.9	10.4	7.0	60
Harnett	8	11	7	9	124,118	125,646	127,777	125,847	6.4	8.8	5.5	6.9	61
Swain	1	1	1	1	14,652	14,750	14,901	14,768	6.8	6.8	6.7	6.8	62
Union	15	13	15	14	210,410	215,416	219,212	215,013	7.1	6.0	6.8	6.7	63
Pitt	10	16	9	12	174,501	175,446	176,749	175,565	5.7	9.1	5.1	6.6	64
Camden	0	0	2	1	9,802	10,092	10,380	10,091	0.0	0.0	19.3	6.6	65
Jackson	3	2	3	3	41,111	40,951	41,070	41,044	7.3	4.9	7.3	6.5	66
Alamance	8	11	11	10	154,151	154,256	154,732	154,380	5.2	7.1	7.1	6.5	67
Hoke	4	4	2	3	50,951	51,434	52,259	51,548	7.9	7.8	3.8	6.5	68
Franklin	4	1	7	4	62,346	63,496	64,185	63,342	6.4	1.6	10.9	6.3	69
Guilford	15	40	42	32	509,388	513,089	518,113	513,530	2.9	7.8	8.1	6.3	70
Jones	0	0	2	1	10,636	10,579	10,601	10,605	0.0	0.0	18.9	6.3	71
Beaufort	2	3	4	3	48,010	47,791	47,782	47,861	4.2	6.3	8.4	6.3	72
Onslow	13	11	12	12	194,201	197,742	200,922	197,622	6.7	5.6	6.0	6.1	73
Montgomery	3	0	2	2	28,059	27,742	27,716	27,839	10.7	0.0	7.2	6.0	74
Person	2	2	3	2	39,309	39,231	39,254	39,265	5.1	5.1	7.6	5.9	75
Wilson	4	5	5	5	82,433	82,175	83,044	82,551	4.9	6.1	6.0	5.7	76
Currituck	0	1	3	1	23,550	24,055	25,171	24,259	0.0	4.2	11.9	5.5	77
Pasquotank	2	2	2	2	39,740	38,919	38,919	39,193	5.0	5.1	5.1	5.1	78
Lenoir	1	1	7	3	59,401	59,016	58,950	59,122	1.7	1.7	11.9	5.1	79
Mecklenburg	39	55	58	51	986,516	1,010,211	1,032,073	1,009,600	4.0	5.4	5.6	5.0	80
Wake	36	51	59	49	966,424	985,146	1,004,455	985,342	3.7	5.2	5.9	4.9	81
Durham	16	14	13	14	289,042	291,413	296,492	292,316	5.5	4.8	4.4	4.9	82
Bertie	2	0	1	1	20,450	20,581	20,611	20,547	9.8	0.0	4.9	4.9	83
Perquimans	0	1	1	1	13,771	13,823	14,013	13,869	0.0	7.2	7.1	4.8	84
Wayne	5	4	9	6	126,287	125,656	125,936	125,960	4.0	3.2	7.1	4.8	85
Northampton	1	1	1	1	21,348	20,958	20,720	21,009	4.7	4.8	4.8	4.8	86
Martin	1	1	1	1	23,870	23,608	23,448	23,642	4.2	4.2	4.3	4.2	87
Anson	0	2	1	1	26,635	26,429	26,429	26,498	0.0	7.6	3.8	3.8	88
Orange	5	5	5	5	140,723	141,422	143,063	141,736	3.6	3.5	3.5	3.5	89
Warren	2	0	0	1	20,668	20,368	20,282	20,439	9.7	0.0	0.0	3.3	90

Polk	0	0	2	1	20,077	20,603	20,754	20,478	0.0	0.0	9.6	3.3	91
Greene	0	0	2	1	21,296	21,059	21,046	21,134	0.0	0.0	9.5	3.2	92
Gates	0	0	1	0	11,569	11,263	11,470	11,434	0.0	0.0	8.7	2.9	93
Caswell	0	0	2	1	23,582	23,708	23,806	23,699	0.0	0.0	8.4	2.8	94
Washington	0	0	1	0	12,914	12,754	12,691	12,786	0.0	0.0	7.9	2.6	95
Duplin	2	0	2	1	60,760	60,453	60,742	60,652	3.3	0.0	3.3	2.2	96
Chatham	1	3	0	1	67,857	68,770	69,856	68,828	1.5	4.4	0.0	1.9	97
Hertford	1	0	0	0	24,588	24,511	24,560	24,553	4.1	0.0	0.0	1.4	98
Hyde	0	0	0	0	5,769	5,837	5,895	5,834	0.0	0.0	0.0	0.0	99
Tyrrell	0	0	0	0	4,157	4,114	4,084	4,118	0.0	0.0	0.0	0.0	99
STATE	**699**	**808**	**998**	**835**	**9,873,948**	**9,956,488**	**10,054,192**	**9,961,543**	**7.1**	**8.1**	**9.9**	**8.4**	

Data Sources: NC DHHS: DPH, Injury and Violence Prevention Branch and DMHDDSAS, Quality Management Section

ATTACHMENT 3

DATA 2000 CERTIFIED NC OFFICE-BASED OPIOID TREATMENT PROGRAM SITES*

BUSINESS ACTIVITY	**LAST NAME**	**FIRST NAME**	**CITY**	**County**	**LME-MCO**
PRACTITIONER-DW/100	BRADFORD	ARTHUR LOUIS MD	FAYETTEVILLE	Cumberland	Alliance
MILITARY PRACTITIONER-DW/30	ALGEO	DONALD W.	FORT BRAGG	Cumberland	Alliance
PRACTITIONER-DW/30	CHANDLER	MARK STEVEN MD	FAYETTEVILLE	Cumberland	Alliance
PRACTITIONER-DW/30	CHOWDHURY	SHABBIR A MD	FAYETTEVILLE	Cumberland	Alliance
PRACTITIONER-DW/30	DESAI	VIREN D	FAYETTEVILLE	Cumberland	Alliance
PRACTITIONER-DW/275	DAVIS	ALAN S MD	FAYETTEVILLE	Cumberland	Alliance
PRACTITIONER-DW/30	EATON	KATHLEEN MARIE MD	FORT BRAGG	Cumberland	Alliance
PRACTITIONER-DW/100	FERGUSON	ROBERT LEE MD	FAYETTEVILLE	Cumberland	Alliance
PRACTITIONER-DW/30	FLEISHMAN	KENNETH E MD	FAYETTEVILLE	Cumberland	Alliance
PRACTITIONER-DW/30	FONDINKA	GODFREY S MD	FAYETTEVILLE	Cumberland	Alliance
PRACTITIONER-DW/30	HARRIS	TONI	FAYETTEVILLE	Cumberland	Alliance
PRACTITIONER-DW/30	KANTESARIA	ATUL N MD	FAYETTEVILLE	Cumberland	Alliance
PRACTITIONER-DW/30	KISHBAUGH	DAVID DO	FAYETTEVILLE	Cumberland	Alliance
PRACTITIONER-DW/30	KUBIT	VICTOR FRANCIS MD	FAYETTEVILLE	Cumberland	Alliance
MILITARY PRACTITIONER-DW/30	KANE	SHAWN MD	FORT BRAGG	Cumberland	Alliance
PRACTITIONER-DW/30	MAXWELL	JAMES HENRY MD	WADE	Cumberland	Alliance
PRACTITIONER-DW/30	MAZZARULLI	ANTHONY A MD	FAYETTEVILLE	Cumberland	Alliance
PRACTITIONER-DW/30	BURKS	TANDEKA N MD	FAYETTEVILLE	Cumberland	Alliance
PRACTITIONER-DW/30	PARK	HYUNSOON E MD	FORT BRAGG	Cumberland	Alliance
PRACTITIONER-DW/30	PARKER	DAVID R	FAYETTEVILLE	Cumberland	Alliance
PRACTITIONER-DW/30	ROBERTS	LEROY JR MD	FAYETTEVILLE	Cumberland	Alliance

PRACTITIONER-DW/30	SHUH	MONSON MD	FAYETTEVILLE	Cumberland	Alliance
PRACTITIONER-DW/30	SHAH	SANJAY BACHUBHAI MD	FAYETTEVILLE	Cumberland	Alliance
PRACTITIONER-DW/30	UBA	DANIEL C MD	FAYETTEVILLE	Cumberland	Alliance
PRACTITIONER-DW/275	AUGUSTIN	NERVA,MD	FAYETTEVILLE	Cumberland	Alliance
MILITARY PRACTITIONER-DW/30	AVALLONE	AARON G	FORT BRAGG	Cumberland	Alliance
MILITARY PRACTITIONER-DW/30	BARTOSZEK	MICHAEL W.	FORT BRAGG	Cumberland	Alliance
PRACTITIONER-DW/100	BITNER	HUBERT, P MD	FAYETTEVILLE	Cumberland	Alliance
MILITARY PRACTITIONER-DW/30	CHANG	MIN HO MD	FORT BRAGG	Cumberland	Alliance
MILITARY PRACTITIONER-DW/30	FELDMAN	ANDREW, MD	FORT BRAGG	Cumberland	Alliance
PRACTITIONER-DW/275	KIM	SEUNG WON (MD)	FAYETTEVILLE	Cumberland	Alliance
PRACTITIONER-DW/30	KIM	EUGENE H MD	FORT BRAGG	Cumberland	Alliance
MILITARY PRACTITIONER-DW/30	LAM	SHERRELL TONG	FORT BRAGG	Cumberland	Alliance
MILITARY PRACTITIONER-DW/30	MAGERA	JOHN ROBERT MD	FORT BRAGG	Cumberland	Alliance
PRACTITIONER-DW/30	OKOBI	ANTHONY O (MD)	FORT BRAGG	Cumberland	Alliance
PRACTITIONER-DW/30	PLUNKETT	ANTHONY	FORT BRAGG	Cumberland	Alliance
PRACTITIONER-DW/30	PRICE	TRACY L. B. (MD)	FAYETTEVILLE	Cumberland	Alliance
MILITARY PRACTITIONER-DW/30	RUNSER	LLOYD MD	FORT BRAGG	Cumberland	Alliance
MILITARY PRACTITIONER-DW/30	TINKHAM	NICHOLAS H. (MD)	FORT BRAGG	Cumberland	Alliance
MLP-PA-DW/30	ADAMO	ASHLEY, D PA-C	FAYETTEVILLE	Cumberland	Alliance
MLP-NP-DW/30	DRESCHER	CAROL A NP	FAYETTEVILLE	Cumberland	Alliance
MLP-PA-DW/30	HILL	CRYSTAL DAWN	FAYETTEVILLE	Cumberland	Alliance
MLP-NP-DW/30	SMITH	KIM	FAYETTEVILLE	Cumberland	Alliance

PRACTITIONER-DW/100	BAKER	JOHN HARRISON MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	GIRAGOS	JOHN G MD PA	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	HOLMES	VALERIE, F	DURHAM	Durham	Alliance
PRACTITIONER-DW/275	MCEWEN	J DUNCAN MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/100	MINDEL	EUGENE DAVID MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/100	STRAHL	NATHAN	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	SCHOOFF	KENNETH G MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	BOWLBY	LYNN A MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	BRONNER	LESLIE L	DURHAM	Durham	Alliance
PRACTITIONER-DW/100	FINCH	JAMES W MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/100	GREENBLATT	LAWRENCE MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/100	GRIFFIES	WILLIAM SCOTT MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/100	GIBBS	CAROL MINNETTE	DURHAM	Durham	Alliance
PRACTITIONER-DW/100	GYARTENG-DAKWA	KWADWO MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/100	HENDRICKS	ANNE L. MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	MONROE	YVONNE L MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	MELTON	CATHLEEN M MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	MILLET	ROBERT	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	MARKS	DAVID M MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/275	MUND	PAMELA MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/275	MARUM	TIFFANY MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/100	MANNELLI	PAOLO	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	MAYTAN	MARGARET W	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	OWENS	THOMAS D MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/100	PRICE	WILLIAM A MD	DURHAM	Durham	Alliance
PRACTITIONER-	PRAKKEN	STEVEN	DURHAM	Durham	Alliance

DW/30					
PRACTITIONER-DW/100	PURDY	TERESA R MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/275	PITTS	VENUS I	DURHAM	Durham	Alliance
PRACTITIONER-DW/100	REID	INDIA F	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	STEIN	ROY M	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	WARDEN	KENDALL CARNES MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	WILLIAMS	ALTON MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	ALKHALDI	HANA AOUS	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	CONNER	MATTHEW, J (MD)	DURHAM	Durham	Alliance
PRACTITIONER-DW/100	DAVIS	AMELIA, N, MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	DENNIS	NORA	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	DOGRA	SUNIL MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	EDWARDS	JAMES M (MD)	DURHAM	Durham	Alliance
PRACTITIONER-DW/100	ERAMI	CAUVEH (MD)	DURHAM	Durham	Alliance
PRACTITIONER-DW/100	GRADDY	LOGAN G. MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/100	HELTON	GREGORY	DURHAM	Durham	Alliance
PRACTITIONER-DW/275	HALLIDAY	SHARON RAYES	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	HUCHKO	MEGAN, J	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	KNUTSON	KATHERINE H MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/275	PARKER	LYLE A.,MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	PARRIS	WINSTON C.V.	DURHAM	Durham	Alliance
PRACTITIONER-DW/275	SYED	ARJUMAND B	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	SMITH	ANA CARLA, P., MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	SPESSOT	ALEXANDRA L MD	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	SCHOFIELD	KELLY	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	TINNEY RAILEY	QIONNA M. (MD)	DURHAM	Durham	Alliance

PRACTITIONER-DW/30	VILLERS	MARGARET S. (MD)	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	WILDER	ELIJAH BRYAN	DURHAM	Durham	Alliance
MLP-NP-DW/30	PARKER	VALERIE	DURHAM	Durham	Alliance
PRACTITIONER-DW/30	BUTLER	RICHARD CARSON MD	CLAYTON	Johnston	Alliance
PRACTITIONER-DW/30	STANLEY	KARL HARVEY JR MD	CLAYTON	Johnston	Alliance
PRACTITIONER-DW/30	SINGAREDDY	SANJAY	SMITHFIELD	Johnston	Alliance
PRACTITIONER-DW/30	EDMUNDSON	HENRY JR MD	SMITHFIELD	Johnston	Alliance
PRACTITIONER-DW/100	BARTELS	GEORGE THOMAS MD	CARY	Wake	Alliance
PRACTITIONER-DW/275	DAUD	MIAN BASHIR MD	CARY	Wake	Alliance
PRACTITIONER-DW/30	GREENBERG	LAWRENCE B MD	CARY	Wake	Alliance
PRACTITIONER-DW/30	GROCE	JAMES GRAY MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	GRIGG	WENDELL JR MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	NATARAJA	HEGGADADEVANAKOTE,N	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	SCHILKE	CLIFFORD HAROLD MD	CARY	Wake	Alliance
PRACTITIONER-DW/30	SVED	MARGERY	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	SMITH	JAMES ALMER III, MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/100	AKHTAR	AFAQUE MD	FUQUAY VARINA	Wake	Alliance
PRACTITIONER-DW/30	BAJWA	WAHEED K MD	CARY	Wake	Alliance
PRACTITIONER-DW/30	BOWEN	JANET W MD	GARNER	Wake	Alliance
PRACTITIONER-DW/30	BROWN	JOSEPHINE R MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	CUSHING	WILLIAM T MD	CARY	Wake	Alliance
PRACTITIONER-DW/30	CLOUTIER	CHARLES ALBERT MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	CHILDERS	JEFFREY B MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	CHELTENHAM	MARK P	ROLESVILLE	Wake	Alliance
PRACTITIONER-DW/275	DOSHI	USHA	GARNER	Wake	Alliance
PRACTITIONER-DW/30	FRUTH	JOANNE M MD	RALEIGH	Wake	Alliance

PRACTITIONER-DW/30	FERNANDEZ	GONZALO ANDRES MD	GARNER	Wake	Alliance
PRACTITIONER-DW/30	GAVAZOV	MIROSLAV MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/100	GREEN	HEIDI L	RALEIGH	Wake	Alliance
PRACTITIONER-DW/100	HILLSMAN	PHILIP L MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/100	IGBOEKWE	VINCENT CHUKWUMA MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/100	O'ROURKE	KRYSTOL JOHNSTON MD	CARY	Wake	Alliance
PRACTITIONER-DW/30	KLAUSNER	BRIAN T	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	MAUNEY	J DAVID MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	MOONEY	ALFONSO J MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	MATTIOLI	MARK ANTHONY	RALEIGH	Wake	Alliance
PRACTITIONER-DW/275	MORSE	ERIC D MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/100	MIAH	ROHIMA D MD	CARY	Wake	Alliance
PRACTITIONER-DW/275	MIZELLE	ERIC Q	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	O'CONOR	LORRAINE	RALEIGH	Wake	Alliance
PRACTITIONER-DW/275	PATKAR	ASHWIN A MD	CARY	Wake	Alliance
PRACTITIONER-DW/100	PRUCHA, JR.	RONALD J	CARY	Wake	Alliance
PRACTITIONER-DW/30	PALAKURTHI	HIMA BINDU MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	RAINES	LAWRENCE M III MD	CARY	Wake	Alliance
PRACTITIONER-DW/275	STANTON	ELIZABETH S MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	SHEITMAN	BRIAN B MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/275	SMITH	CARL LYNWOOD SR MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	SIDDIQUI	ADEEL M MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	TOPE	JOHN JEFFREY MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/275	WADLEY	ROBERT D MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/100	WILEY	JERRY W MD	RALEIGH	Wake	Alliance
PRACTITIONER-	WEBER	THOMAS J	RALEIGH	Wake	Alliance

DW/30					
PRACTITIONER-DW/100	BOWEN	MARGARET-MARY P	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	BRAYBOY	JACOB, R	RALEIGH	Wake	Alliance
PRACTITIONER-DW/100	BATTLE	JAMILA, R (MD)	CARY	Wake	Alliance
PRACTITIONER-DW/100	GOCHNOUR	JULIE MARIE	RALEIGH	Wake	Alliance
PRACTITIONER-DW/275	DITTMER	JOSHUA, E, (MD)	RALEIGH	Wake	Alliance
PRACTITIONER-DW/100	DITTMER	CHRISTINE, D, MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/275	FREDERICK	MAXIMUS EZIUDO MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	GUPTA	MONA R	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	GARRETT	SUSAN THERESE	RALEIGH	Wake	Alliance
PRACTITIONER-DW/100	HARRISON	DIONNE DILLON	RALEIGH	Wake	Alliance
PRACTITIONER-DW/275	HARRISON	MYLEME N OJINGA MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/275	HE	JUN (MD, PHD)	RALEIGH	Wake	Alliance
PRACTITIONER-DW/100	NAFTEL	HERMAN	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	NGUYEN	HIEN, N.	APEX	Wake	Alliance
PRACTITIONER-DW/30	RAO-PATEL MD	ANURADHA	RALEIGH	Wake	Alliance
PRACTITIONER-DW/100	RASUL	IJAZ	GARNER	Wake	Alliance
PRACTITIONER-DW/30	SARANGA	VINAY P (MD)	APEX	Wake	Alliance
PRACTITIONER-DW/30	SARANGA	RESHMI (MD)	APEX	Wake	Alliance
PRACTITIONER-DW/30	MEYER	NADIA S MD	RALEIGH	Wake	Alliance
PRACTITIONER-DW/100	WILLIAMS	JOSEPH B (MD)	RALEIGH	Wake	Alliance
PRACTITIONER-DW/30	GEORGE	ALYSSA, W, M.D.	RALEIGH	Wake	Alliance
MLP-NP-DW/30	ANDERSON	DONNA	RALEIGH	Wake	Alliance
MLP-NP-DW/30	BUSTOS	JESSICA T	CARY	Wake	Alliance
MLP-PA-DW/30	CROSS	HARRY GILES, PA	RALEIGH	Wake	Alliance
MLP-NP-DW/30	WALTER	EMILY	RALEIGH	Wake	Alliance
MLP-NP-DW/30	GRAHAM	KIMBERLY M	RALEIGH	Wake	Alliance
MLP-PA-DW/30	KENDLEHART	ERIN	RALEIGH	Wake	Alliance
MLP-NP-DW/30	STRICKLAND	MELISSA	RALEIGH	Wake	Alliance

MLP-PA-DW/30	ALEXANDER	SANDRA T (MPAP)	RALEIGH	Wake	Alliance
			TOTAL WAKE SITES		**175**
PRACTITIONER-DW/30	CRISP	GREGORY H. MD	BURLINGTON	Alamance	Cardinal
PRACTITIONER-DW/30	FAHEEM	UZMA S (M.D)	BURLINGTON	Alamance	Cardinal
PRACTITIONER-DW/275	AHLUWALIA	SHAMSHER S MD	BURLINGTON	Alamance	Cardinal
PRACTITIONER-DW/30	KHAN	FAROOQUE S MD	BURLINGTON	Alamance	Cardinal
PRACTITIONER-DW/30	MCGRATH	TIMOTHY J	MEBANE	Alamance	Cardinal
PRACTITIONER-DW/100	HALL	GEORGE D MD	CONCORD	Cabarrus	Cardinal
PRACTITIONER-DW/30	LEVIN	LAURA ANN MD	CONCORD	Cabarrus	Cardinal
PRACTITIONER-DW/275	NOFAL	PHILIP ALEXANDER JR MD	CONCORD	Cabarrus	Cardinal
PRACTITIONER-DW/30	EL SAFY	JOUMANA H	CONCORD	Cabarrus	Cardinal
PRACTITIONER-DW/275	DIMKPA	RAJESHREE TULLOO	KANNAPOLIS	Cabarrus	Cardinal
PRACTITIONER-DW/30	AHO	NICOLE, F (MD)	CONCORD	Cabarrus	Cardinal
PRACTITIONER-DW/275	CARTER	NATHAN M. M.D.	CONCORD	Cabarrus	Cardinal
PRACTITIONER-DW/30	ROWLING	JASON C. DO	CONCORD	Cabarrus	Cardinal
MLP-PA-DW/30	JOYNER	COLBY E (PA-C)	CONCORD	Cabarrus	Cardinal
PRACTITIONER-DW/100	SPILLMANN	CELIA L M MD	YANCEYVILLE	Caswell	Cardinal
PRACTITIONER-DW/30	LOHR	LLOYD DERMOT MD	LEXINGTON	Davidson	Cardinal
PRACTITIONER-DW/30	LEKWAUWA	UREH NNENNA MD	THOMASVILLE	Davidson	Cardinal
PRACTITIONER-DW/30	RICHARDSON	CAROL W (M.D.)	LEXINGTON	Davidson	Cardinal
PRACTITIONER-DW/30	DETRICK	KENNETH JOHN MD	ADVANCE	Davie	Cardinal
PRACTITIONER-DW/30	KRAMER	STEPHEN I MD	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	KIRLEY	STEPHEN WALTER MD	CLEMMONS	Forsyth	Cardinal
PRACTITIONER-DW/100	PHAN	THAI T MD	WINSTON-SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	SPIVEY	DAVID L MD	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	AKHTAR	NADEEM MD	KERNERSVILLE	Forsyth	Cardinal
PRACTITIONER-	BAILEY	RAHN KENNEDY MD	WINSTON	Forsyth	Cardinal

DW/100			SALEM		
PRACTITIONER-DW/30	CREQUE	HALIMENA M MD	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	CHALLA	SURYA K MD	WINSTON-SALEM	Forsyth	Cardinal
PRACTITIONER-DW/275	CHINN	MARK	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/100	DUNHAM	CHARLES K MD	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	GLIGOROVIC	PREDRAG V	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	JARRETT	DAVID B MD	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/100	KIMBALL	JAMES N MD	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	EDWARDS	JESSICA A	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	MARSHALL	WILLIAM J MD	CLEMMONS	Forsyth	Cardinal
PRACTITIONER-DW/275	MANTIN	ARIE MD	CLEMMONS	Forsyth	Cardinal
PRACTITIONER-DW/30	PUGH	RAEFORD THEODORE JR MD	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/100	THOTAKURA	RAJAKUMAR MD	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/100	THOTAKURA	UMALAKSHMI KANURU	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	STEPHENS	WAYLAND CHAD (MD)	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	SPANGLER	JOHN GIVEN MD	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/275	WILLIAMS	BARRY N MD	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	WYDERSKI	RICHARD J MD	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	AKERS	LALITA, M, MD	WINSTON-SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	AYERS	DEREK, C (DO)	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	BUTTAR	TAYYBA,G MD	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	BELL	TIFFANI L MD	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/275	CARMEN	KEVIN, P, MD	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/100	DERREBERRY	JESSICA C (MD)	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	DOUGLAS	HEATHER, E, (MD)	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	IKWECHEGH	OBINNA . O	WINSTON SALEM	Forsyth	Cardinal

PRACTITIONER-DW/100	IHEAGWARA	CHINEDU M (MD)	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	KNEBL KOHL	GISELA E, MD	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	KLEIN	KELLEY-ANNE, C	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	OBASI	IKENNA E	WINSTON-SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	PATEL	RAJ K (MD)	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	RUKSTALIS	MARGARET R	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/275	SMITH	BRYAN G (M.D.)	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/275	SCHEUTZOW	MARK H (MD)	WINSTON-SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	SUBEDI	JAGANNATH (MD)	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	SMITH	RICHARD	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/30	WEBSTER	LAURENCE S M.D.	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/100	YUAN	WEIQING S, MD	WINSTON SALEM	Forsyth	Cardinal
PRACTITIONER-DW/100	STOVER	PHILLIP E MD	LOUISBURG	Franklin	Cardinal
PRACTITIONER-DW/30	CHEEVERS	TANYA R	BUTNER	Granville	Cardinal
PRACTITIONER-DW/30	FORD	STEPHEN M MD	BUTNER	Granville	Cardinal
PRACTITIONER-DW/100	HENRY	CAMILLE MAY MD	BUTNER	Granville	Cardinal
PRACTITIONER-DW/30	LARSON	THOMAS C MD	BUTNER	Granville	Cardinal
PRACTITIONER-DW/30	OATES	ELIZABETH W MD	BUTNER	Granville	Cardinal
PRACTITIONER-DW/30	SNYDER	MARK P MD	BUTNER	Granville	Cardinal
PRACTITIONER-DW/30	WU	SHEUE-MEI	BUTNER	Granville	Cardinal
PRACTITIONER-DW/30	CARROLL	VICTORIA, L.	BUTNER	Granville	Cardinal
PRACTITIONER-DW/30	KHALID	ABDUL SHAKOOR MD	BUTNER	Granville	Cardinal
PRACTITIONER-DW/30	KAESEMEYER	NADIYA	BUTNER	Granville	Cardinal
PRACTITIONER-DW/30	ARTIS	KARLUS C MD	SCOTLAND NECK	Halifax	Cardinal
PRACTITIONER-DW/30	MAMEDI	RAVINDER MD	ROANOKE RAPIDS	Halifax	Cardinal
PRACTITIONER-	MOORE	RICHARD	ROANOKE	Halifax	Cardinal

DW/30			RAPIDS		
PRACTITIONER-DW/100	ARONOFF	GERALD M MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	BENFIELD	EDWARD S II MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	CASAT	CHARLES DEAN	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	ASHLEY	CARLENE D DO	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	ELLIS	CLARENCE O MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	HENDRA	JILL L DO	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	HIGHLEY	FRANK SHAPLEY MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/100	LOMBARDI	VINCENT A MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	NILENDER	OLAV MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	OLOWOFOYEKU	BAMISEGUN V MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/275	OWENSBY	CHARLTON N MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/275	RAAD	GEORGE L MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	SEARLES	ANTHONY D MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	TRAXLER	MARYANN MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	THOMPSON	ERVIN MAGNUS MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/275	WRIGHT-ETTER	PAMELA J MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/100	WYATT	STEPHEN ARMSTRONG DO	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	AGHA	MAHER SALAH MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	ABRAHAM	KURIAN C MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	AJAYI	BAMIDELE, A (MD)	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/100	BURSON	JANA K MD	CORNELIUS	Mecklenburg	Cardinal
PRACTITIONER-DW/30	BRAR	PREETINDER P SINGH MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/100	BAUER	STEVEN ROBERT DO,PC	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	BOCHACKI	ZOFIA	DAVIDSON	Mecklenburg	Cardinal
PRACTITIONER-DW/100	BRAY	KIRSTEN N MD	CHARLOTTE	Mecklenburg	Cardinal

PRACTITIONER-DW/30	CARLTON	THOMAS KERN III MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/100	DODDS	CHERYL CONNOR MD	DAVIDSON	Mecklenburg	Cardinal
PRACTITIONER-DW/100	ETTER	KEVIN MCKELVEY MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/275	EKWONU	TAGBO J MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/100	FITZGERALD	THOMAS M JR MD	DAVIDSON	Mecklenburg	Cardinal
PRACTITIONER-DW/275	FERNANDO	JAY GRAYSON MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/100	GOLDBERGER	NEAL M MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	GOINS	WENDELL AUBREY	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/275	GAFFNEY	MARY E DO	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/275	GOLDBERG	NEIL LESLIE	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/100	GRAY	LEE V MD	HUNTERSVILLE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	NEWBY	STEPHANIE F. MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	HARTNAGEL	WILLIAM R MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	HALL	JOHN D MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	HUYNH	TUAN A MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	IFILL-TAYLOR	DARLENE (MD)	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	KUROSKI-MAZZEI	ALYSON R (DO)	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	LORD	CHRISTOPHER E MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	LOUIE	ANGELA K MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/100	MELVIN	JEAN ALLEN MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/275	MCEWEN	LUTHER MORRIS MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	MANEJWALA	OMAR SHARIF MD	MATTHEWS	Mecklenburg	Cardinal
PRACTITIONER-DW/30	OKONNEH	HENRY A MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	ONAFOWOKAN	JOEL A	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/275	OVERTON	EDWARD A DO	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-	RAYES-PRINCE	EMILY J MD	CHARLOTTE	Mecklenbu	Cardinal

DW/100				rg	
PRACTITIONER-DW/30	REGER	LANCE B MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	SEWARD	DANIEL P MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	SHAH	DEVENDRA C MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	SHAH	AMISHI YOGESH MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	SWANEY	MICHAEL J (MD)	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/100	STOUDMIRE	JONATHAN K MD	MATTHEWS	Mecklenburg	Cardinal
PRACTITIONER-DW/100	SEMEKO	ERIC	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	TAM	KIM H MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/275	TAUB	NEAL	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/275	TAYLOR	WILLIAM F MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/275	TROMBLEY	MICHAEL J MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/100	THOMPSON	JILL ELLEN MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	VAN HORN	WILLIAM A MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/100	WYNN	RICHARD THOMAS WEAVER MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	WILSON	LARRY TERRELL	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/100	YOUSUFF	SARAH, S, MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	YEOMANS	JAY A MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/100	ZENG	GUANGBIN MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	ARENA	MICHAEL C (MD)	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	BESTHA	DURGA P	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	COTOMAN	DAN N (MD)	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	CHRISTO	MICHAEL	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/100	CHANDER	PUSHPA	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	DUNCAN	GINA N., MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	DAINER	ERIN M MD	CHARLOTTE	Mecklenburg	Cardinal

PRACTITIONER-DW/30	DIEB	RAMI	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	HORNER	DONALD S MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/100	IBANEZ	NOEL D	DAVIDSON	Mecklenburg	Cardinal
PRACTITIONER-DW/100	JACOBS MD	GORDON W	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	LUCCERINI	SILVIA , L	MATTHEWS	Mecklenburg	Cardinal
PRACTITIONER-DW/30	LEWIS	BRIAN	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	MARFO	MAGDALENE (M.D.)	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	MANOS	HEATHER M (MD)	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	MOGABGAB	EDWARD R.	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	NYANDJO	CLEMENCE, T, MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	RUCCI	JENNIFER MARIE, MD	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	ROSE	TOKUNBOH, T (MD)	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	RACHAL	JAMES	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/275	SEITZ	KENT	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	SEGURA	JENNIFER S (MD)	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	SANTOS CUBINA	JAVIER (MD)	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	HERMAN	ERICA E MD	CHARLOTTE	Mecklenburg	Cardinal
MLP-PA-DW/30	JOHNS JR	PHIL O (MSBS)	CHARLOTTE	Mecklenburg	Cardinal
MLP-NP-DW/30	LISTON	LAURA	CHARLOTTE	Mecklenburg	Cardinal
MLP-NP-DW/30	WALLACE	MARQUITA	CHARLOTTE	Mecklenburg	Cardinal
MLP-NP-DW/30	BYERS	KAISHA, W, PA-C	CHARLOTTE	Mecklenburg	Cardinal
PRACTITIONER-DW/30	MALTBIE	ALLAN A MD	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/100	GARBUTT	JAMES CAMERON MD	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	HAGGERTY	JOHN J	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	PEDERSEN	CORT ANDREW MD	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-	BRADFORD	DANIEL	CHAPEL HILL	Orange	Cardinal

DW/30					
PRACTITIONER-DW/100	FEDORIW	KELLY BOSSENBROEK MD	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	GREASON	FRANCES C MD	HILLSBOROUGH	Orange	Cardinal
PRACTITIONER-DW/30	DEVRIES	ABIGAIL	CARRBORO	Orange	Cardinal
PRACTITIONER-DW/30	GERKIN	JONATHAN S	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	OBARR	ALLEN HAMRICK MD	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	HUTTO	BURTON MD	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	HALL	AUSTIN B	CARRBORO	Orange	Cardinal
PRACTITIONER-DW/100	BYRNE	JENNIE L MD	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	KNERR	JULIA MD	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/275	LOPEZ-CLAROS	MARCELO E MD	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/100	MALLOY	ERIN M MD	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	MONTANA	LESLIE	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	HOWELL	JENNIFER O MD	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	ROGERS	HEATHER A MD	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	TANNER	T BRADLEY MD	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/275	THORP	JR JOHN M MD	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/275	WEED	BARRY, C, (MD)	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	WILEY CENE	CRYSTAL N	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	BARNHILL	JESSICA,L, MD	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/275	BADER	MATTHEW THOMAS	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	BOYCE	ROSS	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	CARLSON	LAURA G (MD)	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	DOTTERS-KATZ	SARAH, K (MD)	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	GRACE	MATTHEW R (MD)	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	GRANT	JACQUELINE H (MD)	CHAPEL HILL	Orange	Cardinal

PRACTITIONER-DW/30	KIMMEL	MARY C	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	LINDQUIST	LISA KATHARYN	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	MCPHERSON	JESSICA A (MD)	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/100	JORDAN	ROBYN	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	MATTHEWS	WILLIAM, B, MD	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	MORRIS	SANDRA BETH	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	PARK	ELIZA M (MD)	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/100	REDDY	VINAY,C, (MD, MPH)	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	RUMINJO	ANNE (MD)	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	REED	ROBIN, M	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	SHERMAN	PAULA	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	STRAIN	ANGELA K (MD)	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	SMID	MARCELA	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	TAYLOR	REBECCA VICTORIA	HILLSBOROUGH	Orange	Cardinal
PRACTITIONER-DW/100	WOOTEN	CANDRA, K	CHAPEL HILL	Orange	Cardinal
MLP-NP-DW/30	JOHNSON	ELISABETH A (MSN, FNP)	CHAPEL HILL	Orange	Cardinal
PRACTITIONER-DW/30	JENSEN	THOMAS, P MD	ROXBORO	Person	Cardinal
PRACTITIONER-DW/100	DOONQUAH	KOFI A MD	REIDSVILLE	Rockingham	Cardinal
PRACTITIONER-DW/30	STACKS	WARREN D MD	MADISON	Rockingham	Cardinal
PRACTITIONER-DW/275	RUSSELL	DAVID NORMAN MD	SALISBURY	Rowan	Cardinal
PRACTITIONER-DW/30	ASHISH-MISHRA	SONIA MD	SALISBURY	Rowan	Cardinal
PRACTITIONER-DW/100	CHANDER	ERNEST R MD	SALISBURY	Rowan	Cardinal
PRACTITIONER-DW/30	GUPTA	NITYANAND D MD	SALISBURY	Rowan	Cardinal
PRACTITIONER-DW/30	PATEL	RAMESH D MD	SALISBURY	Rowan	Cardinal
PRACTITIONER-DW/100	SHAH	BINOY J (MD)	SALISBURY	Rowan	Cardinal
PRACTITIONER-	TROYER	ERIC C MD	LANDIS	Rowan	Cardinal

DW/275					
PRACTITIONER-DW/100	HAZEL	LETITIA MARIE	SALISBURY	Rowan	Cardinal
PRACTITIONER-DW/30	TEDROW	UMPAI POOPAT DO	SALISBURY	Rowan	Cardinal
PRACTITIONER-DW/275	SPELLS	LORI B E (MD)	SALISBURY	Rowan	Cardinal
PRACTITIONER-DW/30	YANG	LAO P (MD)	SALISBURY	Rowan	Cardinal
MLP-PA-DW/30	MCCORKLE	ALEXIS, W (PA-C)	SALISBURY	Rowan	Cardinal
MLP-NP-DW/30	TREASURE	KAREN, R	SALISBURY	Rowan	Cardinal
PRACTITIONER-DW/30	MCHALE	ROBERT J	ALBEMARLE	Stanly	Cardinal
PRACTITIONER-DW/30	BUNNOW	THOMAS LAWRENCE MD	WAXHAW	Union	Cardinal
PRACTITIONER-DW/100	EMERY	HENRY R JR MD	WEDDINGTON	Union	Cardinal
PRACTITIONER-DW/30	HARDY	STEPHEN C	WAXHAW	Union	Cardinal
PRACTITIONER-DW/30	OKWARA	ADANMA M (MD)	MONROE	Union	Cardinal
PRACTITIONER-DW/30	OKWARA	BENEDICT ONWUKWE MD	MONROE	Union	Cardinal
PRACTITIONER-DW/30	SMITH	DAVID NATHANIEL	WAXHAW	Union	Cardinal
PRACTITIONER-DW/30	TSERING	CHOCK MD	MONROE	Union	Cardinal
PRACTITIONER-DW/275	ONAFUYE	RASHEED A (MD)	MONROE	Union	Cardinal
PRACTITIONER-DW/100	SALISU	ADAMU	MONROE	Union	Cardinal
PRACTITIONER-DW/100	WRIGHT	WILLIAM FORD	MONROE	Union	Cardinal
			TOTAL CARDINAL SITES		**246**
PRACTITIONER-DW/30	PRATHER	TRINA D MD	ELIZABETHTOWN	Bladen	Eastpointe
PRACTITIONER-DW/100	VAZQUEZ	ANGEL LUIS MD	WHITEVILLE	Columbus	Eastpointe
PRACTITIONER-DW/30	WHITE	DIANE, C, MD	WHITEVILLE	Columbus	Eastpointe
MLP-NP-DW/30	MCKEITHAN	DIANA M.	WHITEVILLE	Columbus	Eastpointe
PRACTITIONER-DW/30	OLATIDOYE	CONSTANCE	ROSE HILL	Duplin	Eastpointe
PRACTITIONER-DW/100	BARKER	MARSHALL JAY	SNOW HILL	Greene	Eastpointe
PRACTITIONER-DW/30	PREECHA	BHOTIWIHOK MD	KINSTON	Lenoir	Eastpointe
PRACTITIONER-DW/275	SCOTT	LORI C. MD	KINSTON	Lenoir	Eastpointe

PRACTITIONER-DW/30	MALLETTE	JULIUS Q	KINSTON	Lenoir	Eastpointe
PRACTITIONER-DW/30	MACNICHOL	GLENN E MD	ROCKY MOUNT	Nash	Eastpointe
PRACTITIONER-DW/30	PICKETT	JOHN R (DO)	ROCKY MOUNT	Nash	Eastpointe
PRACTITIONER-DW/30	PATEL	DIVYA J	ROCKY MOUNT	Nash	Eastpointe
PRACTITIONER-DW/30	CUMMINGS	SAMUEL M MD	LUMBERTON	Robeson	Eastpointe
PRACTITIONER-DW/100	OSMAN	MOHAMED B MD	ST PAULS	Robeson	Eastpointe
PRACTITIONER-DW/30	PURDY	RANDALL LEE JR MD	LUMBERTON	Robeson	Eastpointe
PRACTITIONER-DW/30	PEACE	ROBIN YOLANDA MD	LUMBERTON	Robeson	Eastpointe
PRACTITIONER-DW/100	THOMAS-MONTILUS	SANDHYA MD	LUMBERTON	Robeson	Eastpointe
PRACTITIONER-DW/275	MCCORMICK	CAROLYN BRUMM MD	LUMBERTON	Robeson	Eastpointe
PRACTITIONER-DW/30	SCANNELL	MARGARET A	LUMBERTON	Robeson	Eastpointe
PRACTITIONER-DW/30	HYMAN	HENRY TED DO	CLINTON	Sampson	Eastpointe
PRACTITIONER-DW/30	BOTWRIGHT JR	GENE R	LAURINBURG	Scotland	Eastpointe
PRACTITIONER-DW/275	GAGLIANO	LOUIS A MD	GOLDSBORO	Wayne	Eastpointe
PRACTITIONER-DW/100	BHATTI	MUHAMMAD A MD	GOLDSBORO	Wayne	Eastpointe
PRACTITIONER-DW/30	CUMMINGS	DE LORA BERTHA MD	GOLDSBORO	Wayne	Eastpointe
PRACTITIONER-DW/30	RAUF	ZAHID MD	GOLDSBORO	Wayne	Eastpointe
PRACTITIONER-DW/275	TABE	WILSON E MD	GOLDSBORO	Wayne	Eastpointe
PRACTITIONER-DW/275	AHMED	MAQSOOD	GOLDSBORO	Wayne	Eastpointe
PRACTITIONER-DW/30	MCGILL	MONICA, A (M.D.)	GOLDSBORO	Wayne	Eastpointe
PRACTITIONER-DW/100	ULLAH	ABM E MD	GOLDSBORO	Wayne	Eastpointe
PRACTITIONER-DW/30	ANDERSON	ALTON R MD	WILSON	Wilson	Eastpointe
PRACTITIONER-DW/30	GABRIEL	ZIZETTE M MD	WILSON	Wilson	Eastpointe
PRACTITIONER-DW/30	SAINT LOUIS	IMMACULA MD	WILSON	Wilson	Eastpointe
PRACTITIONER-DW/30	VERMA	KRISHNA, M. MD	WILSON	Wilson	Eastpointe
			TOTAL EASTPOINTE SITES		**33**

PRACTITIONER-DW/275	FREEMAN	JOHN JACKSON MD	MORGANTON	Burke	Partners
PRACTITIONER-DW/30	KREBS	GEORGE H JR MD	MORGANTON	Burke	Partners
PRACTITIONER-DW/30	SCHMITT	PHILIP J MD	MORGANTON	Burke	Partners
PRACTITIONER-DW/30	SHERRILL	JOHN HOLLOWAY MD	RUTHERFORD COLLEGE	Burke	Partners
PRACTITIONER-DW/30	SHAH-KHAN	SADAR MAHMOOD	MORGANTON	Burke	Partners
PRACTITIONER-DW/30	FRASCA	ANTHONY MD	MORGANTON	Burke	Partners
PRACTITIONER-DW/30	HUSSEIN	DIAA ELDIN A MD	MORGANTON	Burke	Partners
PRACTITIONER-DW/100	KIRK	DAVID WILLIAM MD	MORGANTON	Burke	Partners
PRACTITIONER-DW/30	MOHIUDDIN	MASOOD MD	MORGANTON	Burke	Partners
PRACTITIONER-DW/30	MAZZOLA	JOSEPH C DO	MORGANTON	Burke	Partners
PRACTITIONER-DW/30	MEEK	THOMAS E	RUTHERFORD COLLEGE	Burke	Partners
PRACTITIONER-DW/275	SWISHER	AARON M MD	HILDEBRAN	Burke	Partners
PRACTITIONER-DW/30	MARTIN	GARY LEONARD MD	HILDEBRAN	Burke	Partners
MLP-NP-DW/30	MILLS	MICHELLE, G, NP-C	MORGANTON	Burke	Partners
PRACTITIONER-DW/30	BRANYON	DAVID W MD, PLLC	HICKORY	Catawba	Partners
PRACTITIONER-DW/30	FASANELLO	RICHARD ANTHONY DO	NEWTON	Catawba	Partners
PRACTITIONER-DW/30	LOVE	CAROLYN ARNZIETTA MD	HICKORY	Catawba	Partners
PRACTITIONER-DW/30	ESPIRITU	MARIA CARMEN E	HICKORY	Catawba	Partners
PRACTITIONER-DW/30	GOLD	STEVEN A MD	CONOVER	Catawba	Partners
PRACTITIONER-DW/275	HANSEN	HANS C MD	CONOVER	Catawba	Partners
PRACTITIONER-DW/30	HO	JAMES J MD	HICKORY	Catawba	Partners
PRACTITIONER-DW/275	RUDISILL	ELBERT ANDREW JR MD	HICKORY	Catawba	Partners
PRACTITIONER-DW/275	SYNN	JAY MD	HICKORY	Catawba	Partners
PRACTITIONER-DW/30	MALHOTRA	KAAYA DO	HICKORY	Catawba	Partners
PRACTITIONER-DW/30	SULLIVAN	JUSTIN L. DO	HICKORY	Catawba	Partners
PRACTITIONER-	WILLIAMS	DENNIS R MD	HICKORY	Catawba	Partners

DW/100					
MLP-PA-DW/30	RUDISILL	KATHY	HICKORY	Catawba	Partners
PRACTITIONER-DW/275	BRADLEY	GEORGE L DO	SHELBY	Cleveland	Partners
PRACTITIONER-DW/275	CALABRIA	RAFAEL A MD	SHELBY	Cleveland	Partners
PRACTITIONER-DW/100	LUVIS	CLAUDE MD	GASTONIA	Gaston	Partners
PRACTITIONER-DW/30	SHUKLA	VIKRAM R MD	GASTONIA	Gaston	Partners
PRACTITIONER-DW/30	AKHIMIEN	AZEMOBO C MD	GASTONIA	Gaston	Partners
PRACTITIONER-DW/100	BALL	TRACEI D MD	BELMONT	Gaston	Partners
PRACTITIONER-DW/100	FORINASH	ROBERT A MD	GASTONIA	Gaston	Partners
PRACTITIONER-DW/100	GIHWALA	RAMESH MD	GASTONIA	Gaston	Partners
PRACTITIONER-DW/30	GIRMAY	AREGAI A MD	GASTONIA	Gaston	Partners
PRACTITIONER-DW/30	OWUSU-ADDO	YAW A MD	GASTONIA	Gaston	Partners
PRACTITIONER-DW/30	OKONKWO	CORNELIUS S DO	GASTONIA	Gaston	Partners
PRACTITIONER-DW/275	PATEL	SUBHASH P MD	GASTONIA	Gaston	Partners
PRACTITIONER-DW/275	SHUKLA	NILIMA V MD	GASTONIA	Gaston	Partners
PRACTITIONER-DW/275	SMITH	MICHAEL A MD	MOUNT HOLLY	Gaston	Partners
PRACTITIONER-DW/30	SLOAND	TIMOTHY P MD	GASTONIA	Gaston	Partners
PRACTITIONER-DW/30	DUNHAM	MAYISHA, W, MD	GASTONIA	Gaston	Partners
PRACTITIONER-DW/100	LUVIS	CHARMAINE, N (DO)	GASTONIA	Gaston	Partners
PRACTITIONER-DW/100	LUVIS	SHERRYL	GASTONIA	Gaston	Partners
MLP-NP-DW/30	PAYNE	SUSAN PAULETTE NP, DNP	GASTONIA	Gaston	Partners
MLP-NP-DW/30	THOMPSON	JULIE,P.	GASTONIA	Gaston	Partners
PRACTITIONER-DW/100	HILL	PATRICIA KAYE MD	STATESVILLE	Iredell	Partners
PRACTITIONER-DW/100	BREMNOR	JUDY D MD	MOORESVILLE	Iredell	Partners
PRACTITIONER-DW/275	KEARNEY	BOBBY PAXTON MD	STATESVILLE	Iredell	Partners
PRACTITIONER-DW/30	PEREZ	JOSE EDUARDO MD	STATESVILLE	Iredell	Partners
PRACTITIONER-DW/100	SINGLETON	AMY, H, MD	STATESVILLE	Iredell	Partners

PRACTITIONER-DW/30	SHAH	NIMESH BHUPENDRA MD	STATESVILLE	Iredell	Partners
PRACTITIONER-DW/30	WOLYNIAK	JOSEPH	MOORESVILLE	Iredell	Partners
PRACTITIONER-DW/100	ZAPATA	MARIO G MD	STATESVILLE	Iredell	Partners
PRACTITIONER-DW/30	LAGUERRE	PATRICK, J (MD)	MOORESVILLE	Iredell	Partners
MLP-NP-DW/30	HAYES	BARBARA J	STATESVILLE	Iredell	Partners
MLP-NP-DW/30	DAVIS	CAROLYN	MOORESVILLE	Iredell	Partners
PRACTITIONER-DW/30	MOISE	DUANE M DO	LINCOLNTON	Lincoln	Partners
PRACTITIONER-DW/30	CORTEZ	ERWIN P. (MD)	DENVER	Lincoln	Partners
PRACTITIONER-DW/100	RAINES	BEN A DO	ELKIN	Surry	Partners
PRACTITIONER-DW/100	NOVEMBRE	EMIDIO M DO	ELKIN	Surry	Partners
PRACTITIONER-DW/100	SHUCK	LINDA M	DOBSON	Surry	Partners
PRACTITIONER-DW/100	STORK	RICHARD J MD	ELKIN	Surry	Partners
			TOTAL PARTNERS SITES		**64**
PRACTITIONER-DW/30+B53B530:B548	PILAGIN	LORETTA J MD	WADESBORO	Anson	Sandhills Center
PRACTITIONER-DW/100	CHALLA	VENKATA RAMANA MD	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/30	KAPLAN	DAVID MANN	STOKESDALE	Guilford	Sandhills Center
PRACTITIONER-DW/100	LUGO	IRVING A MD	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/100	SIMPSON	THOMAS EDWARD MD	JAMESTOWN	Guilford	Sandhills Center
PRACTITIONER-DW/30	SENA	CAROL LITTLE	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/30	STEINER	JANE L MD	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/100	WHEELER	ANTHONY H MD	HIGH POINT	Guilford	Sandhills Center
PRACTITIONER-DW/275	BROWN	THOMAS WALTER MD	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/275	STALLINGS	SHEILA C MD	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/275	CORRINGTON	KIP A MD	OAK RIDGE	Guilford	Sandhills Center
PRACTITIONER-DW/275	CARAVAGLIA	GINA M DO	HIGH POINT	Guilford	Sandhills Center
PRACTITIONER-DW/30	D'ALLURA	SAL A DO	HIGH POINT	Guilford	Sandhills Center

PRACTITIONER-DW/100	DAVIS	JEROME ERVIN MD	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/275	HEJAZI	MASOUD S MD	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/100	KAUR	RUPINDER D	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/30	KIM	JAMES Y MD	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/30	MALDONADO	EDGARDO G MD	HIGH POINT	Guilford	Sandhills Center
PRACTITIONER-DW/30	NELSON	KRISTINE A	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/30	OSEI-BONSU	GEORGE	HIGH POINT	Guilford	Sandhills Center
PRACTITIONER-DW/275	PLUMMER	CHARLES WAYNE MD	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/100	PAVELOCK	RICHARD M MD	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/100	REDDY	KESHAVPAL GUNNA MD	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/30	SKEEN	JAMES T MD	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/100	AKINTAYO	MOJEED A (M.D)	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/275	BOOK	ROY, D (MD)	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/30	BLOOM	MITCHELL, J, M.D.	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/30	CONSTANT	PEGGY (MD)	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/30	ENIOLA	KEHINDE,T	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/30	FISCHER	TIMOTHY LEE	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/30	GAGE	GIULIANA	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/30	KALE	GAUTAM,K,(MD,MS)	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/30	PADGETT	JOSEPH	HIGH POINT	Guilford	Sandhills Center
PRACTITIONER-DW/30	STINSON	JACOB, J, DO	GREENSBORO	Guilford	Sandhills Center
PRACTITIONER-DW/30	WASHO	MICHAEL J. MD	GREENSBORO	Guilford	Sandhills Center
MLP-NP-DW/30	CROUSE	BLAIR R.	GREENSBORO	Guilford	Sandhills Center
MLP-NP-DW/30	STEELE	ANTHONY T. NP	HIGH POINT	Guilford	Sandhills Center
PRACTITIONER-DW/100	GITTELMAN	DAVID K, DO	LILLINGTON	Harnett	Sandhills Center
PRACTITIONER-DW/275	DAVE	NAILESH D.	LILLINGTON	Harnett	Sandhills Center

PRACTITIONER-DW/100	JAMES SURGERS	SHERRI Y MD	DUNN	Harnett	Sandhills Center
PRACTITIONER-DW/100	MARIA	JOSETTE	DUNN	Harnett	Sandhills Center
PRACTITIONER-DW/30	SMITH	KAREN LINNEA MD	RAEFORD	Hoke	Sandhills Center
PRACTITIONER-DW/100	AJMANI	AJAY K MD	SANFORD	Lee	Sandhills Center
PRACTITIONER-DW/30	ASADI	KATHERINE ANNE	SANFORD	Lee	Sandhills Center
PRACTITIONER-DW/275	WOODYEAR, JR.	JOHN M MD	TROY	Montgomery	Sandhills Center
PRACTITIONER-DW/100	COLLINS	GREGORY BRUCE MD	PINEHURST	Moore	Sandhills Center
PRACTITIONER-DW/275	FLEURY	ROBERT ANDRE MD	PINEHURST	Moore	Sandhills Center
PRACTITIONER-DW/100	PETER	PREMKUMAR MD (DBA PREM)	WEST END	Moore	Sandhills Center
PRACTITIONER-DW/275	CORRIGAN	FRANCIS C MD	PINEHURST	Moore	Sandhills Center
PRACTITIONER-DW/30	CLARY	GREG LAWSON MD	PINEHURST	Moore	Sandhills Center
PRACTITIONER-DW/100	FOX	OLIN M MD	PINEHURST	Moore	Sandhills Center
PRACTITIONER-DW/100	JERRY	JASON MATTHEW	PINEHURST	Moore	Sandhills Center
PRACTITIONER-DW/100	KLENZAK	SCOTT MICHAEL MD	PINEHURST	Moore	Sandhills Center
PRACTITIONER-DW/30	MANDELL	MARY THOMAS MD	PINEHURST	Moore	Sandhills Center
PRACTITIONER-DW/30	TAYLOR	JAMES EDWARD	PINEHURST	Moore	Sandhills Center
PRACTITIONER-DW/30	HIRSCH	JO ELLEN (MD)	PINEHURST	Moore	Sandhills Center
MLP-PA-DW/30	BELL	AMY, M, (PA-C)	PINEHURST	Moore	Sandhills Center
MLP-PA-DW/30	MITCHEL	ROGER	SOUTHERN PINES	Moore	Sandhills Center
MLP-NP-DW/30	SCHWARTING	JANE	PINEHURST	Moore	Sandhills Center
PRACTITIONER-DW/275	CAMPBELL	STEPHEN DOUGLAS MD	ASHEBORO	Randolph	Sandhills Center
PRACTITIONER-DW/100	GULLAPALLI	SWARUPARANI V MD	ASHEBORO	Randolph	Sandhills Center
PRACTITIONER-DW/275	LEE	KEUNG WAI MD	ASHEBORO	Randolph	Sandhills Center
PRACTITIONER-DW/30	PEKAREK	ELIZABETH M MD	ASHEBORO	Randolph	Sandhills Center
			TOTAL SANDHILLS SITES		**63**
PRACTITIONER-DW/30+B5B595:B61	SWAMINATHAN, M.D	VISWANATHAN	WASHINGTON	Beaufort	Trillium

4					
PRACTITIONER-DW/100	CORLEY	BONNIE S MD	WASHINGTON	Beaufort	Trillium
PRACTITIONER-DW/100	GARCIA	PAUL	WASHINGTON	Beaufort	Trillium
PRACTITIONER-DW/30	KOLAPPA	KALAVATHI MD	WASHINGTON	Beaufort	Trillium
PRACTITIONER-DW/30	SEIBEL	KATHLEEN M. M.D.	WASHINGTON	Beaufort	Trillium
MLP-NP-DW/30	BUNCH	AMANDA C FNP	WASHINGTON	Beaufort	Trillium
PRACTITIONER-DW/30	FERGUSON	STEVEN W MD	POWELLSVILLE	Bertie	Trillium
PRACTITIONER-DW/30	ALMIRALL	PETER D MD	OAK ISLAND	Brunswick	Trillium
PRACTITIONER-DW/100	AZZATO	JOHN A MD	SOUTHPORT	Brunswick	Trillium
PRACTITIONER-DW/30	FAULKNER	ROBERT W MD	SOUTHPORT	Brunswick	Trillium
PRACTITIONER-DW/100	JOSEPH	DAVID A MD	SHALLOTTE	Brunswick	Trillium
PRACTITIONER-DW/30	LICATA	ROBERT MICHAEL MD	SHALLOTTE	Brunswick	Trillium
PRACTITIONER-DW/30	MACCALLUM	DANIEL B MD	SOUTHPORT	Brunswick	Trillium
PRACTITIONER-DW/275	SEDER	JEFFREY DAVID MD	SUPPLY	Brunswick	Trillium
PRACTITIONER-DW/100	ALATAR	KIRA M, MD	LELAND	Brunswick	Trillium
PRACTITIONER-DW/275	CHRISTIE	NATHAN MD	LELAND	Brunswick	Trillium
PRACTITIONER-DW/30	LEPORE	HENRY MD	SUNSET BEACH	Brunswick	Trillium
PRACTITIONER-DW/30	PRICE	KEVIN D DO	SHALLOTTE	Brunswick	Trillium
PRACTITIONER-DW/30	TESTER	PATRICK W	LELAND	Brunswick	Trillium
PRACTITIONER-DW/30	WILLEFORD	KENNETH LEE MD	SUPPLY	Brunswick	Trillium
PRACTITIONER-DW/100	KING, JR.	LUNSFORD	SHALLOTTE	Brunswick	Trillium
MLP-NP-DW/30	WILLEFORD	CARLEEN M DNP	SUPPLY	Brunswick	Trillium
PRACTITIONER-DW/30	JAWORSKI	DAVID A MD	MOREHEAD CITY	Carteret	Trillium
PRACTITIONER-DW/275	MCKNIGHT	KEVIN	MOREHEAD CITY	Carteret	Trillium
PRACTITIONER-DW/275	CAMPBELL, JR.	GARLON L (MD)	MOREHEAD CITY	Carteret	Trillium
MLP-PA-DW/30	SHELTON	DONNA L.	EMERALD ISLE	Carteret	Trillium
PRACTITIONER-DW/30	HARRIS	PAMELA D DO	NEW BERN	Craven	Trillium
PRACTITIONER-	FOLUKE	ALFRED KWASI MD	NEW BERN	Craven	Trillium

DW/100					
PRACTITIONER-DW/100	NUNN	MICHAEL K DO	NEW BERN	Craven	Trillium
MILITARY PRACTITIONER-DW/30	HAUCK	HEATHER NOELLE	CHERRY POINT	Craven	Trillium
PRACTITIONER-DW/100	SMITH	MICHAEL L MD	DUCK	Dare	Trillium
PRACTITIONER-DW/30	MANN	WILLIAM O DO	MANTEO	Dare	Trillium
PRACTITIONER-DW/30	SUPAN-MCPHERSON	KAREN A	NAGS HEAD	Dare	Trillium
PRACTITIONER-DW/30	STROUD	ZACHARY BLAINE	KITTY HAWK	Dare	Trillium
PRACTITIONER-DW/100	WESSON	PATRICIA WRIGHT MD	AHOSKIE	Hertford	Trillium
PRACTITIONER-DW/100	BENTSEN	BIRGER S MD	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/30	SIMON	JEFFREY SCOTT MD	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/100	ARMITAGE	MARK T MD	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/30	BRIDGER	DEWEY H III MD	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/100	BOEKER	TOM MD	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/100	FERNANDO	LIONEL MD	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/100	GERRY	RUSSELL H MD	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/100	GOTTSCHALK	BERNARD J MD	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/30	GURKIN	BRETT A	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/100	HARRIS	JOHN JOEL, JR.	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/30	ISENBERG	AMY V MD	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/30	LIEDERBACH	STEPHEN J MD	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/30	MCMATH	JONATHAN C. MD	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/275	MATHEW	RANO T MD	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/30	GRAHAM	LINDA H MD	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/100	NEWBERRY	MICHAEL MD	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/275	NJAPA	ANTHONY KECHANTE DO	WILMINGTON	New Hanover	Trillium
PRACTITIONER-	PECORARO	FRANCIS SALVATORE	WILMINGTON	New	Trillium

DW/30		MD		Hanover	
PRACTITIONER-DW/100	ROSE III	JUNIUS H	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/30	SOTIR	CATHERINE LEE MD	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/275	SCONTSAS	GEORGE JOHN MD	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/275	AGBAFE-MOSLEY	DOROTHY, EJINKONYE, MD	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/30	COOK	CRAIG ASHLEY	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/30	FRANK	HARRISON G.	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/100	FEHR	ADRIENNE D (DO)	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/30	GOBALEZA	DOMINADOR, G, III (M.D.)	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/100	KINNEY	KAREN A (MD)	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/275	LYSNE	DWIGHT H (MD, MDIV)	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/30	MCKINNEY	TARA A.S. MD	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/30	OVERSTREET GALEANO	MAYRA A (MD)	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/30	ODIBO	MICHAEL C. M.D	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/100	SALAMI	SAKA A. MD	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/30	SAMPSON, JR	JOSEPH	WILMINGTON	New Hanover	Trillium
MLP-NP-DW/30	BOGART	MEGAN E	WILMINGTON	New Hanover	Trillium
PRACTITIONER-DW/100	LILLQUIST	PATRICIA ANN MD	HUBERT	Onslow	Trillium
PRACTITIONER-DW/30	SPEED	SHARON Y	JACKSONVILLE	Onslow	Trillium
PRACTITIONER-DW/100	WILLIAMS	JOHNNY L MD	JACKSONVILLE	Onslow	Trillium
PRACTITIONER-DW/275	WHITLOCK	GARY T III MD	JACKSONVILLE	Onslow	Trillium
PRACTITIONER-DW/100	BARNES	VICTOR R MD	JACKSONVILLE	Onslow	Trillium
PRACTITIONER-DW/30	BUGLISI	LUCILLE ANN MD	JACKSONVILLE	Onslow	Trillium
PRACTITIONER-DW/100	CAIN	WILBERT MD	JACKSONVILLE	Onslow	Trillium
PRACTITIONER-DW/100	MIKHAIL	ASHRAF G (MD)	JACKSONVILLE	Onslow	Trillium
PRACTITIONER-DW/275	MOORE	BARRY A MD	JACKSONVILLE	Onslow	Trillium

PRACTITIONER-DW/275	REVELL	JEREMY EDWARD MD	JACKSONVILLE	Onslow	Trillium
PRACTITIONER-DW/30	SANCHEZ-MARTINEZ	MARIO J MD	JACKSONVILLE	Onslow	Trillium
MILITARY PRACTITIONER-DW/30	SWAIN	MATTHEW S., DO	CAMP LEJEUNE	Onslow	Trillium
PRACTITIONER-DW/100	TAYLOR	STANLEY DOUGLAS MD	JACKSONVILLE	Onslow	Trillium
PRACTITIONER-DW/30	WILSON	ROBERT W MD	CAMP LEJEUNE	Onslow	Trillium
PRACTITIONER-DW/30	ATLI	AYSEL	CAMP LEJEUNE	Onslow	Trillium
PRACTITIONER-DW/30	ALTMAN	EVAN, M, DO	CAMP LEJEUNE	Onslow	Trillium
PRACTITIONER-DW/100	AHLBERG	DAVID J MD	JACKSONVILLE	Onslow	Trillium
PRACTITIONER-DW/30	ALABI	OLUWASEYE DO	CAMP LEJEUNE	Onslow	Trillium
PRACTITIONER-DW/30	BLAIR III	JAMES S	SURF CITY	Onslow	Trillium
PRACTITIONER-DW/100	SPRAGUE	MARIE	JACKSONVILLE	Onslow	Trillium
MILITARY PRACTITIONER-DW/30	TEMPLE	RICHARD W.	CAMP LEJEUNE	Onslow	Trillium
MILITARY PRACTITIONER-DW/30	WILLIAMSON	BENJAMIN BRIAN (MD)	CAMP LEJEUNE	Onslow	Trillium
PRACTITIONER-DW/100	BOWENS	WILLIAM C MD	ELIZABETH CITY	Pasquotank	Trillium
PRACTITIONER-DW/275	DRURY	JAMES ANTHONY DO	ELIZABETH CITY	Pasquotank	Trillium
PRACTITIONER-DW/30	ROBERTSON	C. BRACEY III MD	ELIZABETH CITY	Pasquotank	Trillium
PRACTITIONER-DW/30	TUCKER	ANTHONY, A	ELIZABETH CITY	Pasquotank	Trillium
PRACTITIONER-DW/30	GARG	SHYAM L MD	HAMPSTEAD	Pender	Trillium
PRACTITIONER-DW/30	CARLSON	RICHARD	BURGAW	Pender	Trillium
PRACTITIONER-DW/30	FINESTONE	DOUGLAS HOWARD MD	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/30	HOLTER	JOHN F MD	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/100	WARD	LAWRENCE F DO	WINTERVILLE	Pitt	Trillium
PRACTITIONER-DW/100	AMES	DAVID MD	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/30	BRYANT	DWAYNE GREGORY MD	GREENVILLE	Pitt	Trillium

PRACTITIONER-DW/30	COYLE	MICHAEL P MD	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/30	DOSS	WILLIAM LAFAYETTE III MD	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/30	DANIEL	MYRIAM MARIE MD	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/100	FLYNN	RUTH C	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/275	LANE	WINSTON EARL III MD	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/30	LANG	MICHAEL C	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/100	LONGEST	SONYA B	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/100	MCCLELLAND	SCOTT R DO	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/100	O'DANIEL	MARK BARNARD DO	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/30	SMITH	BRIAN T MD	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/30	SMITH	BILLY R MD	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/30	TIPTON	DAVID GLEN MD	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/100	ZHU	GENING MD	WINTERVILLE	Pitt	Trillium
PRACTITIONER-DW/30	ANAND	VIVEK	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/100	ELLIS	RICKIE W (MD)	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/30	FLETCHER	ANDREW, S, MD	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/30	GANPAT	PETER, P, (MD)	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/30	HARPER	NATHAN RUSSELL	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/100	KAOUD	HANY	WINTERVILLE	Pitt	Trillium
PRACTITIONER-DW/275	LEONHARDT	GARY, G. MD	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/30	MUTHUKANAGAR AJ	PURUSHOTHAMAN	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/30	RYAN	DAVID H	GREENVILLE	Pitt	Trillium
PRACTITIONER-DW/30	STANCIU	CORNELIU, N., (MD)	GREENVILLE	Pitt	Trillium
MLP-NP-DW/30	EURE	JO ANNE H MSN RN ANP	GREENVILLE	Pitt	Trillium
MLP-NP-DW/30	FLETCHER	MIHAELA, N	GREENVILLE	Pitt	Trillium
			TOTAL TRILLIUM SITES		**127**

PRACTITIONER-DW/30	LATHAM	GEORGIA S MD	GLADE VALLEY	Alleghany	Vaya
PRACTITIONER-DW/275	STRICKLAND	DANIEL M (MD)	WEST JEFFERSON	Ashe	Vaya
PRACTITIONER-DW/30	ANIXTER	WILLIAM L MD	BLACK MOUNTAIN	Buncombe	Vaya
PRACTITIONER-DW/100	BUIE	STEPHEN	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	CALDWELL	RONALD R MD PA	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	CRANE	STEVEN D MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/100	DUNKIN	PAMELA A MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	EASON	DAVID M MD	BLACK MOUNTAIN	Buncombe	Vaya
PRACTITIONER-DW/30	HARTYE	JAMES K MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/100	HOLMAN	SUSAN C MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	JONES	LAWRENCE RALPH MD	ARDEN	Buncombe	Vaya
PRACTITIONER-DW/30	KAUFMAN	CAROL H MD	BLACK MOUNTAIN	Buncombe	Vaya
PRACTITIONER-DW/30	MARTIN	J PAUL MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/100	PARKS	RONALD R MD	BLACK MOUNTAIN	Buncombe	Vaya
PRACTITIONER-DW/30	ROWE	JOHN E MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	ZACHER	ALLAN	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/100	BUZZANELL	CHARLES A MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/100	BIRD	ANTONIO M MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	BLAKE	DANIEL JACKSON MD	BLACK MOUNTAIN	Buncombe	Vaya
PRACTITIONER-DW/30	BERG	MARY HERNDON MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	COOK	DAVID C MD	WEAVERVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	COULSON	CAROL C MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	DOWLING	MICHAEL SCOTT MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	DAVIS	BRADLEY S. MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	FAGAN	ERNEST BLAKE MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-	FRAYNE	DANIEL J MD	ASHEVILLE	Buncombe	Vaya

DW/30					
PRACTITIONER-DW/30	GILPIN	ALLEN	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	HICKS	MELISSA M MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	HEY	DANIEL S MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/100	JOHNSON	DANIEL S MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/100	KHOURY	ADA C MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/275	KOTULLA	JERRY MD	ARDEN	Buncombe	Vaya
PRACTITIONER-DW/30	LETSON	AUSTIN KELLETT III MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	LEHMAN	NANCY C MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	MANLY	DAVID T MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	MICHALETS	JAMES PATRICK MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	PLAUT	TIMOTHY ARNOLD MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	RIVERS	CAROLE Y MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	RUSSELL	ANNEMARIE I MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	MOORE	STACIA D	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	SCHECHTER	JUSTIN O MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/100	SCHROEDER	KARL V MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/275	SCHROER	BRADY J DO	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	TRUJILLO	GLORIA M	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	WALLENIUS	STEVEN T MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	ZENN	RICHARD D MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/100	ALBERT	AARON, D, (MD)	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	AIKEN	BENJAMIN, A, (MD)	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	ALEXANDER	SUSAN, C, (MD)	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/100	ABRAMSON	SYDNEY LEONARD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	DOIRON	PAULETTE N (MD)	ASHEVILLE	Buncombe	Vaya

PRACTITIONER-DW/30	EVANS	NICOLE S (DO)	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	FARMER	JENNIFER, B, (MD)	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	FENDER	TRACE I (MD)	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	GARCIA	KELLY, E, (MD)	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	HOUSER	WINONA, S, (MD)	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/100	KREMPASKY	MICAH H (MD)	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	KNOLL	HEIDI M (MD)	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	KAVASSERI	KARTHIK	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	KNOWLSON	LAUREN, V, MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	LORENCZ	ERIN, E, (MD)	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	LONG	RACHEL, K, MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	MILLER	ELIZABETH KELLY MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	MULLINS	NATHAN H. MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	MASON	MARK T (MD)	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	MARTIN	CRAIG M	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	MCLEAN	WILLIAM	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	REED	LISA, N, MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	OAT-JUDGE	JULIA, E, MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	POULTON	GINGER, J, MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/100	ROLLINS	ELIZABETH, S. (MD)	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	RAY	WILLIAM C (MD)	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	SMITH	ERIC D MD	CANDLER	Buncombe	Vaya
PRACTITIONER-DW/30	SCHOOF	MALORIE, L, (MD)	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	SHEGOG	MARGARETTE	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	SWERLICK	ARIN, E	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-	SAGER	BRENT, A, MD	ASHEVILLE	Buncombe	Vaya

DW/30					
PRACTITIONER-DW/30	WEIGEL	FREDERICK D MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	WOLF	SARAH, K, MD	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	WILSON	ERICA, F, (MD)	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	WHITE	JESSICA L (MD)	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	WHITEMAN	KEITH	ASHEVILLE	Buncombe	Vaya
MLP-NP-DW/30	KINSER	CYNTHIA A	ASHEVILLE	Buncombe	Vaya
MLP-NP-DW/30	NOLAN	TIMOTHY NP	ASHEVILLE	Buncombe	Vaya
MLP-NP-DW/30	RAMAGE	MELINDA A	ASHEVILLE	Buncombe	Vaya
MLP-NP-DW/30	SEALY	BRIAN H (MSN)	ASHEVILLE	Buncombe	Vaya
PRACTITIONER-DW/30	BUJOLD	EDWARD J MD	GRANITE FALLS	Caldwell	Vaya
PRACTITIONER-DW/30	BELL	JOSEPH TAYLOR MD	HUDSON	Caldwell	Vaya
MLP-NP-DW/30	CHURCH	THOMAS G FNP	LENOIR	Caldwell	Vaya
PRACTITIONER-DW/30	CAIN	JAMES ALTON MD	MURPHY	Cherokee	Vaya
PRACTITIONER-DW/30	HOLDER	LARRY B MD	MURPHY	Cherokee	Vaya
PRACTITIONER-DW/30	CLAYTON	THOMAS VANN MD	ANDREWS	Cherokee	Vaya
PRACTITIONER-DW/100	REY	MICHAEL T MD	WAYNESVILLE	Haywood	Vaya
PRACTITIONER-DW/275	BROWN	MICHAEL ASHLEY MD	WAYNESVILLE	Haywood	Vaya
PRACTITIONER-DW/275	CRIDER	STEVEN SNOWDEN MD	CLYDE	Haywood	Vaya
PRACTITIONER-DW/100	TEATER	DONALD R MD	WAYNESVILLE	Haywood	Vaya
PRACTITIONER-DW/100	WILLIS	BRENDA S (MD)	CANTON	Haywood	Vaya
PRACTITIONER-DW/30	MACNAMARA	MARINA	CLYDE	Haywood	Vaya
PRACTITIONER-DW/30	PETERS	CLAUDIA A. (MD)	WAYNESVILLE	Haywood	Vaya
MLP-NP-DW/30	LIPHAM	SARAH	WAYNESVILLE	Haywood	Vaya
PRACTITIONER-DW/30	BATE	DAVID SOULE MD	HENDERSONVILLE	Henderson	Vaya
PRACTITIONER-DW/275	BOTHE	BRIAN M MD	HENDERSONVILLE	Henderson	Vaya
PRACTITIONER-DW/100	BIERRENBACH	RICARDO C MD	HENDERSONVILLE	Henderson	Vaya
PRACTITIONER-DW/30	COYLE	BRENT	HENDERSONVILLE	Henderson	Vaya
PRACTITIONER-	CSAPO	ILONA	HENDERSONVIL	Henderson	Vaya

DW/275			LE		
PRACTITIONER-DW/30	FRALIX	TERESA ANN MD	HENDERSONVILLE	Henderson	Vaya
PRACTITIONER-DW/30	HUDSPETH	RICHARD WILLIAM MD	HENDERSONVILLE	Henderson	Vaya
PRACTITIONER-DW/100	LOWE-HOYTE	CHARMAINE P MD	HENDERSONVILLE	Henderson	Vaya
PRACTITIONER-DW/30	LAUTENSCHLAEGER	NATASCHA SUSANNE, MD	HENDERSONVILLE	Henderson	Vaya
PRACTITIONER-DW/30	PUCILOWSKI	OLGIERD A MD	HENDERSONVILLE	Henderson	Vaya
PRACTITIONER-DW/30	BRODSKY	AARON P (MD)	HENDERSONVILLE	Henderson	Vaya
PRACTITIONER-DW/30	COLADONATO	MICHAEL JOSEPH MD	FLETCHER	Henderson	Vaya
PRACTITIONER-DW/30	GILMER	BENJAMIN	FLETCHER	Henderson	Vaya
PRACTITIONER-DW/30	HALL	JONATHAN CLARK	HENDERSONVILLE	Henderson	Vaya
PRACTITIONER-DW/30	KOLB	TODD A.	HENDERSONVILLE	Henderson	Vaya
PRACTITIONER-DW/30	PIOR	JESSICA S (MD)	HENDERSONVILLE	Henderson	Vaya
PRACTITIONER-DW/30	SANTIN	AMY, J, MD	FLETCHER	Henderson	Vaya
PRACTITIONER-DW/30	VERRASTRO	GENEVIEVE	HENDERSONVILLE	Henderson	Vaya
PRACTITIONER-DW/30	ZAFFINO	MARYSHELL, BROSCHE, MD	HENDERSONVILLE	Henderson	Vaya
PRACTITIONER-DW/30	BUCKNER	DONALD THOMAS JR MD	SYLVA	Jackson	Vaya
PRACTITIONER-DW/30	GRIMES	JEFFERY R MD	WHITTIER	Jackson	Vaya
PRACTITIONER-DW/30	HOLMES	MATTHEW E MD	SYLVA	Jackson	Vaya
PRACTITIONER-DW/275	LINDSAY	THOMAS F MD	CASHIERS	Jackson	Vaya
PRACTITIONER-DW/100	EMERSON	SCOTT SHERLOCK, DO	SYLVA	Jackson	Vaya
PRACTITIONER-DW/30	HALBERG	ANDY DO	SYLVA	Jackson	Vaya
PRACTITIONER-DW/30	HUNLEY	LAWSON, Z, D.O	FRANKLIN	Macon	Vaya
PRACTITIONER-DW/30	POWERS	TONYA K MD	MARION	McDowell	Vaya
PRACTITIONER-DW/30	HERBERT	LINDSAY F (DO)	OLD FORT	McDowell	Vaya
PRACTITIONER-DW/30	ULRICH	BRUCE	OLD FORT	McDowell	Vaya
PRACTITIONER-DW/30	AGBODZA	KWAMI DELALI MD	SPRUCE PINE	Mitchell	Vaya

PRACTITIONER-DW/30	CARROLL, MD	JAMES B	BAKERSVILLE	Mitchell	Vaya
PRACTITIONER-DW/30	WILLETT	DWIGHT JAMES (MD)	BAKERSVILLE	Mitchell	Vaya
PRACTITIONER-DW/30	NORTH	STEPHEN W	SPRUCE PINE	Mitchell	Vaya
PRACTITIONER-DW/275	KORNMAYER	JOHN DANIEL DO	COLUMBUS	Polk	Vaya
PRACTITIONER-DW/30	PASTERNACK	JENNIFER M MD	MILL SPRING	Polk	Vaya
PRACTITIONER-DW/100	ROBERTS	JOHN M MD	MILL SPRING	Polk	Vaya
PRACTITIONER-DW/100	SMITH	ROY E MD	MILL SPRING	Polk	Vaya
PRACTITIONER-DW/100	VIAR	JEFFREY KIP	COLUMBUS	Polk	Vaya
PRACTITIONER-DW/30	SLOSS	KATHERINE A MD	LAKE LURE	Rutherford	Vaya
PRACTITIONER-DW/30	ARDAMAN	MILES FERDI	RUTHERFORDTON	Rutherford	Vaya
PRACTITIONER-DW/100	JOSEPH	MATHUKUTTY	RUTHERFORDTON	Rutherford	Vaya
PRACTITIONER-DW/100	HYDE	LEE SANFORD	CHEROKEE	Swain	Vaya
PRACTITIONER-DW/100	FARRELL	MARY ANNE, MD	CHEROKEE	Swain	Vaya
PRACTITIONER-DW/30	GUINEY	BENJAMIN F (MD)	CHEROKEE	Swain	Vaya
PRACTITIONER-DW/30	HYDE	REBECCA GAIL MD	CHEROKEE	Swain	Vaya
PRACTITIONER-DW/100	ROSS	ROBERT E MD	CHEROKEE	Swain	Vaya
PRACTITIONER-DW/100	WHEELER	JENNIFER WARD (DO)	CHEROKEE	Swain	Vaya
MLP-PA-DW/30	BERNIER	LISA	CHEROKEE	Swain	Vaya
MLP-NP-DW/30	MACKEL	GEORGE	CHEROKEE	Swain	Vaya
PRACTITIONER-DW/100	MARTIN	GERALD R MD	BREVARD	Transylvania	Vaya
PRACTITIONER-DW/100	NASH	ALLAN DALE MD	BREVARD	Transylvania	Vaya
PRACTITIONER-DW/30	DEVAULT	WILLIAM LEONARD MD	BOONE	Watauga	Vaya
PRACTITIONER-DW/30	ROUNTREE	MICHAEL BRIAN MD	BOONE	Watauga	Vaya
PRACTITIONER-DW/275	WILKINS	LUCIEN MD	BOONE	Watauga	Vaya
PRACTITIONER-DW/30	MORETZ	REBECCA L (MD)	BOONE	Watauga	Vaya
PRACTITIONER-DW/275	PIERRE	FRANTZ, ELI, M.D.	BOONE	Watauga	Vaya
PRACTITIONER-	JUSTIS	CHRISTOPHER	NORTH	Wilkes	Vaya

DW/100		MORROW	WILKESBORO		
PRACTITIONER-DW/275	OENBRINK	RAYMOND J DO	WILKESBORO	Wilkes	Vaya
PRACTITIONER-DW/30	PINKERTON	JERRY L MD	NORTH WILKESBORO	Wilkes	Vaya
PRACTITIONER-DW/100	RANDALL	WENDELL L MD	NORTH WILKESBORO	Wilkes	Vaya
PRACTITIONER-DW/30	RAO	ARUN A (MD)	WILKESBORO	Wilkes	Vaya
PRACTITIONER-DW/30	SOMSOOK	SAM SUPARP MD	NORTH WILKESBORO	Wilkes	Vaya
PRACTITIONER-DW/30	MCGAHEY	GEETA JYOTHI MD	BURNSVILLE	Yancey	Vaya
PRACTITIONER-DW/30	DEGUZMAN	DOROTHY	BURNSVILLE	Yancey	Vaya
			TOTAL VAYA SITES		**164**
Data Source - DEA, as of 04.25.17, downloaded 06.02.17			**STATEWIDE TOTAL**		**872**

Cautions: This list includes all waivered practitioners, and does not differentiate between those currently practicing and those not prescribing. It should also be noted that practitioners are not restricted to the site where they are certified. For example, a practitioner may be certified on Main St in Asheville, but may prescribe at a different location which would not be reflected on this list.

ATTACHMENT 4

Estimated Numbers of Persons Aged 12 or Older in NC Using Prescription Pain Relievers Non-medically or Using Heroin in Past Year by County as of July 2017

July 2017 Population Projections		Rx Pain Relievers Nonmedical Use		Heroin Use		Total Persons
County	**Ages 12+**	**Prevalence**	**Persons**	**Prevalence**	**Persons**	
Alamance	138,580	4.55%	6,305	0.20%	277	6,583
Alexander	33,310	4.43%	1,476	0.20%	67	1,542
Alleghany	10,059	4.43%	446	0.20%	20	466
Anson	22,793	4.32%	985	0.20%	46	1,030
Ashe	24,077	4.43%	1,067	0.20%	48	1,115
Avery	16,066	4.43%	712	0.20%	32	744
Beaufort	41,659	4.66%	1,941	0.20%	83	2,025
Bertie	17,795	4.66%	829	0.20%	36	865
Bladen	30,320	4.42%	1,340	0.20%	61	1,401
Brunswick	114,670	4.99%	5,722	0.20%	229	5,951
Buncombe	228,494	4.86%	11,105	0.20%	457	11,562
Burke	78,226	5.06%	3,958	0.20%	156	4,115
Cabarrus	173,278	4.35%	7,538	0.20%	347	7,884
Caldwell	72,404	4.43%	3,207	0.20%	145	3,352
Camden	8,950	4.66%	417	0.20%	18	435
Carteret	62,552	4.99%	3,121	0.20%	125	3,246

Caswell	20,935		4.55%	953	0.20%	42		994	
Catawba	134,126		5.06%	6,787	0.20%	268		7,055	
Chatham	65,731		4.55%	2,991	0.20%	131		3,122	
Cherokee	24,845		4.43%	1,101	0.20%	50		1,150	
Chowan	12,352		4.66%	576	0.20%	25		600	
Clay	9,968		4.43%	442	0.20%	20		462	
Cleveland	84,591		5.06%	4,280	0.20%	169		4,449	
Columbus	49,305		4.42%	2,179	0.20%	99		2,278	
Craven	84,241		4.66%	3,926	0.20%	168		4,094	
Cumberland	265,599		4.61%	12,244	0.20%	531		12,775	
Currituck	23,371		4.66%	1,089	0.20%	47		1,136	
Dare	32,260		4.66%	1,503	0.20%	65		1,568	
Davidson	144,138		4.35%	6,270	0.20%	288		6,558	
Davie	37,034		4.40%	1,629	0.20%	74		1,704	
Duplin	50,365		4.42%	2,226	0.20%	101		2,327	
Durham	255,821		4.61%	11,793	0.20%	512		12,305	
Edgecombe	46,097		4.42%	2,037	0.20%	92		2,130	
Forsyth	315,829		4.40%	13,896	0.20%	632		14,528	
Franklin	56,571		4.55%	2,574	0.20%	113		2,687	
Gaston	184,967		5.06%	9,359	0.20%	370		9,729	
Gates	10,261		4.66%	478	0.20%	21		499	
Graham	7,536		4.43%	334	0.20%	15		349	
Granville	51,898		4.55%	2,361	0.20%	104		2,465	
Greene	18,175		4.42%	803	0.20%	36		840	
Guilford	450,163		4.70%	21,158	0.20%	900		22,058	
Halifax	44,573		4.55%	2,028	0.20%	89		2,117	
Harnett	106,551		4.32%	4,603	0.20%	213		4,816	
Haywood	54,500		4.43%	2,414	0.20%	109		2,523	
Henderson	101,133		4.86%	4,915	0.20%	202		5,117	
Hertford	21,292		4.66%	992	0.20%	43		1,035	
Hoke	42,596		4.32%	1,840	0.20%	85		1,925	
Hyde	5,026		4.66%	234	0.20%	10		244	
Iredell	152,326		5.06%	7,708	0.20%	305		8,012	
Jackson	37,348		4.43%	1,655	0.20%	75		1,729	
Johnston	162,627		4.61%	7,497	0.20%	325		7,822	
Jones	9,060		4.66%	422	0.20%	18		440	
Lee	48,990		4.32%	2,116	0.20%	98		2,214	
Lenoir	49,859		4.42%	2,204	0.20%	100		2,303	
Lincoln	73,012		5.06%	3,694	0.20%	146		3,840	
Macon	31,167		4.43%	1,381	0.20%	62		1,443	
Madison	19,550		4.86%	950	0.20%	39		989	
Martin	20,419		4.66%	952	0.20%	41		992	
McDowell	39,748		4.43%	1,761	0.20%	79		1,840	
Mecklenburg	903,242		4.55%	41,098	0.20%	1,806		42,904	
Mitchell	13,490		4.86%	656	0.20%	27		683	
Montgomery	24,032		4.32%	1,038	0.20%	48		1,086	

Moore	84,328		4.32%	3,643	0.20%	169		3,812	
Nash	81,406		4.42%	3,598	0.20%	163		3,761	
New Hanover	197,774		4.99%	9,869	0.20%	396		10,264	
Northampton	18,492		4.66%	862	0.20%	37		899	
Onslow	153,163		4.99%	7,643	0.20%	306		7,949	
Orange	127,083		4.55%	5,782	0.20%	254		6,036	
Pamlico	11,886		4.66%	554	0.20%	24		578	
Pasquotank	33,873		4.66%	1,578	0.20%	68		1,646	
Pender	52,431		4.99%	2,616	0.20%	105		2,721	
Perquimans	12,085		4.66%	563	0.20%	24		587	
Person	34,424		4.55%	1,566	0.20%	69		1,635	
Pitt	150,728		4.66%	7,024	0.20%	301		7,325	
Polk	18,965		4.86%	922	0.20%	38		960	
Randolph	122,968		4.32%	5,312	0.20%	246		5,558	
Richmond	38,557		4.32%	1,666	0.20%	77		1,743	
Robeson	111,397		4.42%	4,924	0.20%	223		5,147	
Rockingham	79,982		4.40%	3,519	0.20%	160		3,679	
Rowan	121,496		4.35%	5,285	0.20%	243		5,528	
Rutherford	58,776		4.86%	2,857	0.20%	118		2,974	
Sampson	53,813		4.42%	2,379	0.20%	108		2,486	
Scotland	29,881		4.42%	1,321	0.20%	60		1,381	
Stanly	53,321		4.35%	2,319	0.20%	107		2,426	
Stokes	41,279		4.40%	1,816	0.20%	83		1,899	
Surry	63,415		5.06%	3,209	0.20%	127		3,336	
Swain	12,818		4.43%	568	0.20%	26		593	
Transylvania	30,783		4.86%	1,496	0.20%	62		1,558	
Tyrrell	3,686		4.66%	172	0.20%	7		179	
Union	194,052		4.35%	8,441	0.20%	388		8,829	
Vance	38,181		4.55%	1,737	0.20%	76		1,814	
Wake	890,364		4.14%	36,861	0.20%	1,781		38,642	
Warren	17,962		4.55%	817	0.20%	36		853	
Washington	10,658		4.66%	497	0.20%	21		518	
Watauga	50,314		4.43%	2,229	0.20%	101		2,330	
Wayne	104,551		4.42%	4,621	0.20%	209		4,830	
Wilkes	60,754		4.43%	2,691	0.20%	122		2,813	
Wilson	70,365		4.42%	3,110	0.20%	141		3,251	
Yadkin	32,384		5.06%	1,639	0.20%	65		1,703	
Yancey	15,888		4.86%	772	0.20%	32		804	
NORTH CAROLINA	**8,754,236**		**4.57%**	**399,795**	**0.20%**	**17,508**		**417,304**	

Population Data: NC Office of State Budget and Management (OSBM). Last updated: 9/19/16 Downloaded: 4/17/17. (https://ncosbm.s3.amazonaws.com/s3fs-public/demog/countytotals_singleage_2017.html)

Prevalence Rates:

- **Heroin Use:** SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014 and 2015. Table 78 Selected Drug Use, Past Year Alcohol Use Disorder, and Past Year Mental Health Measures in North Carolina, by Age Group: Percentages, Annual Averages Based on 2014-2015 NSDUHs (12/20/16).

NORTH CAROLINA OPIOID STR GRANT

TI080257

STRATEGIC PLAN

AUGUST 29, 2017

Overview

In 2014, House Bill 97 was introduced with several sections directly addressing prescription drug abuse. While it did not pass, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, in collaboration with stakeholders from across the state, began the work of developing the North Carolina Strategic Plan to Reduce Prescription Drug Abuse, which was supported by the National Governor's Association and Substance Abuse and Mental Health Services Administration (SAMHSA) policy academies. The following year, Session Law 2015-241, mandated not only the development of the strategic plan, but also the creation of the Prescription Drug Abuse Advisory Committee (PDAAC), which is tasked with implementing activities guided by strategies within the plan. It is a collaboration among DMHDDSAS, DPH, LME-MCOs, treatment providers, healthcare systems, law enforcement, regulatory boards, local health departments, community coalitions and others to plan, implement and evaluate comprehensive strategies to prevent drug overdose and treat opioid use disorders. Over 200 agencies, organizations, and individuals participate in PDAAC work. Subcommittees include the following: (1) First Responders, (2) Health Care, (3) Treatment and Recovery and (4) Data, Surveillance and Research.

In June 2017, the Opioid Action Plan was presented at the state's Opioid Misuse and Overdose Prevention Summit. This action plan will serve as the state's strategic plan for the Opioid STR grant and serve as a guide or blueprint for addressing the many complexities of the opioid epidemic in North Carolina. We believe the Opioid Action Plan is somewhat broader in scope than our original Opioid STR application, and it also spans 2017 through 2021. It will serve to focus the strategies specific to the Opioid STR grant application, as well as the gaps identified in the needs assessment. We believe this approach will not only aid us in meeting the deliverables and outcomes identified in the Opioid STR grant, but will also help us attain additional systemic and longer-term goals specific to addressing the epidemic.

In this past long session, the General Assembly renamed the PDAAC to the Opioid and Prescription Drug Abuse Advisory Committee (OPDAAC) to clarify the parameters and focus of this group. Additionally, we have created a Coordinating Workgroup that is comprised of a smaller number of individuals from the OPDAAC that will focus on specific tasks and deliverables. The first meeting of the Coordinating Workgroup is scheduled for August 30, 2017 and the primary topic or problem analysis will be how we better connect individuals who have come to an emergency department for an opioid overdose or use to treatment and recovery supports. As an example, this is directly related to one of the identified activities in the Opioid STR application; the development of rapid response teams and peer supports to be dispatched to emergency departments or other locations as quickly as possible after an individual

experiences an overdose reversal. These conversations will aid us in identifying mechanisms and infrastructure necessary for implementation, combined with our findings relative to areas in most need.

Following is the Opioid Action Plan in its entirety. The Action Plan contains seven (7) areas of focus that are most relevant for the Opioid STR strategic plan. Those are: (1) Coordinated Infrastructure, (2) Decrease the Oversupply of Prescription Drugs, (3) Decrease the Diversion and Flow of Illicit Drugs, (4) Increase Community Awareness and Prevention, (5) Increase Naloxone Availability, (6) Expand Treatment Access, (7) Expand Recovery Supports and (8) Measure Impact. As stated above, we believe this Action Plan should function as the Strategic Plan for the Opioid STR grant because of its comprehensiveness, because of the collaboration and contributions of numerous people and agencies and because of the momentum this group has. We hope to build off this energy to help us better attain the goals of the Opioid STR grant, reduce needs and gaps by making treatment and recovery supports more available and accessible and overall improve the health and well-being of individuals with an opioid use disorder.

NORTH CAROLINA'S OPIOID ACTION PLAN

2017-2021

UNDERSTANDING THE CRISIS

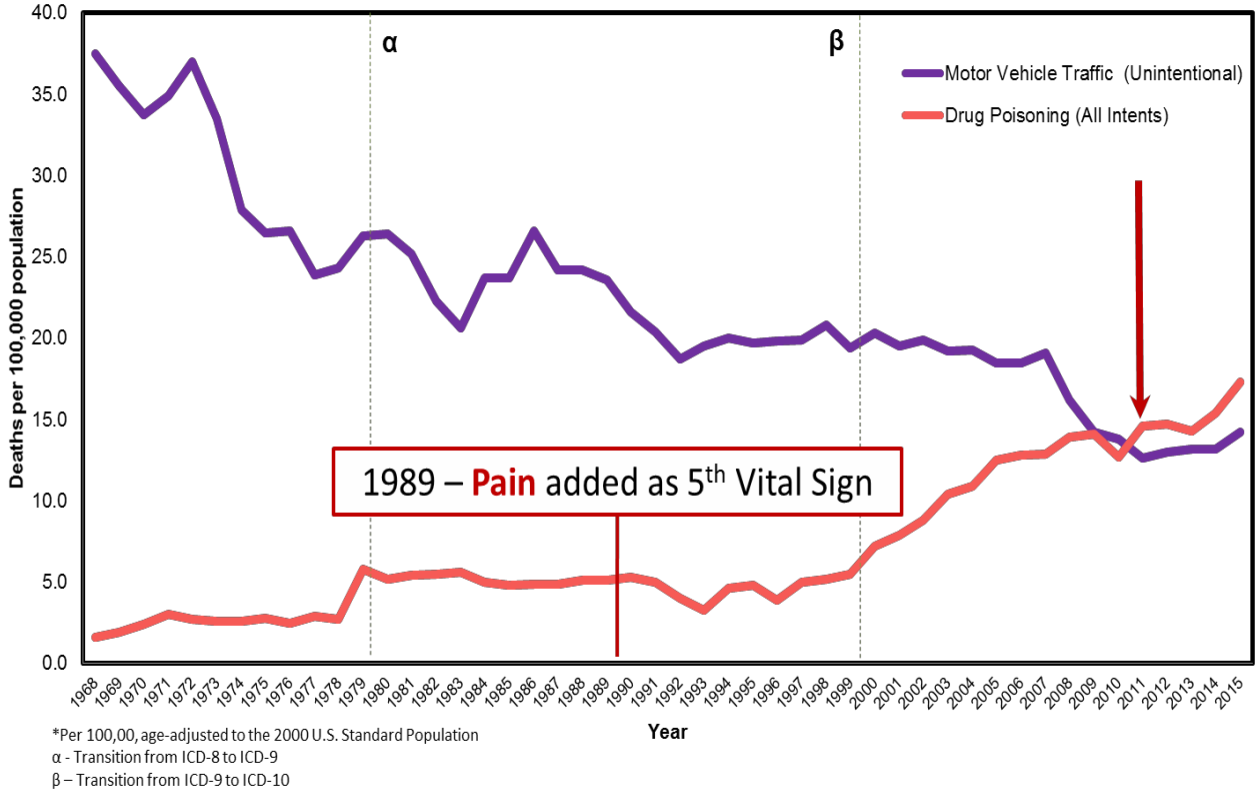
3 PEOPLE **DIE** EACH DAY FROM **OPIOID OVERDOSE** IN NC

So 2016.

NC is experiencing the **consequences** of 25+ years of prescribing **more opioids at higher doses.**

Death Rates* for Two Selected Causes of Injury,

North Carolina, 1968-2015



*Per 100,00, age-adjusted to the 2000 U.S. Standard Population
α - Transition from ICD-8 to ICD-9
β – Transition from ICD-9 to ICD-10

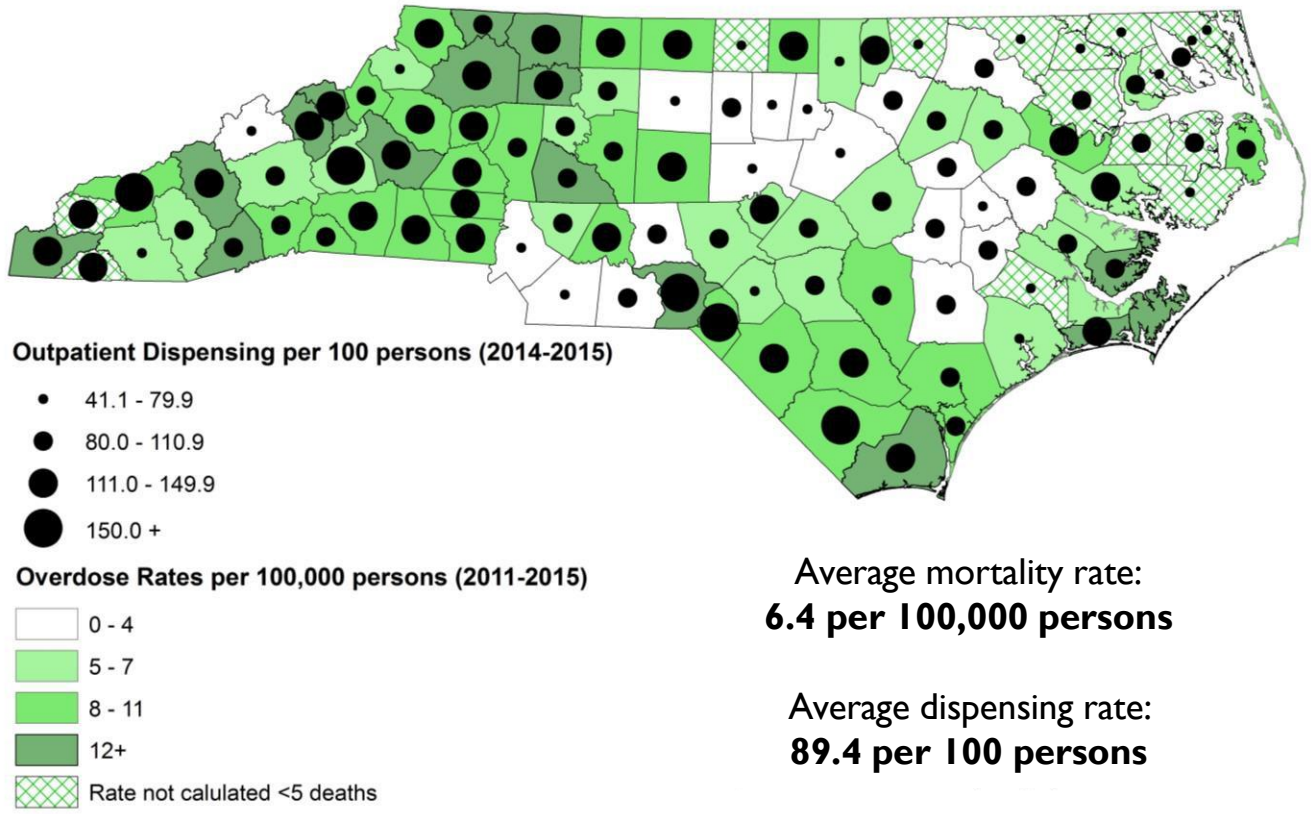
National Vital Statistics System, http://wonder.cdc.gov, multiple cause dataset
Source: Death files, 1968-2015, CDC WONDER
Analysis by Injury Epidemiology and Surveillance Unit

While this medical practice has improved pain control for some…

…it has also contributed to **opioid addiction, overdose, and death.**

Opioid overdose is more common in counties where more prescriptions are dispensed

North Carolina Residents, 2011-2015



Average mortality rate:
6.4 per 100,000 persons

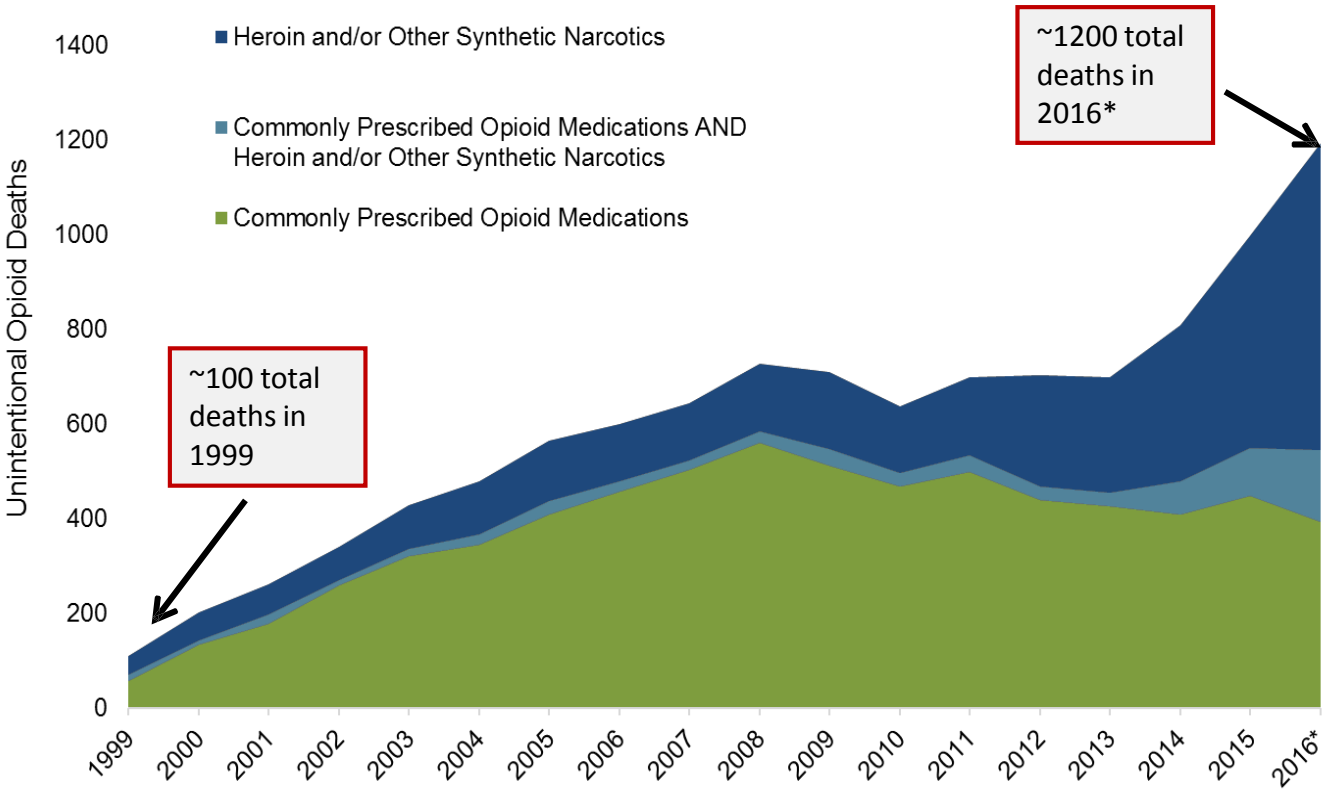
Average dispensing rate:
89.4 per 100 persons

Data Source: Proescholdbell SK, Cox ME, Asbun A. Death Rates from Unintentional and Undetermined Prescription Opioid Overdoses and Dispensing Rates of Controlled Prescription Opioid Analgesics-2011-2015. NC Med J. 2017 Mar-Apr; 78(2):142-143.

With unprecedented availability of cheap **heroin** and **fentanyl**...

MORE PEOPLE ARE DYING.

Unintentional opioid deaths have increased more than 10 fold*
Heroin or other synthetic narcotics are now involved in over 50% of deaths*



*2016 data are provisional
Source: N.C. State Center for Health Statistics, Vital Statistics-Deaths, 1999-2016

Unintentional medication/drug (X40-X44) with specific T-codes by drug type.
Commonly Prescribed Opioid Medications=T40.2 or T40.3; Heroin and/or Other Synthetic Narcotics=T40.1 or T40.4.
Numbers of deaths from other synthetic narcotics may represent both prescription synthetic opioid deaths and non-pharmaceutical synthetic opioids because synthetic opioids produced illicitly (e.g., non-pharmaceutical fentanyl) are not identified separately from prescription ('pharmaceutical') synthetic opioids in ICD-10 codes.

FOR EVERY OPIOID POISONING DEATH

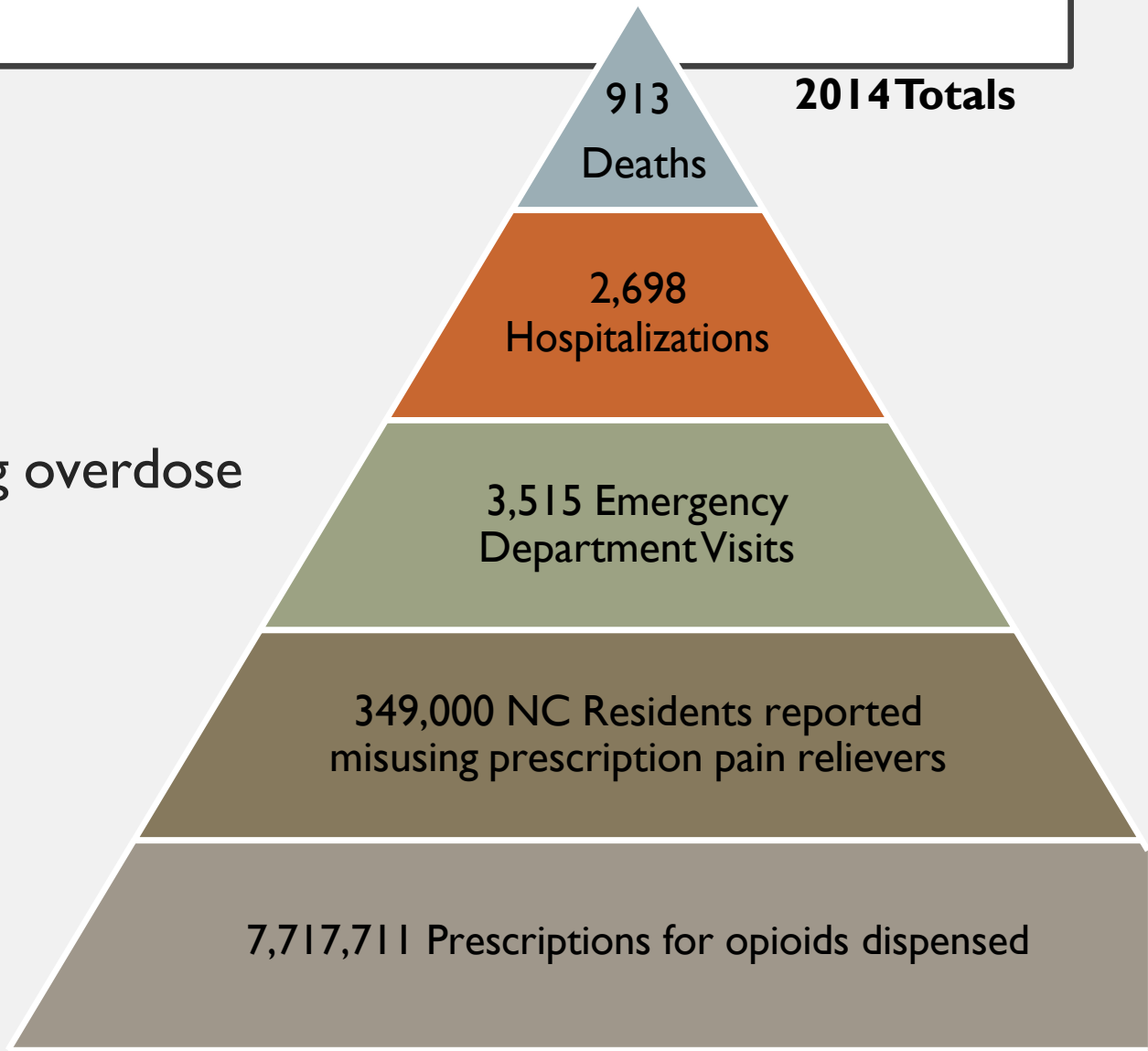
There were…

just under 3 hospitalizations

nearly 4 ED visits due to medication or drug overdose

over **380 people who misused** prescription pain relievers

and almost **8,500 prescriptions** for opioids dispensed



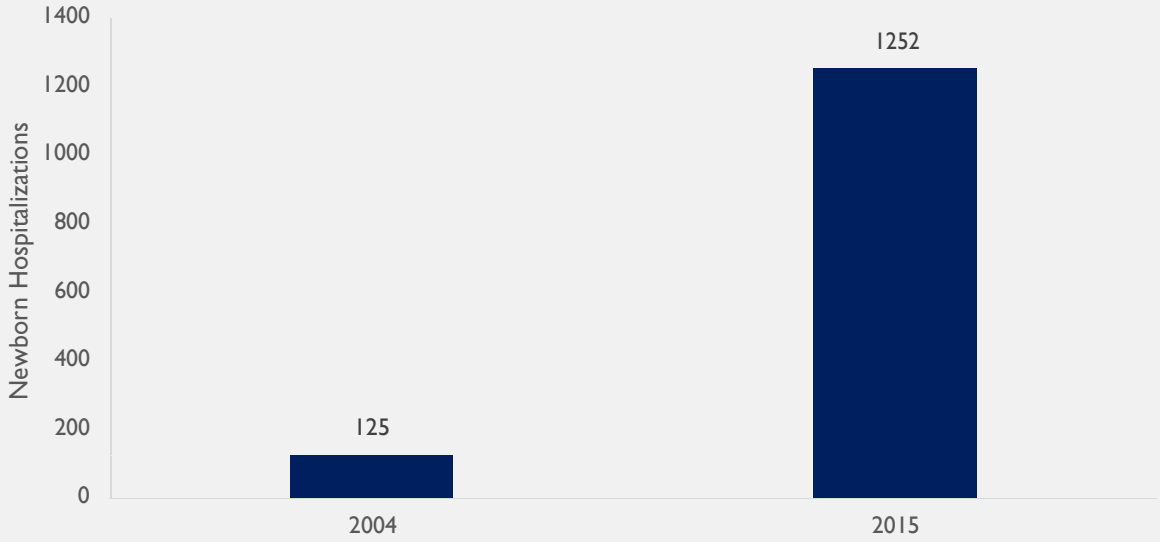
Source: N.C. State Center for Health Statistics, Vital Statistics-Deaths, 2014; N.C. State Center for Health Statistics, Vital Statistics- Hospitalizations, 2014;

Printed: 10/5/2017 9:13 PM - North Carolina - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020

THE EPIDEMIC IS DEVASTATING OUR **FAMILIES**

Number of Hospitalizations Associated with Drug Withdrawal in Newborns

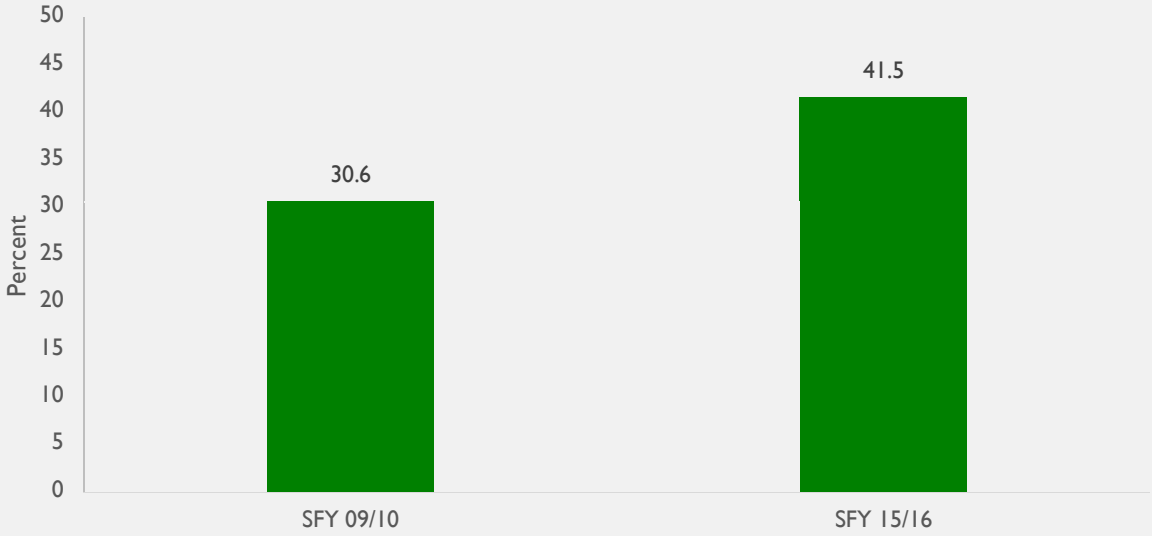
North Carolina Residents, 2004-2015



Source: N.C. State Center for Health Statistics, Hospital Discharge Dataset, 2004-2015 and Birth Certificate records, 2004-2015
Analysis by Injury Epidemiology and Surveillance Unit

Percent of Children Entering Foster Care in NC with Parental Substance Use as a Factor in Out-of-Home Placement

SFY 09/10-15/16



Source: NC DHHS Client Services Data Warehouse, Child Placement and Payment System
Prepared by Performance Management/Reporting & Evaluation Management, July 2016

Many organizations* across NC are addressing the opioid overdose epidemic.

*Logos not all inclusive

North Carolina has achieved some **successes** …

AND HAS MORE WORK TO DO.

Overdose death is preventable.

FOCUS AREAS

Given that the opioid epidemic is complex, we plan to implement comprehensive strategies in the following focus areas to reduce opioid addiction and overdose death:

1. **Create a coordinated infrastructure**
2. **Reduce oversupply of prescription opioids**
3. **Reduce diversion of prescription drugs and flow of illicit drugs**
4. **Increase community awareness and prevention**
5. **Make naloxone widely available and link overdose survivors to care**
6. **Expand treatment and recovery oriented systems of care**
7. **Measure our impact and revise strategies based on results**

PRESCRIPTION DRUG ABUSE ADVISORY COMMITTEE (PDAAC)

- Session Law 2015-241, Section 12F.16.(m), established PDAAC
- PDAAC is convened by the NC Department of Health and Human Services and has met quarterly since March 2016
- Over 215 members represent a variety of organizations and fields
- This Action Plan builds on recommendations from the PDAAC, which will lead coordination and implementation of the Plan
- This Plan does not include all efforts or partners, but outlines certain key actions to reduce opioid addiction and overdose death

ACTION PLAN

1. COORDINATED INFRASTRUCTURE

Strategy	Action	Leads
PDAAC leadership	Designate an Opioid Action Plan Executive Chair for the PDAAC to lead NC Opioid Action Plan	DHHS
Advisory council	Convene a group of current and former opioid users and others in recovery to guide Plan components and implementation of strategic actions	DHHS, NCHRC, RCOs, DPS
Build and sustain local coalitions	Convene local stakeholders and facilitate activities to: 1) Increase naloxone access; 2) Establish syringe exchange programs; 3) Increase linkages to SUD and pain treatment support; 4) Establish peer recovery support services; 5) Organize drug takeback programs and events/encourage safe storage of medications; 6) Promote the adoption of fair chance hiring practices; 7) Promote education to prevent youth substance use initiation in schools and other venues; and, 8) Identify and advocate for local funding	NCACC, LHDs, Local coalitions, DPH, DMH, AHEC, LME/MCOs

2. REDUCE OVERSUPPLY OF PRESCRIPTION DRUGS

Strategy	Action	Leads
Safe prescribing policies	Develop and adopt model health system policies on safe prescribing (e.g. ED and surgical prescribing policies, co-prescribing of naloxone, checking the CSRS, linking to PCPs)	NCHA, DMA, Licensing boards and professional societies
	Create and maintain continuing education opportunities and resources for prescribers to manage chronic pain	GI,AHEC, CCNC, DMA, Licensing boards and professional societies
CSRS utilization	Register 100% of eligible prescribers and dispensers in CSRS	DMH, Licensing boards and professional societies
	Provide better visualization of the data (easy to read charts and graphs) to enable providers to make informed decisions at the point of care	DMH, IPRC, CHS, GDAC, DIT
	Develop connections that would enable providers to make CSRS queries from the electronic health record	DMH, GDAC, NCHA, DIT
	Report data to all NC professional boards so they can investigate aberrant prescribing or dispensing behaviors	Licensing boards and professional societies
Medicaid and commercial payer policies	Convene a Payers Council to identify and implement policies that reduce oversupply of prescription opioids (e.g. lock-in programs) and improve access to SUD treatment and recovery supports	DHHS, DMA, BCBSNC, SHP and other payers, CCNC, LME/MCOs
Workers' compensation policies	Identify and implement policies to promote safer prescribing of opioids to workers' compensation claimants	Industrial Commission, workers' compensation carriers

3. REDUCE DIVERSION AND FLOW OF ILLICIT DRUGS

Strategy	Action	Leads
Trafficking investigation and response	Establish a trafficking investigation and enforcement workgroup to identify actions required to curb the flow of diverted prescription drugs (e.g. CSRS access for case investigation) and illicit drugs like heroin, fentanyl, and fentanyl analogues	AG, HIDTA, SBI, DEA, Local law enforcement
Diversion prevention and response	Develop model healthcare worker diversion prevention protocols and work with health systems, long-term care facilities, nursing homes, and hospice providers to adopt them	NCHA, AG, DMH, Licensing boards and professional societies
Drug takeback, disposal, and safe storage	Increase the number of drug disposal drop boxes in NC – including in pharmacies, secure funding for incineration, and promote safe storage	DOI Safe Kids NC, SBI, Local law enforcement, AG, NCAP, NCRMA, CCNC, LHDs
Law enforcement and public employee protection	Train law enforcement and public sector employees in recognizing presence of opioids, opioid processing operations, and personal protection against exposure to opioids	DPH, Local law enforcement

4. INCREASE COMMUNITY AWARENESS AND PREVENTION

Strategy	Action	Leads
Public education campaign	Identify funding to launch a large-scale public education campaign to be developed by content experts using evidence-based messaging and communication strategies Potential messages could include: ▪ Naloxone access and use ▪ Patient education regarding expectations around pain management/opioid alternatives ▪ Patient education to be safe users of controlled substances ▪ Linkage to care, how to navigate treatment ▪ Safe drug disposal and storage ▪ Stigma reduction ▪ Addiction as a disease: recovery is possible	DHHS, Advisory Council, PDAAC, Partners
Youth primary prevention	Build on community-based prevention activities to prevent youth and young adult initiation of drug use (e.g. primary prevention education in schools, colleges, and universities)	DMH, LME/MCOs, Local coalitions

5. INCREASE NALOXONE AVAILABILITY

Strategy	Action	Leads
Law enforcement naloxone administration	Increase the number of law enforcement agencies that carry naloxone to reverse overdose among the public	NCHRC, DPS, OEMS, Local law enforcement, AG
Community naloxone distribution	Increase the number of naloxone overdose rescue kits distributed through communities to lay people	NCHRC, DPH, LHDs, LME/MCOs, OTPs, CCNC
Naloxone co-prescribing	Create and adopt strategies to increase naloxone co-prescribing within health systems, PCPs	NCHA, NCAP, CCNC, Licensing boards and professional societies
Pharmacist naloxone dispensing	Train pharmacists to provide overdose prevention education to patients receiving opioids and increase pharmacist dispensing of naloxone under the statewide standing order	NCAP, NCBP, CCNC
Safer Syringe Initiative	Increase the number of SEP programs and distribute naloxone through them	NCHRC, DPH, LHDs

6. EXPAND TREATMENT ACCESS

Strategy	Action	Leads
Care linkages	Work with health systems to develop and adopt model overdose discharge plans to promote recovery services and link to treatment care	NCHA, LME/MCOs
	Link patients receiving office-based opioid treatment to counseling services for SUD using case management or peer support specialists	DMH, RCOs, APNC, CCNC, LME/MCOs, NCATOD
Treatment access	Increase state and federal funding to serve greater numbers of North Carolinians who need treatment	All
MAT access: Office-based opioid treatment	Offer DATA waiver training in all primary care residency programs and NP/PA training programs in NC	DHHS, NCHA, AHEC, NCAFP, Medical Schools
	Increase providers' ability to prescribe MAT through ECHO spokes and other training opportunities	DMH, UNC, ORH, AHEC, FQHCs
	Increase opportunities for pharmacists to collaborate with PCPs and specialty SUD providers to coordinate MAT	NCAP, NCBP, AHEC, UNC
Integrated care	Increase access to integrated physical and behavioral healthcare for people with opioid use disorder	DHHS, Health systems, LHDs

6. EXPAND TREATMENT ACCESS, Cont'd

Strategy	Action	Leads
Transportation	Explore options to provide transportation assistance to individuals seeking treatment	DMH, LME/MCOs, DSS, Local government
Law Enforcement Assisted Diversion	Implement additional Law Enforcement Assisted Diversion (LEAD) programs to divert low level offenders to community-based programs and services	NCHRC, AG, DAs, DMH
Special Populations: Pregnant women	Increase number of OB/GYN and prenatal prescribers with DATA waivers to prescribe MAT	NCOGS, Professional societies
	Support pregnant women with opioid addiction in receiving prenatal care, SUD treatment, and promoting healthy birth outcomes	DMA, CCNC, DPH, DMH, LME/MCOs, DSS
Special populations: Justice-involved persons	Provide education on opioid use disorders and overdose risk and response at reentry facilities, local community corrections, and TASC offices	DPS, DMH, NCHRC
	Expand in-prison/jail and post-release MAT and on-release naloxone for justice involved persons with opioid use disorder	DPS, DMH, Local government

6. EXPAND RECOVERY SUPPORT

Strategy	Action	Leads
Community paramedicine	Increase the number of community paramedicine programs whereby EMS links overdose victims to treatment and support	OEMS, DMH, LMEs/MCOs
Post-reversal response	Increase the number of post-reversal response programs coordinated between law enforcement, EMS, and/or peer support/case workers	NCHRC, Local LE, OEMS, RCOs, AG, LME/MCOs
Community-based support	Increase the number of community-based recovery supports (e.g. support groups, recovery centers, peer recovery coaches)	DMH, RCOs, ORH, LME/MCOs
Housing	Increase recovery-supported transitional housing options to provide a supportive living environment and improve the chance of a successful recovery	DMH, LME/MCOs, Local government and coalitions
Employment	Reduce barriers to employment for those with criminal history	Local government and coalitions
Recovery Courts	Maintain and enhance therapeutic (mental health, recovery and veteran) courts	Local government, Judges and DAs

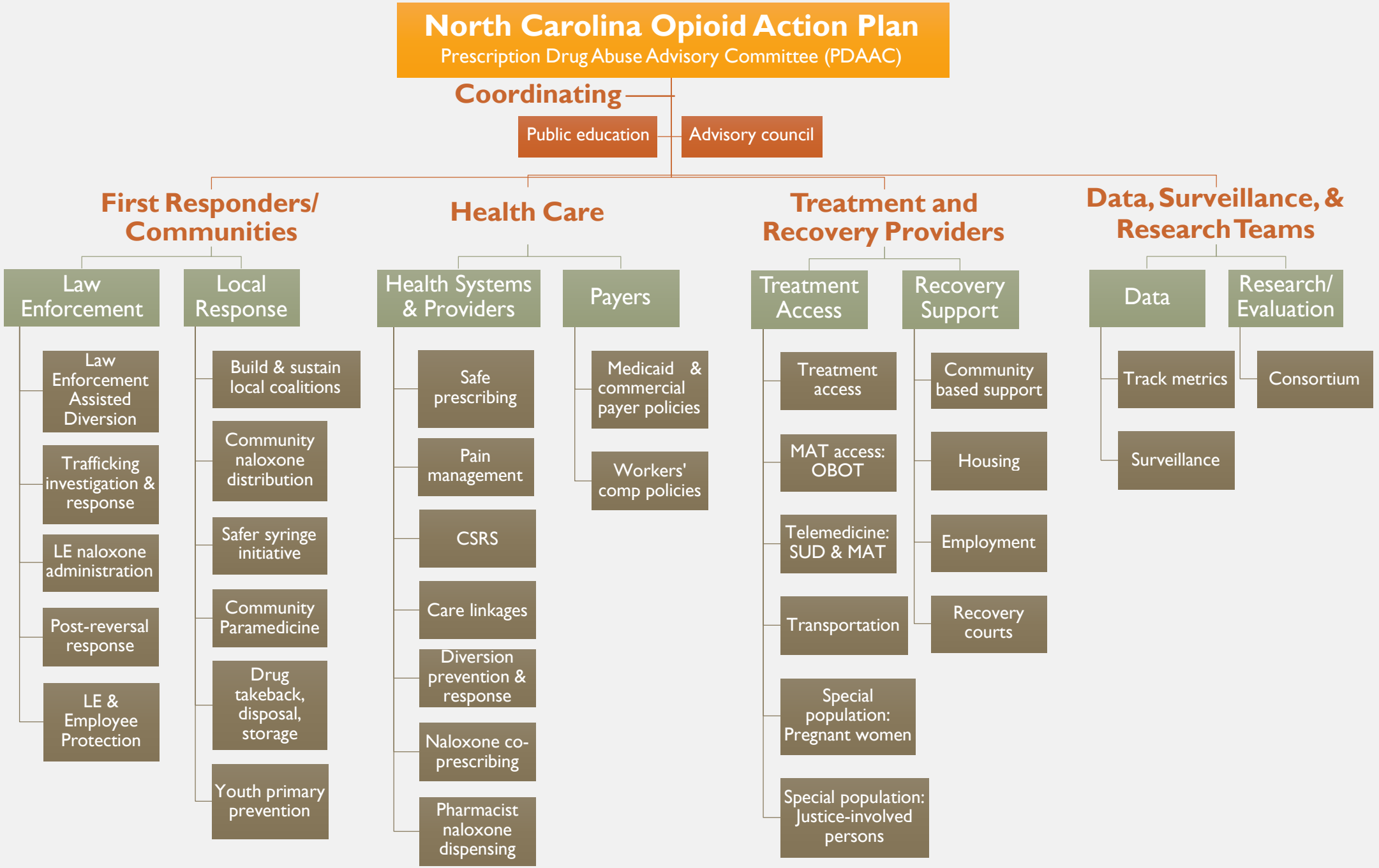
7. MEASURE IMPACT

Strategy	Action	Leads
Metrics/Data	Create publicly accessible data dashboard of key metrics to monitor impact of this plan	DPH, DMH
Surveillance	Establish a standardized data collection system to track law enforcement and lay person administered naloxone reversal attempts	OEMS, Law Enforcement, CPC, NCHRC
	Create a multi-directional notification protocol to provide close to real-time information on overdose clusters (i.e. EMS calls, hospitalizations, arrests, drug seizures) to alert EMS, law enforcement, healthcare providers	HIDTA, SBI, DEA, DPH, OEMS, CPC, LHDs, Local law enforcement
Research/ Evaluation	Establish an opioid research consortium and a research agenda among state agencies and research institutions to inform future work and evaluate existing work	UNC, Duke, RTI, other Universities/colleges, DPH, DMH, AHEC/Academic Research Centers

COORDINATED ACTIONS

To successfully combat this epidemic, the Action Plan envisages coordinated actions among:

- **First Responders and Communities**
- **Health Care/Payers**
- **Treatment and Recovery Providers**
- **Data, Surveillance, and Research Teams**

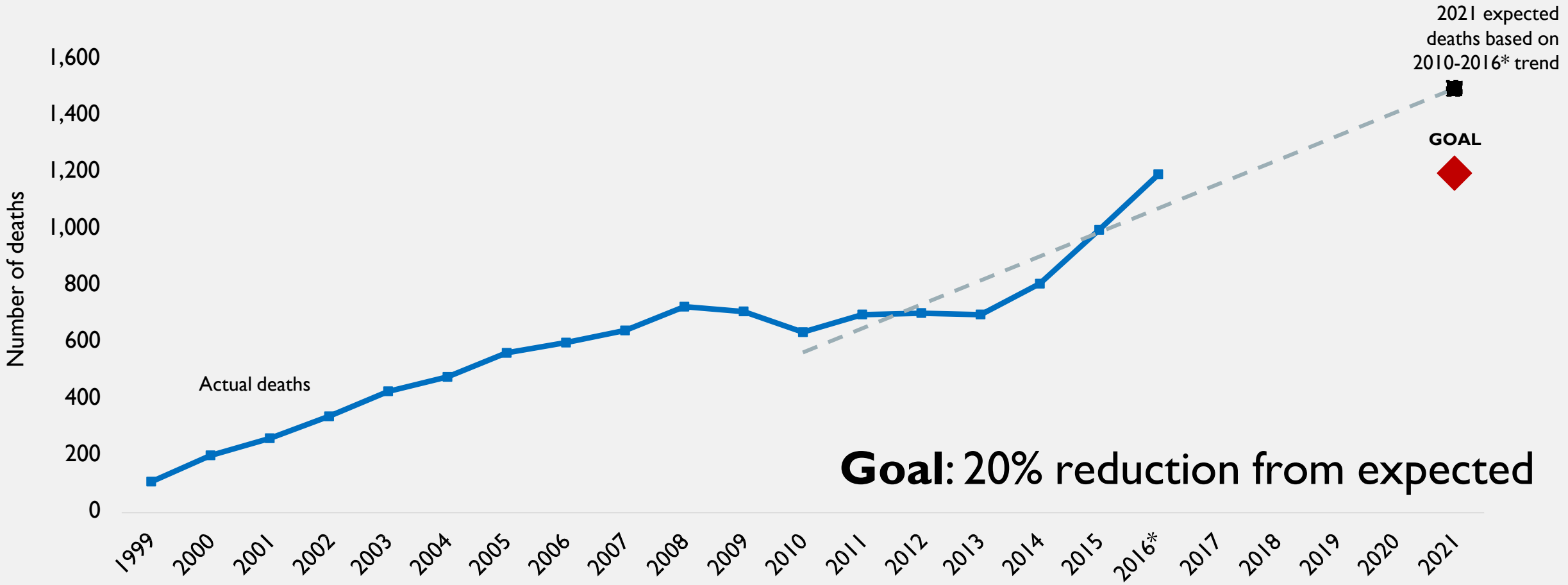


MEASURING PROGRESS

METRICS FOR NC'S OPIOID ACTION PLAN

Metrics	Current Data	2021 Trend/Goal
OVERALL		
Number of unintentional opioid-related deaths (ICD10)	1,194 (2016, provisional)	20% reduction in expected 2021 number
Rate of opioid ED visits (all intents)	38.2 per 100,000 residents (2015)	20% reduction in expected 2021 rate
Reduce oversupply of prescription opioids		
Rate of multiple provider episodes for prescription opioids (times patients received opioids from ≥5 prescribers dispensed at ≥5 pharmacies in a six-month period), per 100,000 residents	27.3 per 100,000 residents (2016)	Decreasing trend
Total number of opioid pills dispensed	555,916,512 (2016)	Decreasing trend
Percent of patients receiving more than an average daily dose of >90 MME of opioid analgesics, per quarter	12.3% (Q1 2017)	Decreasing trend
Percent of prescription days any patient had at least one opioid AND at least one benzodiazepine prescription on the same day, per quarter	21.1% (Q1 2017)	Decreasing trend
Reduce Diversion/Flow of Illicit Drugs		
Percent of opioid deaths involving heroin or fentanyl/fentanyl analogues	58.4% (2016, provisional)	----------
Number of acute Hepatitis C cases	182 (2016, provisional)	Decreasing trend
Increase Access to Naloxone		
Number of EMS naloxone administrations	13,069 (2016, provisional)	----------
Number of community naloxone reversals	3,616 (2016)	Increasing trend
Treatment and Recovery		
Number of buprenorphine prescriptions dispensed	467,243 (2016)	Increasing trend
Number of uninsured individuals with an opioid use disorder served by treatment programs	12,248 (SFY16)	Increasing trend
Number of certified peer support specialists (CPSS) across NC	2,383 (2016)	Increasing trend

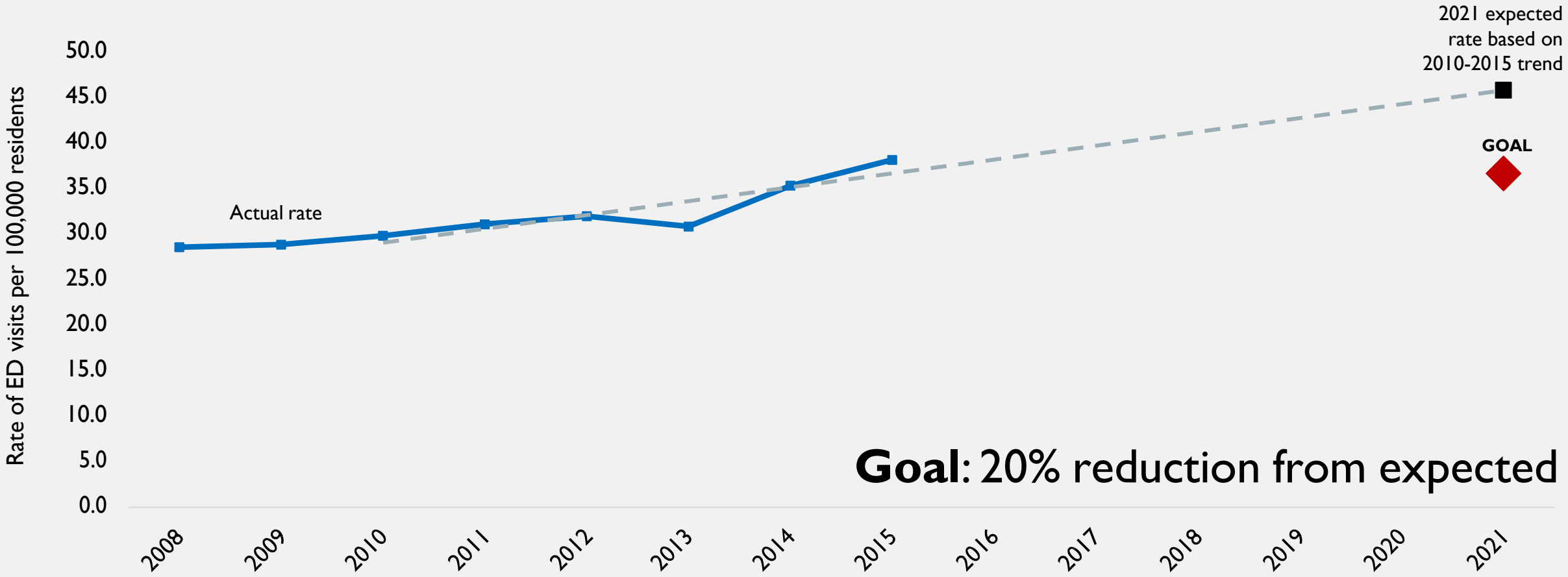
NUMBER OF UNINTENTIONAL OPIOID-RELATED DEATHS



*2016 data are preliminary and subject to change, current as of June 1, 2017

Source: NC State Center for Health Statistics, Vital Statistics-Deaths, 1999-2016* (ICD10 coded data)

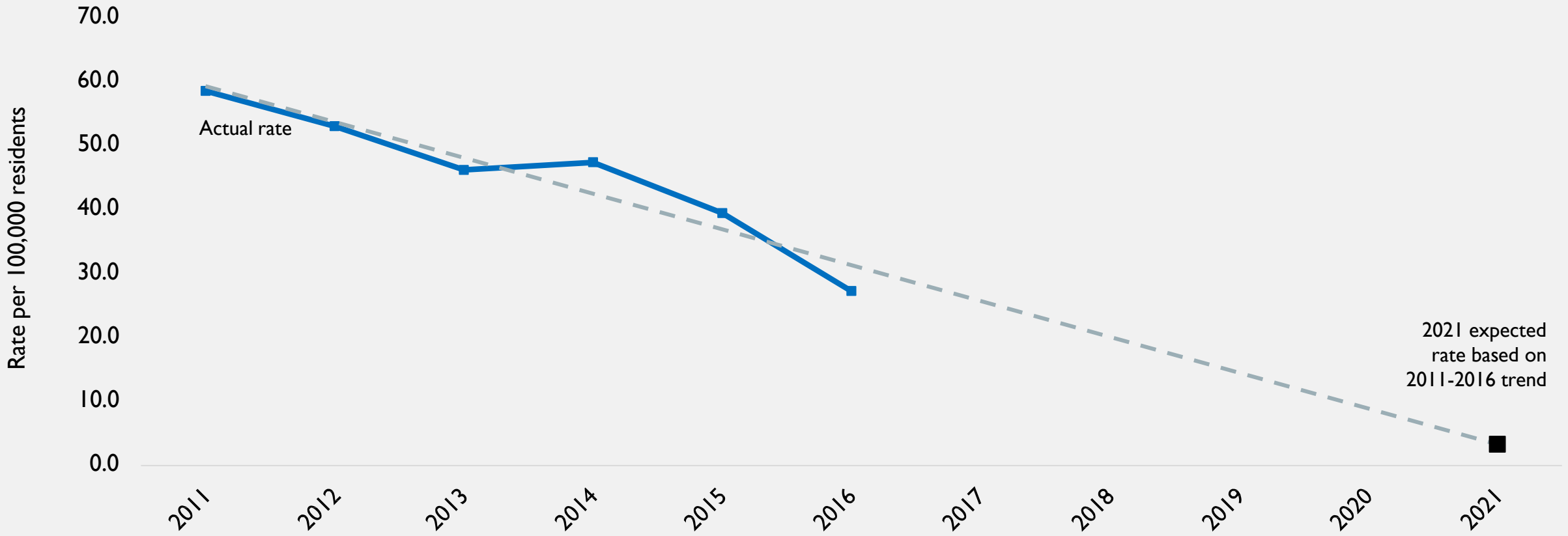
RATE OF OPIOID ED VISITS



Goal: 20% reduction from expected

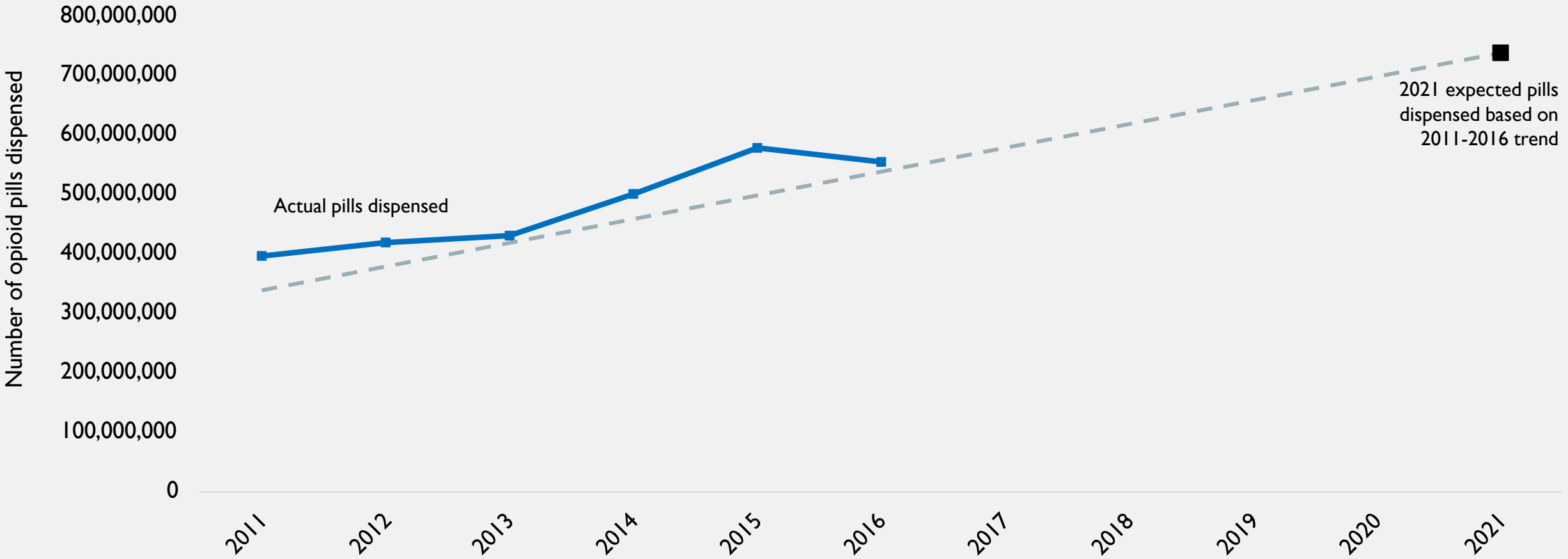
Source: NC Division of Public Health, Epidemiology Section, NC DETECT, 2008-2015

RATE OF MULTIPLE PROVIDER EPISODES FOR PRESCRIPTION OPIOIDS (TIMES PATIENTS RECEIVED OPIOIDS FROM ≥5 PRESCRIBERS DISPENSED AT ≥5 PHARMACIES IN A SIX-MONTH PERIOD), PER 100,000 RESIDENTS



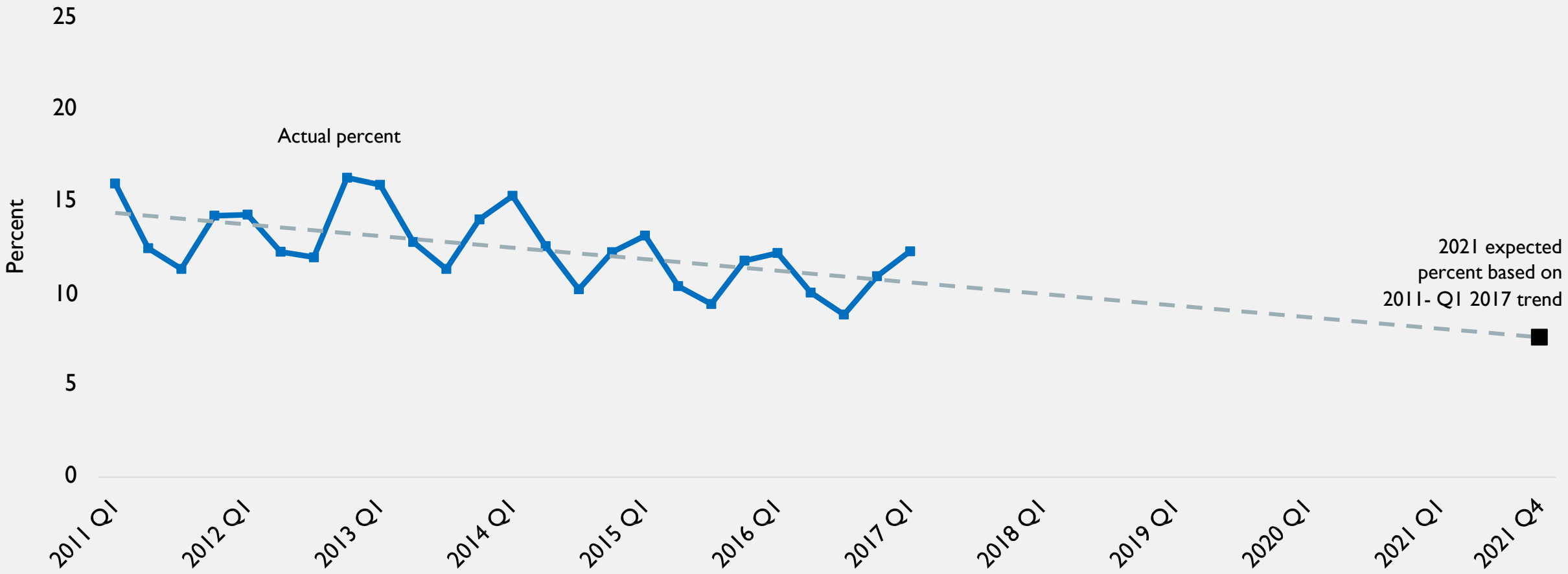
Source: NC Division of Mental Health, Controlled Substance Reporting System, 2011-2016

TOTAL NUMBER OF OPIOID PILLS DISPENSED



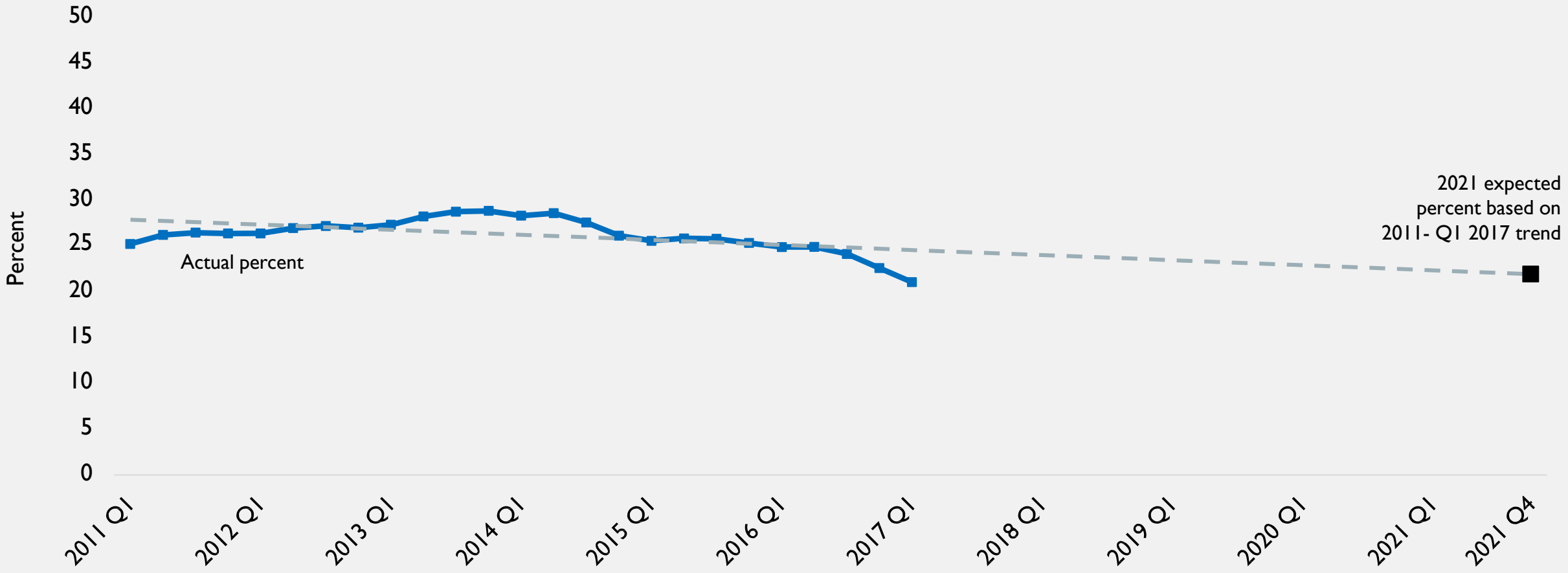
Source: NC Division of Mental Health, Controlled Substance Reporting System, 2011-2016

PERCENT OF PATIENTS RECEIVING MORE THAN AN AVERAGE DAILY DOSE OF >90 MME OF OPIOID ANALGESICS, PER QUARTER



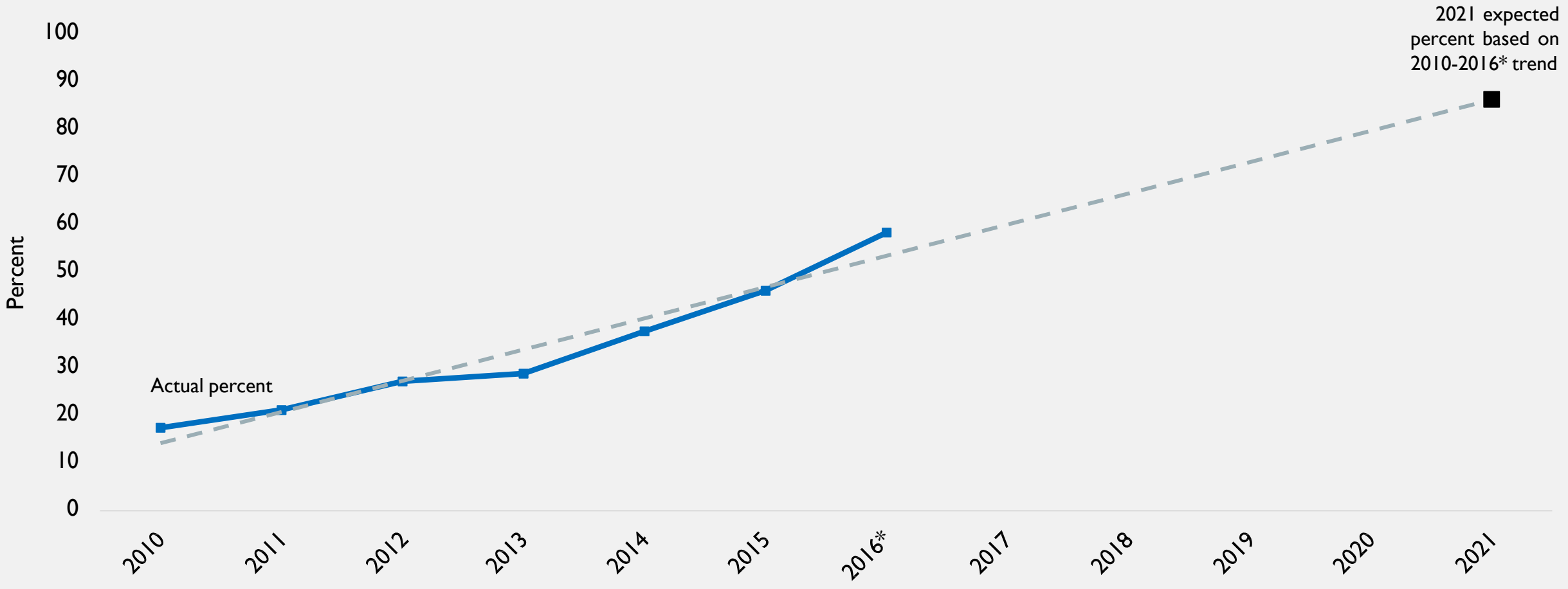
Source: NC Division of Mental Health, Controlled Substance Reporting System, 2011-Q1 2017

PERCENT OF PRESCRIPTION DAYS ANY PATIENT HAD AT LEAST ONE OPIOID AND AT LEAST ONE BENZODIAZEPINE PRESCRIPTION ON THE SAME DAY, PER QUARTER



Source: NC Division of Mental Health, Controlled Substance Reporting System, 2011-Q1 2017

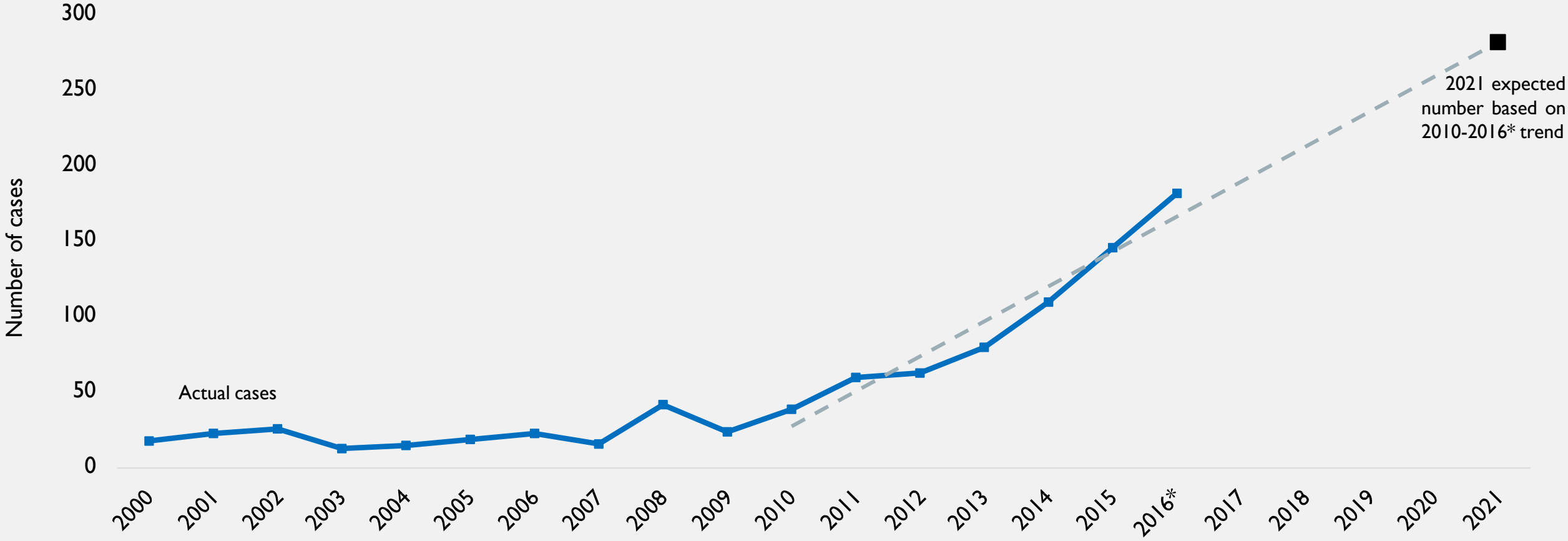
PERCENT OF OPIOID DEATHS INVOLVING HEROIN OR FENTANYL/FENTANYL ANALOGUES



*2016 data are preliminary and subject to change, current as of June 1, 2017
**Increasing numbers of deaths due to other classes of designer opioids are expected

Source: NC Office of the Chief Medical Examiner (OCME) and the OCME Toxicology Laboratory, 2010-2016*

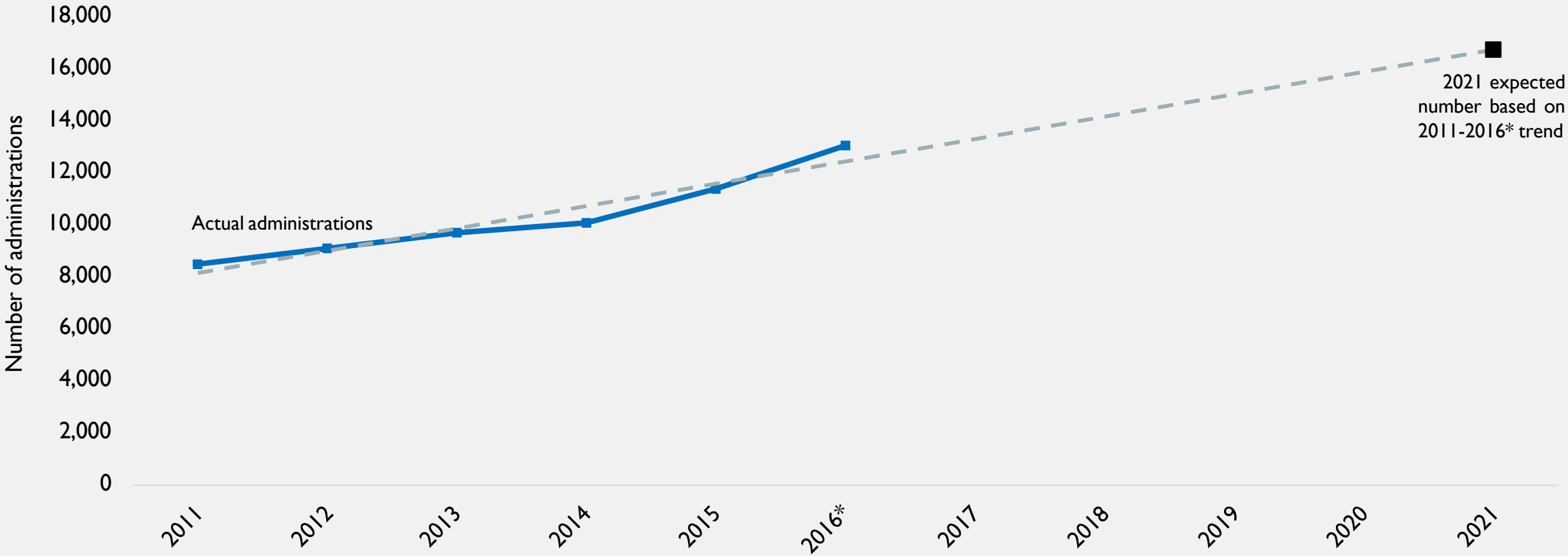
NUMBER OF ACUTE HEPATITIS C CASES



*2016 data are preliminary and subject to change, current as of April 1, 2017

Source: NC Division of Public Health, Epidemiology Section, NC EDSS, 2000-2016*

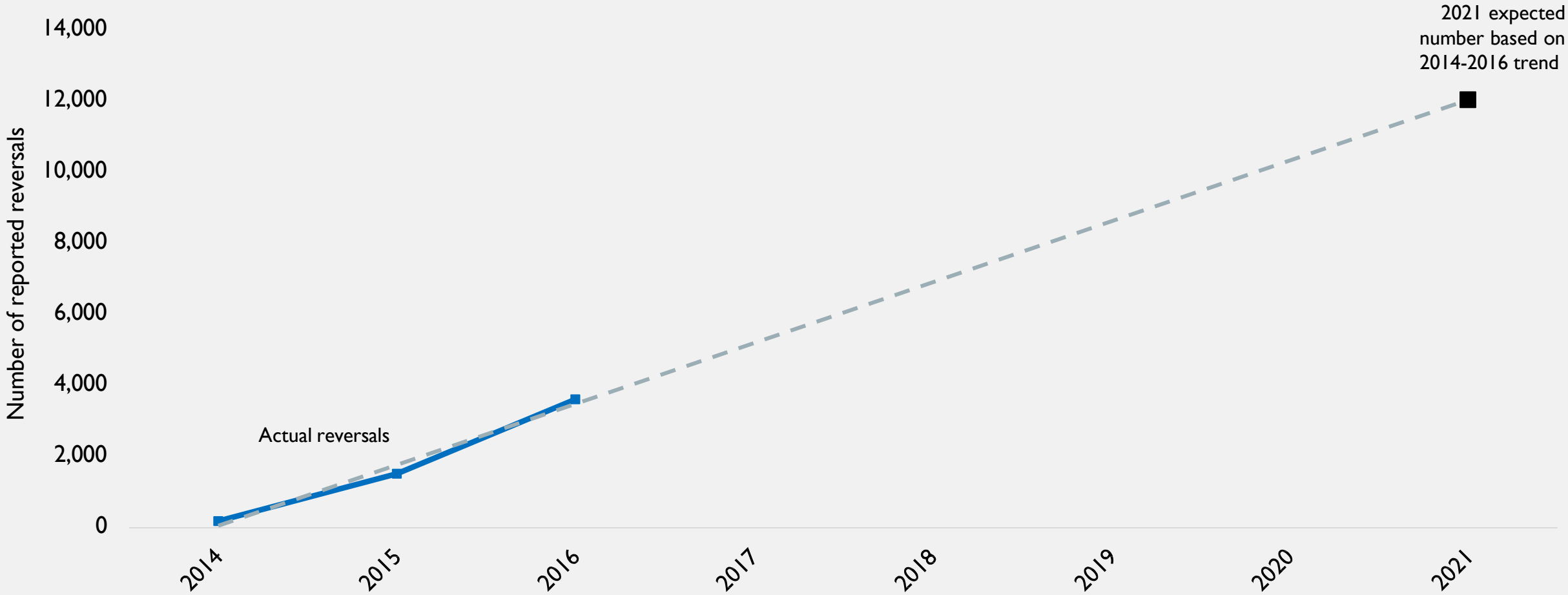
NUMBER OF EMS NALOXONE ADMINISTRATIONS



*2016 data are preliminary and subject to change

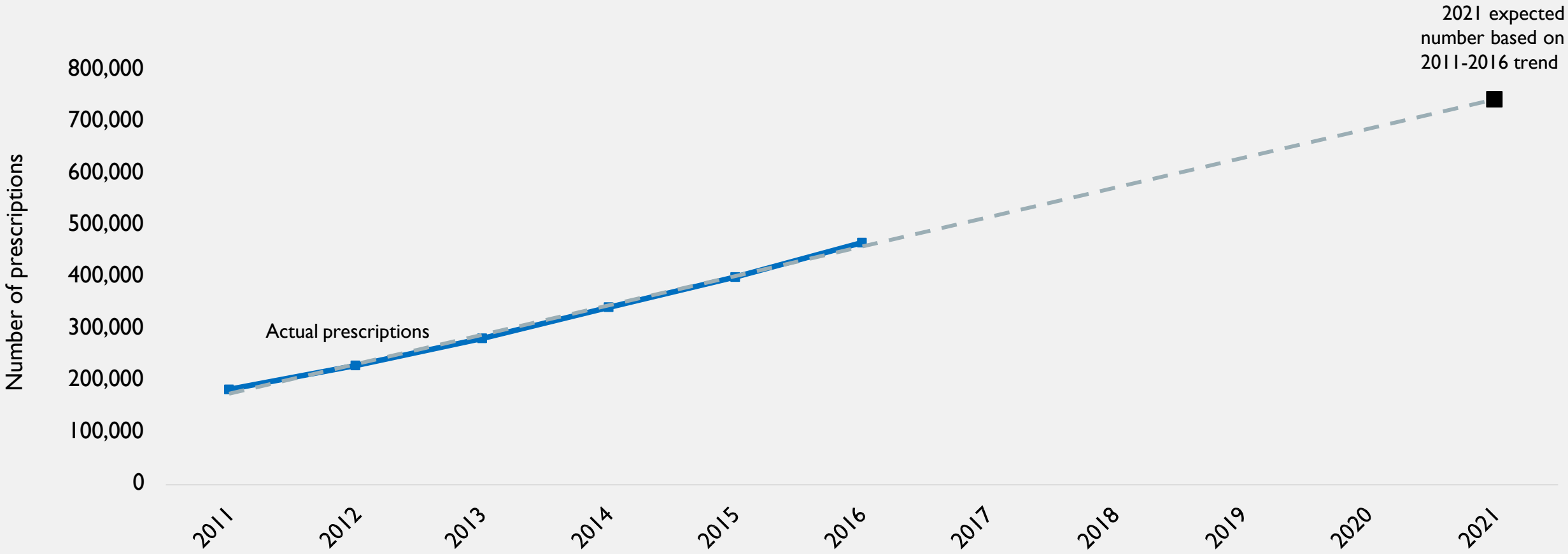
Source: NC Office of Emergency Medical Services (OEMS), EMSpic-UNC Emergency Medicine Department, 2012-2015

NUMBER OF REPORTED COMMUNITY NALOXONE REVERSALS



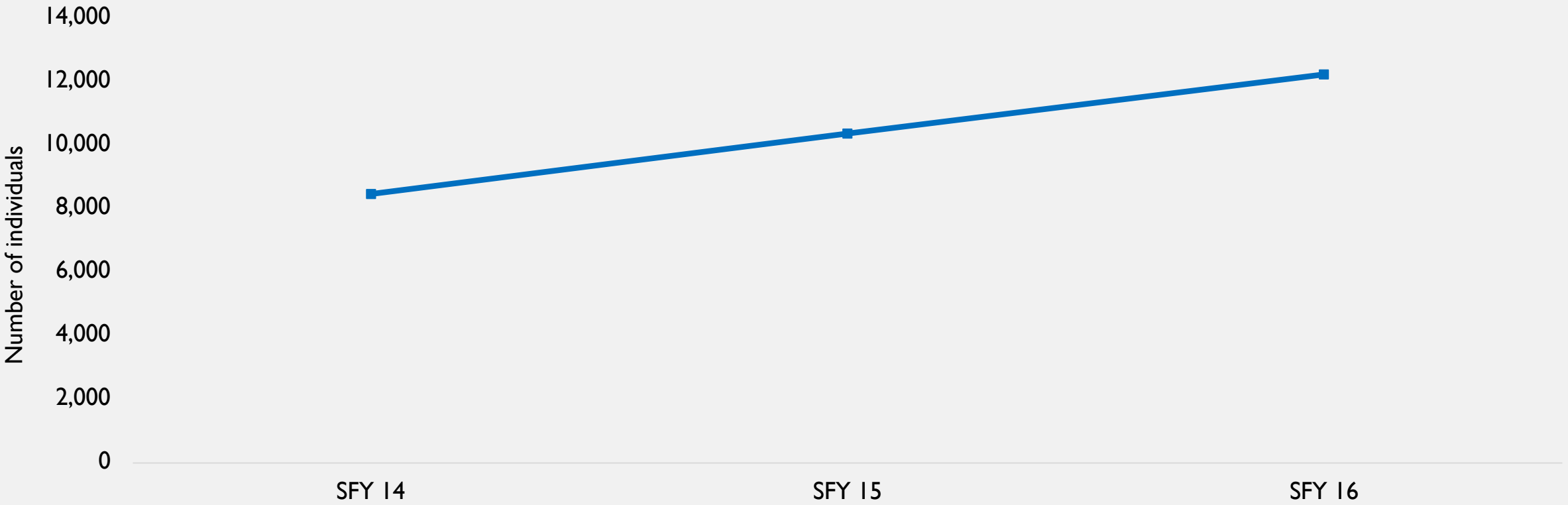
Source: NC Harm Reduction Coalition (NCHRC), 2014-2016

NUMBER OF BUPRENORPHINE PRESCRIPTIONS DISPENSED



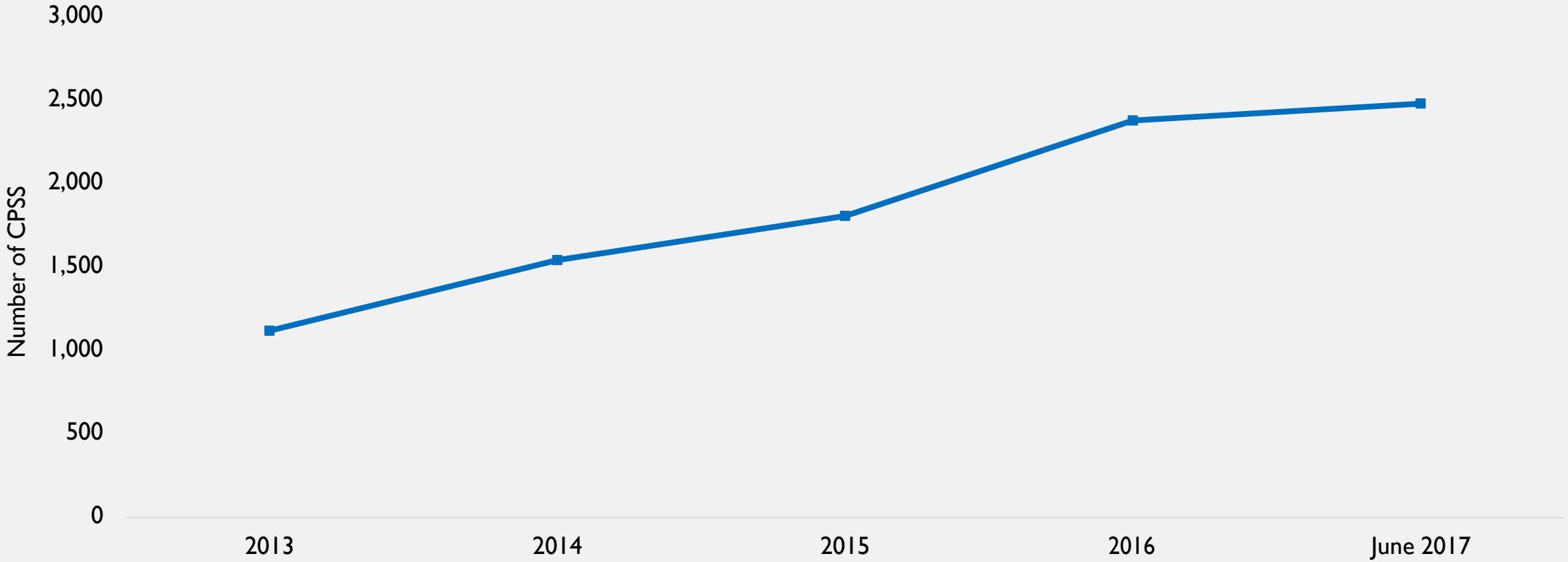
Source: NC Division of Mental Health, Controlled Substance Reporting System, 2011-2016

NUMBER OF UNINSURED INDIVIDUALS WITH AN OPIOID USE DISORDER SERVED BY TREATMENT PROGRAMS



Source: NC Division of Mental Health, Claims Data, 2014-2016

NUMBER OF CERTIFIED PEER SUPPORT SPECIALISTS (CPSS) ACROSS NC



Source: UNC-Chapel Hill, School of Social Work, Behavioral Health Springboard, 2013-June 2017

ACRONYMS

- **AG**: Attorney General's Office
- **AHEC**: Area Health Education Centers
- **AOC**: Administrative Office of the Courts
- **APNC**: Addiction Professionals of NC
- **BCBSNC**: Blue Cross Blue Shield of NC
- **CCNC**: Community Care of NC
- **CHS**: Carolinas Healthcare System
- **CPC**: Carolinas Poison Center
- **CSRS**: Controlled Substances Reporting System
- **DA**: District Attorney
- **DATA**: Drug Addiction Treatment Act of 2000
- **DEA**: Drug Enforcement Administration
- **DHHS**: Department of Health and Human Services
- **DMA**: Division of Medical Assistance
- **DMH**: Division of Mental Health, Developmental Disabilities & Substance Abuse Services
- **DIT**: Department of Information Technology
- **DOI**: Department of Insurance
- **DPH**: Division of Public Health
- **DPS**: Department of Public Safety
- **DSS**: Division of Social Services
- **ECHO**: Extension for Community Healthcare Outcomes
- **ED**: Emergency Department
- **EMS**: Emergency Medical Services
- **FQHC**: Federally Qualified Health Center
- **GDAC**: Government Data Analytics Center
- **GI**: Governor's Institute on Substance Abuse
- **HIDTA**: High Intensity Drug Trafficking Areas
- **IPRC**: Injury Prevention Research Center
- **LEAD**: Law Enforcement Assisted Diversion
- **LHD**: Local Health Department
- **LMEs/MCOs**: Local Management Entities/Managed Care Organizations
- **MAT**: Medication Assisted Treatment

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ACRONYMS

- **NC**: North Carolina
- **NC DETECT**: Disease Event Tracking and Epidemiologic Collection Tool
- **NCACC**: NC Association of County Commissioners
- **NCAFP**: NC Academy of Family Physicians
- **NCAP**: NC Association of Pharmacists
- **NCATOD**: NC Association for the Treatment of Opioid Dependence
- **NCBP**: NC Board of Pharmacy
- **NCHA**: NC Hospital Association
- **NCHRC**: NC Harm Reduction Coalition
- **NCMB**: NC Medical Board
- **NCOGS**: North Carolina Obstetrical and Gynecological Society
- **NCRMA**: NC Retail Merchants Association
- **NP**: Nurse Practitioner
- **OCME**: Office of the Chief Medical Examiner
- **OEMS**: Office of Emergency Medical Services
- **ORH**: Office of Rural Health
- **OTP**: Opioid Treatment Program
- **PA**: Physician Assistant
- **PCP**: Primary Care Provider
- **PDAAC**: Prescription Drug Abuse Advisory Committee
- **RCOs**: Recovery Community Organizations
- **RTI**: Research Triangle Institute
- **SBI**: State Bureau of Investigation
- **SEP**: Syringe Exchange Program
- **SCHS**: State Center for Health Statistics
- **SHP**: State Health Plan
- **SUD**: Substance Use Disorder
- **TASC**: Treatment Accountability for Safer Communities
- **UNC**: University of North Carolina at Chapel Hill

NC Opioid Action Plan: Version I, June 2017

NC DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

2016-2019 STATE STRATEGIC PLAN
JULY 1, 2016

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2016-2019 State Strategic Plan
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Executive Summary

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) provides this statewide strategic plan for its services for the period covering July 1, 2016 to June 30, 2019 as required by North Carolina Session Law 2006-142, House Bill 2077.

The DMH/DD/SAS engaged in a systematic effort to include consumers, individuals with lived experience, and family members in the development of mental health, intellectual/developmental disabilities, substance use disorders, and traumatic brain injury services and supports. The DMH/DD/SAS worked in collaboration with identified stakeholders and partners to develop a list of five priorities all directed toward improving the overall services and supports. Each identified priority may include several specific initiatives. These priorities include:

1. Prevention and Education
2. Intervention and Treatment
3. Housing and Employment
4. Quality Monitoring and Management
5. Integrated Care

Although there have been a number of changes to the service delivery system and priorities for funding, the success of this system rests with all stakeholders including individuals, their families, providers, Local Management Entity/Managed Care Organizations (LME/MCOs), the DMH/DD/SAS, DHHS, and the NC General Assembly*. It has become clear that resources are limited and the need to prioritize will require ongoing communication and collaboration amongst all stakeholders to best address the needs of individuals in need of services and supports. The strategies and priorities in this plan provide focus and mechanisms for measuring the success of meeting these needs.

*During the 2016 legislative session, Session Law 2016-94, House Bill 1030, was passed which calls for a more comprehensive *Strategic Plan for the Improvement of Behavioral Health Services*. This most recent plan is tasked to the Department of Health and Human Services (DHHS) and will likely result in changes to the DMH/DD/SAS Statewide Strategic Plan for 2016-2019, as it is scheduled to be completed during this time period. The DMH/DD/SAS believes that its mission, vision, and goals are consistent with the planning that has commenced for the broader strategic planning initiative.

Mission

The mission of the NC Department of Health and Human Services (NC DHHS) is, ***in collaboration with its partners, to protect the health and safety of all North Carolinians and to provide essential services.*** This mission is driven by a vision that all ***North Carolinians will enjoy optimal health and well-being.***

NC DHHS articulates a set of values to be incorporated into every employee's performance plan to infuse all work activities with consistent understanding of how the public service is to be delivered. The values are:

- Accountability
- Customer Service
- Diversity and Inclusion
- Safety and Health
- Teamwork and Collaboration

The mission of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) is, to provide people with, or at risk of, mental illness, intellectual/developmental disabilities, and substance use disorders and their families the necessary prevention, intervention, treatment services, and supports they need to live successfully in communities of their choice. Every employee of DMH/DD/SAS is responsible for performing their duties in keeping with a public demonstration of the DHHS values.

Goals

DMH/DD/SAS considers the overarching goals of DHHS as a structure within which to state that the Division goals, in turn, support the goals of the Department. The Division goals are used to assure that any initiative undertaken by the Division supports and conforms to the goals of the Department as a whole. The goals for DMH/DD/SAS are:

1. Promote access to quality mental health services, substance use disorder services, and supports to persons with intellectual/developmental disabilities and to persons who have experienced traumatic brain injury;
2. Advance knowledge and innovative solutions to mental health, intellectual/developmental disabilities, and substance use disorders services challenges;
3. Promote economic and social well-being, community integration, and self-determination for individuals and families;
4. Promote prevention and well-being across the life span;
5. Ensure efficiency, transparency, and accountability of Division programs and initiatives; and
6. Develop strategies to ensure continuity of work processes and products in the workplace.

North Carolina's Service System

The North Carolina General Assembly has described in legislation the nature and structure of the public behavioral health services system for mental health, intellectual/developmental disabilities, and substance use disorders. The authority for the behavioral health system is assigned to the Secretary of DHHS. The Secretary delegates the responsibility for the community services system to the Senior Director of /DMH/DD/SAS.

The community behavioral health service system is managed by Local Management Entities acting as Managed Care Organizations (LME/MCOs). The LME/MCOs are responsible for developing and maintaining a network of providers to offer the array of services necessary to support their local communities. The LME/MCOs also assist, assess, and direct consumers' access to services in the system, monitor the service providers, and process payments for Medicaid and non-Medicaid State-funded* services.

The LME/MCOs manage their Medicaid community services network in accordance with the federal requirements found in a 1915(b)(c) waiver. The waiver allows the LME/MCOs to adjust the services continuum by developing alternative services and enrolling providers that reflect the needs of their communities.

**Non-Medicaid State funds are state appropriated funds combined with those available through federal block grants and other discretionary grants.*

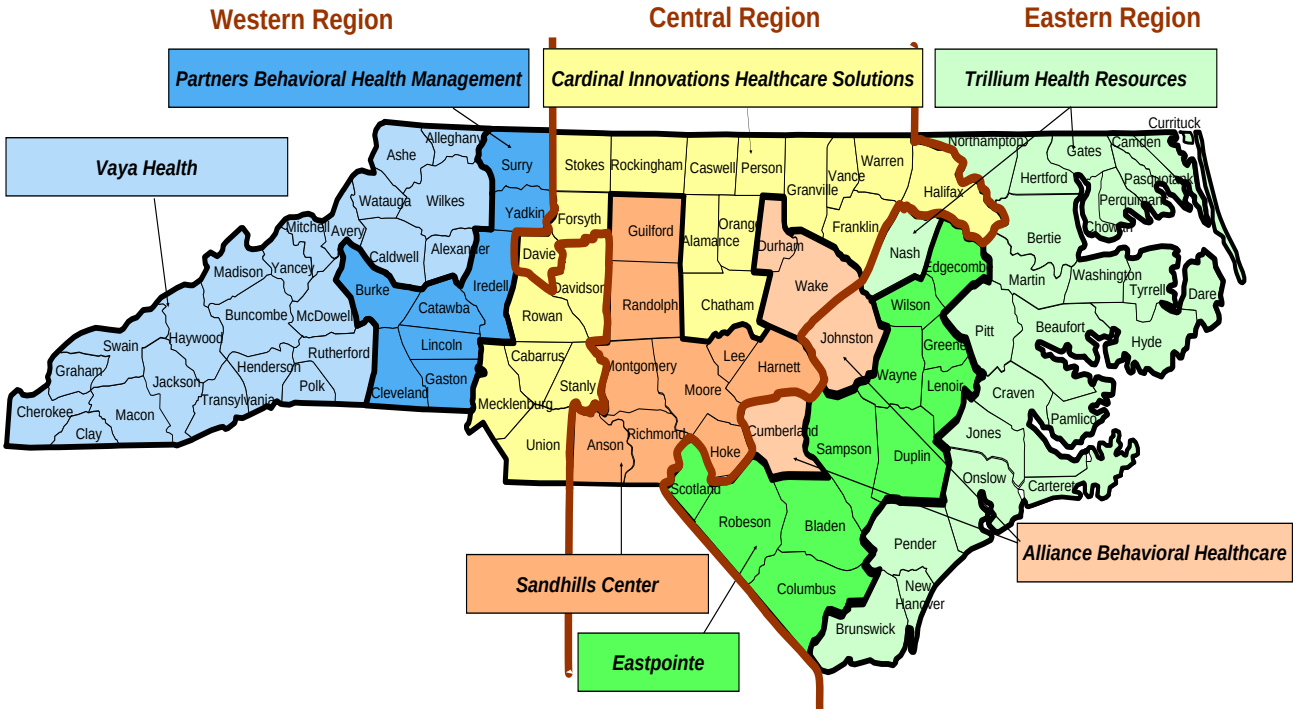
DMH/DD/SAS manages the LME/MCO service system through development of policy, assistance with creation of services, and distribution of appropriated funding, grants, and monitoring support. The Division's organizational structure is designed to implement North Carolina's public mental health, developmental disability, and substance use service system. The Division is organized to efficiently and effectively address the development and oversight of the service system. The organization chart in effect at the time this document was written is presented in **Appendix A**.

The Senior Director's Office sets the overall policy direction of the public mh/idd/sud/tbi system under the leadership and supervision of the Secretary of DHHS. The policy direction provides strategic, clinical, and operational oversight for the public behavioral health services system, and the Division, to ensure the quality and effectiveness of service delivery, the development and enhancement of a full continuum of care, and to strengthen the clinical relationship between the public, private, and academic sectors.

DMH/DD/SAS leadership fosters collaborative efforts with the Division of Medical Assistance (DMA) to ensure coordinated oversight of the 1915 (b)(c) Medicaid waiver, NC Medicaid Reform, and the DMA Quality Strategy for the North Carolina Behavioral Health Prepaid Inpatient Healthcare Plans (PIHPs) that are also known as the LME/MCOs. DMH/DD/SAS staff are members of the intra-departmental monitoring teams (IMTs) responsible for monitoring the operations of the LME/MCOs, promotion of best practices, and service outcomes related to the waivers, block grants, and state funded services. The Division also collects and analyzes quality metrics reported by the LME/MCOs regarding performance on behalf of both Medicaid and non-Medicaid State-funded service recipients.

The current configuration of LME/MCOs is as follows: Alliance Behavioral Healthcare, Cardinal Innovations Healthcare, Eastpointe LME/MCO, Partners Behavioral Health Management, Sandhills Center, Trillium Health Resources, and Vaya Health. A map of the catchment areas for each is shown below:

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



- *Reflects LME-MCOs as of 7/1/17.*
- *Includes the move of Nash County to Trillium Health Resources on 7/1/17.*

Stakeholder Involvement

DMH/DD/SAS is committed to achieving all goals through collaboration with all stakeholders. The Division values the input of consumers, self-advocates, and family members and promotes a sustainable system where consumers' rights are protected and consumers and family members are involved in the planning and management of the service system. This commitment is first embodied in the creation and maintenance of the State Consumer and Family Advisory Committee (SCFAC). The Consumer Empowerment Team of the Division provides staff and support to the SCFAC which is made up of consumers and family members from all disability service groups. The SCFAC reviews the policies and activities of DMH/DD/SAS and DMA and submits recommendations to the Secretary of DHHS for changes and improvements.

Each LME/MCO is required by legislation to convene a local Consumer and Family Advisory Committee like the SCFAC. The local CFACs serve the LME/MCOs as the SCFAC serves the Secretary of DHHS. The Consumer Empowerment Team of DMH/DD/SAS provides staff, support, and training to the members of the local CFACs across the state.

Other stakeholder engagement efforts include the external collaboration between the various Divisions within DHHS (i.e. Division of Public Health (DPH), Division of Social Services (DSS), Division of Vocational Rehabilitation Services (DVRSS), Division of Health Services Regulation (DHSR), other state Departments such as the Department of Public Instruction (DPI) and the Department of Public Safety (DPS), county managements, LME/MCOs direct service providers, consumers, families, and other community stakeholders. A listing of the organizations that assure stakeholder participation in planning and management of system can be found in **Appendix B**.

DMH/DD/SAS has a Consumer Policy Advisor to work closely with the Executive Operations Team and to review the Division's initiatives in support of consumer and family input. The Consumer Policy Advisor has input into policy and program development to suggest methods for engaging consumers in providing feedback and to assure that the feedback is incorporated into the final products.

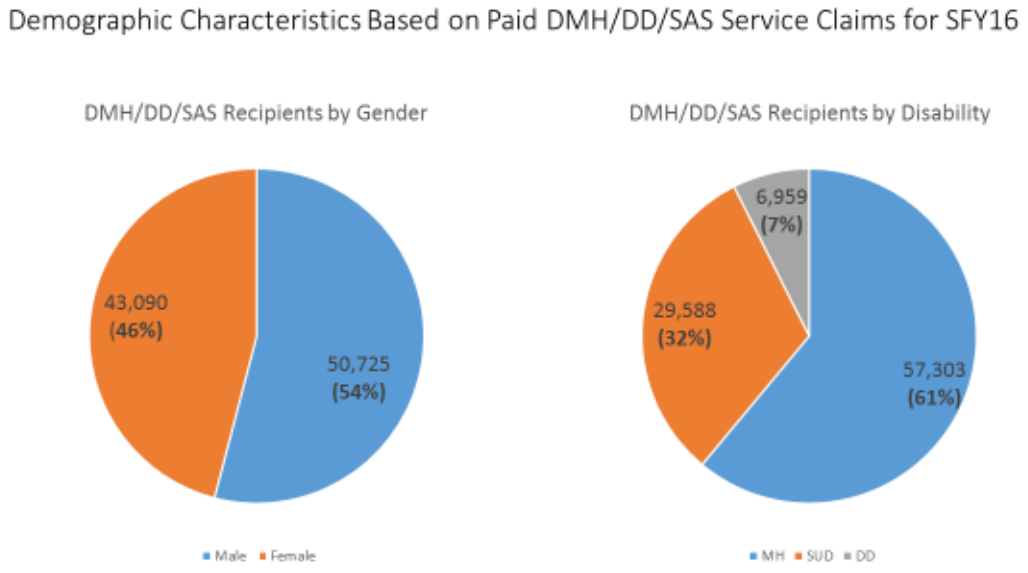
Services

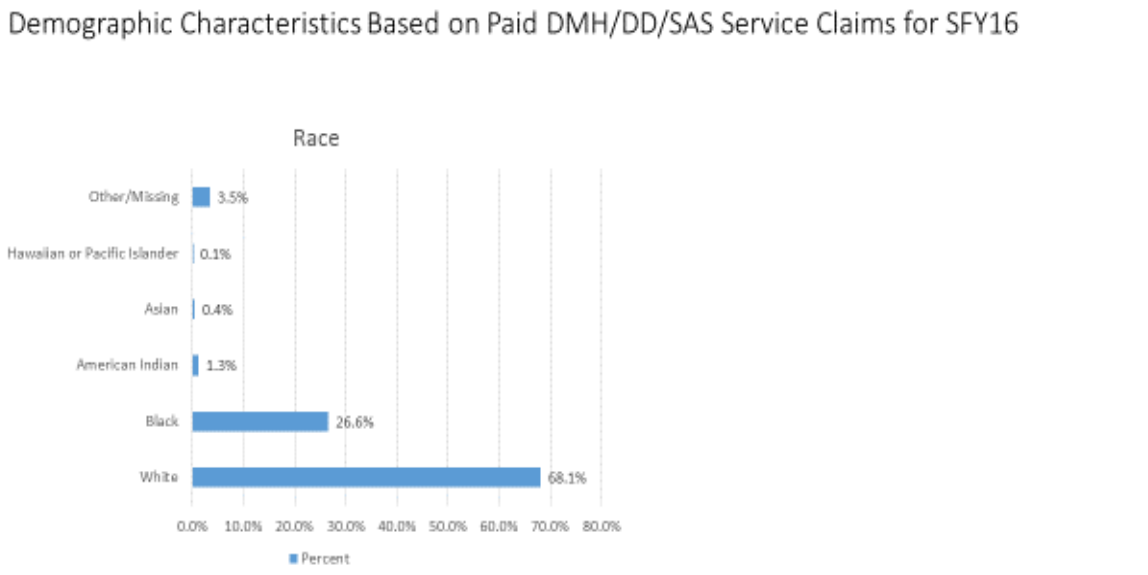
DMH/DD/SAS funds priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals. When in existence, services selected for funding are "evidence-based" which means they have demonstrated success in improving outcomes and/or supporting recovery for individual well-being. Evidence-based practices are the most effective and efficient use of limited public funding. Providing a full array of services, available to consumers based on medical necessity, is important to provide the "just right" degree of service — no more and no less than is needed to consumers.

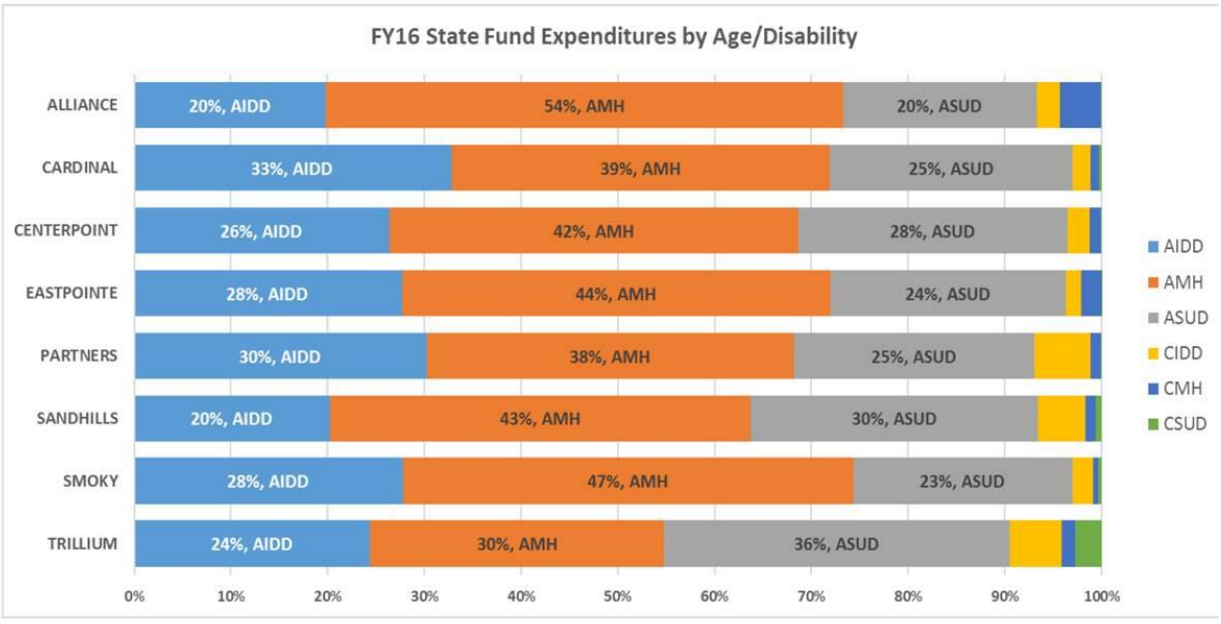
Priority Populations

DMH/DD/SAS contracts with the LME/MCOs identifying groups of citizens in need that constitute priority populations for services. Current Priority Populations are described in **Appendix C.**

Who We Serve







Includes State and Block Grant fund expenditures.

10

DMH/DD/SAS Contract Requirements for LME/MCOs

The LME/MCOs operate through contractual agreements with DHHS. DMH/DD/SAS, DMA and the Division of State Operated Health Facilities (DSOHF) each have contracts with the LME/MCOs to define and describe the responsibilities of each party in the provision of the state's public mh/idd/sud/tbi services system.

The DMH/DD/SAS contract stipulates what aspects of the LME/MCO business and services must meet specific requirements for creating policy, services, a service network; managing funds including payment for services and requirements for solvency; maintaining performance standards with regards to internal performance and service delivery; and monitoring of the service providers and network and reporting on business services and activities to the Division.

Key elements of the DMH/DD/SAS and LME/MCO contract pertaining to the Strategic Plan for DMH/DD/SAS are:

- A Community Behavioral Health Service Needs, Providers, and Gaps Analysis;
    - Annually the LME/MCO must conduct a Community Behavioral Health Service Needs, Providers, and Gaps Analysis. This analysis encourages a continuous process of identifying gaps and developing strategies, goals and actions to address the needs and gaps within the service system.
- The identification of key Priority Populations and Services to be funded and monitored during the timeframe of the Strategic Plan;

  LME/MCOs are developing in sophistication and comprehensiveness of best-practice service array and service delivery. The identification of specific Priority Populations and Services develops incrementally to expand the services, and identification of persons to receive them. The current Service Array is in **Appendix D**.
- The requirement for Quality Management and Improvement plans by the LME/MCO;
    - The LME/MCO is required to conduct consumer surveys, investigate consumer complaints and use other reporting data available to review and analyze trends in their own performance. The contract specifies some of the specific performance measures, benchmarks, and key quality measures that the LME/MCO must use to assess their performance and inform their plans for improvement.

- Critical Performance Indicators for Consumer Care.
    - The LME/MCOs report and are monitored on adherence to critical performance measures in five categories:
        - Prevention and Early Intervention;
        - Access to Community Care;
        - Crisis, Inpatient and Institutional Care;
        - Coordination and Community Care; and
        - Transitions to Community Living.
    - The contract defines the source for the data, the elements to be collected and reported and the benchmarks for success.

State Strategic Plan: Foundation

North Carolina General Statute 122C-102(a) requires that "The Department shall develop and implement a State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services. The purpose of the State Plan is to provide a strategic template regarding how State and local resources shall be organized and used to provide services."

The NC public mh/idd/sud/tbi services system has been migrating from a fee-for-service (FFS), professional-driven care delivery system that segments and separates the various services, i.e. medical, mental health, substance use and intellectual/developmental disabilities, to a more comprehensive, person-centered care delivery system that encourages self-care and involvement in care delivery by consumers and families. The goal of the transformation is a service model that uses a cohesive integration of medical and mh/idd/sud/tbi services and supports. The challenge to DHHS is how to move from the design and delivery of specific services to treat individuals with specific diagnoses to policy structure and management that supports prevention and population health without losing the capacity for continuing to serve individuals through the transition.

Each of the Divisions within DHHS are charged to develop elements within their purview to contribute to the overarching goals expressed through the "Quadruple Aim" articulated in the application for an 1115 Demonstration Waiver for Medicaid services: a better experience of care for consumers, improved clinician engagement and support, better health in our community, and per capita cost containment.

On July 14, 2015, a Task Force for Mental Health and Substance Use through Executive Order No. 76. The results of the Task Force endeavors are a list of recommendations for the Divisions of DHHS to pursue to improve the linkages between agencies for the transfer of best practices, heighten awareness and reduce stigma associated with mental health treatment, facilitate the justice system engagement with DHHS on behalf of young people with mental health and substance use issues, and improve access to services and support for children in foster care and their families including those youth who are transitioning out of the foster care system. The final report can be viewed at the following link: http://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/mental-health-task-force/governors-task-force-mhsu-final.pdf

Partner Agencies

DMH/DD/SAS has internalized the results and recommendations from the state's expansive efforts to examine the appropriate role in service and support for the vulnerable citizens who experience the impact of mental health and/or substance use disorders, intellectual/developmental disorders, or any combination of these along with the emotional, social and economic impact to individuals and families. The Division has identified the need to work in concert with other Divisions of DHHS, consumers and other stakeholders to:

- Coordinate with DMA for policy recommendations to support Medicaid and waiver services;
- Work with DSS and DPH to assure that access and services are consistently available for the vulnerable citizens identified as priority populations;
- Align with DPI to support children receiving appropriate instruction in whatever home or treatment status they reside so that the children may transition to adult independence;
- Support the targeting of services from DVRSS to assure that adolescents transitioning to adulthood and consumers transitioning from structured home settings to more independent living, have ample opportunity to become gainfully employed;
- Manage the distribution and use of funds made available to the system through state legislative appropriations, federal block and other grant funding opportunities to improve the health and well-being of consumers and families; and
- Maintain dialogue with consumers, families, LME/MCOs, providers and other stakeholders to assess and monitor the success of service and funding initiatives or pilots and the impact of the ongoing changes for consumers in the development of the transformed system.

Using the direction from the foundation planning and working with identified partners, DMH/DD/SAS has identified the following categorical priorities for system development and enhancement for the next three years.

Priorities:

- Prevention and Education
- Intervention and Treatment
- Housing and Employment
- Quality Monitoring and Management
- Integrated Care

The remainder of the Strategic Plan identifies specific initiatives that DMH/DD/SAS is implementing to improve the mh/idd/sud/tbi experience of the citizens of North Carolina. Each initiative is accompanied by a description of the tasks necessary to implement the initiative, the outputs that the initiative will generate, and the intended outcome for consumers. For some innovative initiatives, there is not baseline data available to demonstrate change or improvement based on the implementation of the initiative. For those initiatives, the outputs are intended to indicate that there is progress toward development of the initiative system and the outcome is stated in terms of when and how the metric will be developed to demonstrate the success of the initiative.

Priority: Prevention and Education

In a waiver environment, DMHDDSAS and DMA each provide administrative funds to LME/MCOs, Medicaid provides 75-80% of service funds. State, block grant, and county funding to LME/MCOs makes up the balance. DMHDDSAS is responsible for setting appropriate policies and ensuring the quality of care in the MH/DD/SA service system, in addition being accountable for the use of state and block grant funds for prevention, intervention, treatment and recovery services. The array of services and supports in the MH/DD/SA system range from prevention, early intervention, crisis intervention, treatment and recovery and building resiliency.

The Community Wellness, Prevention and Health Integration Section is charged with prevention of substance abuse and mental disorders, promotion of mental health and wellness, suicide prevention, and early intervention strategies, including early childhood mental health, school behavioral health, health integration and trauma informed care. This section provides leadership and devotes its resources—programs, policies, staff time and expertise, information and data, contracts, and grants—toward helping North Carolina act on the knowledge that behavioral health is essential for health; prevention and early intervention work; treatment is effective; and people recover.

Alcohol, tobacco and other drug issues are identified in the top 5 initiatives for Healthy NC 2020. The goals and objectives outlined in the plan for Healthy NC-2020 align with the direction for overall health and wellness that is a cornerstone of the waiver discussion. Recommendations are presented in Prevention for the Health of NC 2020 (www.nciom.org).

This strategic prevention framework (SPF) aligns with System of Care (SOC) framework for children, youth and families and adults with behavioral health needs. Both frameworks provide a foundation from which strategic planning, data-driven decision-making and implementation of evidence informed and evidence based practices and policies that promote community wellness, prevention and early intervention, and health integration.

This DMH/DD/SAS Plan implementation requires effective collaboration among stakeholder partners and people with lived experience who promote effective strategies and outcome measures.

Serving priority populations has been accomplished by:

- ***Building capacity of communities and prevention workforce***
- ***Building infrastructure***
- ***Responding to current and emerging trends.***
- ***Supporting individuals, communities and systems be more responsive to substance abuse concerns***

To advance innovative, effective, cost saving prevention initiatives to ensure safe and healthy communities for all North Carolinians, DMH/DD/SAS identifies the following goals and objectives:

Priority: Prevention and Education

Initiative: State, Block Grant, SPF Rx, PFS and CURES ATOD Prevention Grants- Support evidence based programming and best practices; partner with key stakeholders on health disparities, suicide prevention, trauma, early childhood mental health, alcohol, tobacco and other drug (ATOD) issues; promote awareness about the dangers of prescription drug misuse; make data driven decisions and utilize quality assurance tools

Step	Tasks	Outputs/Measures	Outcome
Increase NC DMH/DD/SAS's capacity to support the implementation of quality evidence based programming and best practices by stakeholders and implementers across North Carolina.	• Promote and enhance utilization of evidence based interventions at the state and local level in appropriate settings • Increase the number of evidence-based/best practices available to LME/MCOs and providers across the state that consider risk and protective factors and cut across all substances and related mental, emotional and behavioral disorders • Sustain effective evidence-based environmental strategies at the state and local level	• Evidence based program guides • Meeting agendas, memos and materials discussing evidence based programs • Number of evidence-based, best practice trainings and technical assistance available to providers • Number of local collaboratives, providers and coalitions supporting environmental strategies	• DMH/DD/SAS effectively supports the utilization of quality, sustainable, evidence-based programming by stakeholders and implementers in North Carolina

Priority: Prevention and Education

Initiative: State, Block Grant, SPF Rx, PFS and CURES ATOD Prevention Grants- Support evidence based programming and best practices; partner with key stakeholders on health disparities, suicide prevention, trauma, early childhood mental health, alcohol, tobacco and other drug (ATOD) issues; promote awareness about the dangers of prescription drug misuse; make data driven decisions and utilize quality assurance tools

Step	Tasks	Outputs/Measures	Outcome
Increase collaboration with other state agencies/offices and local stakeholders to special populations affected by health disparities, trauma, adverse childhood experiences (ACEs), suicide and child fatalities, young children and families (ECMH)	• Enhance programs by identifying and collaborating with key stakeholders who share common interests • Partner with agencies/offices or stakeholders on grant applications • Collaborate with public health and other state offices to create cross training opportunities • Participate on state-level boards, task forces and committees where substance abuse, trauma, adverse childhood experiences (ACEs), suicide, early childhood, and disparity issues are relevant	• Number of meetings with key stakeholders, state agency partners • Number of shared grant applications • Number of cross-training opportunities • Number of state level boards/committee meetings	• DMH/DD/SAS effectively collaborates with special populations affected by health disparities, other state agencies/offices and local stakeholders

Priority: **Prevention and Education**
Initiative: **DMH/DD/SAS and DPI Partnership**

Step	**Tasks**	**Outputs/Measures**	**Outcome**
Participate in DPI work groups to develop recommendations for continuum of behavioral health services in schools	• To be announced as work group established priorities	• Consensus recommendations developed for school based mental health workgroup	• Improved behavioral health service continuum available to school age children and youth.

Priority: Prevention and Education

Initiative: State, Block Grant, SPF Rx, PFS and CURES ATOD Prevention Grants- Support evidence based programming and best practices; partner with key stakeholders on health disparities, suicide prevention, trauma, early childhood mental health, alcohol, tobacco and other drug (ATOD) issues; promote awareness about the dangers of prescription drug misuse; make data driven decisions and utilize quality assurance tools

Step	Tasks	Outputs/Measures	Outcome
Promote awareness to key stakeholders about the impact of prescription drug abuse in North Carolina and continue to work to prevent and reduce the impact of prescription drug and opiate abuse related problems	• Create a statewide media campaign to raise awareness of prescription drugs, focusing on safe storage and disposal and the dangers of overprescribing • Create and disseminate information about how prescription drug abuse affects North Carolinians-both in cost and impact • Create and disseminate information about how prescription drug abuse affects North Carolinians-both in cost and impact • Implement NC Strategic Plan to Reduce Prescription Drug Abuse	• Number of statewide campaign media materials • Number of local communities participating in a statewide media campaign • Number of statewide informational materials • Number of DMH/DD/SAS resource promotions	• DMH/DD/SAS initiatives increase awareness amongst North Carolinians about the impact of prescription drug abuse and reduce the impact of prescription and opiate abuse related problems

Priority: Prevention and Education

Initiative: State, Block Grant, SPF Rx, PFS and CURES ATOD Prevention Grants- Support evidence based programming and best practices; partner with key stakeholders on health disparities, suicide prevention, trauma, early childhood mental health, alcohol, tobacco and other drug (ATOD) issues; promote awareness about the dangers of prescription drug misuse; make data driven decisions and utilize quality assurance tools

Step	Tasks	Outputs/Measures	Outcome
Improve, enhance and expand DMH/DD/SAS's capacity to make data-driven decisions and quality improvement	• Explore avenues and partnerships for creating a statewide youth and college-aged survey to assess consumption and consequences of substance abuse every two years • Continue to train key stakeholders and communities to use data to increase buy-in, create action and evaluate progress and success • Increase accountability for prevention through uniform reporting • Increase access to data sources relevant to North Carolina (i.e. public health, court, schools)	• Statewide youth survey • Statewide college survey • Number of trainings on data support, implementation and evaluation • Uniform data reporting tool • Number of partnerships with key stakeholders with access to data • Administrative data created and disseminated	• DMH/DD/SAS utilizes data-driven decisions and manages the oversight of all programs with quality improvement tools

Priority: Prevention and Education **Initiative: Controlled Substance Reporting System**			
Step	Tasks	Outputs/Measures	Outcome
Improve the Controlled Substances Reporting System (CSRS)	• Improve CSRS functionality to manage high volume of transactions • Clean and analyze controlled substance prescription data submitted to the CSRS • Publish county level controlled substance prescription data • Publish CSRS utilization data • Provide controlled substance prescription history data to healthcare licensing boards • Send educational letters to prescribers that have patients that meet pre-determined substance use risk behavior metrics	• An operational state-run prescription drug monitoring program • Amount of prescribed controlled substances in in communities • Number of CSRS users • Number of CSRS queries • Number of reports provided to healthcare licensing boards • Number of educational letters sent to prescribers	• Improved access, utilization, functionality and capability of the CSRS • Readily available information for stakeholders to understand impact of the opioid epidemic • Decreasing amount of prescribed controlled substances in communities • Increased number of practitioners utilizing CSRS • Identification and timely investigation and analysis of aberrant prescribing behaviors • Reduce risk of substance use disorders, accidental overdoses, and death

Priority: Prevention and Education **Initiative: Drug Disposal-:** Develop and launch a statewide, comprehensive, evidence based public relations campaign that targets the general public, parents and caregivers the misuse of prescription drugs, related overdose deaths, dangers of abusing/misusing prescription drugs, and proper storage and disposal of medications			
Step	Tasks	Outputs/Measures	Outcome
Improve Drug Disposal	• Increase disposal resources for controlled substances • Provide education regarding the collection of controlled substances, location of drop-boxes and process for disposal in a safe and effective manner.	• Number of available drop-boxes across the state • Number of incinerations performed	• Increased number of available drop-boxes • Increased number of incinerations performed

Additional details about the strategies to reduce prescription drug abuse can be found in the 2016 North Carolina Strategic Plan to Reduce Prescription Drug Abuse http://governorsinstitute.org/wp-content/uploads/2016/07/NC-Strategic-Plan-to-Reduce-Rx-Drug-Abuse-FINAL.pdf

Mental Health First Aid

North Carolina was showcased as a best practice program for statewide implementation of Mental Health First Aid (MHFA) at the 2016 National Council for Behavioral Health's Mental Health First Aid Instructor Summit. DHHS has trained more than 37,000 individuals in Mental Health First Aid and has over 500 certified instructors across the state.

Mental Health First Aid teaches people how to identify, understand and respond to signs of mental illnesses and substance use disorders. It trains people in the necessary skills to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis. Like CPR training, it uses role-play and simulations to demonstrate how to offer initial help and connect people to appropriate professional, peer, social and self-help care.

DMH/DD/SAS is committed to continuing to support expansion of Mental Health First Aid knowledge in the state. https://www.mentalhealthfirstaid.org/cs/

Priority: Prevention and Education **Initiative: Mental Health First Aid**			
Step	**Tasks**	**Outputs/Measures**	**Outcome**
Adult & Youth Mental Health First Aid Dissemination	• Sponsor annual instructor certification courses • Sponsor participant manuals • Provide statewide infrastructure for instructor network communication and supports	• Increase the number of North Carolinians trained in Adult & Youth Mental Health First Aid • Increase the number of Adult & Youth MHFA Instructors	• Reduce the stigma, increase awareness, and increase likelihood that people trained in Mental Health First Aid will assist community members in crisis.

North Carolina Problem Gambling Program

The North Carolina Problem Gambling Program provides prevention, education, outreach and treatment statewide at no cost to anyone who is concerned about their own or a family member's gambling problem. Through pre and post testing, the evidence-based prevention curriculum *Stacked Deck* continues to reduce problem gambling by changing students' attitudes, beliefs, knowledge and behaviors towards gambling. The *Sure Bet Series* provides annually over 125 hours of live training to mental health and addiction professionals, teachers and community-based leaders in multiple sites across North Carolina. An outreach campaign encourages young adults 18-34 years of age to visit www.morethanagamenc.com, use the live chat feature or text morethanagamenc to 53342.

A toll-free helpline is answered by trained professionals capable of providing information about problem gambling services, a brief needs assessment, crisis intervention and referral to treatment and follow-up. Callers are referred to a provider in their area for face-to-face counseling. A brief-intervention phone-based counseling service is also available for those unable to travel to in-person appointments. The program also supports statewide training for counselors in gambling addiction and therapeutic interventions. Visit http://morethanagamenc.com, text "morethanagamenc" to 53342, or call 1-877-718-5543 for more information.

Crisis Intervention Teams

People with mental health crises comprise at least 10% of all calls to which law enforcement officers respond. However, only about 1% (8 hours) of the 640 hours of basic law enforcement training that officers receive in North Carolina concerns managing people with behavioral health challenges.

Crisis Intervention Teams (CITs) are pre-booking jail diversion programs that aim to provide people in crisis the care they need instead of incarceration. Behavioral health professionals have established CIT programs to provide law enforcement with the skills they need to work with someone in a crisis in this 40 hour training program. CIT programs also emphasize law enforcement and behavioral health systems working collaboratively to develop a network of services to support people in crisis. CIT helps to:

- Reduce officer and consumer injuries
- Reduce the arrest of people with behavioral health challenges
- Increase referrals to treatment for people with behavioral health challenges

Priority: Prevention and Education **Initiative: Crisis Intervention Team Training (CIT)**			
Step	**Tasks**	**Outputs/Measures**	**Outcome**
Crisis Intervention Team Training (CIT) Dissemination	• Support CIT certification courses • Lead the statewide CIT committee	• Increase the number of CIT certified law enforcement officers • Increase the number of other first responders (fire fighters, EMTs and paramedics) who are CIT certified	• Reduce the stigma among law enforcement and other first responders • Reduce arrests people with behavioral health challenges • Increase referrals to crisis services and treatment

Suicide Prevention

Suicide is a devastating problem that has major emotional consequences for the family and friends of people who die by suicide, and physical and psychological consequences for those who survive suicide attempts. Death by suicide is one of the top ten leading causes of death for people ages 5-64 in North Carolina. Each year more than 1,000 North Carolinians die from suicide, nearly 300 are veterans; 6,000 people are hospitalized due to self-inflicted injuries and more than 8,000 are treated in emergency departments.

In 2015, coordinated by NC DHHS, jointly developed by Divisions of Public Health and Mental Health, Developmental Disabilities, and Substance Abuse Services, with support from the UNC-CH, Injury Prevention Research Center (IPRC), the state of North Carolina created a ***Strategic Plan for Suicide Prevention (NCDHHS, 2015).*** The Plan describes a multi-faceted, multi-year approach to both understanding the circumstances and data surrounding suicides and methods and steps to reduce the number of persons who experience symptoms that can lead to suicide as a final action.

http://www.sprc.org/sites/default/files/2015-NC-SuicidePreventionPlan-2015-0505-FINAL.pdf

In 2012, the NC DMHDDSAS in coordination with the NC Institute of Medicine (NCIOM) facilitated a task force of national, state, and community subject matter experts, including those with lived experience and survivors, who informed a set of recommendations for ***Suicide Prevention & Intervention Plan for MH/DD/SA population (NCIOM, 2012)*** Recommendations focus on clinical provider roles to reduce suicide contemplations, attempts, deaths among those living with mental health, intellectual/developmental disabilities and/or substance use disorders.

http://www.nciom.org/wp-content/uploads/2012/08/SuicidePrev-report_web.pdf

Priority: Prevention and Education **Initiative: Suicide Prevention**			
Steps	**Tasks**	**Output/Measures**	**Outcome**
Implement the NC Strategic Plan for Suicide Prevention*	• Promote implementation of recommendations from the NC Institute of Medicine Suicide Prevention and Intervention Plan* • Disseminate state proclamations and related awareness and mental health promotion, wellness and survivor support events • Continue to serve as Division designee on the NC Child Fatality Task Force and related committees and workgroups	• Number of deaths by suicide • Increase number of prevention and mental health promotion events and activities	• Decreased number of deaths by suicide by providing education and awareness of the warning signs of serious emotional disturbance in children and youth and mental illness in adults, including in transition age youth/young adults older and aging adults and those with co-occurring disorders.
Continue Funding for Promotion of Mental Health and Suicide Prevention Training – (in collaboration with Division of Public Health, through state and federal funds) and with other departments and partners.	• Facilitate Gatekeeper suicide prevention trainings such as ASIST (Applied Suicide Intervention Skills Training) and QPR (Question, Persuade, Refer) in order to expand effective community prevention efforts. • Facilitate CALM (Counseling on Access to Lethal Means), CAMS, CRM (Community Resilience Model) and ACEs (Adverse Childhood Experiences) trainings	• Number of trainings delivered	• Increased awareness of warning signs for suicide • Increased means restriction
National Suicide Prevention Lifeline 1-800-273-8255, Veterans Press 1 Chat at http://www.suicidepreventionlifeline.org/	• Provide funding for the NC Suicide Prevention Lifeline through Community Mental Health Services Block Grant • Promote access to the Lifeline and related resources	• Number of calls received, response rate • Web based information posted on DMHDDSAS web and LME/MCO and provider networks	• Increase the number of individuals seeking help • Decrease the number of deaths by suicide

Services for North Carolina Veterans

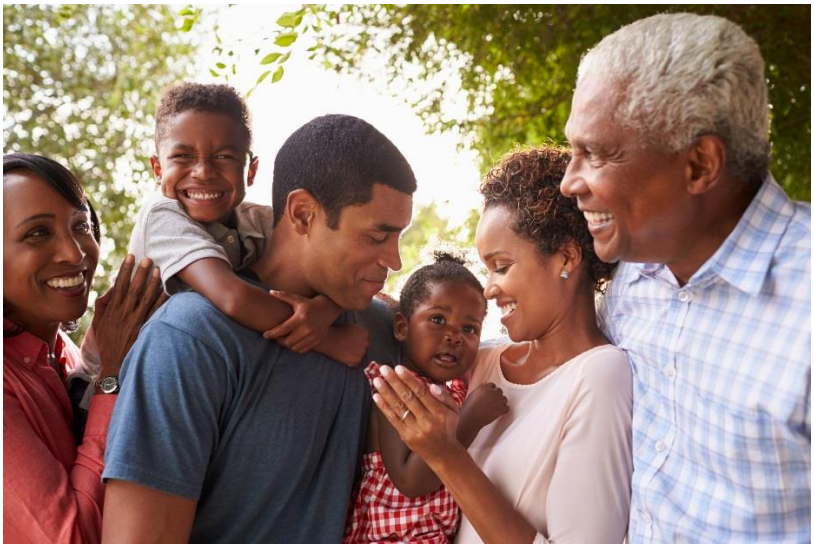
Priority: Prevention and Education **Initiative: Services for NC Veterans**			
Steps	**Tasks**	**Outputs/Measures**	**Outcome**
Veterans Support Specialist (VSS)	• Provide SME/Financial support to Peer Support Training program for State/County Veterans Service Officers (VSO) in partnership with NC DMVA and Duke EPIC program.	• Curriculum Development • Conduct 40 hr. (classroom & webinar) certification sessions.	• Regular VSS training sessions for VSOs

Priority: Prevention and Education **Initiative: Services for NC Veterans (Governor's Workgroup)**			
Steps	**Tasks**	**Outputs/Measures**	**Outcome**
Governor's Workgroup on Veterans, Service members and their Families	• Provide Financial/Administrative support through Governor's Institute on Substance Abuse. • Host nationally recognized, monthly Inter-Agency forum addressing Veterans issues • Host Website & Newsletter • Compile and Report on Veterans Services in NC	• Monthly Attendance • # of Out of State Presenters & Attendees • Number of new satellite initiatives (interagency partnerships) • Meaningful improvement Statewide Veterans Statistics	• More effective statewide communication and collaboration of programming and response to issues affecting Veterans, Service members and their Families in NC

Priority: Prevention and Education **Initiative: Services for NC Veterans (NC STRIVE)**			
Step	**Tasks**	**Outputs/Measures**	**Outcome**
NC STRIVE (Student Transition Resource Initiative for Veterans Education)	• Provide Financial/Administrative support through Governor's Institute on Substance Abuse. • Plan and Promote Regional conferences for educators and clinicians, designed to enhance student Veteran success by providing information, resources and opportunities for achieving academic and career goals. • Promote Regional networks of connected SMEs providing support to student Veterans • Provide valuable training opportunities, such as: QPR, CIT, Motivational Interviewing Techniques, VA navigation, GI Bill maximization, Military Culture, Transition resources.	• GI Bill student graduation rate • Number of GI Bill Students • Participant Surveys • Number of attendees at Regional sessions	• Reduce student Veteran BH/MH related incidents on campuses • Increase the level of knowledge of Veterans related issues among higher educators • Increase the number of resources available to campus Veterans representatives and counselors.

Priority: Intervention, Treatment and Recovery

DMH/DD/SAS funds priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals. Services selected for funding are "evidence-based" which means they have demonstrated success in improving outcomes and/or supporting recovery for individual well-being. Evidence-based practices are the most effective and efficient use of limited public funding. Providing a full array of services, available to consumers based on medical necessity, is important to provide the "just right" degree of service; no more and no less than is needed to support consumers. The services are arranged in Benefit Plan categories and there are specific expectations for services (or approved alternative services) to be make available to special populations (see Appendix D). All service provision at the local level is dependent on the availability of funds.



Services to Children and Families

Children and families are resilient and resiliency should be fostered and supported to promote increased social-emotional health, wellness and quality of life by receiving the appropriate evidence-based screening, assessment, and treatment services tailored to the individual/family at the appropriate time.

Priority: **Intervention, Treatment and Recovery** **Initiative**: **Children with MH/IDD and complex needs**			
Step	**Tasks**	**Outputs/Measures**	**Outcome**
Coordination with Disability Rights North Carolina, Department of health and Human Services, providers, Local Management Entities/Managed Care Organizations, families and other stakeholders.	• Identify the target population and appropriate screening and assessment tools. • Identify best practices for the treatment of children with complex MH and IDD and their families. • Identify training models and/or curriculum focuses on supporting children diagnosed with complex MH and IDD needs and their families. • Monitor the use of NC START services and supports.	• Screening and assessment tools for identified target population. • Best practices support and promotion for the treatment of children with complex MH and IDD. • MH and IDD focused training model/curriculum • Tracking of the total number of children and adolescents supported through NC START.	• Reduce the time for youth with complex needs and MH and IDD to access the appropriate level of care. • Increases capacity of services providers and professionals with skills to better support individuals with complex MH and IDD needs. • Increase opportunities for children with complex needs and MH and IDD receive supports and services in the communities they live.

Priority: **Intervention, Treatment and Recovery** **Initiative: Child Case Management**			
Step	**Tasks**	**Outputs/Measures**	**Outcome**
Support implementation of child case management roll out.	• Explore models of child case management to meet the needs of vulnerable populations including youth involved with social services and juvenile court. • Participate in stakeholder group re: child case management.	• Support and promote models of child case management targeted populations.	• Improves connections for children by funding a more proactive, regular and often face-to-face contact and support.

Priority: **Intervention, Treatment and Recovery** **Initiative: Pilot NC Wraparound for children and adolescents with high need/complexity and their families**			
Step	**Tasks**	**Outputs/Measures**	**Outcome**
Track outcomes for high fidelity wraparound enrolled children and families.	• Identify data of interest to collect. • Train staff on data collection tools • Analyze and compile data	• Creation and use of quarterly dashboard reports	• Pilot completed and evaluated to assess whether children served have improved clinical and social outcomes (reduction of symptoms, enrolled in school, reduced law enforcement involvement, and living with family in their communities with reduced use of crisis services and restrictive interventions). • Plan developed to roll out High Fidelity Wraparound to other sites. • Post grant funding plan developed
Develop funding plan for NC Wraparound post grant funding.	• Identify potential funding options. • Develop timeline to maintain pilot. • Educate stakeholders including payers of cost effectiveness of high Fidelity Wraparound.	• Funding options created and evaluated.	
Develop Wraparound training plan that allows expansion and fidelity monitoring after grant funding.	• Contract nationally recognized HFW coaching and training consultant. • Coach, train and certify cohort of Wraparound staff to gain the skills needed to train/coach/monitor. • Develop plan for monitoring credentialing process. • Develop plan for fidelity monitoring during and after grant. • Develop Wraparound training standards for NC. • Develop a plan for training post grant.	• A standardized, comprehensive training plan for NC • wraparound post grant. • Track the percentage of Wraparound staff who complete certification within expected time frames.	

Priority: **Intervention, Treatment and Recovery** **Initiative: Crisis Solutions Initiative-Child Priorities**			
Step	**Tasks**	**Outputs/Measures**	**Outcome**
Assess the needs for crisis services for children and adolescents.	• Review available data including LME/MCO Needs and Gaps Analysis and QM crisis data. • Review how QM, Crisis Services, and Adult Services developed the adult crisis continuum. • Work with Crisis Solutions to adapt crisis continuum for children. • Review need for facility based crisis service, emergency therapeutic foster care.	• Clear understanding of gaps and needs in child crisis services in the community and in more restrictive settings.	• Develop data driven strategies so children in crisis have timely access to crisis services in their communities.

Priority: Intervention, Treatment and Recovery **Initiatives: Core Competencies for outpatient and in-home services clinicians.**			
Step	**Tasks**	**Outputs/Measures**	**Outcome**
Evaluate feasibility of Modular Approach to Therapy (MATCH) pilot.	• Secure community stakeholder support. • Develop funding plan for MATCH pilot. • Develop training plan and schedule with purveyor. • Develop outcome monitoring plan.	• Evidence of stakeholder support. • Funding plan developed. • Outcome monitoring plan developed. • Training plan developed.	• Decision on whether to proceed with MATCH pilot.

Priority: Intervention, Treatment and Recovery **Initiative: Best Practices in residential care.**			
Step	**Tasks**	**Outputs/Measures**	**Outcome**
Evaluate the feasibility of statewide Six Core Strategies and Building Bridges Initiatives to eliminate use of seclusion and restraint in PRTFs, facility based crisis services, and state hospitals and increase trauma informed, family driven practices.	• Secure support from PRTFs, facility based crisis services, and state hospitals. • Develop funding plan. • Develop training plan and schedule with consultants. • Develop outcome monitoring plan.	• Evidence of stakeholder support. • Funding plan developed. • Outcome monitoring plan developed. • Training plan developed.	• Decision on whether to proceed with statewide dissemination of Six Core Strategies/Building Bridges Initiative.
Priority: Intervention, Treatment and Recovery **Initiative: Promote the establishment of Family Partner Coordinators and Family Partners as part of the overall NC System of care (SOC) Workforce.**			
Step	**Tasks**	**Outputs/Measures**	**Outcome**
Contract with North Carolina Families United (NCFU) to develop the roles of Family Partners and Family Partner Coordinators at the local level.	• Monitor contract with NC Families United. • State SOC Coordinator work with NCFU to distinguish between FPC and SOC Coordinator roles and develop guidance document which encourages the partnering with SOC Coordinator to ensure that there are coordinated efforts in local SOC development.	• Job descriptions for Family Partner Coordinator and Family Partner position are developed in consultation with LME/MCO including identification of core competencies for each position. • Active contact list of Family Partner Coordinators and Family Partners is maintained.	• Baseline inventory of FPCs and FPs will enable the creation of a workforce development plan for family peers.

Priority: Intervention, Treatment and Recovery **Initiative: Juvenile Justice Substance Abuse Mental Health Partnerships (JJSAMHP)**			
Step	**Tasks**	**Outputs/Measures**	**Outcome**
JJSAMHP Teams (Teams include LME-MCO representative, Juvenile Justice Chief or representative, and local providers)	• Monitor work of local partnerships to ensure compliance with the 5 JJSAMHP domains (screening/referral, evidenced based assessment, engagement, evidenced based treatment, & Juvenile Crime Prevention Council (JCPC) involvement/Recovery Oriented Systems of Care)	• Increase access to timely, evidence based screening, assessment, and treatment for eligible juvenile justice involved youth.	• Juvenile Justice involved Youth and families will have increased access to services which meet their needs and encourage engagement for successful treatment completion and completion of justice system requirements.

Priority: Intervention, Treatment and Recovery **Initiative: First Episode Psychosis**			
Step	**Tasks**	**Outputs/Measures**	**Outcome**
Increase access to evidence based Coordinated, Specialty Care programs (CSC) for treatment of First Episode Psychosis. (FEP)	• Monitor progress on two current CSC sites. • Identify 2 additional sites through an "Invitation to Apply" to the current MCOs • Technical assistance to MCOs and their contract CSC providers regarding SAMSHA MHBG requirements for the 10% set-aside FEP funds • Ensure that new programs are provided foundational clinical and programmatic trainings on implementation of CSC programs • Ensure development of education and training plans for human service professionals re: identification of individuals with FEP. • Ensure the development and implementation of a database to track client outcomes and program fidelity	• Early Intervention Services through evidenced based Coordinated Specialty Care Programs will be provided at 4 sites in North Carolina for individuals experiencing First Episode Psychosis • A Quality Assurance Database will track clinical and programmatic outcomes for all funded CSC sites. • Human Services Professionals in the catchment areas of the 4 CSC sites will be able to identify individuals experiencing FEP and make referrals to the CSC program in their catchment area.	• Reduction of psychotic symptoms of individuals served by FEP program • Reduce visits to ER for individuals served in FEP program • Increase employment and school enrollment for individuals served in FEP programs • Increase treatment adherence • Decrease participant drop outs

Priority: Intervention, Treatment and Recovery

Initiative: Promote the roles of State and Community Collaboratives in the SOC Framework

Step	Tasks	Outputs/Measures	Outcome
Technical assistance to SOC Coordinators re: Community Collaboratives	• Revision of Community Collaborative and SOC Coordinator expectation documents • On-going tracking of those expectations through bi-annual reports • Development and on-going revision of Community Collaborative Toolkit • Track in SOC annual report if Community Collaboratives are reviewing LME/MCO system performance indicators and crisis and inpatient service indicators • Development of SOC technical assistance checklist and implementation of TA schedule	• Revised SOC bi-annual report to track progress on new expectations	• LME/MCOs consider feedback from Community Collaboratives in Gaps and needs Analysis as evidenced by Community Collaboratives giving their LME/MCO written and verbal feedback.
Support State Collaborative Training/Workforce Development Committee	• Re-establish protocol for reviewing Child and Family Team curricula • DMH staff will partner with appropriate State Collaborative subcommittee to develop a communication protocol with local collaboratives.	• Protocol is developed. • State and Local Community Collaborative Communication protocol is developed	• State Collaborative has greater participation from Community Collaboratives in monthly meetings.
Support State Collaborative School-based MH Committee	• Inventory local community collaboratives to see how many have school representatives and what if any school mental health initiatives are underway at local level	• Community collaboratives school mental health initiative inventory	• Community collaboratives school mental health initiative inventory completed
Facilitate cross system work group	• Identify concerns re: behavioral health system from key state partners • Consider exploration of cross system state level MOAs	• Inventory state system partners concerns re: behavioral health system	• Group meets monthly with consistent participation

Priority: Intervention, Treatment and Recovery
Initiative: Psychiatric Residential Treatment Facilities (PRTF) Education Initiative (Senate Bill 744 2014-100 Section 8.39 (a))

Step	Tasks	Outputs/Measures	Outcome
Fulfill legislative mandate through funding and joint oversight with Department of Public Instruction(DPI) for education within PRTFs.	• Joint site visits with DPI to provide technical assistance and monitoring of progress • PRTF Collaborative • PRTF Training Academy • Develop and monitor contracts for education within PRTFs • Maintain current list of all NC licensed PRTFs • Maintain PRTF Education Handbook developed by DPI and DMH/DD/SAS and distribute to new PRTFs as they as licensed	• Monitor number of PRTFs with full approval a Non-Public Exceptional Children's (EC) Programs. • Individualized Education Program (IEPs) of children identified as Exceptional Children will be reviewed and updated. • Based on educational screenings and observations, children who have not been identified as Exceptional Children (EC) but who may be eligible will be referred to the EC Director of the facility's catchment LEA for Child Find for additional evaluation to determine eligibility.	• Children receive appropriate education-related assessment and instruction in PRTFs as required under Part 4 of Article 6 of Chapter 122C of the General Statutes. • Children will be transitioned to the most appropriate school setting that meets their individual needs upon discharge from the PRTF.

Priority: Intervention, Treatment and Recovery

Initiative: Work First/Child Protective Services Substance Use Initiative: Coordination with the Division of Social Services to meet G.S. 108A-29.1 regarding urine drug testing for Work First Program assistance and 108A-25.2 regarding individuals convicted of certain drug-related felonies.

Step	Tasks	Outputs/Measures	Outcome
Execute an inter-agency memorandum of agreement	• Delineate mutual and individual roles and responsibilities of each agency.	• Inter-agency collaboration • Data to provided General Assembly	• Adherence to General Statutes
Reduce potential substance use barriers for families eligible for TANF, individuals with Class H or I controlled substance felonies and individuals with a substantiated CPS case or found in need of services.	• Provide funding support to LMEs for Qualified Professionals in Substance Abuse to be out-stationed in county DSS to provide education, assessment, training, consultation, services coordination and data reporting.	• Number of individuals accessing appropriate substance use disorder and mental health services and supports	• Access to TANF and/or Food and Nutrition Service benefits • Timely access to appropriate care • Coordination of Services

Priority: Intervention, Treatment and Recovery

Initiative: Perinatal & Maternal Substance Use & CASAWORKS for Families Residential

Step	Tasks	Outputs/Measures	Outcome
Gender responsive family-centered substance use disorder treatment for pregnant women and women with dependent children	• Allocate funds to LME/MCOs to support contracts with providers using Substance Abuse Prevention Treatment Block Grant Women's Set aside funds as required for provision of service	• Number of pregnant and parenting women who gender responsive family-centered substance use disorder treatment	• Reduction in substance use and mental health symptom severity • Reduction in experiences of interpersonal violence HIV risk behavior, criminal justice involvement, improved birth outcomes, improved housing & recovery stability for the woman & her children

Priority: Intervention, Treatment and Recovery **Initiative: Perinatal Substance Use Project**			
Step	**Tasks**	**Outputs/Measures**	**Outcome**
Coordination of a statewide Substance Abuse Treatment Prevention Block Grant required capacity management system for linking pregnant and parenting women and their children to needed substance use disorder treatment services, and other community or interim services.	• Maintain bed availability lists (updated weekly) • Distribute notice of bed availability to healthcare, community agency professionals, and behavioral health treatment providers weekly • Manage calls from health care providers, community agencies, families, and pregnant women and women with children seeking treatment • Coordinate referral for women &their children to substance use disorder treatment services & interim services • Train and provide technical assistance to professionals, community providers and public regarding perinatal and maternal substance use;	• Number of trainings completed • Number of referrals • Number of bed notices distributed	• Reduced barriers and increased access for pregnant & parenting women & their children to access needed treatment services • Early identification of potential substance use disorders and appropriate referral for services; • Increased awareness of substance use treatment services for pregnant & parenting women & their children.

Priority: Intervention, Treatment and Recovery **Initiative: NC Fetal Alcohol Prevention Program (FASD)-** FASDinNC strives to prevent alcohol exposed pregnancies by providing training, education, and resources to women of childbearing age and the professionals that serve them.			
Step	**Tasks**	**Outputs/Measures**	**Outcome**
NC Fetal Alcohol Prevention Program (FASDinNC)	• Provide funding to support NC Fetal Alcohol Prevention Program • Provide program oversight and monitoring • Provide consultation and technical assistance	• Executed contract • Monthly consultations • Quality reports	• Decrease the number of alcohol exposed pregnancies, improved birth outcomes, and increased resources for families and individuals with an FASD.

Traumatic Brain Injury

Priority: Intervention, Treatment and Recovery **Initiative: TBI Education and Training-** Education and training is critical in developing a foundation of understanding about the causes, consequences and effective skills when working with individuals who have TBI.			
Steps	**Tasks**	**Outputs/Measures**	**Outcome**
Coordination with Division of Medical Assistance, Local Management Entities/Managed Care Organizations (LME/MCO's), Brain Injury Association of North Carolina and other stakeholders in the development and implementation of TBI education and training activities statewide.	• Provide TBI education and training opportunities statewide to LME/MCO's, provider agencies, professionals and other interested stakeholders. • Conduct TBI training with TBI Waiver providers. • Develop/update TBI online training modules or training curriculums	• Number of TBI trainings provided statewide. • Number of TBI trainings provided to TBI Waiver providers • Number of online training modules or training curriculums updated/developed.	• Increased knowledge and awareness regarding TBI. • Increased professional skill development in the field of TBI • Increased availability of TBI training on a variety of pertinent topics

Priority: Intervention, Treatment and Recovery **Initiative: TBI Screening and Data Collection-** Traumatic Brain injury (TBI) screening, data collection and analysis provide a critical foundation to understanding the extent and scope of need within this disability group.			
Steps	**Tasks**	**Outputs/Measures**	**Outcome**
Coordination with Local Management Entities/Managed Care Organizations (LME/MCO), Division of Mental Health/Developmental Disabilities/Substance Abuse Services-Quality Management Section, Division of Medical Assistance, Division of Public Health, survivors, families and other stakeholders.	• Conduct TBI Screening using the Ohio State TBI Identification Method Tool • Determine categories of Medicaid claims data to review using NC Tracks/Conduct data collection • Review the Behavioral Risk Factor Surveillance System (BRFSS) data results	• Number of people screened as likely having a TBI. • Number of people that access publicly funded services. • Number of BRFSS surveys completed where the respondent likely sustained a TBI.	• Increase knowledge about the numbers of individuals living with TBI statewide. • Increase knowledge of the number of individuals with TBI accessing public benefits accessed. • Data reviews will provide a better understanding of the numbers of individuals living with TBI statewide and the types of services and supports they need. • Provide data outcomes to the legislature as requested and to the stakeholder community.

Priority: Intervention, Treatment and Recovery

Initiative: The Traumatic Brain Injury (TBI) Waiver will provide home and community based services to individuals with TBI within a pilot area of the state.

Steps	Tasks	Outputs/Measures	Outcome
Coordination with the Division of Medical Assistance, Alliance Behavioral Healthcare, other Local Management Entities/Managed Care Organizations (LME/MCO's), survivors, families and other stakeholders in the implementation of the TBI Waiver.	• Complete approval process with Centers for Medicare and Medicaid Services (CMS) to initiate the TBI Waiver. • Develop service program assessment tools, service plan template, protocols and processes to be implemented in the Waiver implementation. • Monitor Waiver implementation activity • Conduct meetings and trainings with LME/MCO's, providers and stakeholders regarding Waiver activity and TBI in general.	• Number of TBI trainings provided. • Number of service providers added to the provider network as service capacity needs increase. • Number of individuals receiving TBI Waiver services • Number of individuals on the registry of unmet needs.	• Increase capacity of service providers with skills to better support individuals with TBI • Increase opportunities for individuals with TBI to receive services and supports within their home community • Determine feasibility for expansion of the TBI Waiver beyond the pilot area, funding permitting.

Crisis Services

The North Carolina Crisis Solutions Initiative focuses on identifying and implementing the best known strategies for crisis care while reducing avoidable visits to emergency departments and involvement with the criminal justice system for individuals in behavioral health crises. Crisis services or emergency services are available in North Carolina for adults experiencing issues with mental health, substance abuse, and intellectual/development disabilities. There are a variety of crisis services available throughout North Carolina, including Facility Based Crisis Programs (FBC), Mobile Crisis Management (MCM) and Behavioral Health Urgent Care (BHUC).

Step	Tasks	Outputs/Measures	Outcome
Crisis Services (including FBCs, BHUCs and Community Paramedicine Pilot Program) - Assess the needs for crisis services and access to specialized behavioral health crisis services in alternative community-based settings.	• Work with Crisis Solutions to adapt crisis continuum for children. • Review continued needs for facility based crisis service, emergency therapeutic foster care, and mobile stabilization services • Expand option for child FBCs and BHUCs being developed across the state • Monitor progress of development of three child FBC sites • Review available data including LME/MCO Needs and Gaps Analysis and QM crisis data. • Review how QM, Crisis Services, and Adult Services developed the adult crisis continuum.	• Clear understanding of gaps and needs in crisis services in the community and in more restrictive settings. • Plan to address those needs include policy revision, funding, and training. • Monthly review of data (including utilization rates) for alternative community based child sites. • Track clinical and operational outcomes of all three child FBC and six BHUC sites across the state.	• Increase in timely access to crisis services for individuals in crisis within their communities. • Decrease in psychiatric inpatient hospitalizations and use of emergency departments. • Increase in capacity of crisis service providers. • Increase in utilization rates and access for children at FBCs and BHUCs.

Recovery- Oriented System of Care

Recovery-Oriented System of Care Framework

Summary

The Addictions and Management Operations Section, within the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, creates policies and oversees programs that support treatment and recovery for individuals with substance use disorders, including youth, adolescents and adults, as well as specialized services for women, veterans and members of the military and their families. It has adopted the National Institute on Drug Abuse's definition of addiction:

Addiction is a chronic disease characterized by drug seeking and use that is compulsive, or difficult to control, despite harmful consequences. The initial decision to take drugs is voluntary for most people, but repeated drug use can lead to brain changes that challenge an addicted person's self-control and interfere with their ability to resist intense urges to take drugs. These brain changes can be persistent, which is why drug addiction is considered a "relapsing" disease—people in recovery from drug use disorders are at increased risk for returning to drug use even after years of not taking the drug. It's common for a person to relapse, but relapse doesn't mean that treatment doesn't work. As with other chronic health conditions, treatment should be ongoing and should be adjusted based on how the patient responds. Treatment plans need to be reviewed often and modified to fit the patient's changing needs.

As the "Single State Authority" (SSA), the Division 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), medication assisted therapies, 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. The continuum further includes evidence-based practices included in the

state's Medicaid-reimbursable service definitions, such as Therapeutic Foster Care, Multi-Systemic Therapy and Family Functional Therapy for children and youth. Additionally, LME/MCOs have also developed and implemented, with DMH/DD/SAS approval, alternate service definitions such as peer and recovery supports, transition services, wellness and living skills, to create a more robust continuum of care. Evidence shows that addressing non-clinical needs and clinical needs simultaneously enhances long-term recovery.

Treating Addiction as a Chronic Condition

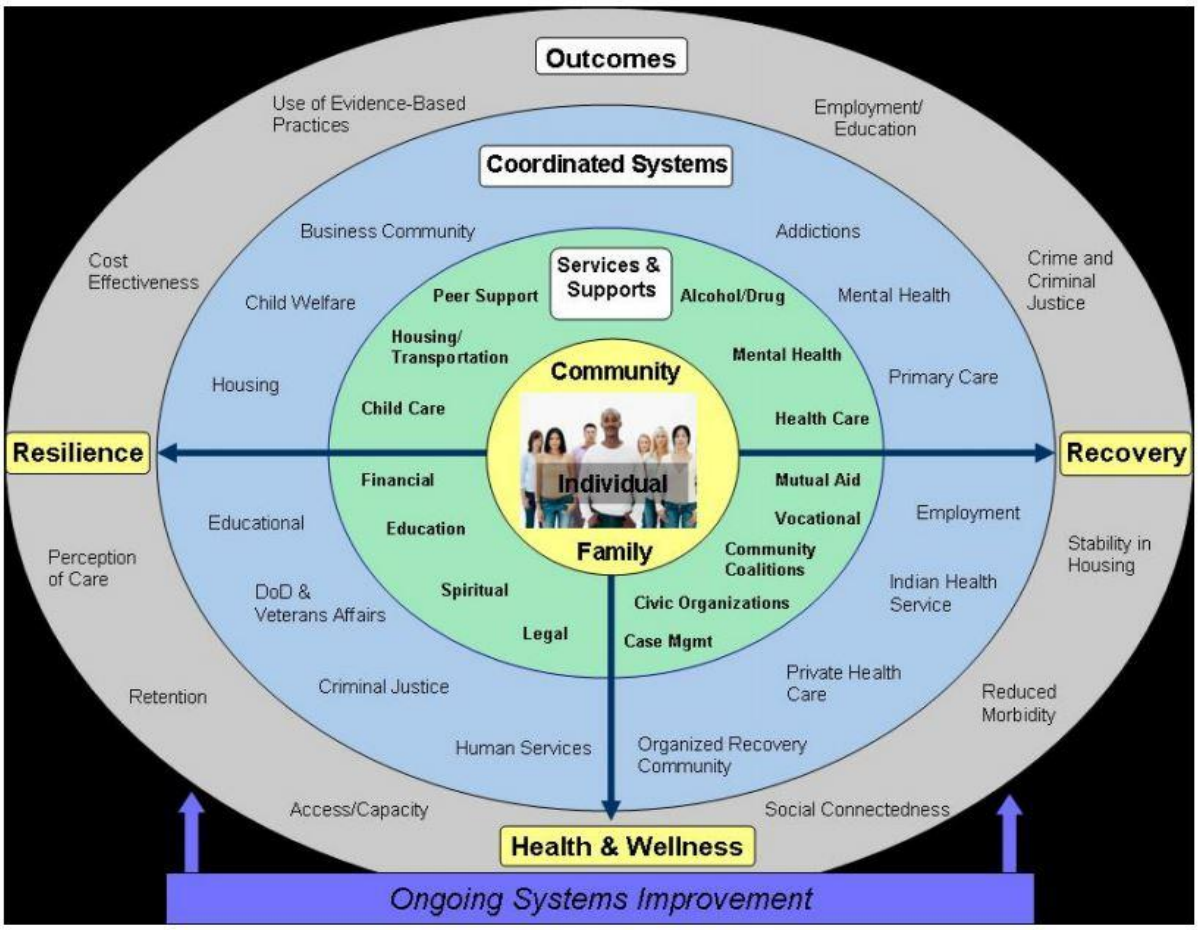
Historically, the nation and North Carolina have treated addiction as an acute condition, when it is a chronic one. Similar to other chronic conditions such as diabetes, an individual may have periods of recovery followed by a return to use. Recovery supports can extend a person's time in recovery and identify the need for a return to treatment earlier. Several practices must be changed to respond better to the individual with a substance use disorder.

These include:

- Immediate access to care
- Involving the person in need with decisions about his/her care
- Expectation for evidence-based care (incentivize)
- Long-Term Recovery Supports at all levels of care and post-treatment

Figure 1 gives a snapshot of a Recovery Oriented System of Care inclusive of services and supports, coordinated systems, and outcomes. While a true Recovery Oriented System of Care (ROSC) must be defined and developed at the community level, the state can encourage use of a variety of recovery supports by defining and attaching funding to the components. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services encourages physicians to use the American Society of Addiction Medicine's standards of care.

Figure 1: Conceptual Framework of a Recovery-Oriented System of Care



Help Individuals Access Care Immediately

Treatment is often identified for individuals several days or weeks after they are open to entering care. People with a substance use disorder cannot wait for care to become available, or they will often not be able to stay connected to the caregiver. We must walk them through the point of entry and assist them without delay. This means treatment must be available outside of normal business hours and on weekends. Individuals who travel more than one mile to outpatient substance use disorder treatment services have been found approximately 50% less likely to complete recommended treatment (Journal of Rural Health, 2016).

Involve the Person in Decisions about Care

Individuals must be offered a menu of recovery resources and support as they decide their path to treatment. Using the **NIATx' model**, providers can engage the person in need through understanding the individual and asking what they think they need or want. There are many pathways to recovery, the same path does not work for everyone. Offering a menu of both clinical services and recovery supports to individuals delivers better results. The Substance Abuse and Mental Health Services Administration (SAMHSA) Access to Recovery grant offers a model for this type of service delivery.

Expand Evidence-Based Practices and Best Practices in Treatment

The state must continue to train providers on evidence-based practices, encourage universities that train students in the field of mental health and substance use to learn evidence based practices, and include incentives for these practices. Integrating primary care and substance use disorder treatment is important for enhanced health outcomes of the person served.

Enhancing Long-Term Recovery Supports and Including These as an Expectation of Service

- **Recovery Management Check-Ups:** Routine check-ups with individuals post treatment to assess health and wellness as determined jointly between the individual and the caregiver. Typically visits are conducted shortly prior to discharge from treatment in order for the individual to become acquainted with the peer, which increases the likelihood that the individual will remain connected to or involved with the peer. After completion of treatment, recovery management check-ups are typically conducted in the community or at the person's home.

- **Recovery Check-Ins:** Routine phone calls and/or emails with the person in recovery to determine they have adequate supports in place. This type of outreach helps the person in recovery continue a connection with providers and allows for faster identification of challenges that may lead to return to use. If there is a return to use, individuals are able to re-enter care faster, and possibly at a lower level on the ASAM scale.

- **Peer Support Specialists:** Peer Support Specialists have lived experience and complete 40 hours of state-approved training and an additional 20 hours of content-specific training to become certified. They are can engage with individuals in need of treatment at every level of care, from crisis to recovery. They are typically paired with a person with a similar background to enhance the connection between individuals. The Centers for Medicaid and Medicare have acknowledged Peer Support as an evidenced based model of care.

- **Recovery Messaging / Language**: Shame and discrimination are reasons many delay or do not seek treatment. Research supports better outcomes for individuals that enter care earlier. Reduction of stigma through person-centered language and by treating individuals with respect is key to a recovery-oriented approach. Recovery messaging training has shown to be an effective means to change perception of individuals, families, and providers.

- **Health Literacy for Individuals with SUD and their Families:** Teaching individuals in need of care and their families about substance use disorder enhances outcomes and quality of services. Individuals and families can be more proactive in their care and reduce triggers that can result in return to use. Social Media can help individuals connect with community groups that support recovery, activities that support recovery and applications can be customized to support wellness for individual's post-treatment.

Priority: Intervention, Treatment and Recovery
Initiative: Recovery Oriented System of Care - The implementation of a Statewide Recovery-Oriented System of Care (ROSC) for individuals with needs related to substance use is essential to the promotion of self-directed approaches to support sustained recovery and improved health, wellness and quality of life.

Step	Task	Output/Measures	Outcomes
Develop annual plan with stakeholder and consumer input for the further development, expansion and implementation of SUD treatment and recovery services	• Review Needs and Gaps Analyses submitted by LME-MCOs • Solicit input from the SUD Federation • Review and adjust LME-MCO budgets as necessary to assure gaps and needs are covered and funds are expended • Realign funds to reduce gaps and needs	• Development and submission of the SABG Annual Plan • Development and submission of the SABG Annual Report • Fully-expended budgets	• Approved SABG Annual Plan • Approved SABG Annual Report • Improved access to treatment and recovery supports and services in under-served areas of the state

Step	Tasks	Output/Measures	Outcomes
Develop system capacity to support a Recovery-Oriented System of Care	• Ensure LME-MCO contracts include substance use disorder treatment and recovery support services, goals and outcomes • Develop/enforce performance improvement initiatives • Complete a fiscal impact analysis on new best practices, development of a continuum of care, with a focus on recovery supports • Develop system capacity to support recovery-oriented systems of care including financing, policy enhancement, workforce development, technology, system partnerships, and other identified resources • Create service definitions and reimbursement rates for identified recovery support services • Provide recovery messaging training to DMHDDSAS staff	• Number of individuals that have access to appropriate care within 48 hours of accessing treatment • Initiation and engagement of substance use disorder treatment (2 services received within 14 days and 2 or more additional services within the next 30 days). • Reduced readmissions to inpatient care and detox/facility based crisis • Timely follow-up after discharge from inpatient care and detox/facility based crisis. • Increased utilization of recovery support services • Recovery messaging training developed and delivered to internal staff	• Fully realized recovery-oriented system of care framework • Improved outcomes related to return to use, education, employment, reduced criminal justice involvement, stable housing, improved health, and social connectedness • Improved understanding of addiction and recovery within the Division; more appropriate language used

Priority: Intervention, Treatment and Recovery
Initiative: Medication Assisted Treatment: Medication assisted treatment (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.

Step	Tasks	Output/Measures	Outcomes
Improve Access to Medication Assisted Treatment	• Identify areas of unmet need • Increase the number of patients referred to treatment for a substance use disorder related to opioids. • Establish and expand mentoring for physicians who provide MAT • Promote physician participation in office and tele-health MAT programs	• Number of buprenorphine providers and patients • Amount of state and federal resources available for treatment • Rate of ED visits and hospitalizations among Medicaid patients receiving MAT • Rate of overdose deaths among individuals receiving MAT	• Increased number of buprenorphine providers and patients • Increased number of physician mentors and mentees • Decreased rate of ED visits and hospitalizations among Medicaid patients receiving MAT • Decreased rate of overdose deaths among individuals receiving MAT

Priority: Housing and Employment

National studies indicate the two most stabilizing factors that support ongoing recovery and community engagement are housing and employment. A statewide, multi-disciplinary supportive housing system is essential to ensuring individuals with mental illness, intellectual or developmental disabilities or substance use disorders live where they want to live, with maximum desired integration into their communities.

Priority: Housing and Employment

Initiative: Housing In-Reach -To provide education and information to individuals in Adult Care Homes and state psychiatric hospitals who have a Serious Mental Illness diagnosis focused on available community based services, supports and housing options.

Step	Tasks	Outputs/Measures	Outcome
Support to staff-Provide technical assistance and consultation to LME/MCO In-Reach-staff.	• Provide technical assistance to TCLI staff on the TCLI database elements. • Provide consultation to TCLI staff regarding the scope of the In-Reach function.	• Data entered into the TCLI database • Number of eligible participants that receive In-Reach	• Improve the accuracy of data entered into the TCLI database. • Increase number of eligible participants that receive In-Reach.
Support efforts to reduce barriers to engage individuals with SMIs in ACHs	• Provide education and guidance around the appropriate reporting protocol including but not limited to Adult Protective Services, Division of Health Service Regulation and long term care ombudsmen when there are access issues, concerns or problems providing In-Reach in adult care facilities.	• Strengthened, collaborative relationships between LME/MCO staff and facility staff. • LME/MCO TCLI staff understand and follow reporting protocol process regarding challenges and barriers.	• In-Reach staff will have access to work with individuals in adult care facilities.

Priority: Housing and Employment

Initiative: Housing : A statewide, multi-disability supportive housing system is essential for ensuring individuals with I/DD, mental illness, and substance use disorders live where they want to live, with maximum desired integration into their communities

Step	Tasks	Outputs/Measures	Outcome
Identifying and promoting the utilization of available housing resources (Transitions to Community Living, Targeted Units, CoC Rental Assistance Program, Oxford Houses and use of the SocialServe.com, NCHousingSearch.org Database, etc.)	• Promote the use and support of individuals that would benefit from Oxford Houses • Encourage use of SocialServe.com and NC HouingSearch.org bed availability database.	• Number of individuals supported to live in affordable community-based housing. • Number of individuals recovering from SUD living in Oxford Houses	• Increase number of individuals living in private residence. • Increase number of individuals receiving MH or SUD services living in their home community. • Increase number of individuals recovering from SUD living in Oxford Houses.
Creating a full service spectrum of housing options and supports that can be made available to individuals in their home, with the possibility of changing intensity of services in the community housing setting of their choice.	• Efforts to partner with other Divisions and NC Housing Finance Agency to reduce barriers to individuals accessing Targeted and Key Rental Assisted Units • Maintain Transition Management Services through the LME/MCO provider networks.	• Number of individuals receiving Transition Management Services	• Increase number of individuals receiving Transition Management Services. • Increase number of individuals living in private residences.

Housing and Employment

Initiative: Housing : A statewide, multi-disability supportive housing system is essential for ensuring individuals with I/DD, mental illness, and substance use disorders live where they want to live, with maximum desired integration into their communities

Step	Tasks	Outputs/Measures	Outcome
Supporting reasonable accommodations and removing barriers to housing.	• Partner to support educating Stakeholders to support the removal of barriers to housing due to criminal background • Partner to support educating Stakeholders to support individuals served on Reasonable Accommodations.	• Number of individuals receiving housing services.	• Increase number of individuals receiving housing services.
Promote technology as a way of increasing the capacity of individuals with disabilities to live safely in their own homes.	• Increase in new intervention strategies and expansion of best practices within the supported housing field • Increase accessibility to safe and stable housing	• Number of individuals receiving housing services	• Increase number of individuals receiving housing services.
Meeting housing goals established for the Transitions to Community Living Initiative.	• Increase accountability of community group home providers based on provider's licensure rules and acceptable best practice standards	• Number of individuals with SMI diagnosis supported to live in community-based housing	• Increase number of individuals with SMI diagnosis receiving housing services.

Priority: Housing and Employment			
Initiative: Promote the use of assistive technology. Supporting independence through the use of technology for individuals with disabilities to live, work, learn and be active in their communities			
Step	**Tasks**	**Output/Measures**	**Outcome**
Identify the baseline for current use of assistive technology.	• Review service definitions to incorporate assistive technology. • Examine use of assistive technology to facilitate independent living for consumers. • Examine use of assistive technology to facilitate employment for consumers. • Communicate to LME/MCOs, providers, consumers and their families' educational information about the advantages of assistive technology.	• Number of assistive technology assessments billed. • Reliable process to identify and quantify persons who are able to live independently due to assistive technology. • Reliable process to identify and quantify persons who are able to work due to assistive technology. • Communication plan with schedule for periodic offerings through various media to inform stakeholders.	• To demonstrate that persons receiving assistive technology are more independent and self-sufficient than persons who do not have access to assistive technology. • The metrics for this outcome will not be available until there has been an opportunity to establish a baseline, complete the tasks to incorporate assistive technology in the lives of consumers and then to compare the achievements, outcomes, for those persons.

Priority: Housing and Employment

Initiative: Promote the use of assistive technology. Supporting independence through the use of technology for individuals with disabilities to live, work, learn and be active in their communities

Steps	Tasks	Output/Measures	Outcome
Identify and provide funding resources for technology supports.	• Review costs/funding requirements to identify barriers to use of assistive technology. • Research additional funding opportunities to pay for assistive technologies for consumers.	• List of barriers and elements of plan(s) to reduce or eliminate barriers. • New funding sources available for consumers' assistive technology.	• The metrics for this outcome will not be available until there has been an opportunity to establish a baseline, complete the tasks to incorporate assistive technology in the lives of consumers and then to compare the achievements, outcomes, for those persons.
Develop/revise policies to promote/support use of assistive technology.	• Review licensure rules to identify barriers inhibiting use of assistive technology. • Include assistive technology for consumers in revised LME/MCO state contract.	• List of barriers and elements of plan and process to reduce or eliminate barriers. • LME/MCO contract signed with assistive technology supports language included	• Policies promoting and supporting the use of assistive technology.
Provide resources to increase number of professionals with assistive technology certification.	• Provide announcements of training links to DMH/DD/SAS website. • Investigate providing funding for training offer at major conference.	• Number of training opportunities communicated. • Number of persons trained.	• Increased number of professional with assistive technology certification.

Priority: Housing and Employment **Initiative: Employment : Youth Transitions Support for I/DD (Education and Employment Opportunities**			
Step	**Tasks**	**Outputs/Measures**	**Outcome**
Advisory members finalize gaps/needs assessment by 7.15.17.	• Draft chapter of 2017 report addressing gaps and system needs by 7.31.17.	• DMH/DD/SAS, DVRS, DSS; DPI, UNC; and NCCCS endorse report chapter by 8.31.17; submit for DHHS review by 10.15.17.	• Completed report is submitted.
Advisory endorses recommendations to expand and sustain postsecondary education and employment opportunities for youth, age 14-24, by 7.31.17.	• Draft chapter of 2017 report addressing recommendations to expand and sustain postsecondary education and employment opportunities for youth by 8.15.17.	• DMH/DD/SAS, DVRSS, DSS; DPI, UNC; and NCCCS endorse report chapter by 8.31.17; submit for DHHS review by 10.15.17.	• [Present recommendations to]* develop a program and fiscal policies to expand and sustain postsecondary education and employment opportunities for people with disabilities by 11.15.17.
Advisory develops recommendations to plan and implement approaches to public awareness about postsecondary education and employment by 8.15.17	• Draft chapter of 2017 report addressing recommendations to plan and implement approaches to public awareness about postsecondary education and employment by 8.31.17.	• DMH/DD/SAS, DVRSS, DSS; DPI, UNC; and NCCCS endorse report chapter by 8.31.17; submit for DHHS review by 10.15.17	• Plan and implement approaches to public awareness about postsecondary education and employment for people with disabilities by 11.1.17.

Priority: Housing and Employment Initiative: Youth Transitions Support for I/DD (Education and Employment Opportunities)			
Steps	**Tasks**	**Outputs/Measures**	**Outcome**
Advisory develops recommendations for planning and implementing joint policies and common data indicators for tracking the outcomes of people with disabilities after leaving high school by 8.31.17.	• Draft chapter of 2017 report addressing recommendations for planning and implementing joint policies and common data indicators for tracking the outcomes of people with disabilities after leaving high school by 9.15.17.	• DMH/DD/SAS, DVRSS, DSS; DPI, UNC; and NCCCS endorse report chapter by 9.30.17; submit for DHHS review by 10.15.17.	• Present recommendations for planning and implementing joint policies and common data indicators for tracking the outcomes of people with disabilities after leaving high school by 11.15.17.
Advisory develops options for technology to link agency databases by 8.31.17.	• Draft chapter of 2017 report addressing options for technology to link agency databases by 9.15.17.	• DMH/DD/SAS, DVRSS, DSS; DPI, UNC; and NCCCS endorse report chapter by 9.30.17; submit for DHHS review by 10.15.17.	• Consider options for technology to link agency databases by 11.15.17.

Priority: Housing and Employment **Initiative: I/DD Employment**			
Steps	**Tasks**	**Outputs/Measures**	**Outcome**
Explore methods and options to increase access to statewide, evidence- based employment practices, benefits counseling, work incentives, assistive technology, language access, and transportation solutions.	• Expand technology support for employment programs, across disabilities, by increasing knowledge of job accommodations through collaboration with the NC Assistive Technology Program. • Develop information designed to reduce concerns about benefit loss for people receiving SSI/SSDI who are considering and/or seeking employment or return to work. • Develop information designed to increase the understanding of the benefits of engaging in CIE.	• Percentage of individuals who have competitive, integrated employment (CIE), as defined through WIOA, and per DMH/DD/SAS policy. • Disseminate information about Benefits Counseling and benefits of CIE to individuals accessing ADVP, LTVS, and SE services (or their successors) and survey a portion to measure and track the percentage of individuals that have access to information and/or services intended to increase engagement in CIE (e.g., Supported Employment, LTVS, Benefits Planning)	• A shared standard for CIE across DHHS. • A plan for measuring the number of individuals working in CIE. • Collect and publish data on percentage of individuals accessing Benefits Counseling and/or services intended to create CIE. • Established method to track data on the percentage of youth with disabilities 14 to 24 who transition from DPI services to DMH/DD/SAS services with previous work experience.

Priority: Housing and Employment **Initiative: Employment**			
Step	Tasks	Outputs/Measures	Outcome
Explore methods and options to increase access to statewide, evidence- based employment practices, benefits counseling, work incentives, assistive technology, language access, and transportation solutions (cont'd).	• Analyze relative to the Advisory Committee on Increasing Competitive Integrated Employment (ACICIEID) recommendations to US Department of Labor (2016) available outcomes data for individuals receiving employment services	• Administer a survey to assess the percentage of youth with disabilities age 14 to 24 who had a work experience during high school	• Increased statewide evidenced-based employment practices
Explore methods to develop and maintain a flexible full service spectrum of I/DD, employment services that promotes CIE.	• Pursue LME/MCO contracts that include a prioritization on employment services, goals, and outcomes relating to individuals obtaining and maintaining CIE. • Increase focus on youth in transition and career pathways through employment and post-secondary education, in collaboration with system stakeholders. • Research natural and peer mentorship in the • Continue partnerships with DVRSS, DMA, DOC, DPI, NCCCS and other community stakeholders by collaborating on policy and service development	• Percentage of individuals earning at or above minimum wage. • Number of individuals engaging in Supported Employment and/or LTVS services, or their successors. • Number of hours of paid employment per week. • Number of hours of support provided per week.	• Utilizing data available to DMH/DD/SAS • Increase I/DD individual's job retention • Increase number of individuals earning above minimum wage • Increase number of paid hours Worked. • MOU/MOA between DMA, DVRSS, and DMH/DD/SAS outlining/ensuring compliance with WIOA requirements for DMA, DMH/DD/SAS, and DVRSS as it concerns individuals eligible for 1915(c) waiver services

Priority: Housing and Employment **Initiative: Employment- Alignment with the Workforce Innovations and Opportunity Act (WIOA) and NC Unified State Plan for WIOA**			
Step	**Tasks**	**Outputs/Measures**	**Outcome**
Review and Promote alignment with the WIOA and NC Unified State Plan for WIOA	• Support compliance with WIOA and NC Unified State Plan recommendations by collaborating with DVRSS, DMA, DOC, DPI, NCCCS and other community stakeholders. • Obtain and sustain an MOA/MOU with DVRS to share relevant data.	• Assess progress annually on employment indicators through the National Core Indicators .	• Increase in individuals entering CIE, consistent with the requirements of WIOA; the HCBS Settings Rule; and state policy. • Maintain alignment with WIOA and NC Unified State Plan requirements.

Priority: Housing and Employment

Initiative: Employment

Step	Tasks	Outputs/Measures	Outcome
Promote the inclusion of work goals in Person-Centered-Plans, including goals relating to increasing Career Exploration.	• Provide guidance and consultation to LME/MCO and providers around the inclusion of work goals in the PCP's. • Implement a requirement that Competitive Integrated Employment (CIE) is addressed in PCPs of youth 14-24 and recommend to DMA that this also occur with ISPs for waiver recipients. • Provide training to care coordinators, providers, families and individuals on informed choice	• Number of individuals receiving state-funded services with work goals in their PCPs • Percentage of ISPs with work goals addressed, including informed choice goals showing work was discussed and exploration options reviewed. • Disseminate information on informed choice and CIE to care coordinators, providers, families, and individuals.	• Increase percentage of people who have a goal of integrated employment (CIE) in their individualized service plan. • Decrease the proportion of people who do not have a job in the community (CIE) but would like to have one. • Number of hours worked bi-weekly by people with jobs in the community. • Increase the proportion of people who have a job in the community.

Priority: Housing and Employment **Initiative: Employment**			
Step	Tasks	Outputs/Measures	Outcome
Promote North Carolinian youth transitioning into Competitive Integrated Employment and/or Post-Secondary Education.	• Explore developing, across state agencies, a consistent definition of CIE and shared employment service definitions promote same, across funding streams, and with PHPs/LME/MCOs • Explore advancing rates that incentivize CIE. • Promote standardization of payment to providers for similar services, accounting for differences related to incentivizing performance/ outcomes or other reasonable differences in costs settings • Promote aligning provider and staff qualifications with new, or updated, employment-related service definitions and reimbursement rates. • Identify options for leveraging federal match for current, state-only funded service definitions to create a cost-neutral method for increasing access to competitive integrated employment (CIE) services statewide. • Explore options for improved data-tracking of CIE through the implementation of standardized employment-related service definitions	• Conduct a review of state-funded IDD employment-related service definitions and make recommendations on needed edits or new services, with US Office of Disability Employment Policy input, to the State Services Committee in fall 2017. • Recommended employment-related 1915(c) service definitions with US Office of Disability Employment Policy input, for internal approval with intent-to-submit to CMS for proposed initiation on August 1, 2018.	• Utilizing data available to DMH/DD/SAS (e.g. CFS (GDAC) and NCI): • Increase proportion of individuals accessing non-congregate setting, employment-related services.

Quality Monitoring and Management

Priority: Quality Monitoring and Management **Initiative: Promote accountability, efficiency and transparency for publicly funded MH/DD/SAS services through LME/MCO System Performance Monitoring.**			
Step	Tasks	Outputs/Measures	Outcome
DMH/DD/SAS shall use system performance measures to monitor the LME/MCO's performance on outcome measures and performance indicators.	• DMH/DD/SAS contract language to support performance measures, achievement standards and remediation for unsatisfactory performance.	• LME/MCO submission of annual Quality Improvement Plans and Quality Improvement Projects. • LME/MCO Performance Reports including: o Administrative Functions o Performance Measures & Critical Performance Indicators o Clinical Outcomes	o Data analysis from monitoring MH/DD/SAS system performance to develop and inform strategies for improvement.
Support for systems and processes for collecting data on: • Administrative Functions • Performance Measures • Critical Performance Indicators	• Contract expectations and performance measures include Critical Performance Indicators to fulfill statutory requirements. • Development of resource documents for supporting data collection and reporting requirements.	• Updated Performance Measure Guidelines annually. • Updated LME/MCO reporting requirements document annually	• Data analysis from monitoring MH/DD/SAS system performance to develop and inform strategies for improvement.

Priority: Quality Monitoring and Management **Initiative: Promote accountability, efficiency and transparency for publicly funded MH/DD/SAS services through LME/MCO System Performance Monitoring.**			
Step	Tasks	Outputs/Measures	Outcome
Promote annual development of standards and benchmarks to improve performance with: Administrative Functions Performance Measures Critical Performance Indicators	• Update Systems Performance Monitoring standards and benchmarks annually based on national or state data and with consideration of clinical best practices. • Ensure accurate methodology to improve data quality. • Establish a separate threshold for Critical Performance Indicators, which triggers Technical Assistance requirement. • Accurately calculate performance measures from NC Tracks data at the Division level.	• Expectations, standards and benchmarks published annually. • Update Performance Measure Guidelines annually. • Decreased LME/MCO reporting requirements on some performance measures.	• Data analysis from monitoring MH/DD/SAS system performance to develop and inform strategies for improvement.
Support systems and processes for addressing unsatisfactory performance and promoting positive performance.	• Use standardized process for Critical Performance Indicators Technical Assistance requirement. • Use standardized process for Plans of Correction and LME/MCO Quality Improvement Projects.	• DMH/DD/SAS will calculate and publish quarterly the LME/MCO's performance. • Documented Plans of Correction and Quality Improvement Projects.	• Data analysis from monitoring MH/DD/SAS system performance to develop and inform strategies for improvement.
DMH/DD/SAS to make decisions and take actions to improve system performance	• DMH/DD/SAS Quality management structure will support the evaluation of LME/MCO's overall performance through compliance with reporting requirements, and statewide measures of service quality.	• Technical assistance provided as appropriate for LME/MCOs who do not meet standards and benchmarks. • Successful LME/MCO practices promotion for service system success.	• Data analysis from monitoring MH/DD/SAS system performance to develop and inform strategies for improvement.

Additional information about the Division's commitment to Quality Monitoring and Management can be found in the Quality Management Plan (**Appendix E**).

Integrated Care

Priority: Intervention, Treatment and Recovery
Initiative: Integrated Care- DMHDDSAS supports whole person care and a multi-disciplinary approach to provide collaboration with Primary Care, Mental Health, Substance Use and Intellectual and Developmental Disabilities professionals statewide. The goal is to emphasize the importance of linking Behavioral Health and Physical Health.

Steps	Tasks	Outputs/Measures	Outcome
Increase awareness of bidirectional and collaborative models including: primary care and behavioral health integration	• Provide education and awareness related to integrated care models.	• Education materials disseminated to the LME-MCOs	• Increased awareness of Integrated Care models.
Encourage LME-MCO engagement in Integrated Care activities.	• Inventory and track Integrated Care activities across LME-MCOs.	• Number of Integrated Care projects completed within the LME-MCOs	• Increased number of Integrated Care projects within the LME-MCOs.
Improve quality of care for Mental Health and Substance Use Disorders and medical co-morbidity	• Educate PCPs on providing screenings for depression and tobacco cessation intervention.	• Number of PCPs receiving education material • Number of Tobacco screenings completed • Number of Substance use screenings completed	• Increased awareness of providing screenings for MH, SU and medical co-morbidity
Improve quality of care related to anti-psychotic use, Behavioral Health and Primary Care Physician visits.	• Educate PCPs on the need to provide Glucose Screenings to children (less than 21 years old) taking an anti-psychotic medication at any point in the past 12 months. • Educate PCPs on the need to provide specific screenings for Mental Health and Substance Use Disorders in chronic conditions.	• Number of MH and SU Screenings Completed.	• Increased awareness of providing screenings for MH, SU and medical co-morbidity

Next Steps

In conclusion, it is important to note that the DMH/DD/SAS State Strategic Plan is not a static document, but rather the result of a fluid process consisting of regular reviews of the data and assessments of progress in order to promote a culture of continuous improvement. This 3 year plan that will be updated annually.

Next steps include

- Ongoing work with subject matter experts and stakeholders around the specific initiatives found within each of the functional priority categories.
- Reviewing key measures regularly and monitoring progress
- Publishing updates annually
- Ensuring alignment with the Behavioral Health Strategic Plan referenced in S.L. 2016-94

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

According to the US Census Bureau, as of July 2016, North Carolina had an estimated total population of 10,146,788 people, making it the ninth largest state in the United States, with a population increase of 6.4% over the last six years. According to the National Survey on Drug Use and Health (NSDUH), 2008-2011, for those with a family income less than 139% of the federal poverty level and uninsured, prevalence of a substance use disorder for individuals between the ages of 18 to 64 was 12.5%. The prevalence estimate for those uninsured with annual incomes between 133 and 399% of federal poverty level and a substance use disorder was 13.4%. This NSDUH report also showed that North Carolina had a penetration rate of 5.3% for individuals between 18 and 64 years of age living between 133 and 399% of federal poverty level for receiving some type of treatment for a substance use disorder. North Carolina is not a Medicaid expansion state, and recent data indicates that over 685,000 individuals with incomes less than 139% of the federal poverty level are uninsured, as well as an additional 625,217 uninsured with incomes between 139 and 399% *(Data Source: American Community Survey, 2011.)*. These data clearly indicate that those living in poverty have a higher prevalence of substance use disorders than those not living in poverty. Given the number of people living in poverty in North Carolina and the above prevalence, it can be estimated that over 175,000 individuals between the ages of 18 and 64 are in need of treatment for a substance use disorder and have no insurance coverage.

According to our data, for state fiscal year 16, July 2015 through June 2106, 39,142 individuals who were uninsured received at least one service for a substance use disorder, as illustrated in the chart below:

Jul 2015 - Jun 2016	**Uninsured**			
Age/Disability	Number Of Uninsured Population	Est. Prevalence	Number That Received At Least One Service	Percent That Received At Least One Service
Child SA (Ages 3-17)	141,186		371	0.26%
Adult SA (Ages 18+)	1,477,107		38,771	2.6%
All Ages and Disabilities (Ages 3+)	1,559,320		109,161	7.0%
Substance Use Disorder	1,618,293	129,463	39,142	2.4%

North Carolina has fully transitioned to a new 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 Medical Assistance (DMA), the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the Division of

Public Health (DPH). Providers enrolled in DMA, DMH/DD/SAS and DPH health plans submit claims for payment of covered health care services through the NCTracks Provider Portal. NCTracks coordinates processing among the payers to ensure the proper assignment of the payer, benefit plan and pricing methodology for each service on a claim. NCTracks processes health care claims for about 70,000 enrolled DHHS providers who serve over 1 million North Carolina citizens. Providers who are contracted by Local Management Entities (LMEs) to enroll and perform state funded DMH/DD/SAS services submit their claims to the LME.

Over the last several years, North Carolina has implemented a 1915(b)/(c) waiver that is statewide. All 100 counties are part of a catchment or service area covered by one of seven local management entities/managed care organizations (LME/MCOs) that assure the delivery of services that are of the appropriate intensity and duration for consumers with intellectual/developmental disabilities or mental health/substance use issues. Each LME/MCO contracts with providers, the majority of whom are nationally accredited, for specific services for specific populations; i.e., adults with a substance use disorder, children with a serious emotional disturbance, etc. In order for LME/MCOs to be eligible to receive categorical substance abuse block grant funds, the LME/MCO must assert and assure that the federally mandated priority populations be served; i.e., pregnant women with a substance use disorder, individuals injecting drugs, etc.

The Division of MH/DD/SA Services and the Division of Medical Assistance require the LME/MCOs to annually complete a *Provider Capacity, Community Needs Assessment and Gaps Analysis.* DMH/DD/SAS and DMA 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. A statewide, in-depth analysis to aggregate results of the most current reports from each LME/MCO is still underway; therefore selected needs and gaps from the 2016 reports can be found in the Attachment section titled ***2016 Community Mental Health, Substance Use and Developmental Disabilities Services Needs and Gaps Analysis***. Designated staff will work with the LME/MCOs to identify strategies to address gaps related to the provision of prevention, treatment and recovery support services for youth and adults at risk or with substance use disorders.

Additionally, the Division recently completed its ***2016-2019 State Strategic Plan***, which can be found in the Attachment section.

Community integration/recovery support is another area that has been and will continue to be a focus of the state. The ability to obtain and sustain safe, affordable housing is one of the most significant challenges facing persons in the early stages of recovery. In addition, having meaningful work is integral to many individuals' recovery. The state has an ongoing contract with Oxford House, Inc. to provide housing for people in recovery and has set aside $100,000 for the support of statewide consumer housing through the Cross Area Service Program (CASP) Substance Abuse Services initiative. A substantial portion of block grant funds were utilized last fiscal year to support recovery housing (in addition to Oxford Houses). In that safe, affordable housing continues to be an area of need, the Division will work with LME/MCOs and providers to identify barriers that impede an individual's access to housing and employment.

Because of the strong association between substance use and trauma, the state will continue to emphasize trauma-informed care as well as the use of evidence-based practices in the treatment of substance use disorders. North Carolina supports a full continuum of substance abuse services including prevention, intervention and treatment for pregnant and parenting women and their families and women seeking custody of their child(ren). The Perinatal and Maternal Substance Abuse Initiative is composed of specialized programs for pregnant and parenting women with a substance related disorder and their children. These programs provide comprehensive, gender-responsive, substance abuse services that include, but are not limited to the following: screening, assessment, case management, outpatient substance abuse and mental health services, parenting skills, residential services, referrals for primary and preventative health care and referrals for appropriate interventions for their children. The children in these families benefit from various services, including those provided by the local health departments (pediatric care), early intervention programs, etc. The NC CASAWORKS for Families Residential Initiative is a collaborative project between the Division of MH/DD/SAS and the Division of Social Services. This Initiative supports eight comprehensive residential substance abuse programs for women receiving Work First cash assistance and their children. Emphasis will be placed on identifying and removing any barriers to accessing these services, increasing referrals and improving outcomes. Due to the increased use of prescription pain medications, the Division will emphasize improved access to and retention in opioid treatment programs for pregnant women.

Over the past several years, North Carolina 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 grant provides 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. The Secretary has appointed Dr. Susan Kansagra, Section Chief of the North Carolina Division of Public Health, Chronic Disease and Injury Section, to oversee and coordinate all activities within the DHHS related to the opioid crisis. 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 Medical Assistance (DMA), the Office of Rural Health (ORH) and the Office of Emergency Medical Services (OEMS). The Attorney General's office is also highly involved. Epidemiologic data available from the Injury and Violence Prevention Branch, Injury Epidemiology and Surveillance Unit (NC DPH) show that prescription opioid poisoning deaths increased by 256 percent between 2000 and 2015 while deaths from heroin overdoses increased by 800 percent, indicating that the state, like the rest of the country, is facing a problem of epidemic proportions.

There are currently over 60 opioid treatment programs in the state, of which approximately half are eligible to provide services to publicly-funded consumers. The Division will focus efforts on improving access, retention and outcomes specific to these programs. Please see in the Attachments section the ***North Carolina Opioid STR Needs Assessment*** for additional information

specific to the opioid epidemic in North Carolina, as well as the ***Opioid STR Strategic Plan*** which identifies areas of focus and strategies for meeting identified needs.

North Carolina is home to a large number of active military, National Guard and Reserves, veterans, and military families, ranking third in the country on this criterion. In a recent study, the NC Institute of Medicine noted that 35% of North Carolinians have some relationship to the military. The number of reserve component members in the state sum up to 22,000. A total of 116,000 are in the active military, while a total of 775,020 are veterans and 190,896 are dependents of service members. DMH/DD/SAS serves the needs of the military primarily 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.

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 Problem Gambling section within DMHDDSAS, NC Center for Health Statistics, PIRE, NC Department of Public Instruction, University of North Carolina School of Public Health, Department of Epidemiology and NC Action For Children, Research Triangle Institute, Wake Forest University Health Systems. The SEOW meets regularly to identify needs and to develop data resources to assist with planning. Over the last year they have facilitated the development of three data resources. The first, Data Days, are a series of presentations intended to profile two data sources available within the state, highlighting what data they can provide and how providers can utilize them. The second, the NC Support data dashboard, is dashboard that provides administrative data for every county in the state to create either county profiles or a comparison of risk indices for counties across the state. It captures a wide array of administrative data, over time, including those variables that indicate consumption and consequences, retail access to alcohol (with tobacco and prescription drugs coming soon), community context, and the outcomes of other risky behaviors. During FY2018 it will be adding views for LME/MCOs regions, our main contracting units. Third, the SEOW oversaw the development and administration of a statewide youth prevention survey, which provides a data resource for by LME/MCO.

The SEOW also has recently reviewed and prioritized needs for substance use prevention. They identified multiple criteria by which we might determine priorities, and then ranked their importance and specified the target substances they suggested as most important to prioritize. Through this process the SEOW determined that that tobacco & ENDS products and prescription drugs & other opioids produced the greatest threats to the state and should be prioritized as targets for prevention.

The state will coordinate and collaborate with is partners to address these 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.

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.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's **NBHQF**. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at **http://www.samhsa.gov/data/quality-metrics/block-grant-measures**. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).
3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-

identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

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

Footnotes:

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

To ensure the needs of those we serve are being met the Division monitors key indicators to help assure that the system is working as intended, opportunities for improvement area identified and acted upon, desired improvements are recognized and efforts to sustain successful practices are implemented and monitored to maintain achievements, as priorities change. The Quality Management Plan identifies performance measures and procedures for monitoring state established block grants, waivers, and Division priorities including the review of:

- Gap Analysis and Community Needs Assessment
- Network Development Plans
- Performance Improvement Projects
- Intra-departmental Monitoring Reviews
- Block Grant & Clinical Monitoring Reviews
- Monthly Monitoring Reports
- DMA & DMH Performance Measures
- Performance Contract Reports/Data Requirements
- Stakeholder Satisfaction Surveys
- Service Utilization and Financial Analysis
- Consumer Functional Outcome Data (State, Regional, Provider & Individual Level)
- Reports regarding emergencies, critical incidents, complaints and grievances

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

NC Treatment Outcomes and Program Performance System (NC-TOPPS) is a web-based program that gathers outcome and performance data on behalf of mental health and substance abuse consumers in North Carolina's public system of services. The NC-TOPPS system provides reliable information that is used to measure the impact of treatment and to improve service and manage quality throughout the service system.

NC- TOPPS information provides one method for the collection of the Division's consumer functional outcomes data. Consumer functional outcomes data are the DHHS source of information utilized to monitor the direct impact of services.

NCTracks is the Multi-Payer Medicaid Management Information System for the North Carolina Department of Health and Human Services. It has three separate portals for specific internet access to different sectors of the business (Providers, Recipients and internal operation needs)

- The system adjudicates claims from DMA/DMH/DPH and ORHCC (professional, institutional, pharmaceutical and BH related);
- Shares the claims processing engine of the NCTracks to process and pay claims for the Division of MH/DD/SA Services;
- Establishes a central repository of recipient and provider data across the Division's circle of services and programs;
- Allows the state to more closely monitor the delivery of MH/DD/SA services, and to properly measure and track the Local Management Entities-Managed Care Organizations (LME-MCOs) performance;
- Reduces the potential for over-billing and duplicate payments for the same units of service and
- Simplifies the claims filing practices for the LME-MCOs and reduces the claims payment cycle time.

More information can be found on the DMHDDSAS NCTracks website at: https://www.ncdhhs.gov/providers/provider-info/health-care/nctracks

ECCO is the Division's substance use planning and reporting system. It captures data on CSAP strategy, service type, IOM target, implementation fidelity, people served, and staff time spent by intervention. This allows the state to monitor plans for training and technical assistance, and to analyze prevention provider performance from broad CSAP strategies to service types to specific interventions.

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client identifying information)?

Yes - by capturing key information on an individual's service needs and life situation during a current episode of care, NC-Treatment Outcomes and Program Performance System (NC-TOPPS) aids in developing meaningful treatment plans and evaluating the impact of services on an individual's life.

Clinicians have access to the Individual Report in the NC-TOPPS system. The report does have identifying information and only the clinical responsible for treatment has access to the report. The Individual Report includes information from the initial interview and the two most recent update Interviews. In a sense it is a report card on how the individual is progressing in treatment and can help drive the dialog between the clinician and the individual on progress and planning for next steps in treatment.

4. If not, what changes will the state need to make to be able to collect and report on these measures?

N/A

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Health Disparities

Priority Type: SAT

Population(s): PWWDC, PWID, Other (Rural, Homeless, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Improve availability and delivery of integrated healthcare

Objective:

Increase the number of individuals participating in treatment for a substance use disorder who receive a detailed medical history, physical examination and/or health care screening.

Strategies to attain the objective:

Promotion of integrated care and increased utilization of E&M codes.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals participating in treatment for a substance use disorder who receive a detailed medical history, health care screening and/or physical examination.

Baseline Measurement: During FY17, 8,547 individuals received a health-related service, as evidenced by the billing of specific, identified Evaluation and Management CPT codes.

First-year target/outcome measurement: FY18 will demonstrate a 2% increase in the number of individuals who receive improved physical health care, as evidenced by claims for E&M codes.

Second-year target/outcome measurement: FY19 will demonstrate an additional 2% increase in the number of individuals who receive improved physical health care, as evidenced by claims for E&M codes.

Data Source:

NC Tracks

Description of Data:

Paid claims of E&M codes

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 2

Priority Area: Juvenile Justice

Priority Type: SAT

Population(s): Other (Adolescents w/SA and/or MH, Criminal/Juvenile Justice, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

To appropriately address treatment needs of juvenile justice-involved youth as directed by assessment.

Objective:

Maintain the percentage of juvenile-justice involved youth who complete treatment.

Strategies to attain the objective:

DMHDDSAS will collaborate with the Department of Public Safety, Juvenile Justice and other key stakeholders to identify and maximize resources for justice-involved youth and families with substance use and co-occurring issues.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of juvenile justice-involved youth who complete treatment.

Baseline Measurement: Juvenile justice-involved youth have completed treatment at a rate of 61% on average over the last 5 state fiscal years.

First-year target/outcome measurement: Juvenile justice-involved youth will complete treatment at a rate of 60% or higher.

Second-year target/outcome measurement: Juvenile justice-involved youth will complete treatment at a rate of 60% or higher.

Data Source:

NC TOPPS

Description of Data:

The NC TOPPS (Treatment Outcomes and Program Performance System) is a web-based program that gathers outcome and performance data on behalf of mental health and substance use disorder consumers in North Carolina's publicly-funded system of services. The NC TOPPS system provides reliable information that is used to measure the impact of treatment and to improve service and manage quality throughout the service system.

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 3

Priority Area: Community Integration

Priority Type: SAT

Population(s): Other (Homeless)

Goal of the priority area:

Greater access to supported housing through the development of additional Oxford Houses in NC

Objective:

To provide Substance Use Disorder (SUD) recovery home management services, a cost-effective approach to enhance recovery from substance use disorder by providing technical services, outreach and support for the establishment of new self-run recovery homes throughout the State of NC.

Strategies to attain the objective:

1. DMHDDSAS will continue to provide no less than the current level of funding to Oxford House, Inc. to support additional staff to increase outreach efforts and the number of Oxford House beds;
2. DMHDDSAS will notify LME/MCOs of newly opened Oxford Houses in their catchment areas;
3. The contractor will assure that LME/MCOs are aware of newly opened Oxford Houses and the processes for referral.

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 women with children

Baseline Measurement: At the end of SFY 16, there were 1588 total beds available for men, women and women with children.

First-year target/outcome measurement: No less than 1630 total NC Oxford House beds will be available to adults with SUD at the end of SFY18.

Second-year target/outcome measurement:

Data Source:

Monthly Oxford House Activity Reports and Attestation Reports, which are completed on newly opened Oxford Houses.

Description of Data:

Same as above

Data issues/caveats that affect outcome measures::

None anticipated

Indicator #: 2

Indicator: Number of re-entering (transitioning from incarceration) individuals recovering from SUDs housed in an Oxford House

Baseline Measurement: At the end of SFY-16, 65 new re-entering individuals in recovery from SUD were served and mentored.

First-year target/outcome measurement: Serve and mentor an additional 5 re-entering individuals for a total of no less than 70 re-entering individuals.

Second-year target/outcome measurement: Serve and mentor an additional 5 re-entering individuals for a total of no less than 75 re-entering individuals.

Data Source:

Oxford House NC Criminal Justice Program Quarterly Reports

Description of Data:

Oxford House NC Criminal Justice Program Quarterly Report totals

Data issues/caveats that affect outcome measures::

None anticiapted

Priority #: 4

Priority Area: SUD Services for Pregnant Women and Women of Child-Bearing Age with an Opioid Use Disorder

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Access to quality SUD treatment for pregnant women and women of child bearing age with an opioid use disorder

Objective:

Increased access to SUD treatment for pregnant women and women of child bearing age with an opioid use disorder

Strategies to attain the objective:

(1) Ensure that all NC Perinatal and Maternal Substance Use Initiative programs provide medication assisted treatment or provide access and coordination with opioid treatment programs and/or office based buprenorphine providers.
(2) The NC Plan of Safe Care Interagency Collaborative will meet monthly, through the end of 2017 and, quarterly thereafter, and will identify and address gaps and barriers to access SUD treatment services for this population.
(3) Development and dissemination of educational materials for women seeking services and treatment and healthcare professionals working with women who may be affected by the new CAPTA Plan of Safe Care Division of Social Services policies.
(4) Provision of training and technical assistance to SUD treatment providers, LME-MCOs, healthcare providers, hospitals, social services and other stakeholders on opioid and other substance use during pregnancy, access to gender responsive SUD services, and other related information.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of pregnant women and women of child bearing age with an opioid use disorder participating in SUD treatment

Baseline Measurement: During SFY 16, 530 pregnant women and 6588 women of child bearing age, 18-45, accessed SUD treatment for an opioid use disorder.

First-year target/outcome measurement: Increase by 2% the number of pregnant women and women of child bearing age with an opioid use disorder receiving SUD treatment services

Second-year target/outcome measurement: Increase by an additional 2% the number of pregnant women and women of child bearing age in SUD treatment services

Data Source:

NC TOPPS

Description of Data:

This is North Carolina's individual outcomes and program performance database.

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 5

Priority Area: SUD Services for Pregnant and Parenting Women

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Access to gender-responsive, family-centered substance use disorder treatment and related services and supports for pregnant women and women with dependent children

Objective:

Increased access to SUD treatment for pregnant women and women with dependent children

Strategies to attain the objective:

(1) Maintain a dedicated Perinatal Substance Use Specialist position to ensure pregnant and parenting women receive appropriate screening and referral for SUD treatment and supports and prenatal care services through a toll-free hotline.
(2) Maintain and regularly 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 stakeholders and the provision of training and technical assistance.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of pregnant women and women with dependent children referred to gender-responsive SUD treatment through the toll-free hotline

Baseline Measurement: During SFY 17, a total of 404 pregnant women and women with dependent children; 107 pregnant women and 297 women with dependent children received referrals

First-year target/outcome measurement: Increase the number of treatment referrals by 2%

Second-year target/outcome measurement: Increase the number of treatment referrals by an additional 2%

Data Source:

Quarterly and annual Perinatal Substance Use Project reports for 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 #: 6

Priority Area: CPS SUD Assessments

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Increased access to substance use disorder treatment for individuals with a substantiated Child Protective Services (CPS) case

Objective:

Increased identification of individuals with a substance use disorder who are CPS involved

Strategies to attain the objective:

Maintain funding and accessibility to Qualified Professionals in Substance Abuse (QPSAs) statewide to conduct assessments with individuals referred by CPS.

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 were referred for assessment

Baseline Measurement: During SFY 17, a total of 1574 individuals were referred by local CPS for an SUD assessment

First-year target/outcome measurement: Increase the number of SUD assessment referrals by 1%

Second-year target/outcome measurement: Increase the number of SUD assessment referrals by an additional 1%

Data Source:

Quarterly project reports for the Work First/Child Protective Services Substance Use Initiative completed by the LME-MCOs.

Description of Data:

The data in this report includes the number of individuals with a substantiated CPS case or found in need of service due to substance use who were assessed.

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 7

Priority Area: Youth Tobacco and ENDS Products Use

Priority Type: SAP

Population(s): Other (Adolescents w/SA and/or MH, Rural, Military Families)

Goal of the priority area:

Decrease youth access to and demand for tobacco and ENDS products.

Objective:

1. Increase the number of retailers receiving tobacco and ENDS product merchant education.
2. Increase the number of youth served through strategies intended to decrease demand for tobacco and ENDS products, such as those intended to increase perception of harm, decrease favorable norms, and/or decrease youth targeted advertising.

Strategies to attain the objective:

Red Flag tobacco merchant education.
Youth group tobacco merchant environmental scans and merchant education.
Training for prevention providers on working with law enforcement.
Guidance and TTA to law enforcement on tobacco policy enforcement.
Tobacco free schools/communities policies.
Tobacco/ENDS-free social norms communication campaigns.
Youth substance use prevention education.
Parent prevention education.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of retailers receiving tobacco and ENDS product merchant education.

Baseline Measurement: FY2017 prevention providers conducted 2068 tobacco merchant education sessions among 1842 unique tobacco and ENDS product retailers.

First-year target/outcome measurement: FY2018 will demonstrate a 10% increase in unique tobacco and ENDS product retailers receiving merchant education.

Second-year target/outcome measurement: FY2019 will demonstrate an additional 5% increase in unique tobacco and ENDS product retailers receiving merchant education.

Data Source:

SAPTBG Compliance Reports/ECCO

Description of Data:

Data Source Description: ECCO provides the Division an on-line planning and reporting system. By intervention the planning component of the system captures CSAP strategy, IOM target, service type, target populations, substances targeted, as well as indicators of implementation fidelity. Also by intervention, the reporting component of the system captures number of people served by demographic category and staff time (direct, planning, travel, training, and documentation). Fully loaded salaries and other direct expenses will later be added to directly compute expenditures from the system. As designed, we are able to determine people served at what level of effort from a provider implementing a specific intervention to a broad CSAP strategy, IOM target, LME/MCO, prevention provider, target substance, or target group.

Data issues/caveats that affect outcome measures::

None anticipated

Indicator #: 2

Indicator: The number of youth served through strategies intended to decrease demand for tobacco and ENDS products, such as those intended to increase perception of harm, decrease favorable norms, and/or decrease youth targeted advertising.

Baseline Measurement: FY2017 prevention providers served 11,502 youth through strategies intended to decrease demand for tobacco and ENDS products, such as those intended to increase perception of harm, decrease favorable norms, and/or decrease youth targeted advertising.

First-year target/outcome measurement: FY2018 will demonstrate a 10% increase in the number of youth served through strategies intended to decrease demand for tobacco and ENDS products, such as those intended to increase perception of harm, decrease favorable norms, and/or decrease youth targeted advertising.

Second-year target/outcome measurement: FY2019 will demonstrate an additional 5% increase in the number of youth served through strategies intended to decrease demand for tobacco and ENDS products, such as those intended to increase perception of harm, decrease favorable norms, and/or decrease youth targeted advertising.

Data Source:

SAPTBG Compliance Reports/ECCO.

Description of Data:

Data Source Description: ECCO provides the Division an on-line planning and reporting system. By intervention the planning component of the system captures CSAP strategy, IOM target, service type, target populations, substances targeted, as well as indicators of implementation fidelity. Also by intervention, the reporting component of the system captures number of people served by demographic category and staff time (direct, planning, travel, training, and documentation). Fully loaded salaries and other direct expenses will later be added to directly compute expenditures from the system. As designed, we are able to determine people served at what level of effort from a provider implementing a specific intervention to a broad CSAP strategy, IOM target, LME/MCO, prevention provider, target substance, or target group.

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 8

Priority Area: Decrease non-medical use of prescription medications and other opioids

Priority Type: SAP

Population(s): Other (Adolescents w/SA and/or MH, Students in College, Rural, Military Families, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

To decrease retail and social access to prescription medications

Objective:

1. Increase the average number of Controlled Substance Reporting System queries per user.
2. Increase the number of people served by strategies that decrease social access to prescription medications, such as those that promote secure medication storage and safe medication disposal.

Strategies to attain the objective:

Prescriber and dispenser education.
PDMP utilization policy development and enforcement.
Communication campaigns targeting secure medication storage.
Guidance and TTA to develop policies/practices to increase secure medication storage for high risk populations.
Guidance and TTA to develop policies/practices to increase safe medication disposal.
Youth empowerment/advocacy targeting secure medication storage, safe medication disposal, raising awareness of harms.
Parent prevention education.
Youth prevention education.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of Controlled Substance Reporting System queries per user.

Baseline Measurement: FY2017 there were 267,163 Controlled Substance Reporting System queries and 29,123 users for an average of 9.2 queries per user.

First-year target/outcome measurement: FY2018 will demonstrate a 10% increase in Controlled Substance Reporting System queries per user.

Second-year target/outcome measurement: FY2019 will demonstrate an additional 5% increase in Controlled Substance Reporting System queries per user.

Data Source:

Drug Control Unit

Description of Data:

The Drug Control Unit, a part of the Division, oversees North Carolina's Prescription Drug Monitoring Program, the Controlled

Substance Reporting System (CSRS). From prescriptions dispensed they capture individuals receiving prescriptions by demographics and specific prescriptions and prescription class, as well as the prescriber. Relatedly, they capture each query into the system, as well as the role of the person querying the system, prescriber, prescriber delegate, or dispenser.

Data issues/caveats that affect outcome measures::

None anticipated

Indicator #: 2

Indicator: The number of people served by strategies that decrease social access to prescription medications, such as those that promote secure medication storage and safe medication disposal.

Baseline Measurement: FY2017 prevention providers served 319,417 people through strategies that decrease social access to prescription medications, such as those that promote secure medication storage and safe medication disposal.

First-year target/outcome measurement: FY2018 will demonstrate at 5% increase in the number of people served through strategies that decrease social access to prescription medications, such as those that promote secure medication storage and safe medication disposal.

Second-year target/outcome measurement: FY2019 will demonstrate at 2.5% increase in the number of people served through strategies that decrease social access to prescription medications, such as those that promote secure medication storage and safe medication disposal.

Data Source:

SAPTBG Compliance Reports/ECCO.

Description of Data:

ECCO provides the Division an on-line planning and reporting system. By intervention the planning component of the system captures CSAP strategy, IOM target, service type, target populations, substances targeted, as well as indicators of implementation fidelity. Also by intervention, the reporting component of the system captures number of people served by demographic category and staff time (direct, planning, travel, training, and documentation). Fully loaded salaries and other direct expenses will later be added to directly compute expenditures from the system. As designed, we are able to determine people served at what level of effort from a provider implementing a specific intervention to a broad CSAP strategy, IOM target, LME/MCO, prevention provider, target substance, or target group.

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 9

Priority Area: Persons Who Inject Drugs

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

Increase access to medication assisted treatment (MAT) for persons injecting opioid drugs

Objective:

Improve and enhance available MAT outpatient services to adults

Strategies to attain the objective:

1. DMHDDSAS will notify LME/MCOs of newly opened OTPs in their catchment areas.
2. Develop and implement the Drug Regulatory Utilization and Management System (DRUMS) as part of the Controlled Substances Reporting System (CSRS), NC's prescription drug monitoring program. Information processing, communication and management are key to substance use, mental health and physical health care delivery and considerable evidence links information and communication technology (IT) to improvements in patient safety and quality care.Currently, the NC SOTA application, registration, inspection and surveillance systems are paper-based processes. The Division will integrate the NC SOTA processes into DRUMS as a state=-of-the-art MS SQL database utilized to inspect and certify healthcare facilities including opioid

treatment programs, as part of the state and federal Controlled Substances Act. An addition, the Division will develop a functionality within DRUMS to enable office-based opioid treatment (OBOTs) facilities to report monthly patient census information to the NC SOTA.
3. Training and technical assistance to SUD treatment providers, OTPs, LME/MCOs, healthcare providers, hospitals, social services and other stakeholders on opioid and other substance use during treatment.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of PWID with an opioid use disorder participating in medication assisted treatment

Baseline Measurement: This is the first year NC will capture this data

First-year target/outcome measurement: Increase by 2% the number of PWID who receive MAT

Second-year target/outcome measurement: Increase by an additional 2% the number of PWID who receive MAT

Data Source:

NC TOPPS - questions were added to NC TOPPS this state fiscal year to indicate if persons are receiving methadone, buprenorphine products or naltrexone.

Description of Data:

This is NC's individual outcomes and program performance database.

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 10

Priority Area: Veterans and Their Families

Priority Type: SAT

Population(s): Other (Military Families)

Goal of the priority area:

Decrease Veterans suicide

Objective:

Improve access to care for Veterans and their families to address and decrease the rate of suicide among Veterans

Strategies to attain the objective:

1. Contract with the Alcohol/Drug Council of NC (ADCNC) to provide screening and referral services for Veterans and their families.
2. Maintain a dedicated Veterans Services 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 Working Group and conduct a Practice Improvement Collaborative meeting to address Veterans suicides.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of calls received from Veterans and their families, screened and referred to primary and/or behavioral health care resources

Baseline Measurement: 77 Veterans and/or family members contacted ADCNC during FFY16 seeking assistance for primary or behavioral health needs.

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 data

Description of Data:

ADCNC provide demographic data on all calls received to their information and referral line.

Data issues/caveats that affect outcome measures::

None anticipated

Indicator #: 2

Indicator: Practice Improvement Collaborative (PIC) to Address Veterans Suicide

Baseline Measurement: This will be the first year the NC PIC has focused on Veterans suicide

First-year target/outcome measurement: PIC conducted prior to the end of SFY18, strategies identified

Second-year target/outcome measurement:

Data Source:

Materials generated from the PIC

Description of Data:

The PIC will identify and publish strategies recommended from the PIC to address Veterans suicide.

Data issues/caveats that affect outcome measures::

None anticipated

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$67,076,946		$0	$0	$0	$0	$0
a. Pregnant Women and Women with Dependent Children**	$16,637,340		$0	$0	$0	$0	$0
b. All Other	$50,439,606		$0	$0	$0	$0	$0
2. Primary Prevention	$17,962,446		$0	$0	$0	$0	$0
3. Tuberculosis Services	$0		$0	$0	$0	$0	$0
4. Early Intervention Services for HIV	$2,245,306		$0	$0	$0	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention							
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	$2,527,534		$0	$0	$0	$0	$0
11. SABG Total (Row 1, 2, 3, 4 and 10)	**$89,812,232**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

* Prevention other than primary prevention

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

Footnotes:

North Carolina did not meet the threshold for HIV designation for FY18, which will be the third year in a row. Therefore, the figure indicated above in the HIV line is for one year only.

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
Pregnant Women	0	981
Women with Dependent Children	0	0
Individuals with a co-occurring M/SUD	0	24261
Persons who inject drugs	0	9573
Persons experiencing homelessness	0	3780

Please provide an explanation for any data cells for which the stats does not have a data source.
The Division is currently reviewing data sources to attempt to determine the aggregate number in need of treatment services for the sub-populations listed above and will provide that information as soon as possible. Data reviewed to date is only specific to poverty level and prevalence by drug type (such as heroin) are available. The state's primary data collection system (CDW) does not report on women with dependent children. Partial data can be taken from programs funded through the Women's set-aside, but this would only be a partial indicator of the number of women participating in treatment who have dependent children.

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Expenditure Category	FFY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	$32,415,820
2 . Primary Substance Abuse Prevention	$8,981,223
3 . Tuberculosis Services	$0
4 . Early Intervention Services for HIV*	$2,245,306
5 . Administration (SSA Level Only)	$1,263,767
6. Total	**$44,906,116**

* For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Strategy	IOM Target	FY 2018
		SA Block Grant Award
Information Dissemination	Universal	$728,818
	Selective	$80,967
	Indicated	$0
	Unspecified	$0
	Total	**$809,785**
Education	Universal	$1,214,677
	Selective	$708,532
	Indicated	$101,223
	Unspecified	$0
	Total	**$2,024,432**
Alternatives	Universal	$121,510
	Selective	$70,846
	Indicated	$10,120
	Unspecified	$0
	Total	**$202,476**
Problem Identification and Referral	Universal	$0
	Selective	$89,063
	Indicated	$180,865
	Unspecified	$0
	Total	**$269,928**

Community-Based Process	Universal	$1,282,169
	Selective	$53,978
	Indicated	$12,495
	Unspecified	$0
	Total	**$1,348,642**
Environmental	Universal	$2,091,942
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$2,091,942**
Section 1926 Tobacco	Universal	$410,278
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$410,278**
Other	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$0**
Total Prevention Expenditures		**$7,157,483**
Total SABG Award*		**$44,906,116**
Planned Primary Prevention Percentage		**15.94 %**

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

Footnotes:
This total, $7,157,483 plus the one year total listed in Table 6, minus $410,278 (Synar funds are listed in Table 5A under Section 1926 Tobacco, as well as in Table 6) equal the total required prevention (projected) expenditures:

$7,156,483+$2,234,018-$410,278= $8,980,223

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	FY 2018 SA Block Grant Award
Universal Direct	$1,335,947
Universal Indirect	$4,512,577
Selective	$1,003,311
Indicated	$304,648
Column Total	**$7,156,483**
Total SABG Award*	**$44,906,116**
Planned Primary Prevention Percentage	**15.94 %**

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

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Targeted Substances	
Alcohol	☑
Tobacco	☑
Marijuana	☑
Prescription Drugs	☑
Cocaine	☑
Heroin	☑
Inhalants	☑
Methamphetamine	☑
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☑
Targeted Populations	
Students in College	☑
Military Families	☑
LGBT	☑
American Indians/Alaska Natives	☑
African American	☑
Hispanic	☑
Homeless	☑
Native Hawaiian/Other Pacific Islanders	☑
Asian	☑
Rural	☑
Underserved Racial and Ethnic Minorities	☑

Footnotes:

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems		$533,558	$80,000	
2. Infrastructure Support		$1,664,684	$335,000	
3. Partnerships, community outreach, and needs assessment		$2,846,964	$1,520,906	
4. Planning Council Activities (MHBG required, SABG optional)		$0	$0	
5. Quality Assurance and Improvement		$1,021,100	$527,726	
6. Research and Evaluation		$0	$755,556	
7. Training and Education		$3,145,706	$1,248,848	
8. Total	**$0**	**$9,212,012**	**$4,468,036**	**$0**

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[25] 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.[26] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[27]

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.[28] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[29] 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.[30]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health 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.[31] SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[32] 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 behavioral health include: developing models for inclusion of behavioral health 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.[33] 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 behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[34] and ACOs[35] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health 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.[36] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[37]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[38] 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.[39] 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.[40] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[41] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health 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.[42] 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 behavioral health 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.[43] 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.[44] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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[29] http://www.samhsa.gov/health-disparities/strategic-initiatives

[30] http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/

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[44] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/cciio/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).

Integrated activities in the state can be found at all levels. In 2009, then Governor Perdue identified integrated behavioral health care as a priority in her administration and indicated the establishment of a “medical home” as an essential component of an effective mental health system citing Community Care of North Carolina (CCNC) as a model. In 2010, the state Medicaid agency - the Division of Medical Assistance (DMA) - approved the establishment of the Behavioral Health Initiative (BHI) to support the integration of primary and behavioral health care cares in 1,400 primary care practices serving more than a million Medicaid patients. Medicaid-eligible patients with mild to moderate behavioral health problems are served in the primary care practices that have been identified as their medical homes by medical providers who have been trained in the use of brief intervention techniques and motivational interviewing while those with more severe and persistent problems are referred to specialty clinics for behavioral health services. CCNC has developed a sophisticated system that allows the sharing of records by both primary and behavioral health care providers to facilitate care coordination. It further has an informatics system that uses performance measurement and feedback to improve quality of care while controlling costs. The Division of Mental Health, Developmental

Disabilities, and Substance Abuse Services (DMHDDSAS) – the SMHA and SSA – closely collaborate with CCNC for the coordinated treatment of individuals with the most severe and persistent mental health disorders.

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 (SBIRT) funded a licensed clinician (often dually-licensed for mental health and chemical addiction) to screen and provide brief intervention and treatment to patients coming in for their annual health visit who met the threshold for risky alcohol and drug use. Carr Mill Clinic, a behavioral health care provider has a primary care family physician on its staff funded by a grant from the Duke Endowment. Some schools and community centers also practice integrated care through the co-location of primary and behavioral health care providers.

The state aspires towards the full integration of primary and behavioral health care for individuals with mental health and substance use disorders (Level 6). But for the most part, most integrated activities still occur at the basic level of integration (Level 2). Clinics or practices that have received funding for integrated care have advanced to higher levels where collaboration and care coordination are more developed.

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

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

North Carolina recently completed a no cost extension for its Certified Community Behavioral Health Clinic (CCBHC) grant. Although we were not selected as a demonstration site, over 60 provider agencies submitted requests to participate in the certification process. As stated in the first response, many demonstrated implementation of a number of physical health component screenings as part of their intake process.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ○ Yes ◉ No

and Medicaid? ◉ Yes ○ No

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

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ◉ Yes ○ No

6. Do the behavioral health providers screen and refer for:

a) Prevention and wellness education ○ Yes ○ No

b) Health risks such as

i) heart disease ◉ Yes ○ No

ii) hypertension ◉ Yes ○ No

viii) high cholesterol ◉ Yes ○ No

ix) 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?

In 2015, Mental Health America, published a report "Parity or Disparity: The State of Mental Health in America" that ranked states on the basis of the prevalence of mental illness and access to care with higher rankings indicating lower prevalence and higher access to care. North Carolina was ranked as 18th in the country (with a ranking of 11th for adults, and 30th for youth).

The major issues or problems related to the implementation and enforcement of parity provisions that the state is facing are related to (1) the deficit of providers for co-occurring disorders in the state, (2) the absence or inadequacy of information about

parity provisions, and (3) the stigma related to mental health and substance use disorders that prevent many people from seeking treatment or help for their problems.

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

Please indicate areas of technical assistance needed related to this section

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**[45], **Healthy People, 2020**[46], **National Stakeholder Strategy for Achieving Health Equity**[47], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health 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)[48].

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."[49]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[50]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[51]. 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, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health 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.

[45] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[46] **http://www.healthypeople.gov/2020/default.aspx**

[47] **http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf**

[48] **http://www.thinkculturalhealth.hhs.gov**

[49] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[50] **http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208**

[51] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

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, LGBT, 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 behavioral health 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) standard? Yes No

6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? Yes No

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

Please indicate areas of technical assistance needed related to this section

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, (V = Q ? C)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health 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 behavioral health 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. NREPP 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. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

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[52], The New Freedom Commission on Mental Health[53], the IOM[54], and the NQF[55]. 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."[56] 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 behavioral health 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)**[57] are best practice guidelines for the SUD treatment. The CSAT 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)**[58] was developed to help move the latest information available on effective behavioral health 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 behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

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[52] 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

[53] 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.

[54] 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.

[55] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[56] **http://psychiatryonline.org/**

[57] **http://store.samhsa.gov**

[58] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ○ Yes ○ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☐ Leadership support, including investment of human and financial resources.
- **b)** ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☐ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☐ Provider involvement in planning value-based purchasing.
- **e)** ☐ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☐ Quality measures focus on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

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.

Footnotes:

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds,the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? ○ Yes ○ No

2. Are there any concretely planned initiatives in our state specific to self-direction? ○ Yes ○ No

If yes, describe the currently planned initiatives. In particular, please answer the following questions:

a) How is this initiative financed:

b) What are the eligibility criteria?

c) How are budgets set, and what is the scope of the budget?

d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

e) What, if any, research and evaluation activities are connected to the initiative?

f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

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

Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

7. 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 behavioral health 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 behavioral health 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 behavioral health 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 programs requirements, including quality and safety standard? (●) Yes ( ) No

Does the state have any activites related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section

Footnotes:

Please see the NC DMHDDSAS System Integrity Plan SFY18 in the attachments section.

Unapproved Draft 08/07/17
NC MH/DD/SAS QM - JBowman

North Carolina Department of Health and Human Services

Service System Integrity Plan SFY: 2017-2018

for

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Revised
August 2017

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Mission

It is the mission of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) programs to, ***provide people with, or at risk of, mental illness, developmental disabilities, and substance use problems and their families the necessary prevention, intervention, treatment services and supports they need to live successfully in communities of their choice.***

Plan Purpose

It is the purpose of the Service System Integrity Plan to support compliance, proper expenditure and accountability within NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) programs by ensuring that State and Block Grant dollars are utilized appropriately, in accordance with statutory and regulatory framework, and in support of programmatic goals.

Plan Guiding Principles

This Service System Integrity Plan will promote the following principles:

1. Promote a cost efficient and effective behavioral health care system.
2. Ensure adherence to statutory and regulatory standards and practices.
3. Develop and monitor communication methods, training and technical assistance regarding service system integrity.
4. Support appropriate strategies and approaches to carrying out effective Service System Integrity efforts.
5. Proactively recognize areas of risk that may adversely affect Service System Integrity and proactively address vulnerabilities.
6. Fair and reasonable enforcement of system integrity monitoring. Failure to comply with system integrity efforts may result in technical assistance, plans of correction or other actions.

Responsible Staff

Policy and Audit Team - responsible for coordination of System Integrity Plan activities: program monitoring of LME-MCOs for compliance with State and Federal Grant rules and regulations; development of the DMH/DD/SAS subrecipient monitoring plan and oversight of its implementation.

Block Grant Coordinators - responsible for keeping abreast of Block Grant regulations and requirements, communication with DHHS staff and LME-MCOs and coordination of planning goals and strategies relevant to the Block Grant within DMH/DD/SAS.

Chief of Addictions and Management Operations - responsible for programmatic leadership and policies regarding utilization of State and Block Grant funds.

Contract Administrators - responsible for administering the performance contract with Division contractors and monitoring compliance with the terms of the contract.

Financial Audit Team – responsible for quarterly financial monitoring/auditing LME/MCO use of block grant funding for compliance with State and Federal Block Grant rules and regulations regarding funding. Conduct annual State and Federal Non-UCR Settlement, performing routine audits of financial status reports submitted by non-profits; representation on the Center of Excellence contract review committee. Represent Division on IMT and EQRs with the LME/MCO's.

Budget and Finance Section - responsible for budget management of State and Block Grant funds.

LME Performance Team - responsible for administering the performance contract with LME-MCOs and monitoring LME-MCO compliance with the terms of the contract.

Program Managers - responsible for monitoring specific programs and initiatives; ensuring compliance with project objectives and funding requirements.

Quality Management Section - responsible for developing and monitoring performance measures and communicating areas of concern to designated teams and management.

State Services Committee - responsible for ensuring the Service System Integrity Plan for State and Block Grant funds is carried out; ensuring State and Block Grant funds are used in compliance with state and federal requirements and policies.

Plan

1. Budget Review

a) The NC DMH/DD/SAS contracts with the LME-MCOs to administer and oversee State funds and Federal Block Grant funds for the provision of prevention and treatment services for mental health and substance use disorders and services and supports for persons with intellectual/developmental disabilities.

i) NC DMH/DD/SAS allocates State and Block Grant funds to LME-MCOs annually. The Budget and Finance Section sends annual Continuation Allocation letters to the LME-MCOs and tracks all revisions to the initial continuation allocation through subsequent allocation letters.

ii) Federal Block grant funds are awarded by federal fiscal year and tracked by cost centers specific to the award year. The accounts are also separate for Unit Cost Reimbursement (UCR) and expenditure-based (Non-UCR) subcontracting. The Budget and Finance Section ensures that Block Grant funds allocated to LME-MCOs are in accordance with the approved block grant plan), and revises LME-MCO allocations to reflect changes in Federal allocations as necessary based on utilization and changes in availability. LME-MCOs may request a realignment of Federal funds from one account to another; the LME-MCO must make a request in writing and justify the request. These realignments are reviewed by the Budget and Finance Section in coordination with program staff, and when necessary, by the State Services Committee for compliance with funding regulations and Block Grant Plan goals, by the Budget and Finance Section for fund availability, by the DHHS Budget and Analysis Office and approved by the Office of State Budget and Management.

iii) State service funds are allocated to the LME-MCOs once state General Assembly approves an annual budget, and these allocation are communicated to the LME-MCOs via the continuation allocation letter and subsequent allocation letters. The majority of these state funds are allocated into the single stream funds account, however, there are additional specific accounts for funds whose expenditures are subject to specific reporting requirements. These funds are deemed “special categorical” funds. Single stream funds are allocated as non-UCR funds, but LME-MCOs are required to submit claims for services rendered and the value of these claims will be considered in settlement of the single stream funding account. Since the single stream funds are flexible in nature, LME-MCOs do not have to request a realignment of these funds, however for special categorical funds any request to change their designation has to be requested in writing and be considered by the Division.

b) Direct contracts that utilize State and/or Block Grant funds are managed by Program Managers in the program sections of NC DMH/DD/SAS. The Program Managers ensure that the subcontractors fulfill requirements of the Federal government and the approved application for Federal funds. These contracts are reimbursed on an expenditure basis within a contract maximum and are monitored by the Contract Administrators according to Subrecipient Monitoring procedures. The Budget and Finance Section tracks the subrecipient monitoring that is completed by program managers to assure compliance with the requirements and cost principles of the Federal Office of Management and Budget and

the requirements set within the contracts (2 CFR Part 200 - Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards). The Financial Audit Team reports and follows up on the findings as required to the DHHS Office of Internal Auditors, the Controller's office and the State Auditor

c) The Budget and Finance Section manages the administrative portion of State and Federal Block Grant funds through specific cost centers in the State budget for NC DMH/DD/SAS. The annual Cost Allocation Plan determines which administrative expenses are allocated to Federal grants. Budget and Finance works with the responsible staff members to ensure that the correct methodology is utilized. Budget and Finance staff ensures that expenditures are restricted to budgetary limits as allowable under the block grant plan throughout the fiscal year.

2. ***Claims Payment and Adjudication***

a) Claims for Block Grant and State funded UCR services are adjudicated locally by the LME-MCO. The LME-MCO then submits these claims to the State's claims vendor for secondary adjudication for reimbursement. The LME-MCOs have a choice of paying the service provider based on their local adjudication or waiting until the State level adjudication occurs. LME-MCOs have adjudication audits/edits in place to ensure at a minimum, that the provider has a valid contract, the service is not duplicated, the fields contain valid values, the service was authorized by the LME-MCO and the rate is at or below the contract maximum for that service. LME-MCOs also have systems to check that both the consumer and provider are eligible to receive funding for services.

b) The State claims system adjudication includes similar edits that are determined by the State Services Committee. The State claims vendor also adjudicates for diagnostic match with the Benefit Plan eligibility, as well as compliance with other service definition requirements, such as same day exclusions for certain procedure codes. The LME-MCO must also designate in the State's claims adjudication system which of their subcontractors are eligible to earn Federal Block Grant funds.

c) Budget Criteria are established annually by the State Services Committee and published on the NC DMH/DD/SAS website, which designate the criteria for payment from each Federal Block Grant account. For example, certain accounts are limited to specific clinical Benefit Plans and procedure codes. Benefit Plans are specific to Block Grant funding categories, such as "Injecting Drug User/Communicable Disease Risk" and "Adult Substance Abuse Women". Services that meet the Budget Criteria, but are adjudicated after the LME-MCO has pulled down their Federal allocation, count toward justification for the State funds allocation.

Periodically, a transfer or adjustment between accounts or grant award periods may occur after the claim was first adjudicated. LME-MCOs also have the capacity to correct errors on a paid claim.

3. ***Expenditure Analysis***

a) Non-UCR Block Grant and State funds are managed by the LME-MCOs. They subcontract with providers who carry out the Block Grant treatment and prevention goals required by the Federal government and specified in the approved NC Block Grant Assessment and Plan, along with services funded by the NC General Assembly according

to policies set by NC DMH/DD/SAS. Each LME-MCO is responsible for monitoring Non-UCR Block Grant expenditures throughout the fiscal year, both fiscally and programmatically. The State Services Committee, reviews the NonUCR Expenditure Overview report, which summarizes expenditures by LME-MCO and Account, periodically for overall and LME-MCO specific earnings year-to-date relative to budgets. Budget and Finance also tracks these expenditures regularly for utilization review.

b) UCR Block Grant expenditures are monitored periodically by the NC DMH/DD/SAS State Services Committee. The committee reviews a summary report which shows YTD expenditures by Block Grant UCR account. This report displays the earnings relative to the budget for each LME-MCO and for each account as a whole. The Committee identifies earnings issues and recommends transfers of funds as appropriate. Each LME-MCO is expected to monitor Block Grant earnings on at least a monthly basis and take remedial actions at the local level to ensure funds are drawn down appropriately throughout the fiscal year.

4. Compliance Reviews

a) Monitoring of State and Federally-Funded Programs. Program monitoring and record reviews are conducted annually by the Policy and Audit Team which has the lead role in the Division for the standardization of monitoring of the LME-MCOs' compliance with the requirements of designated state and federaly-funded programs. During SFY2017, the annual systems review of the LME-MCOs included the Substance Abuse Prevention and Treatment Block Grant, the Community Mental Health Services Block Grant and the System of Care Expansion Grant. The monitoring tools are posted on the NC DMH/DD/SAS website and are specific to the special program requirements (e.g., Prevention, Women's Set-Aside, IV Drug Users, First Episode Psychosis, High Fidelity Wraparound, etc.). The Block Grant Steering Committee selects a sample of providers and individuals whose services were reimbursed with Federal Block Grant funds from claims reimbursed with Federal Block Grant funds.

b) In accordance with the NC DMH/DD/SAS Policy and Procedure for the Review, Approval and Follow-Up of Plan(s) of Correction, if systemic compliance issues are found, a plan of correction is required. Any contractor must submit a plan of correction within 15 days from receipt of their monitoring report to submit the plan of correction, which is reviewed by the subject matter experts within the NC DMH/DD/SAS. Additionally, within 60 days after the approval of the plan of correction, the Policy and AuditTeam coordinates across the Division from issuance to point of resolution for non-compliant findings from LME-MCOs or non-profit entities with which DMH/SS/SAS contracts.

c) Semi-Annual Compliance Reports are submitted by each LME-MCO to the Block Grant Coordinator within the CPM Section. These Compliance Reports serve as a mechanism to ensure that the LME-MCOs are adhering to the broad categorical requirements of the Substance Abuse Prevention and Treatment Block Grant; i.e., assuring priority admission for specific populations, providing outreach services for certain populations, as well as reporting specific prevention activities. These reports are reviewed by the Block Grant Coordinator and program managers for accuracy and content and feedback is provided to the LME-MCOs by the Block Grant Coordinator.

d) Independent Peer Reviews (IPR) are conducted annually by a third party under contract with the DMH/DD/SAS for the treatment component of both the Substance Abuse and

Mental Health Block Grants. The purpose of IPR is to assess the quality, appropriateness and efficacy of treatment services funded with block grant monies, and to ensure that at least five percent of contracted block grant providers are reviewed. Specific services are selected each fiscal year for review, with the goal of ensuring a representative sample of providers, across all regions of the state that work with a diversity of consumers in a variety of settings. The following criteria are considered in the selection process: (1) total amount of UCR funds paid during the fiscal year; (2) location/region; (3) treatment program modality and size/census; (4) service areas/facility licensure type; (5) availability for review; (6) accreditation status. Reviewers are volunteers, selected based on clinical experience and expertise in the service area being reviewed, appropriate certifications/licensure, cultural sensitivity, interest in the process and completion of the IPR training. Reviewers complete and submit individual reports to DMH/DD/SAS, as well as to the agencies reviewed. In addition, feedback surveys are completed by the reviewers, as well as the participating sites.

5. ***Utilization/Performance Analysis***

a) The Quality Management Section tracks and monitors LME-MCO system performance through a set of contractual indicators and service utilization measures. . Measures are selected to support priorities of the DMH/DD/SAS and, where possible, are based on nationally recognized behavioral health measures. Performance standards are set annually based on the previous year's state average to encourage incremental improvements. When an LME-MCO is found to be performing below standards on performance measures, the LME-MCO Monitoring and Technical Assistance Procedure is followed to improve the performance of the LME-MCO. The LME Performance Team also uses the monthly NC DHHS LME-MCO Performance Summary Report to review with the LME-MCOs their performance standards that do not meet the expected measures. The LME Performance Team member indicates a plan of action needed on the subrecipient monitoring tool and follow-up as needed.

b) The Clinical Quality Committee reviews identified outliers and significant service trends, contingent on the availability of data, to determine if there is concern that service delivery might be out of compliance with the service definition, rules or statutes. Where appropriate, these outliers, trends or compliance concerns will be monitored according to the Targeted Services Monitoring Procedure by the–Policy and Audit Team, once approved and implemented.

c) In cases where the utilization of Federal Block Grant funds is determined to be out of compliance and a payback required, the Budget and Finance Section ensures that those funds are utilized within the period of availability for that block grant award. If the availability period for the returned funds has ended, the DHHS Controllers Office refunds the funds to the Federal government.

6. ***Financial and Year-End Activities***

a) Each LME-MCO's state and block grant non-UCR funds are financially monitored quarterly and settled annually by Business Officers on the Financial Audit Team (see procedures Preparation of Tentative Settlement Report and LME-MCO Settlement Guidelines). These procedures review expenses related to the LME-MCO service delivery to ensure that they

are allowable under state and federal guidelines and are supported with the appropriate documentation. If the LME-MCO has disallowed costs and a payback is required, funds that are received are processed by the Budget and Finance Section according to State policy. Based on findings from the quarterly fiscal monitoring or annual settlement an LME-MCO may be required to enter into a Plan of Correction (POC) to remediate systemic or material findings (please see NC DMH/DD/SAS Policy for the Review, Approval and Follow-Up of Plan(s) of Correction. LME-MCOs have 15 days from receipt of their monitoring report to submit the plan of correction, which is reviewed by the subject matter experts within the NC DMH/DD/SAS.

b) The Office of the State Auditor audits the NC DMH/DD/SAS' monitoring procedures for the Federal Block Grants on an annual basis for compliance with federal regulations. The Financial Audit Team and Budget and Finance Section respond with a plan of correction to any findings and recommendations issued by the State Auditor.

7. ***Disbursement of Funds***

a) NC DMH/DD/SAS checks that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered. This is accomplished in two ways. For Non-UCR (expenditure based allocations) the LME-MCOs are responsible for local management of the funds. The LME-MCO designates a staff person to oversee the Federal CMHBG and SAPTBG funds, who oversees program development, budgets, contracts and reimbursement. The Non-UCR Settlement process conducted by the Financial Audit Team checks that Federal cost principles and regulations are followed. The state has established state wide default rates for most services, and rates that are substantially higher than other established rates for that service are reviewed and approved/denied by the Budget and Finance Section in consultation with Program Managers.

8. ***Promotion of Compliance Practices***

a) NC DMH/DD/SAS assists providers in adopting practices that promote compliance with program requirements, including quality and safety standards through a combination of means including contractual requirements, training, monitoring and independent peer review (as noted in number 4 above). The Compliance Reviews by the Policy Team include plans of correction that address exceptions with the required program elements. Included are elements that relate to consumer safety, such as TB testing and HIV/Early Intervention services. Each LME-MCO has staff designated as the Substance Abuse Point of Contact for their agency. Monthly conference calls are conducted by the Program Managers with the SA Points of Contact to provide technical assistance, updates and trainings on specific or requested topics. Compliance checks are also conducted by staff. For example, Prevention and Early Intervention team staff conduct site visits to review for fidelity to best practices for Project T&D and All Stars. CPM staff also provide training at conferences such as the Summer and Winter Schools for Alcohol and Drug Studies.

9. ***Utilization of Funds Related to Federal Requirements***

a) NC DMH/DD/SAS monitors that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid through an integrated claims adjudication system. This system (NCTracks)

regularly scans for claims where Medicaid eligibility applies and re-adjudicates and reverses payments made with Block Grant funds. The state monitors to ensure that LME-MCOs include State/Block Grant services in their Coordination of Benefit (COB) Policies and Procedures and are sampling State/Block Grant services when they monitor Providers. This will occur as a part of the quarterly fiscal monitoring and annual settlement. The quarterly fiscal monitoring review (conducted by the Financial Audit Team) serves the purpose of observing and understanding the LME-MCO's spending patterns, while ensuring that funds are expended accordingly; all while providing technical assistance. And the annual settlement ensures compliance of the following:

i. Compliance with the requirements of the DMHDDSAS contract;
ii. G.S. 159 (Fiscal Control Act)
iii. The LME-MCOs compliance with G.S. 122C
iv. 2 CFR Part 200 – Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards
v. Compliance with requirements and restrictions of the SAPTBG, CMHSBG, SSBG, CASP dollars and their accompanying state MOE requirements, the PATH Program federal formula grant, SPF-SIG, SDFSCA, and other federally funded or designated projects.
vi. Compliance with all state and federal laws and regulations.

b) NC DMH/DD/SAS fund those priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery. The LME-MCOs adopt and publish the benefit plan for target population consumers that define the services that individuals in each target population may expect to receive. The benefit plan shall be flexible to maximize the services and promote the expected outcomes that consumers may receive while ensuring the LME-MCO delivers services within available funding shall ensure that non-Medicaid funds are utilized for DMHDDSAS specified priority populations. The priority population areas are as follows:

i. Individuals who are at risk of harming self or others
ii. High Risk individuals (for adults with over three (3) crisis and/or inpatient events in the past 12 months, or for children and adolescents with over two (2) crisis and/or inpatient events in the past 12 months)
iii. Individuals with a Mental Illness or Substance Use Disorders who are transitioning from an inpatient, facility-based crisis, detoxification or withdrawal management service, or residential care service setting to the community
iv. Youth and young adults (ages 16 to 25) who experience a first episode psychosis
v. Individuals with Severe and Persistent Mental Illness, who are not stable
vi. Individuals with Co-occurring MI/SU or MI/DD
vii. Individuals who are Homeless or At Risk of Homelessness
viii. Individuals with Traumatic Brain Injury (TBI)
ix. Individuals who are Criminal or Juvenile Justice System involved
x. Individuals who are Deaf or Hard of Hearing
xi. Veterans, military service members and their families
xii. Individuals with complex medical disorders
xiii. Individuals with Department of Justice (DOJ) settlement agreement involvement

xiv. Department of Social Services (DSS) involved adults
xv. Individuals assessed with an American Society of Addiction Medicine (ASAM) level indicating the need for Residential or Inpatient level (Level 3.1 to 4.0) including detoxification or Withdrawal
xvi. Management (Level 3.2TWM to 4.0 WM)
xvii. Individuals who inject drugs
xviii. Pregnant women who use alcohol and/or other drugs
xix. Individuals with Communicable Disease Risk/HIV
xx. Children and adolescents with a mental health disorder and who are living with an adult with a MI or SUD
xxi. Individuals with I/DD who are at risk of abuse, neglect or exploitation
xxii. Individuals with I/DD who are transitioning from institutions and residential placements
xxiii. Individuals with I/DD who are transitional age youth who are moving from school to employment and/or other community involvement
xxiv. DSS involved adults include individuals receiving Work First cash assistance, individuals who are involved with Child Protective Services or individuals who have been convicted of a Class H or I controlled substance felony in NC and who are applicants for or recipients of Food Stamps.

LME-MCOs are responsible for both ensuring continuity of care for individuals in service, and availability of services throughout the year for priority population consumers and applicants for services. Changes to the LME-MCO Benefit Plan shall be submitted to the Division 30 days prior to publication for Division's State Services committee approval.

c) NC DMH/DD/SAS provides SABG funds for primary prevention: universal, selective, and indicated prevention activities and services for persons not identified as needing treatment. The LME-MCOs provide leadership, technical assistance, and participation in community wide prevention and early intervention strategies, coalitions and other initiatives to discourage inappropriate access, misuse, and abuse of legal and illegal substances (alcohol, tobacco, and other drugs) by minors and adults and to improve the emotional health and well-being of individuals in their catchment area. NC DMH/DD/SAS provides MHBG funds for authorized services made available to adults with SMI and children with SED.
d) Block grant funds will not be used for individual co-pays, deductibles and other types of co-insurance for behavioral health services, per 42 U.S.C. §§ 300x–5 and 300x-31. This includes 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).
e) NC DMH/DD/SAS collects, analyzes and reports performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services and to plan the implementation of new services. The North Carolina - Treatment Outcomes and Program Performance System (NC-TOPPS) is a web based program by which DMH/DD/SAS measures the quality of substance abuse and mental health services and the impact on individuals' lives. By capturing key information on an individual's service needs and life situation during a current episode of care, NC-TOPPS aids in developing meaningful

treatment plans and evaluating the impact of services on an individual's life, as well as, the effectiveness of the service system.

Environmental Factors and Plan

8. 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**[59] 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.

[59] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

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?

Does the state have any activites related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

9. 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:

- ***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;
- ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- ***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;
- ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- ***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

- [x] Data on consequences of substance using behaviors
- [x] Substance-using behaviors
- [x] Intervening variables (including risk and protective factors)
- [ ] Others (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- [x] Children (under age 12)
- [x] Youth (ages 12-17)
- [ ] Young adults/college age (ages 18-26)
- [ ] Adults (ages 27-54)
- [ ] Older adults (age 55 and above)
- [ ] Cultural/ethnic minorities
- [ ] Sexual/gender minorities
- [x] Rural communities
- [ ] Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- [x] Archival indicators (Please list)

Archival indicators: The Division has developed a data dashboard, NCSupport, which includes a large array of archival indicators, including those that address alcohol and other drug related consequences, problems indirectly associated with substance use, other related consequences, alcohol availability (tobacco and prescription drug availability coming in FY2018), community crime & violence, academic risk, community stability, family dynamics, poverty/increased risk for socioeconomic deprivation, and other contextual variables.
State developed survey is based primarily on PRIDE survey data and Communities That Care.

- [x] National survey on Drug Use and Health (NSDUH)
- [ ] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [ ] Monitoring the Future
- [ ] Communities that Care
- [x] State - developed survey instrument
- [ ] Others (please list)

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

If yes, (please explain)

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

Since FY2014 SABG primary prevention funds have been allocated on a per capita basis.

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

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- ***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;
- ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
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- ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- ***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

The North Carolina Substance Use Professional Practice Board credentials prevention providers as prevention specialists.
Credentialing registration requires:
• Documentation of high school graduation, completion of GED, Baccalaureate or advanced degree (Use transcripts as documentation as appropriate)
• Supervision agreement with proposed supervision process by either a CCS, CS Intern, or CSAPC with three years experience
• Agreement to adhere to the Ethical Principles of Conduct of the Board
• Completion of 3 clock hours of ethics training
• Resume and Job Description
• Registration Fee of $125.00 (non-refundable) made payable to NCSAPPB
• Completion of SBI/SBI background check to include $38.00 (non-refundable) fee to NCSAPPB.
Full certification requires:
• A minimum of 300 board approved practicum hours documented by a CCS, CSI, or CSAPC with three years of experience
• Three (3) years full-time experience in the field or two (2) years if applicant has a bachelor's degree or higher in a human services field, documented and supervised by a CCS, CSI, or CSAPC with three years experience
• Two evaluations from colleagues/co-workers
• 270 hours of board approved academic/didactic training divided in the following manner: 170 hours in the area of primary prevention; and 100 hours in substance abuse specific material which includes 6 hours in HIV/AIDS training and 3 hours in professional prevention ethics training; and all hours must be in the current Performance Domains as defined by the IC&RC
• $125 Examination Fee
• Successful completion of IC&RC PS examination

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

The North Carolina Training and Technical Assistance Center providing trainings and webinars on foundational prevention strategies, including the Strategic Prevention Framework, youth and family prevention education, building community capacity, and environmental strategies, as well as topics of provider interest, such as working with law enforcement and building community capacity by training and supporting community partners in prevention. Technical assistance is provided proactively to all interested providers following core trainings and for other topics based upon provider interest and self-initiation.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

If yes, please describe mechanism used

The Division requires providers to assess community readiness to address high magnitude intervening variables as a part of the needs assessment process. To do so, they assess the communities resources, staff time, appropriate skills and training to address the intervening variable, as well as the community buy in to help plan, implement and evaluate suggested strategies.

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

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

Plan attached.
Note: We are planning to update our strategic substance use prevention plan in FY2018. Throughout FY17 we worked to develop data resources for our prevention providers, including the development of a data dashboard, NC Support and administration of a youth prevention survey, which will be used by providers for local assessment, as well as to inform our new strategic 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 Division utilizes the NC Practice Improvement Collaborative (PIC) to determine which programs, policies, and strategies are

evidence-based, through a rigorous review process which includes peer reviewed literature, public presentations on each strategy reviewed by the program developer, and evaluation of the evidence by a panel of experts.

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.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☑ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☐ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☐ The SSA funds regional entities to provide prevention services.
- **f)** ☐ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☐ The SSA funds community coalitions to provide prevention services.
- **h)** ☐ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Information Dissemination:
Red Ribbon Week
Parent 360/Parent 360Rx
Generation Rx
Community Resource Directories
Community Presentations/Speaking Engagements
Sticker Shock
Newsletters
Health Fairs

b) Education:

Prevention Education:
Active Parenting
Active Parenting of Teens

Aggression Replacement Training
All Stars
All Stars Junior
Celebrating Families
Children in the Middle
Dare To Be You
Early Risers, Skills for Success
Good Touch, Bad Touch
Hip Hop to Prevent SA/HIV
I Can Problem Solve
I'm Special/Unique You
Keepin' It Real
Life Skills Training (LST)
Media Detective
Media Ready
Nurturing Parent Programs
Parenting Wisely
Positive Action
Prime For Life
Project Alert
Project SUCCESS
Project Towards No Drug Abuse
Project Venture
Reconnecting Youth
Staying Connected With Your Teen
Storytelling for Empowerment
Strengthening Families, 10-14
Strengthening Families, 6-11
Systematic Training for Effective Parenting (STEP)
Teen Intervene
Too Good for Drugs
Clean 68 (Class of 1989 tobacco prevention program)
SADD Clubs

c) Alternatives:

Alternative Activities:
Lead & Seed
Youth advocacy
Summer camps for selective/indicated youth
Recreation Activities
Mentoring
Project Graduation
Prom Promise

d) Problem Identification and Referral:

Problem ID & Referral:
Gain Screening
Teen Court
Aspire Tobacco Education curriculum

e) Community-Based Processes:

Community-Based Process:
Needs Assessment
Strategic Planning
Law Enforcement Task Force
Impacted training
Community-Building
Coalitions

f) Environmental:

Environmental Strategies:
Red Flag Tobacco Merchant Education
Be A Responsible (Alcohol) Server
Alcohol Purchase Surveys
Tobacco Purchase Surveys
Retail Scans

School policy review
Pledges (safe homes, student pledges, etc. small p policy),
Talk it Up, Lock It Up
Social Norms Communication Campaigns
Communities Mobilizing For Change on Alcohol
Environmental Influencer training and TA
PDMP (CSRS) utilization
Safer Prescriber Training
Lock Your Meds Campaign
Medication Take Back Events
Prescription Medication Permanent Lockboxes
Home Medication Lockbox dispersment policies

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

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.

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

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):

Lifetime use
Availability
Easy Retail and Social Access
Permissive family and social norms
Risk of Consequences

Footnotes:

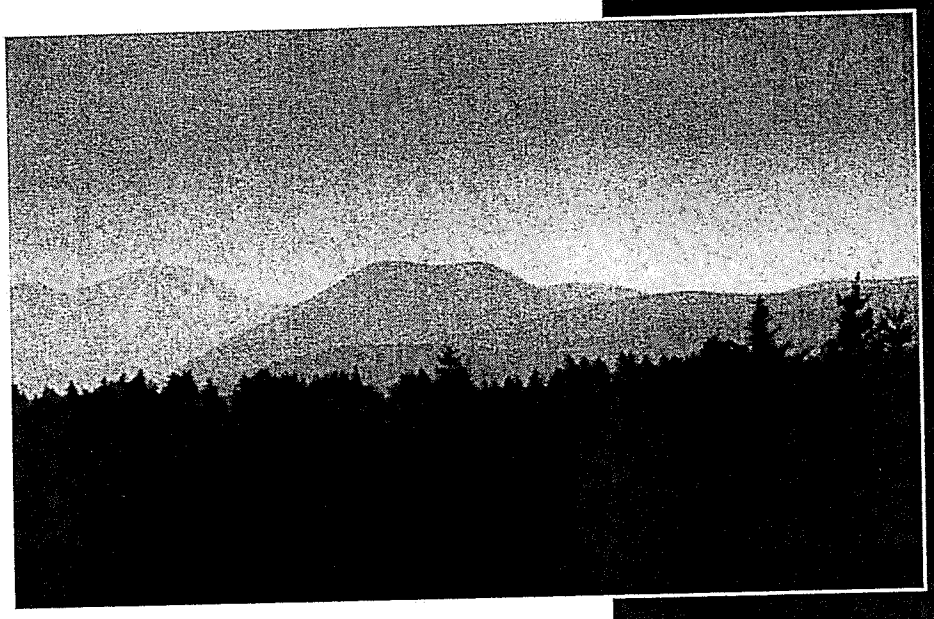
Evaluation Section, #2 -- The Division is newly contracting for evaluation in FY2018, as such there is no current evaluation plan, but there is a plan to develop an evaluation plan.

Review by
Center for Substance
Abuse Prevention

2012

North Carolina's Comprehensive 5 Year Prevention Plan:

Focusing on Substance Abuse and Mental Health Promotion



Strategic Prevention Framework-State
Prevention Enhancement (SPF-SPE)
Cooperative Agreement
Grant #1U79SPO18623-01

November 5, 2012

Submitted to:
Substance Abuse Mental Health Services Administration Center for Substance Abuse Prevention;
NC Cooperative Agreement Advisory Board; LME/MCO SA Point of Contacts; and
SSA Community Policy Management Section, Division of Mental Health/Developmental
Disabilities/Substance Abuse Services , Department of Health and Human Services

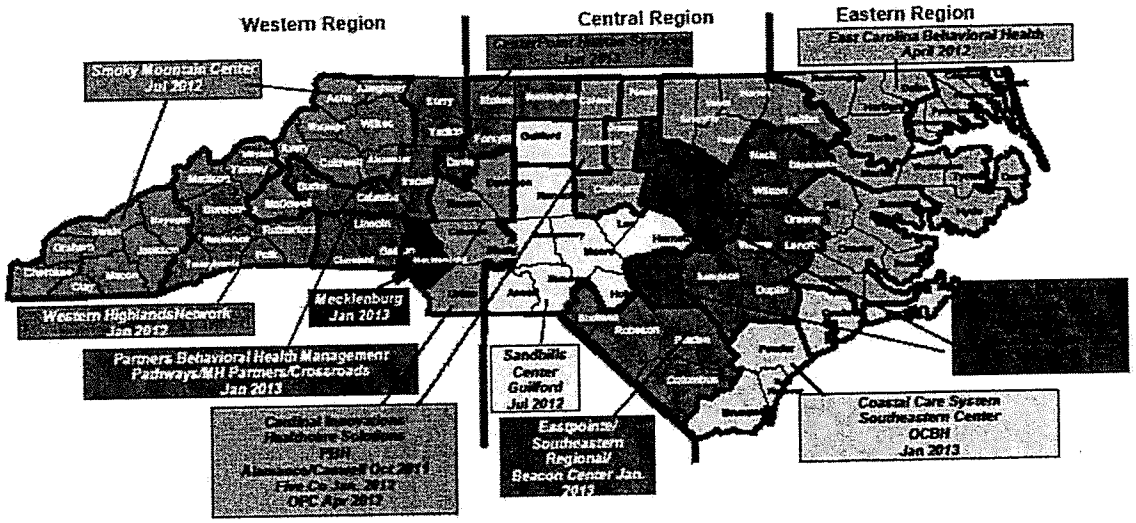
TABLE OF CONTENTS

I. INTRODUCTION

The management of the substance abuse prevention state-wide system is housed in the Department of Health and Human Services, Division of Mental Health, Development Disabilities and Substance Abuse Services (DMHDDSAS), coordinated by professionals in the Office of Prevention, in the Community Policy Management Section. The National Prevention Network (NPN) representative is the Director of the office focusing on the goal to promote substance abuse prevention statewide by developing and sustaining a system and infrastructure for delivery of evidence-based/practice informed strategies—programs, practices, policies. These strategies are based on prevention needs identified by appropriate, culturally relevant, information and data systems. Prevention strategies are delivered through a risk and protective factor framework utilizing the Institute of Medicine's (IOM) Continuum of Care to individual, families and communities.

The Office of Prevention has adopted the definition of substance abuse prevention as a "proactive process and activities aimed at educating, supporting, and empowering individuals, families, communities and systems to effectively meet life challenges and transition by creating and sustaining health, safety, and well-being, free from substance use by youth, and free from substance abuse by individuals across the life span." The planning and delivery of substance abuse services is based on a Logic Model that associates consumption and consequences of substance use—factors related to and influence of the occurrence and magnitude of substance use and related risk behaviors and their consequences. The Office of Prevention works with its Local Management Entities/Managed Care Organizations (LME/MCOs) that serve as county level intermediaries responsible for the implementation of prevention resource development and fiscal allocation to local providers **(Figure 1)**. The LME/MCOs impose guidelines for

Figure 1: Local Management Entities (LMEs)/Managed Care Organizations (MCOs) and their member counties as of July 1, 2012.

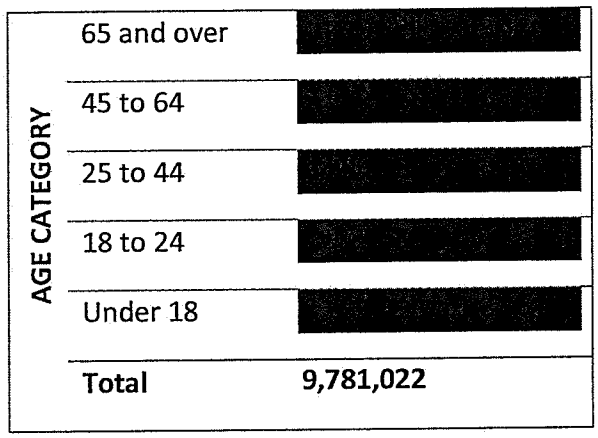


prevention services and executes contracts with local substance abuse prevention providers (sub-recipient communities) based upon guidance from the requirements set aside by the Substance Abuse Prevention Treatment Block Grant Block Grant (SAPTBG) and state-level performance outcomes.

North Carolina stretches five hundred sixty miles long and one hundred and fifty miles wide. The state is bordered by Virginia on the north, by South Carolina and Georgia on the south, Tennessee on the west, and the Atlantic Ocean in the east. Topographically, it can be divided into three sections: the Appalachian Mountains and foothills, the Middle or Piedmont Plateau, and the Coastal Plain in the east. North Carolina shares a colonial past, a history of sectional conflicts, and an agrarian economy with the thirteen states that constitute the American South. The greater presence of prestigious academic institutions, including historically black colleges and universities, research and technology parks, pharmaceutical centers, and banking industries make it distinct from the rest of the South. The influx of migrants, drawn by the area's economic development in the more recent past, has added to the diversity of the State's population that includes eight American Indian tribes. Northwestern areas of the State tend to be more homogenous with values and attitudes associated with the Appalachian culture.

North Carolina's total population is 9.7 million people. **Table 1** below shows the demographic characteristics of North Carolina.

Table 1: The Age Distribution of People in North Carolina in 2012



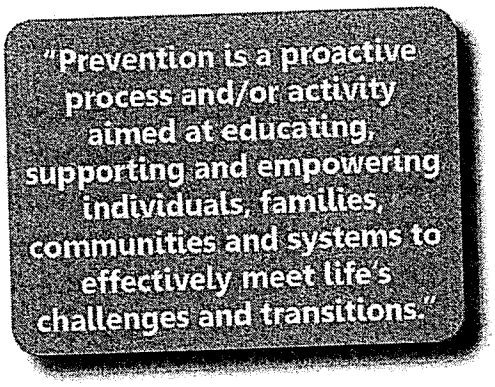
Source: NC OSBM Website-downloaded 8/22/2012

The North Carolina Institute of Medicine (NCIOM) www.nciom.org was commissioned by the General Assembly, to review the substance abuse service system and developed a prevention plan for the state (2009). The Task Force found alcohol and drug use to be the fifth condition leading to Greatest Disability Adjusted Life Years (DALYS) in North Carolina. The Task Force recommended that "the Division of Mental Health, Developmental Disabilities, and Substance

Abuse Services develop a comprehensive substance abuse prevention plan for use at the state and local levels prioritizing efforts to reach children, adolescents, young adults, and their parents".

Funding from the Substance Abuse Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP) Strategic Prevention Framework-State Prevention Enhancement (SPF-SPE) Cooperative Agreement has allowed this plan to be developed for North Carolina with its partners. The Plan entails a comprehensive approach to addressing substance abuse prevention and mental health promotion in the state.

II. FOUNDATION, HISTORY AND GUIDING PRINCIPLES



On the Federal level, prevention of substance abuse and mental illness is the Substance Abuse Mental Health Services Administration's (SAMHSA) Strategic Initiative #1. This initiative aims to create communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. The North Carolina Office of Prevention has worked to uphold a similar paradigm to orchestrate a prevention system that responds to the needs of the communities representing diverse populations and varied cultural norms. In order to support a plan reflective of these needs, there must be an agreed upon definition of prevention.

What is Prevention?

Stakeholders have agreed that prevention is defined as a proactive process and/or activity aimed at educating, supporting and empowering individuals, families, communities and systems to effectively meet life's challenges and transitions by creating and sustaining healthy and safe behaviors. The distinctions between the various types of prevention interventions are based on the population addressed and the probability that the population addressed will experience the potential problem. Three types of targets for prevention efforts are:

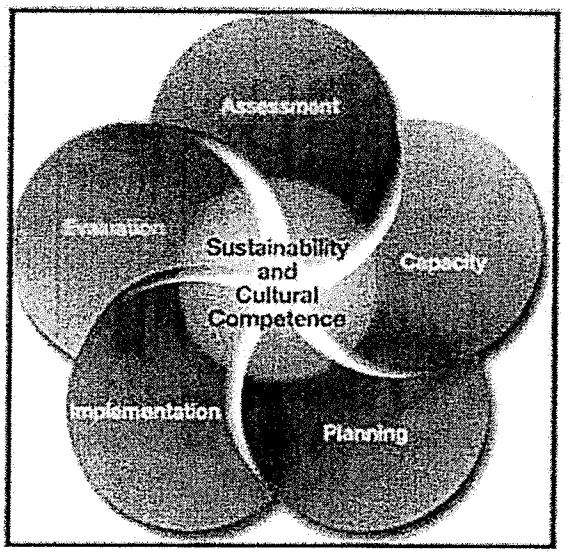
- *Universal:* is targeted at the general public or a whole population group that has not been identified on the basis of individual risk. The intervention is desirable for everyone in the group.
- *Selective:* is targeted at a subgroup of the population whose risk of needing MH/DD/SA services is significantly higher than average. The risk may be imminent or lifetime and may be identified on the basis of psychological, biological, social or environmental risk factors.
- *Indicated:* is targeted at individuals or groups of individuals with detectable signs or symptoms of a problem, therefore identified as high risk, but who do not meet diagnostic levels or who are not having problems due to a diagnosis at the current time.

Used in this context, the overall aim of prevention is preventing the occurrence, delaying the onset of conditions or associated problems, reducing the occurrence of the condition, reducing the duration of the disorder, or halting the progression of severity so individuals do not meet diagnostic levels.

Prevention Models

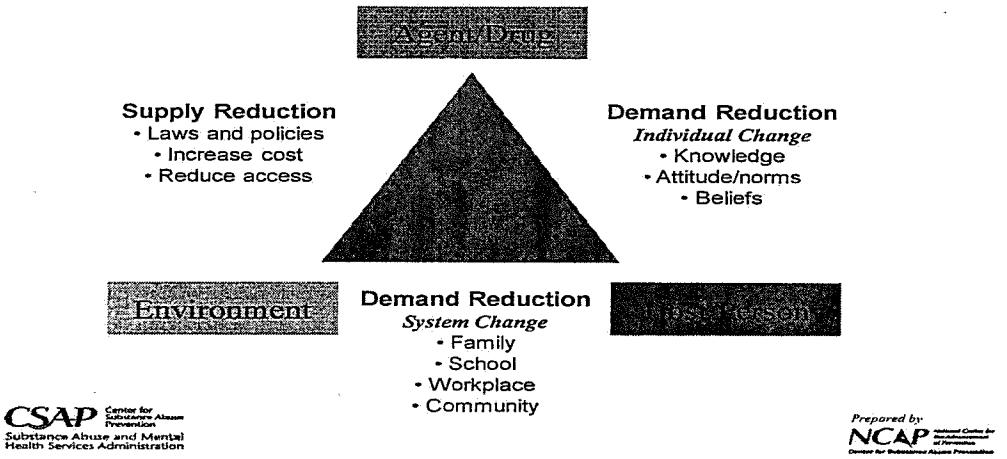
Strategic Prevention Framework. The prevention community in North Carolina, with the leadership of the state Office of Prevention, has adopted the Strategic Prevention Framework (SPF) as the fundamental foundation for all prevention efforts. This planning process helps to ensure comprehensive targeted prevention efforts are implemented across the state. The SPF creates a road map to assess needs, build capacity and develop a comprehensive strategic plan designed to sustain those healthy and safe behaviors **(Figure 2).** The SPF evaluates the process throughout implementation in order to assure effectiveness and allow for adaptations as necessary. This comprehensive method reinforces cultural responsiveness and sustainability throughout the process.

Figure 2: Strategic Prevention Framework.



Public Health Model. The SPF is a tool that, if used properly, will assure the appropriate reach and alignment of foundational prevention models and theories including the Public Health Model. The Public Health Model uses the science of epidemiology to stress that problems arise from interactions among the agent, the host and the environment. As depicted in **Figure 3** with alcohol, tobacco and drug problems, the host is the individual user; the agent is the substance (alcohol, tobacco, drug, other); and the environment is the social, cultural, and physical context in which use occurs. To demonstrate effectiveness, prevention efforts must be directed toward the integration of all three components.

Figure 3: Public Health Model.



Mental Health Approach. The most validated prevention programs emphasize supportive environments and positive reinforcement for pro-social behaviors. The approach to promoting mental health values these considerations as well as identifying "resilience" as a common theme to support positive well-being. Promotion strives to enhance supportive, school, community and family environments and to identify protective factors that enhance well-being and provide tools to avoid adverse emotions and behaviors. The mental health promotion strategy of identifying needs, building capacity, utilizing evidence-based strategies and evaluating progress and results mirrors the strategic prevention framework model.

Prevention efforts use effective programs, policies and practices to address both the needs of universal community wide populations, as well targeted at-risk populations. Comprehensive prevention increases awareness, educates individuals and communities, includes a referral system network, takes into account specific community-based needs, and addresses population level policies and norms.

NC Keys to Sustainability. The NC Keys to Sustainability model, organized around the Strategic Prevention Framework, helps the communities recognize the strengths they have and develop a plan to continue to build upon those strengths in the areas of organizational capacity, effectiveness and community support to ensure the sustainability of positive prevention outcomes.

Keys to Sustainability states a system needs to ensure adequate organizational capacity, demonstrate effectiveness and garner community support and buy in to be sustainable. Research shows that desired positive prevention outcomes will be sustained if the community prevention system values and maintains four core elements:

- a flexible response system that allows the community to respond and adapt to changing needs;
- a decision making system in place that allows them to work together as an effective problem-solving group;
- a planning model such as the strategic prevention framework; and
- the ability to effectively use limited resources.

Understanding that prevention is only effective if the positive outcomes can be sustained, the accomplishments and activities outlined in this 5 Year Substance Abuse Prevention Plan are organized around the four core elements listed above.

Why Prevention?

Substance Abuse and Mental Health Services Administration (SAMHSA-2011) reports that if effective prevention programs were implemented nationwide, substance abuse initiation would decline by 1.5 million youth. Youth who do initiate use will delay that initiation by an average of two years. For subsequent years, this would have an estimated return of:

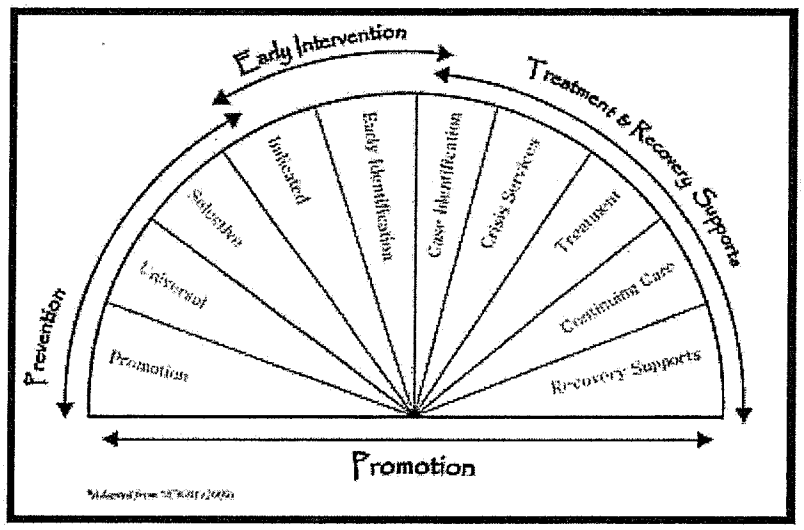
- 5.6 percent fewer youth ages 13–15 would have engaged in drinking;
- 10.2 percent fewer youth would have used marijuana;
- 30.2 percent fewer youth would have used cocaine;
- 8.0 percent fewer youth would have smoked regularly.

SAMHSA reports that these reductions in use would also contribute to a reduction in cost to our cities, counties, states, and the nation. For example, the average effective school-based substance abuse prevention program costs $220 per pupil including materials and teacher training, and these programs could save an estimated $18 per $1 invested if implemented nationwide.

The Center for Disease Control's National Prevention Strategy (2011) report states that full implementation of effective prevention programs nationwide would reduce social costs of substance-abuse-related medical care, other resources, and lost productivity over a lifetime by an estimated $33.7 billion.

Instilling healthy behaviors and practices during youth, particularly in school settings, is far more cost-effective than waiting until unhealthy behaviors are entrenched. A study of the Toward No Tobacco program, found that for every dollar invested in school tobacco prevention programs, almost $20 in future medical care costs would be saved.[2]

Figure 4: North Carolina Institute of Medicine Continuum of Care Model.



Prevention programs, policies and practices can be cost-effective, reduce health care costs, and improve productivity. Investment in prevention and wellness promotion is an essential component to the Continuum of Care **(Figure 4)**. Although the focus of this plan is on prevention and early intervention, there is a need to recognize the importance of a whole spectrum of interventions for mental health promotion and substance abuse issues from

prevention through treatment to maintenance. Prevention across the life span complements and supports treatment and recovery care efforts.

Stakeholders. The Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMHDDSAS) of the NC Department of Health and Human Services (DHHS) is responsible for setting appropriate policies and ensuring the quality of care in the DMHDDSAS system. In addition, it is accountable for the use of state and federal funds for prevention, intervention, treatment and recovery services. The DMHDDSAS serves as the Single State Authority designated by SAMHSA.

The Prevention and Early Intervention (PEI) Team is one of the three Best Practice Teams within the Community Policy Management Section of the DMHDDSAS. The PEI Team is charged with mental health promotion, developmental disabilities support services and prevention of substance abuse and mental disorders, including early intervention strategies across all ages and abilities.

The PEI Team collaborates with the Best Practice and Quality Management teams within the Community Policy Management Section. Best Practice Team members consult on innovative practices for prevention, intervention and treatment. Members of the team serve on the State Epidemiological Outcomes Workgroup (SEOW) and the Policy Consortium. The Quality Management team provides data and evaluation support to the prevention team efforts and disseminates status reports on progress toward measures to the Division and the General Assembly. The Chair of the SEOOW is a member of the Quality Management team.

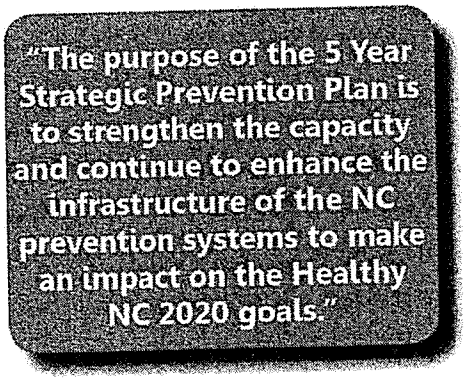
The Local Management Entity/Managed Care Organization (LME/MCO) serves as the county level managers of the prevention services funds. They contract with a network of local providers to ensure appropriate, accessible and cost efficient services are delivered. The providers input data into a statewide prevention data-base, the LME/MCO representative assures the data is provided to the state.

A number of community based partners, including agencies, professionals organizations, consumer groups, and Partnerships, Alliance, Coalitions and Collaboratives (PACCs), constitute the stakeholders for prevention services. A comprehensive prevention infrastructure should involve many partners to be effective and sustainable. The five year prevention plan includes the roles of the partners along with the systems and tools necessary to improve communications and continue collaborations among the partners.

III. GOALS AND OBJECTIVES

The overarching purpose of the DMHDDSAS is to help North Carolinians achieve optimal mental, emotional and behavioral health and well-being. The DMHDDSAS Office of Prevention works with its partner organizations to ensure the sustainability of the substance abuse prevention infrastructure across the state. Understanding that the development of consensus on the constructs, indicators, measures and outcomes for prevention is crucial to move the system forward; the 5 Year Strategic Plan provides the opportunity to outline the steps needed to build and continue to support the infrastructure necessary to ensure statewide collaborations on the local and state level. Those steps include:

- Needs Assessment:
  - a comprehensive data collection and analysis system
  - community friendly access to and culturally responsive dissemination of data
- Capacity:
  - distinct roles and responsibilities of partners essential to the sustainability of an enhanced substance abuse prevention infrastructure
  - training and technical assistance for the prevention workforce
- Strategic Plan:
  - outline for ways to enhance and build upon current training and technical assistance systems and infrastructure
  - communication system strategies vital to mass scale collaborations
  - comprehensive cultural responsiveness approach to strategy implementation
- Implementation:
  - timeline and action steps to necessary to implement strategic plan
  - process for implementation of Evidence-based strategies (programs, practices and policies)
- Evaluation:
  - process and outcome evaluation measures to monitor the effectiveness, reach and alignment of the Prevention Plan.



As a deliverable for The Strategic Prevention Framework State Enhancement Grant (SPF-SPE), North Carolina created a Substance Abuse Prevention and Mental Health Promotion Policy Consortium to support the guiding principles of the 5 Year Strategic Plan. In efforts to maximize resources, build on existing infrastructures and reinforce statewide

collaborations, the Policy Consortium reviewed the numerous plans and recommendations developed by statewide partners.

Policy Consortium consensus was to build on the work that has already been done and create a comprehensive capacity and infrastructure support plan that:

- reinforces the use of the strategic prevention framework (SPF) as the guiding principle behind all prevention efforts;
- creates a template for strategic partners across NC to work together to achieve the Healthy NC 2020 Goals related to substance abuse and mental health *(Appendix A)*; and
- continues to advocate for the recommendations in the 2009 Prevention Action Plan *(Appendix B)*.

The purpose of the 5 Year Strategic Prevention Plan is to strengthen the capacity and continue to enhance the infrastructure of the NC prevention systems in order to achieve the recommendations of the 2009 NCIOM Prevention Action Plan. It will ultimately make an impact on the following Healthy NC 2020 Objectives outlined in **Table 2.**

Table 2: Substance Abuse and Mental Health Focused Healthy NC 2020 Objectives

Healthy NC 2020 Objectives	Baseline	2020 Goal
Substance Use		
Reduce the percentage of high school students who had alcohol on one or more of the past 30 days	35.0% *(2009)*	26.4%
Reduce the percentage of traffic crashes that are alcohol related	5.7% *(2008)*	4.7%
Reduce the percentage of individuals aged 12 years and older reporting any illicit drug use in the past 30 days	7.8% *(2007-08)*	6.6%
Tobacco Use		
Decrease the percentage of adults who are current smokers	20.3% *(2009)*	13.0%
Decrease the percentage of high school students reporting current use of any tobacco product	25.8% *(2009)*	15.0%
Decrease the percentage of people exposed to second-hand smoke in the workplace in the past seven days	14.6% *(2008)*	0%
Mental Health		
Reduce the suicide rate (per 100,000 population)	12.4 suicides per 100,000 *(2008)*	8.3 suicides per 100,000
Decrease the average number of poor mental health days among adults in the past 30 days	3.4 days *(2008)*	2.8 days
Reduce the rate of mental health-related visits to emergency departments (per 10,000 population)	92.0 visits per 10,000 *(2008)*	82.8 visits per 10,000
Injury and Violence		
Reduce unintentional poisoning mortality rate (per 100,000)	11 deaths per 100,000 (2008)	9.9 deaths per 100,000

Building upon the charge to develop a comprehensive prevention plan, the Governor's Task Force for the Healthy Carolinians and the Healthy North Carolina 2020 Steering Committee comprised of statewide leaders, specialists and partners (including the North Carolina Institute of Medicine; the North Carolina Department of Health and Human Services (NC DHHS), Division of Public Health; NC DHHS the Division of Mental Health/Developmental Disabilities/Substance Abuse Services (MH/DD/SAS) including the Office of Prevention; NC DHHS Office of Healthy Carolinians and Health Education; and State Center for Health Statistics), convened for one year to create 40 measurable objectives. One of the primary goals of the Healthy North Carolina 2020 is to motivate the partners and collaborators across the State to achieve a common set of objectives. Ten of these 40 objectives directly relate to substance abuse prevention and mental health promotion. The objectives were formulated into a plan that laid the foundation for "A Better State of Health" in North Carolina *(Appendix A).*

VI. COORDINATION OF SERVICES

The Coordination of Services outlines the roles of various partners essential to the sustainability of effective substance abuse prevention services along with the structures needed to support collaborations of those partners. The communications section includes the systems necessary for partners at both the local and state level to have a voice, be informed, share resources and be empowered in their prevention efforts. The Coordination of Services at a Glance—the Sustainable Perspective highlights current accomplishments and serves as a roadmap of action items needed over the next five years **(Table 3).**

Table 3: Coordination of Services at a Glance—the Sustainable Perspective

Objective	Accomplishments to Date	5 Year Plan
1. To have a flexible response system that allows the prevention system to respond and adapt to changing needs.	☑ LME/MCOs informed of prevention service system structure ☑ Centers for Prevention Resources established ☑ Prevention Providers' Association established ☑ Communications Plan developed	☐ Identify parties responsible for keeping LME/MCOs, providers, coalitions and stakeholders informed of resources, current trends and policy issues ☐ Annual revisions of Communications Plan and Content Strategy
2. To have decision making system in place that allows stakeholders to work together as an effective problem-solving group.	☑ Cooperative Agreement Advisory Board (CAAB) informed ☑ LME/MCO SA Point of Contact representatives briefed ☑ State Epidemiological Outcomes Workgroup (SEOW) established ☑ Policy Consortium established	☐ Hold quarterly CAAB Meetings ☐ Participate in monthly LME/MCO SA point of contact calls ☐ Expand CAAB Membership to: Mental Health, Public Health ,Primary Healthcare ☐ Develop CAAB Behavioral Health Integration sub-committee ☐ Hold quarterly SEOW Meetings ☐ Hold quarterly Policy Consortium Meetings ☐ Develop Policy Consortium Sub-Committees to address identified target policy areas
3. To adopt and utilize a comprehensive planning model.	☑ The Strategic Prevention Framework (SPF) has been adopted as the foundational tool for all prevention activities	☐ Continue to integrate SPF into all collaborative planning functions ☐ Communicate SPF to LME/MCO Care Coordinators

Table 3: Coordination of Services at a Glance—the Sustainable Perspective Continued

4. To effectively use limited resources.	☑ Communications Plan developed that outlines systematic resources distribution and facilitates resource sharing among stakeholders ☑ Websites developed to increase access to resources ☑ PACC Infrastructure established	☐ Expand access to current data resources via NCSEOW.org ☐ Expand mental health resources of preventionistheanswer.org ☐ Facilitate joint trainings between Mental Health and Substance Abuse Prevention providers, including LME/MCO representation ☐ Hold quarterly PACC Leadership Team meetings ☐ Hold quarterly PACC Forums to facilitate resource sharing ☐ Participate in regional LME/MCO forums

Substance abuse prevention and mental health promotion needs are not a result of any one contributing factor but rather a complex derivative of environmental situations, relationships, individual risk factors, availability and norms. In order to address a comprehensive prevention approach, and truly make an impact on needs, the solution must also be complex and involve various sectors that include:

- local, state and federal level;
- individuals, families, organizations and communities;
- strategies for universal, selective and indicated populations;
- schools, places of employment, religious and community settings; and
- law makers, business owners, and
- the public health community at large.

To tackle such a challenging task, systems must be created and sustained to support and allow for the strategic coordination of services. North Carolina (NC) has created networks for this coordination to occur at various levels. The Office of Prevention works with the Local Management Entities/Managed Care Organizations (LME/MCO) to provide management for prevention services and execute contracts with substance abuse prevention providers (sub-recipient communities) based upon Substance Abuse Prevention Treatment Block Grant set-a-side requirements and state performance outcomes. See *Appendix C* for a list of LME/MCOs and their prevention providers. The Office of Prevention and the LME/MCOs will continue to build on and strengthen this system comprised of the following workgroups and collaboratives:

- Cooperative Agreement Advisory Board (CAAB)
- Substance Abuse Prevention Policy Consortium (SAPPC)
- State Epidemiology Outcomes Workgroup (SEOW)
- Partnerships, Alliances, Coalitions and Collaboratives (PACC)

Structures

Cooperative Agreement Advisory Board (CAAB). The Cooperative Agreement Advisory Board (CAAB) is comprised of state, communities, and other organizations representatives involved with substance abuse prevention. The CAAB served as the driver of State and Federal Initiatives and continues to function as the advisory board for the present prevention system. The Board makes recommendations to the Secretary of the North Carolina Department of Health and Human Services and supports prevention activities and initiatives. The Board consists of representatives from various state departments, organizations, universities and agencies. The 5-year plan will include a contact who is a representative of the LME/MCO point of contacts for the Division. **Table 4** outlines the CAAB membership.

Table 4: Cooperative Agreement Advisory Board

Cooperative Agreement Advisory Board Members
ABC Commission
Department of Juvenile Justice and Justice Systems
Faith Works Together Initiative
Department of Public Instruction
Department of Health and Human Services:
• Division of Mental Health
• Division of Public Health
• Office of Minority Health and Health Disparities
Department of Administration
• NC Commission on Indian Affairs
• Youth Advocacy and Involvement Office
• Students Against Destructive Decisions (SADD)
Governor's Highway Safety Office
North Carolina National Guard
NC Parent Resource Center
NC State University
Mothers Against Drunk Driving (MADD)
To be added:
• Mental Health Association Representative
• LME/MCO Point of Contact Representative

The CAAB will continue its role as the advisory group for behavioral health integration and give support and guidance to state-wide, regional and local efforts. The CAAB is composed of stakeholders and resource contacts who can help implement the needed infrastructure enhancement. The CAAB will also be responsible for tracking and monitoring progress of infrastructure development including coordination with the Policy Consortium.

Policy Consortium. Identified representatives of the Cooperative Agreement Advisory Board along with other strategic members across the state have been selected based on their roles within their state or local organizations, or key positions they hold in the community to serve on the Policy Consortium. Membership is representative of federal, state and local policy

boards with expertise in areas ranging from reducing underage drinking policies, suicide prevention, prescription drug abuse policy actions, youth leadership and involvement, working with physicians in primary health care settings, leading mothers and parents in advocacy work and addressing comprehensive behavioral health care needs.

The Policy Consortium provides a mechanism to coordinate and consolidate statewide substance abuse prevention and mental health promotion policy efforts by:

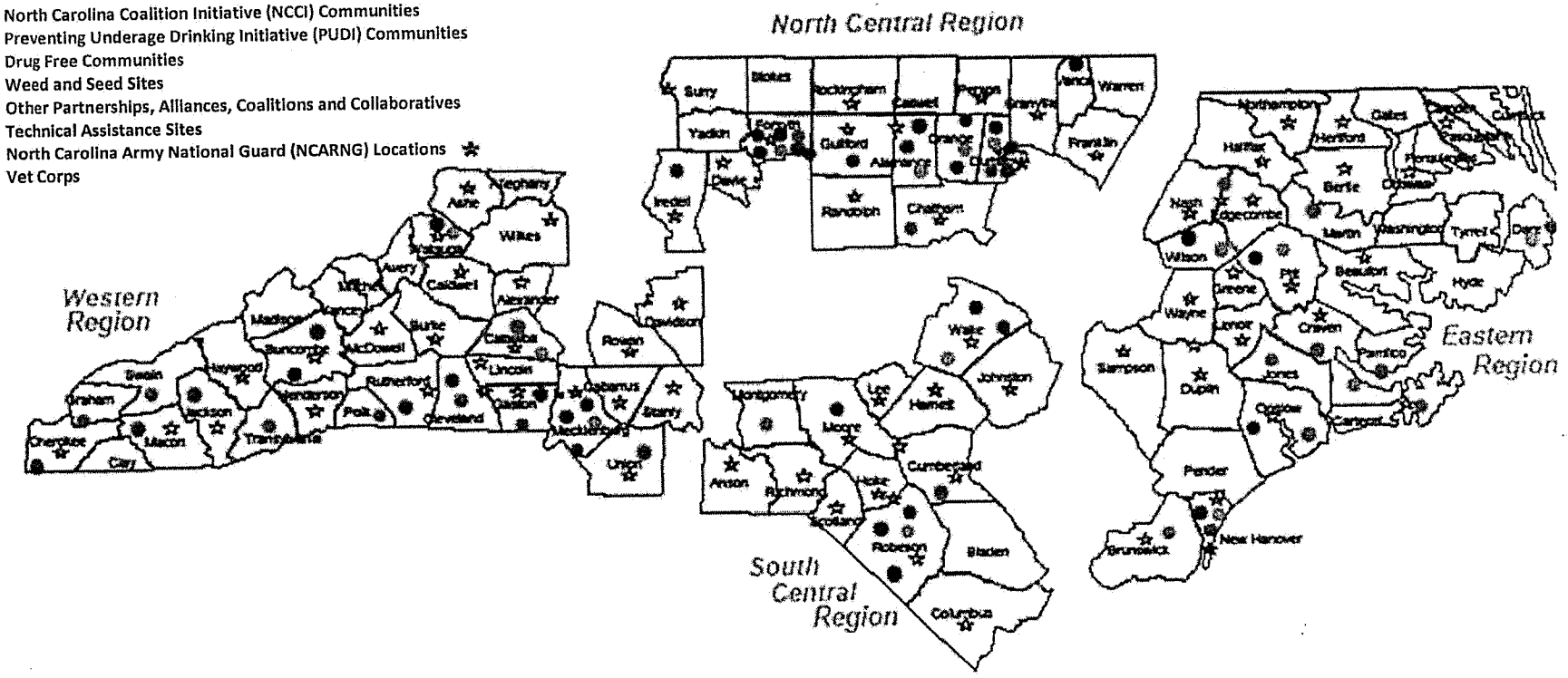
- providing an avenue for stakeholders to come to consensus;
- ensuring that adequate and appropriate data is accessible to track performance assessments and monitoring;
- creating a neutral forum of decision-makers to bring forth statewide policy concerns related to substance abuse prevention;
- supporting local substance abuse prevention and mental health promotion evidence based strategies; and
- developing language for policies to support needed service system improvements.

Membership of the Policy Consortium is identified in *Appendix D*. The key values of the Policy Consortium are outlined in the Memorandum of Understanding (MOU) in *Appendix E*.

State Epidemiology Outcomes Workgroup (SEOW). The role of the SEOW is to lead data expertise and to develop a key set of indicators to describe the magnitude and distribution of substance related consequences and consumption patterns, mental illness and promotion of positive behavioral health. Experts participate in the SEOW based on their interest and expertise with key North Carolina databases and information systems. See SEOW Charter in *Appendix F*. SEOW activities include:

- collecting, analyzing and interpreting data through the development of an EPI profile that incorporates all substance abuse related components and indicators, including evidence of associated problems;
- making recommendations to the CAAB and Policy Consortium on prevention priorities for State resources based on data analyzed and interpreted by the profile;
- developing a systematic, ongoing monitoring system of State substance-related consumption pattern consequences to track progress on addressing prevention priorities and detect trends; and
- providing support and guidance to the North Carolina Centers for Prevention Resources (NC CPRs) in the implementation of the Regional Evidence-Based Workgroups.

Figure 5: North Carolina Substance Abuse Prevention PACCs
Partnerships, Alliances, Coalitions and Collaboratives



Partnerships, Alliances, Coalitions and Collaboratives (PACCs). PACC is the term coined by North Carolina to refer to all the community based groups that have formed around the state to address substance abuse prevention issues. PACC is a unifying term that recognizes all partnerships, alliances, coalitions and collaboratives that support substance abuse prevention efforts regardless of funding or structure. The PACC Initiative aims to identify the ways and means for state and community partners to collaboratively nurture and support communities as they mobilize for change to reduce substance abuse. By uniting the individual PACCs across the state, these groups join together to network, share ideas and combine efforts. This facilitated process prevents duplication and leverages resources to address identified community concerns. See Figure 5 on the previous page for PACC configuration.

The PACC Leadership Team is comprised of coordinators of various initiatives that support PACCs through training, technical assistance, and/or funding. The PACC Leadership team strives to coordinate efforts to maximize resources available to PACCs across the state. Just a few of initiatives represented on the PACC Leadership Team include:

- PUDI-The North Carolina Preventing Underage Drinking Initiative, funded through the Enforcing Underage Drinking Laws Program, implements environmental management strategies to help enforce the nations' underage drinking laws. Preventing Underage Drinking Initiative works with the University of North Carolina-Greensboro to fund collaborative work within their communities to implement strategies that prevent underage drinking, and create a sustainable movement to stop practices that make underage drinking both easy and acceptable. The community collaborates' primary strategies focus on decreasing underage access to alcohol; changing community norms that promote underage and high risk alcohol consumption; and addressing policies pertaining to underage drinking.
- NCCI-The North Carolina Coalition Initiative is funded by the state to build capacity for local coalition development. It is maintained with a cooperative agreement with Wake Forest University Health Sciences Center to ensure a proven community participatory process. NCCI works with the Community Anti-Drug Coalitions of America (CADCA) to provide intensive training and technical assistance to selected communities to tackle substance abuse challenges in their communities.
- PRC-The Parent Resource Center, funded by the Substance Abuse Prevention Treatment Block Grant, promotes and expands parent-centered substance abuse prevention across North Carolina. PRC supports parents, schools, communities, organizations which desire to increase parent involvement.
- National Guard-The North Carolina National Guard Drug Demand Reduction is a joint program comprised of Army and Air Guardsman to support law enforcement agencies and community based organizations to provided drug demand reduction support. They offer a wide range of activities including providing prevention programming in the schools, supporting local coalitions in their substance abuse activities and events.

Linkages

The Division of MHDDSAS incorporates a philosophy to include emphasis on all three disability areas. Experts in the Community Policy Management section integrate best practices for the three areas in a comprehensive approach to address consumer concerns. To expand the CAAB member representation to mental health organizations, public health and primary health care, the Office of Prevention will align with consumer organizations and professional membership groups to ensure representations and consumer involvement. The Office of Prevention works with the North Carolina Centers for Prevention Resources (NC CPRs) to promote linkages in the community. The NC CPRs are regional centers for training and technical assistance. They are dispersed throughout the state and lend their expertise to all providers of substance abuse prevention services. In addition, they coordinate and collaborate with other agencies to provide a continuum of prevention services.

The role of the NC CPRs is to provide regional technical assistance, ensure adequate workforce development training is occurring, work collaboratively with structures, develop regional Evidence-based Workgroups and bring the local components of the state Policy Consortium together to mirror the efforts at the state level including ensuring strong communications among partners.

Linking Mental Health and Substance Abuse Prevention. A sub-workgroup of the CAAB will be developed to ensure a planning process is in place to include relevant cross training. The plan will include a series of cross sector trainings for mental health and substance abuse prevention professionals including suicide prevention trainings, depression screenings and other appropriate services. This plan will outline how to facilitate the relationship between mental health and substance abuse prevention professionals as well as identify braiding of funding opportunities for training and resources on behavioral health. The Office of Prevention currently participates in a cross-services team approach with a child mental health focus facilitated by the Best Practice Team. This team approach will be utilized to give comments and feedback to the CAAB sub-committee on enhancing the planning process. The Mental Health Advisory Board serves as the official group for mental health issues. Our MH liaison will keep them briefed on the direction for the plan and continue to share updates and relevant issues.

Linking Substance Abuse Prevention and Primary Health Care. The CAAB will also develop a plan to facilitate the relationship of substance abuse prevention professionals and primary healthcare providers. The Policy Consortium will be reviewing recommendations that will support the payment of prevention services in primary healthcare settings. Work with primary health care providers has already begun to insure that health educators are informed of prevention issues and have the resources to incorporate best practice prevention strategies in the primary healthcare settings. Pilot sites with the Screening, Brief Intervention and Referral to Treatment (SBIRT) have already developed protocols for engaging primary care offices and using care ambassadors to educate and train consumers of services. (See SBIRT initiative at www.governorsinstitute.org/sbirt.) The Division collaborates with the Governor's Institute on Substance Abuse and Community Care of North Carolina (CCNC) to implement the SBIRT grant project. The Governor's Institute is a non-profit agency that has been providing training on

substance abuse issues and evidence-based practices to physicians and other medical and behavioral care providers since 1991. CCNC consists of 14 networks of 1,360 primary care practices with around 4,500 physicians. Participating practices provide health homes for more than 1,100,000 Medicaid enrollees.

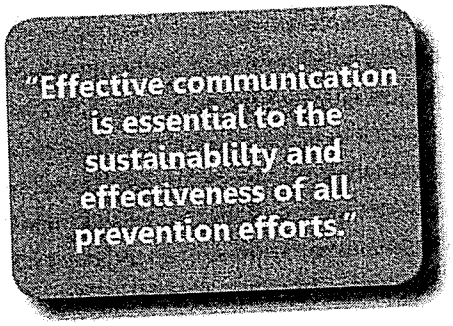
Linking the Roles of Professional and Provider Organizations. North Carolina has the Addiction and Prevention Professionals of North Carolina (APNC), North Carolina Substance Abuse Providers' Association (NCSAPA) and the North Carolina Substance Abuse Prevention Providers' Association (NCSAPPA) and the North Carolina Substance Abuse Federation. Each organization plays a vital role in preparing the workforce for the future including integration with primary healthcare. APNC provides support to the individual professionals. NCSAPA provides organizational support, training and technical assistance for substance abuse providers. And NCSAPPA provides organizational support and advocacy for substance abuse prevention providers and its President represents NCSAPPA on the North Carolina Substance Abuse Federation.

The North Carolina Substance Abuse Federation is a statewide group of individuals and organizations working in partnership to protect the rights of North Carolinians living with mental illness and the disease of addiction with the mission to promote policies to assure quality systems of education, prevention, and the expansion of a continuum of treatment services to effectively meet the needs of the substance abuse population. The bylaws state that membership in the North Carolina Substance Abuse Federation is "open to designated representatives of groups and organizations that identify with the mission." The Federation Bylaws therefore recognize two membership categories: Organizations and Groups. Organizations are defined as entities incorporated to benefit their dues paying members. Groups are incorporated or unincorporated entities organized to advocate and or advise. APNC, NCSAPPA and NCSAPPA are all members of the Federation.

It is important to facilitate a cooperative relationship between these organizations as well as have their representation on the Policy Consortium. In order to create true culture shift, such as the one needed to adapt to the changing way of doing business with the Affordable Care Act and integration with primary healthcare, it is important to prepare both the organizational leadership as well as the individuals practicing in the field. A true collaboration of the provider and professional organizations can provide complimentary support from both the bottom up and top down *(Appendix G).*

Communications

Success of any system linkage, partnership or collaboration depends on clear lines of effective communication. An effective communication system not only creates a forum for resource sharing but also supports ownerships in the vision and direction of prevention as it creates a forum for decision making and input. All are essential components of sustainability of system changes and positive prevention outcomes.



The goals of the communications plan include:

- support effective communication among key stakeholders;
- increase awareness of and access to resources that support the strategic prevention framework process;
- increase awareness of and access to cost-effective training and workforce development opportunities;
- facilitate the building of partnerships that allow for cost effective training opportunities especially those seeking certification;
- increase awareness of NC CPRs as access points for providers and communities and increase the likelihood that communities and partners reach out to connect to additional resources; and
- encourage regional relationship building.

Key elements of the communications plan include:

- *Prevention Is The Answer* Website Enhancement
  The PreventionIsTheAnswer.org website is intended to be the "one-stop" shop for online resources and communications for PACCs and providers across North Carolina. The NC CPRs and the Marketing and Communications Committee (MACC) of the NC Substance Abuse Prevention Providers Association are the communications team that have collaborated on a plan to better utilization of the existing website to ensure that as traffic flow is increased, it is always current and relevant. This plan focuses on:
  - Calendar of Events: The upcoming events/training calendar section of the preventionistheanswer.org website is intended to provide information regarding upcoming workforce development opportunities and media campaigns. Historically, as new trainings and awareness events are discovered, they are added to the site. The communications team has developed a strategy that that aligns the content and schedules of website, social media and email announcements as well as who is responsible for updates. This allows for more frequent updates and further advance promotions of upcoming events.
  - Resources: The Resources tab of the website houses numerous articles, manuals, information and links related to substance abuse prevention. The communications team reviewed the current resources, identified gaps, and created a plan for updating the resources section and highlighting the posted

resources on a rotating schedule to increase awareness of their existence and increase utilization.

- Policy Updates: The Policy Committee of the NC Substance Abuse Prevention Providers Association is responsible for getting information to the communications team to keep the NC prevention community up to date on current policy issues including activities of the Policy Consortium. The chair(s) of the Policy Committee are also active members of the Policy Consortium and assist with communication flow.

In order to do this, communications team members will need to:

- receive quarterly training refreshers on updating the website;
- periodically review the expectations/guidelines for content;
- periodically review the schedule/timeline for planned updates;
- develop guidelines for spontaneous or "unplanned" updates;
- seek out information for posting through increasing connections with existing resources; and
- expand resources section to include health promotions, behavioral health and suicide prevention.

- *Social media alignment*
  This plan will incorporate the use of other social media formats such as Facebook and Twitter and how to strategically use the social media tools to enhance communications, drive traffic to the PreventionIsTheAnswer.org, engage prevention professionals across the state and facilitate prevention conversations.

- *Content strategy*
  A comprehensive content strategy including timeline was developed outlining types of content and schedule for dissemination of materials via website, social media and email *(Appendix H).*

Effective communication is essential to the sustainability and effectiveness of all prevention efforts. The communications plan is a joint collaborative effort of the Office of Prevention, Centers for Prevention Resources, and the Prevention Providers Association. In order to ensure timely communications are managed effectively, it is recommended to support paid staff time solely dedicated to communication efforts including by not limited to:

- website updates;
- email blasts;
- newsletter coordination and dissemination; and
- social media monitoring and engagement.

V. DATA COLLECTION, ANALYSIS and REPORTING

Data informed decisions are the basic fundamental foundation for the Strategic Prevention Framework and essential to align cultural responsive program, practices and policies. The Data Collection, Analysis and Reporting section describes the sustainability of the essential systems necessary to maintain access to data as well new systems needed to help communities use data effectively in their decision-making. The Data Collection, Analysis and Reporting at a Glance—the Sustainable Perspective highlights current accomplishments and serves as a roadmap of action items needed over the next five years **(Table 5).**

Table 5: Data Collection, Analysis and Reporting at a Glance—the Sustainable Perspective

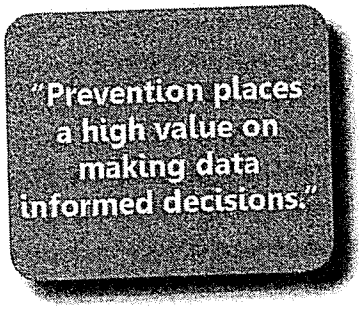
Objective	Accomplishments to Date	5 Year Plan
1. To have a flexible response system that allows the prevention system to respond and adapt to changing needs.	☑ North Carolina Prevention Outcomes Performance System (NCPOPs) Database Created for Statewide Reporting ☑ NCSEOW.org Developed	☐ Increase user friendly access to data resources across the state though NCSEOW.org ☐ Expand reporting features of NCPOPs ☐ Keep NCSEOW.org Website up-to-date to allow real time access to data ☐ Establish EBWs
2. To have decision making system in place that allows stakeholders to work together as an effective problem-solving group.	☑ State Epidemiological Outcomes Workgroup (SEOW) Established to analyze and evaluate statewide data related to substance abuse prevention and make recommendations as to priority focus areas ☑ Evidence Based Workgroups (EBW) Plan Developed	☐ SEOW continues to meet quarterly and update data analysis ☐ Expand SEOW to include EBW subcommittee ☐ Develop Regional EBWs ☐ Utilize EBWs as the recommendation body to assure alignment of evidence-based programs, practices and policies with local needs
3. To adopt and utilize a comprehensive planning model.	☑ The Strategic Prevention Framework (SPF) has been adopted as the foundational tool for all prevention activities.	☐ SPF will continue to be foundation for SEOW and EBW planning and decision making ☐ Providers will be able to report all steps of the SPF in the NCPOPs
4. To effectively use limited resources.	☑ NCPOPs Developed ☑ Social Indicator Study Development ☑ State Epi Profile Developed	☐ Expand NCPOPs to capture funding streams for substance abuse prevention ☐ Periodic Social Indicator Study Updates ☐ Real time data visualization capacity added to NCPOPS

Data is essential to implementing prevention efforts effectively. Data identifies populations at risk, why they are at risk and contributing factors that can be addressed to prevent negative consequences in the future. Data aids in distinguishing between the true needs in a community and the perceived needs which are often times different. Prevention places a high value on making "data informed" decisions which are essential to ensure proper reach and alignment, to document effectiveness and to demonstrate outcomes.

Recognizing the need for infrastructure to support ongoing data collection and analysis, the Prevention and Early Intervention Team and the Quality Management Team of the Division of MHDDSAS works collaboratively with their partners to support several coordinated state-wide initiatives. These efforts are aimed at increasing data availability and ensuring data is analyzed and shared in a format that is culturally appropriate and usable by providers and communities.

Data Collection

The North Carolina State Epidemiology Workgroup (NC-SEOW) was organized as part of the Strategic Prevention Framework-State Incentive Grant (SPF-SIG) initiative. It was formed to review pertinent data and make recommendations on state priorities regarding substance use and abuse. The membership of the NC-SEOW includes experts in alcohol, drugs, and primary care. It is sustained to promote an ongoing, in-depth exchange of data and learning between state and community leaders in order to enhance existing prevention infrastructure.



The NC-SEOW identifies priority substance abuse prevention needs including related short term and long term consequences at both the state-wide and community level. The NC-SEOW focuses on outcomes and priorities of prevention of substance abuse and mental disorders. Their recommendations guide the collaborations, policy focus areas and strategic efforts for the Cooperative Agreement Advisory Board and the Policy Consortium.

The NC-SEOW is an organized body working to support the mission of a data-driven system to prevent substance abuse and mental disorders and promote positive mental well-being. Having access to such data is a critical component of to the Strategic Prevention Framework process. Effective use of this data:

- aids in the identification of target populations;
- guides the selection and implementation of evidence based programs, practices and policies;
- allows for a baseline to measure effectiveness; and
- supports proper reach and alignment of services.

North Carolina substance abuse prevention providers, community organizations and agencies have access to the SEOW(www.ncseow.org) and its abundant list of sources including but not limited to:

- Local Health Assessments (Healthy Carolinians);

- CDC (Wonder);
- Criminal Justice Statistics Center (CJSC);
- School Crime and Violence Annual Report-Department of Public Instruction;
- Fatality Analysis Reporting System (FARS);
- Highway Traffic Safety Data- UNC-Highway Safety Research Center;
- Monitoring the Future Survey (National);
- NC Tobacco Use Survey-Semi-Annual survey data;
- North Carolina BRFSS;
- School Violence Data: NC Department of Public Safety, Division of Juvenile Justice, Center for Prevention of School Violence;
- North Carolina Youth Risk Behavior Surveillance System (YRBSS); and
- SAMHSA National Survey on Drug Abuse and Health (NSDUH).

The NC-SEOW has conducted state-wide assessments and worked with the Research Triangle Institute (RTI) to determine the nature and magnitude of problems associated with substance use and mental illness, examined current databases and explored appropriate risk and protective factors. The complete State Epi Profile can be found at www.NCSEOW.org *(Appendix I).* Access to data is not enough in and of itself. It is important to provide access to information in a format that can be utilized and interpreted effectively by the prevention community.

The NC-SEOW, consulted with RTI to develop the Social Indicator Study which provides prevention needs assessments and planning profiles for each of North Carolina's 100 counties. The complete Social Indicator Study can be found at www.NCSEOW.org. The profiles provide local service providers and planners with descriptions of their county's level of alcohol and drug related problems and various risk and protective factors for such problems. This information can be used to help prevention planners determine appropriate prevention strategies and relevant target populations (Appendix J).

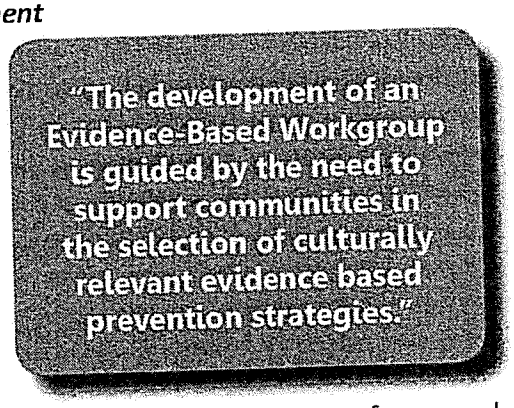
To ensure this critical access to data over the next five years, the NC-SEOW is committed to:

- examine the NC-SEOW membership and ensure representation from relevant groups such as the quality managers at the LME/MCOs, mental health program directors, law enforcement, educators, statisticians, health communications, consumers, consumer advocacy groups, etc. and to ensure it is culturally responsive;
- hold regular NC-SEOW meetings;
- update the Social Indicator Study periodically; and
- continue to make access data available to communities through the NC-SEOW website.

The NC-SEOW will continue assessment, monitoring and surveillance of data to:

- support the needs assessment process of the strategic prevention framework;
- institutionalize data driven decision making for state and community level planning; and
- provide guidance for the Regional Evidence Based Workgroups.

Regional Evidence Based Workgroups (EBW) Development



The state-level EBW will be a sub-committee of the State Epidemiological Outcomes Workgroup (SEOW) with members recruited from the SEOW and supplemented with additional members to address any deficits in requisite skills and sector representation. Because cultural and social norms impacting substance use may differ by region and local conditions, NC is establishing regional (North Central, South Central, Western, and Eastern) EBWs that align with the service areas of the NC Centers for Prevention Resources (NC CPRs). The state-level group will develop the organizing framework to guide decision-making and prioritize the allocation of resources. However, direct support of local community organizations and stakeholders will be facilitated by the regional workgroup. Each regional EBW will designate a member to serve as their representative on the statewide group.

Membership on the EBWs will be representative and inclusive of the state's diversity. However, at its core, the workgroup needs strong representation from individuals with expertise in prevention science and evidence-based prevention strategy implementation. A member with substance abuse-related epidemiological expertise is also important because some communities will need assistance with aligning the needs assessment process with strategy identification and selection. State level EBW membership may include individuals with skills in the following areas:

- LME/MCOs care coordination
- Public health epidemiology;
- Implementation of evidence-based programs, policies, and practices;
- Conducting or facilitating needs assessment at the local level;
- Service provision (prevention and treatment); and
- Prevention research/science

Regional groups will include a similarly diverse membership. Potential members include NC CPRs, service providers (prevention and treatment), representatives from LMEs/MCOs, prevention researchers, and consumers. Members of regional sub-groups should also be knowledgeable about local conditions related to substance use, as well as existing prevention and treatment resources available in the community. It is not expected that regional members will understand the uniqueness of all local communities, but instead will provide a regional perspective that could inform decision making.

The effective implementation of an evidence-based practice workgroup would impact prevention strategy selection at the local, regional, and state levels. More effective strategy selection would improve implementation fidelity and eventually improve targeted outcomes.

State-level agencies could better facilitate the distribution of limited resources; regional systems could better leverage limited resources; and local communities could improve population-based outcomes by engaging in the process. MHDDSAS has been a national leader in understanding the importance of promoting the selection and implementation of evidence based strategies evidenced by its support of the North Carolina Practice Improvement Collaborative (NC-PIC). The Regional Evidence Based Workgroups will mirror the NC Practice Improvement Collaborative (NC-PIC). NC-PIC serves as the evidence based workgroup for mental health, developmental disabilities and substance abuse services. It aims to ensure that each time North Carolinians come into contact with the MHDDSAS system they will receive excellent care that is consistent with our scientific understanding of what works. NC-PIC provides guidance in determining the future evidence based services and supports that will be provided through our public system, ensures that the services are in line with the needs of NC consumers and meets quarterly to review and discuss relevant programs.

Similarly, most local management entities (LME) are beginning to understand the importance of not only selecting evidence-based strategies, but more importantly, selecting the most appropriate evidence based strategies. And many communities, particularly those funded through SPF-SIG, embraced the need to use data-driven decision-making to inform strategy selection. This current alignment in thinking among state, regional, and community stakeholders provides a unique opportunity and space to develop a sustainable infrastructure that will allow North Carolina communities engaged in preventing substance abuse and its related consequences to more effectively achieve desired outcomes.

MHDDSAS has developed a strong regional training and technical assistance framework to support local substance abuse prevention providers, coalitions, and community stakeholders—the NC Centers for Prevention Resources (NC CPRs). To accommodate the geographical considerations, NC is setting up a regional structure that aligns with the NC CPR service areas and a statewide entity that will meet quarterly to develop general guidelines to assist communities in selecting and implementing evidence-based prevention strategies.

- EBWs will incorporate a readiness and capacity component that requires the workgroup to establish processes, protocols, and partners to make an assessment of communities that access the resources of the workgroup.
- The development of an EBW is guided by the need to support communities in the selection of culturally relevant evidence based prevention strategies. This process should be well-defined, simple, and empowering.
- One of the main roles of the EBW will be to assist communities in the selection of culturally relevant evidence based prevention strategies.
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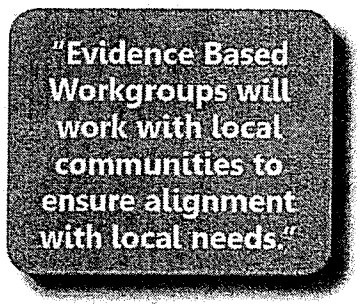


The EBW will need to define criteria for what constitutes an evidence-based strategy, as well as what criteria will be used for making recommendations to communities. SAMHSA's *"Selecting and Identifying Evidence-based Interventions"* will serve as a basic guide for this process. The workgroup will also need to develop a process or criterion for the

acceptance of promising or locally developed prevention strategies that have limited evidence of effectiveness. In addition, the workgroup will need to decide how to evaluate and support requests by communities to make adaptations to approved evidenced-based strategies.

The NC-SEOW will continue to support the development of Regional Evidence Based Workgroups (EBW) that align with and will be coordinated by the four regional Centers for Prevention Resources. The EBW Concept Paper *(Appendix K)* outlines how the four regional workgroups will work with local communities to review the appropriate strategies, programs, practices, policies to help ensure alignment with the needs of the local communities.

The NC-SEOW will continue to work with the Regional Centers for Prevention Resources to:

- develop the policies and procedures for the EBWs;
- select local experts to participate on the EBWs; and
- provide EBWs with community assessment profiles and worksheets to use to help guide workgroups as they make recommendations.

The EBWs will make recommendations to the NC-PIC for promising programs that may need to be evaluated further for their relevance and effectiveness in meeting the needs of NC consumers. The Policy Consortium will be asked to look at the policies and procedures in this recommendation process.

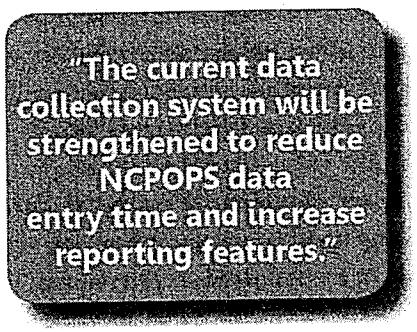
Reporting

The North Carolina Prevention Outcome Performance System (NCPOPS) is the current data collection system for the majority of North Carolina's federally funded substance abuse prevention services. Currently prevention providers develop a profile of their agency, identifying problem statements and selecting appropriate evidence based practices for their target populations and local communities based on the five steps of the Strategic Prevention Framework. The system was created in 2007 and is contracted with KIT Solutions for the collection of the required core elements (NOMS, Demographics, Evidence Based Practices) for the SAPTBG. The system is able to categorize each service by Institute of Medicine (IOM) category and Center for Substance Abuse Prevention (CSAP) Prevention Strategies: information dissemination, education, alternatives, problem identification and referral, community based process and environmental. Access to the system and reports are available on the following levels: state, LME/MCO, and provider. The system was designed to allow the providers to directly input the data and give access to state and LME/MCO managers to allow data acquisition to help inform state and local planning.

"Prevention providers develop a profile of their agency, identifying problem statements and selecting appropriate evidence based practices for their target populations and local communities based on the five steps of the Strategic Prevention Framework."

Currently, NCPOPs tracks data from thirty five (35) substance abuse prevention agencies funded through the Substance Abuse Prevention Treatment Block Grant. The North Carolina Coalition Initiative (NCCI) uses its own system, separate from NCPOPS to track the

strategic prevention framework process, deliverables and outcomes for each of their eight (8) funded coalitions. The Preventing Underage Drinking Initiative tracks the activities and outcomes of their fifteen (15) funded coalitions and their statewide policy efforts in the required Justice Online Reporting System for the Enforcing Underage Drinking Laws (EUDL) initiatives. However, it is anticipated that NCPOPS is being expanded to include data collection, analysis and reporting for the capacity building efforts of NCPUDI, the North Carolina Centers for Prevention Resources (CPR) and the community mobilization efforts of the North Carolina Coalition Initiative (NCCI). The current data collection system will be strengthened to reduce data entry time and increase reporting features. These enhancements will aid local communities by providing them with the tools needed to show their needs, outcomes and progress to their local stakeholders and funders.



System enhancements are also being made to NCPOPs to increase user ability on the local and state level by

- decreasing the amount of time it takes to report and enter data;
- decreasing the amount of time it takes to generate reports that can depict outcomes to key stakeholders; and
- aligning the reporting features with state and federal reporting requirements to reduce resources needed to generate additional reports.

The enhancements will include additional community level data, additional reports and reporting options and Real Time Data Visualization with Dashboard and Scorecard Reports. The NCPOPs enhancements will allow for multi-source data collections through web-based data collection; data standardization; data submission; and hosting and maintenance upgrades. The following additional features will create a seamless integration of data and information:

- Data mashups
- Data warehouse
- Data cleansing and enrichment
- Data consolidation
- Master data file management

The visual and analytic upgrades will turn the data collected into actionable intelligence that will allow community service providers, Local Management Entities and state level staff to have the necessary information for reporting and decision. The Visual Presentation enhancements will include:

- Interactive Maps
- Dynamic Charts
- Instant Reports

Analytic system upgrades will allow for more advanced analysis of the data and enhance reporting features. These enhancements include decision modeling, data mining, spatial analysis (GIS) and meta-analysis.

All of these NCPOPS upgrades and enhancements will:

- optimize by depicting what is the best that can happen;
- include predictive modeling that predicts the likely trends to happen next;
- forecast by showing possible scenarios for trends;
- incorporate statistical analysis that explain why trends are happening;
- involve alert features that make users aware of actions that are needed;
- query what the exact nature of the problem through database searches;
- allow for easily produced ad hoc reports that show how many, how often and where; and
- include standard reporting that tells what happened.

The enhancements to NCPOPS will assist the NC-SEOW with a real picture of the needs and gaps in service for substance abuse prevention in the state and will provide valuable information for the local planning needs of the LME/MCOs. The Spatial Analysis (GIS mapping) will provide a clear picture of the needed services in each community.

A systematic review of the NCPOPS data collection, reporting and analysis will be conducted including satisfaction surveys for the local providers entering the data to ensure the enhancements are aligning with the needs of the community prevention providers, the Local Management Entities and the NC Office of Prevention. Based on this review, the NC Office of Prevention will develop a plan for further enhancements to data collection, analysis, and reporting.

Success for the data collection process will be determined by asking the following questions that will be examined for each database enhancement:

- Were the measures selected for enhancing each database added to the data system?
- Were the timelines met?

Satisfaction surveys and pre/post assessments will be incorporated into training and technical assistance efforts around the state on an ongoing basis and compiled annually to continually monitor the effectiveness of the training and technical assistance efforts.

Analytics in the preventionistheanswer.org, nccprs.org and ncseow.org websites, social media tools and email systems will be installed to track the information and resource distributions, reach and alignment of information with target audiences and engagement of prevention partners outlined in the communications plan.

VI. Technical Assistance and Training Plan

A prepared and informed workforce is critical to the success of any prevention effort and essential to implement every aspect of the Substance Abuse Prevention Plan. The Technical Assistance and Training at a Glance—the Sustainable Perspective highlights current accomplishments and serves as a roadmap of action items needed over the next five years **(Table 6).**

Table 6: Technical Assistance and Training at a Glance—the Sustainable Perspective

Objective	Accomplishments to Date	5 Year Plan
1. To have a flexible response system that allows the prevention system to respond and adapt to changing needs.	☑ Monthly Practice Board approved webinar trainings ☑ Annual training needs assessment developed and implemented	☐ Increase prevention training for stakeholders ☐ Share training needs and assessment results with Statewide Training partners ☐ Include specific prevention topics on training agendas of LME/MCOs
2. To have decision making system in place that allows stakeholders to work together as an effective problem-solving group.	☑ Quarterly Learning Communities provide opportunities to share challenges and successes in implementing strategies	☐ Continue Quarterly Learning Communities and invite participants from LME/MCOs ☐ Expand training access for web-based technologies to Support Stakeholder Planning Meetings
3. To adopt and utilize a comprehensive planning model.	☑ Training on Strategic Prevention Framework and NC Keys to Sustainability ☑ Provided Technical Assistance & Coaching on Utilizing SPF and Sustainability Planning Models	☐ Expand Opportunities for Training and Technical Assistance Sessions to LME/MCOs, Providers and other Community Stakeholders
4. To effectively use limited resources.	☑ Centralized Access to Free Resources, Training, Toolkits, Data and Policy Alerts at preventionistheanswer.org ☑ PACC Leadership Team created to collaborate on training and technical assistance for communities	☐ Expand Development of Website, Social Media and Technology Based Communication Systems ☐ Increase shared training opportunities with collaborative partners to reduce costs and increase access

The *North Carolina Centers for Prevention Resources (NC CPRs)* were created by the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services Office of Prevention as regional hubs for building substance abuse prevention service delivery capacity among local provider organizations and communities. The primary purpose of each NC CPR is to facilitate capacity building, provide technical assistance and increase access to training for area local management entities (LMEs), providers and communities. Four NC CPRs have been established to serve as models of accountability, capacity and effectiveness. The work of the CPRs is guided by the Strategic Prevention Framework (SPF) process.

The goals of the NC CPRs are to provide professional training, technical assistance, coaching and information/resources using various media frameworks and one-on-one contacts.

During year one of the Strategic Prevention Framework-State Enhancement grant, the 5 Year Plan capacity building phase of 2011-2012, the NC CPRs:

- coordinated, supported and/or provided 108 professional training events including 28 web-based training events for professionals and community stakeholders;
- provided support for 309 local, regional and statewide capacity building efforts;
- provided 187 in-person and 1233 telecommunications technical assistance sessions; and
- assisted with increasing a 17% increase in the number of credentialed prevention professionals in the state.

A complete list of activities and core functions of the NC CPRs can be found in Appendix L.

The NC CPRs work closely with training and technical assistance partners across the state to insure workforce development needs of prevention professionals and communities are being met.

- *North Carolina Preventing Underage Drinking Initiative (NC-PUD)* focuses on community-based approaches emphasizing environmental strategies to prevent underage drinking. NC-PUD is responsible for the funding, training, technical assistance, and monitoring of community collaboratives that are implementing environmental management strategies to prevent and reduce underage alcohol use in their communities. NC-PUD is charged with the development and execution of the strategic state plan including short- and long-term goals for preventing and reducing underage drinking in North Carolina.

- *Youth Empowered Solutions* (YES!) a non-profit agency whose staff works to empower youth, in partnership with adults, to create community change.

- The *North Carolina Coalition Initiative (NCCI)* to provide intensive training and technical assistance to selected communities to walk them through the strategic prevention framework and to build their capacity to tackle substance abuse challenges in their communities.

- Partnership for Drug Free NC is charged with developing trainings and technical assistance protocols for media, media relations and advocacy.

- *Faith Works Together* was developed by the Division of MHDDSAS to increase collaborations and help break down the barriers between faith-based organizations and traditional substance abuse and mental health providers.

- *Community Anti-Drug Coalitions of America (CADCA)* is a national organization that provides training and support for Drug Free Community Coalitions funded by the Office of National Drug Control Policy. CADCA also provides state support to maintain coalition efforts in collaboration with state training and technical assistance projects.

- *Center for the Application of Prevention Technologies (CAPT)* provides technical assistance and training to the NC Office of Prevention. CAPT is a national substance abuse prevention training and technical assistance system, funded by the Center for Substance Abuse Prevention, that provides support to North Carolina through task-orders generated by the Office of Prevention after consultation with prevention providers. The Office of Prevention meets annually with the CAPT to review Technical Assistance Needs.

- Other training collaborators include:
    - The *NC Substance Abuse Prevention Providers Association (NCSAPPA)* that advocates and provides recommendations on workforce development needs of providers across the state.
    - The *NC Foundation for Alcohol and Drug Studies (NCFADS)* that hosts intensive week-long summer and winter training schools for substance abuse professionals.
    - *Addictions and Prevention Professionals of NC (APNC)*, the state arm of the National Association of Alcoholism and Drug Abuse Counselors (NAADAC), hosts fall and spring conferences and coordinates regional trainings.

Coordination of Training Plan. The NC Centers for Prevention Resources (NC CPRs) will lead the training and technical assistance coordination and assess workforce development needs , deliver training and technical assistance as well as communicate these needs with local, regional, state and national partners to ensure training needs are met. The NC CPRs have direct linkages to the LME/MCOs through their host agencies in their respective regions. They are charged with:

(1) assessing training, technical assistance and capacity needs of their regions;
(2) developing a plan that builds local, regional and statewide capacity to meet those needs;
(3) implementing the plan and evaluating the effectiveness of the quality, effectiveness and alignment of capacity building; and
(4) responds to training and technical assistance requests in their regions.

The CPRs will work closely with the Workforce Development Committee of the NCSAPPA to conduct an annual needs assessment of workforce development needs on both the regional and statewide level. Data will be collected on an ongoing basis through web-based surveys, technical assistance satisfaction surveys and interviews with collaborating partners such as CAAB, LME/MCO, SEOW, PUDI, NCCI, NCSAPPA, NCFADS and APNC. The CPRs will compile the data annually to outline the following fiscal year training plan.

North Carolina will continue to increase the training and technical assistance capacity of the Faith Works Together initiative by providing webinar technologies and logistics. Continued support will:

- increase the reach across the state to faith-based organizations and affiliates;

- build the bridges between the providers and the faith communities;
- empower faith communities to address the issue;
- equip faith communities with evidence-based strategies; and
- increase the links of faith communities to provider resources.

The NC CPRs will work closely with the PDFNC to ensure media related resources are posted on PreventionIsTheAnswer.org to ensure equal access to all community prevention professionals. The NC CPRs will also collaborate with PDFNC to develop a media tool-kit to walk communities through the process of implementing local campaign messages that compliment statewide initiatives.

As workforce development needs assessments identify training and technical assistance needs outside that of the expertise found in NC Prevention's infrastructure, the NC Office of Prevention will solicit the assistance of SAMHSA's CAPT for federal support.

The Regional Evidence Based Workgroups will provide technical assistance to local community based prevention providers by reviewing needs assessments and strategic plans to ensure that selected strategies, programs, practices, policies identified are the best fit and align with the identified needs in the local communities.

Webinars and eLearn. In efforts to meet the needs of prevention providers in times of diminishing training budgets, the NC CPRs are expanding the online opportunities for trainings. The NC CPRs will ensure the availability of 1-2 monthly online training opportunities that are aligned with identified workforce development needs and that will satisfy the requirements for the Certified Substance Abuse Prevention Consultant credential training needs. The NC CPRs are also expanding the eLearn technologies for a more comprehensive and interactive online training experience. Telecommunications conference options through the CPRs are available for statewide and regional groups to make planning meetings more accessible to those with limited travel budgets. The introduction of technology to connect professionals to each other has changed the landscape of the field in NC.

VII. CULTURAL RESPONSIVENESS PLAN/DIVERSITY PLAN

With the understanding that approaches to cultural competence have continued to evolve, the DMHDDSAS recognized the need to revise its cultural responsiveness plan to reflect current best practices in culturally competent health promotion and prevention services. The NC Office of Prevention worked closely with an independent contractor and received feedback from the Policy Consortium on the development of the 2012 North Carolina Substance Abuse Prevention Cultural Responsiveness Plan. The Plan reviews national and local research, policy, and cultural competence best practices as well as the Division's efforts to develop more culturally responsive prevention services and initiatives. Building upon the work of the collective efforts of those who served on the 2006 Cultural Competence Advisory Group, Division staff, community collaborators, providers, and citizens, the 2012 plan offers a template to begin discussions of moving forward to consensus on a plan that has recommendations to further integrate and enhance cultural competence efforts.

The goals of the 2012 Substance Abuse Prevention Cultural Responsiveness Plan are to build the infrastructure necessary to address each of the cultural responsive domains by targeting the focus areas listed in **Table 7**.

Table 7: Cultural Responsiveness Focus Areas

Cultural Responsive Domains	Focus Areas
Organizational Values: An organization's perspective and attitudes regarding the worth and importance of cultural competence, and its commitment to providing culturally competent care.	☐ Leadership, Investment and Documentation ☐ Information/Data Relevant to Cultural Competence ☐ Organizational Flexibility
Governance: The goal-setting, policy-making, and other oversight vehicles an organization uses to help ensure the delivery of culturally competent care.	☐ Community Involvement and Accountability ☐ Board Development ☐ Policies
Planning and Monitoring/Evaluation: The mechanisms and processes used for: a) long- and short-term policy, programmatic, and operational cultural competence planning that is informed by external and internal consumers; and b) the systems and activities needed to proactively track and assess an organization's level of cultural competence.	☐ Client, Community and Staff Input ☐ Plans and Implementation ☐ Collection and Use of Cultural Competence-Related Information/Data

Table 7: Cultural Responsiveness Focus Areas continued

Communication: The exchange of information between the organization/providers and the clients/population, and internally among staff, in ways that promote cultural competence.	☐ Understanding of Different Communication Needs and Styles of Client Population ☐ Culturally Competent Oral Communication ☐ Culturally Competent Written/Other Communication ☐ Communication with Community ☐ Intra-Organizational Communication
Staff Development: An organization's efforts to ensure staff and other service providers have the requisite attitudes, knowledge and skills for delivering culturally competent services.	☐ Training Commitment ☐ Training Content ☐ Staff Performance
Organizational Infrastructure: The organizational resources required to deliver or facilitate delivery of culturally competent services.	☐ Financial/Budgetary ☐ Staffing ☐ Technology ☐ Physical Facility/Environment ☐ Linkages
Services/Interventions: An organization's delivery or facilitation of clinical, public-health, and health related services in a culturally competent manner.	☐ Client/Family/Community Input ☐ Screening/Assessment/Care Planning ☐ Follow-up

Source: www.hrsa.culturalcompetence/pdf listed in Rivers, M. et al (2012) Cultural Responsiveness Plan for Prevention , In progress for approval.

The 2012 Substance Abuse Prevention Cultural Responsiveness Plan will be vetted through appropriate avenues to revise and refine it with further input to develop consensus and agreement to disseminate the plan. Over the next five years, the identified focus areas will be refined and incorporated into clear goals and objectives for the overall comprehensive prevention plan.

VIII. SUSTAINABILITY

During the Strategic Prevention Framework-State Incentive Grant Initiative (2005-2011), North Carolina worked with the Southeast Center for the Application of Prevention Technologies to train regional professionals to be trainers and technical assistance providers in the Keys to Sustainability evidenced-based model. These regional trainers became the NC Sustainability Team. This team continued to work with the Southeastern CAPT to further adapt the model to meet the cultural needs of North Carolina and develop the NC Keys to Sustainability.

The Sustainability Team uses the NC Keys to Sustainability model to provide training, technical assistance and support to communities across the state. The Keys to Sustainability is a strength based model that uses the Strategic Prevention Framework to assess the community's organizational capacity, ability to demonstrate effectiveness and community support and develop a plan that builds on the strengths in each of those areas.

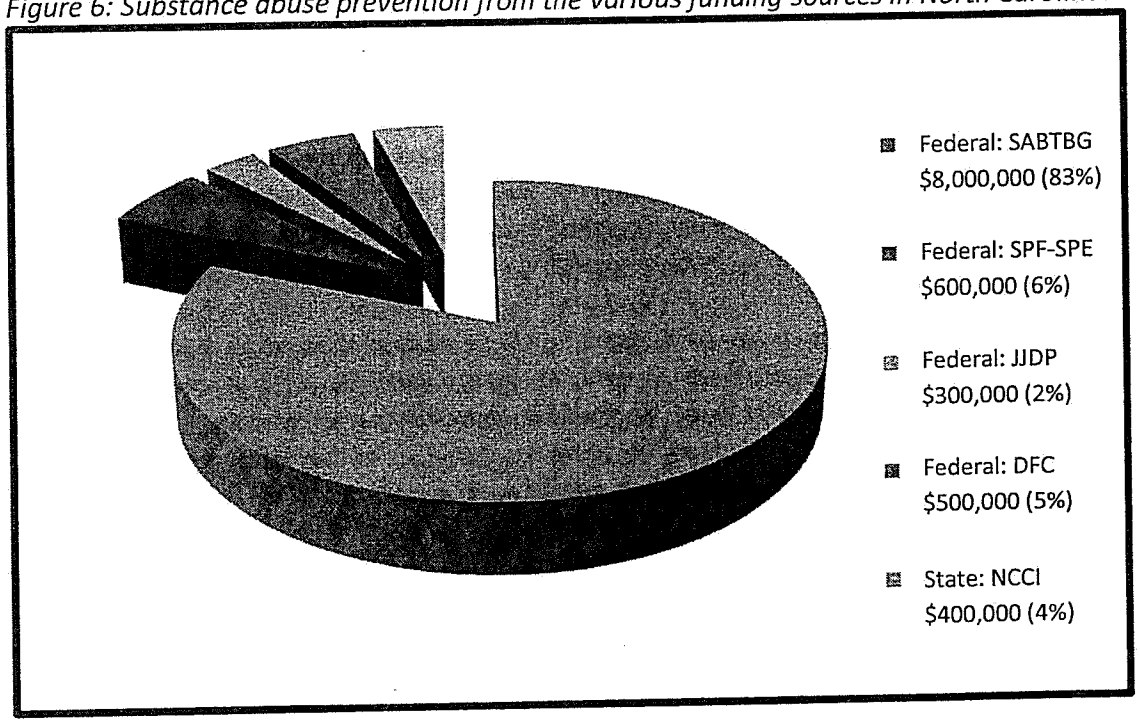
The Sustainability Team uses the NC Keys to Sustainability model to provide training, technical assistance and support to communities across the state. The NC Keys to Sustainability Model helps communities recognize the strengths they have and develop a plan to continue to build upon those strengths in the areas of organizational capacity, effectiveness and community support to ensure the sustainability of positive prevention outcomes.

North Carolina Division of MHDDSAS, Office of Prevention manages funding for substance abuse prevention from several sources to address the various gaps in services and programmatic needs identified by the local communities of the state. Local Management Entities/Managed Care Organizations (LME/MCOs) are a critical partner in the relationship between the state and the local level. LME/MCOs are responsible for managing, coordinating, facilitating and monitoring mental health, developmental disabilities, and substance abuse services in their area.

The majority of funding for substance abuse prevention is provided by the state through federal block grants or discretionary grants. The Substance Abuse Prevention and Treatment Block Grant (SAPTBG) 20% set-aside funds make up the largest portion of funding that target substance abuse prevention services. Approximately 83% of the dedicated substance abuse prevention funding is disseminated through SAPTBG to address relevant programs, practices and policies identified through the "strategic prevention framework" process in local communities **(Figure 6).**

Other federal funding includes a capacity grant from SAMHSA at 6% (SPF-SPE), the Enforcing Underage Drinking Laws 2% (JJDP) and Drug Free Communities at 5% (ONDCP). Some state money is dedicated to coalition building included at 4% (NCCI).

Figure 6: Substance abuse prevention from the various funding sources in North Carolina.



The North Carolina Preventing Underage Drinking Initiative is administered by DMHDDSAS in consultation with the University of North Carolina at Greensboro through the Federal OJJDP Enforcing Underage Drinking Laws (EUDL) Program. The EUDL Program supports and enhances state efforts to prohibit the sale, purchase and consumption of alcoholic beverages to and by minors within local communities (minors defined as individuals under 21 years of age). The EUDL supported coalitions work together to implement relevant environmental strategies. This funding from the Federal OJJDP will not have continued support for NC past June 2013.

The North Carolina Coalition Initiative (NCCI) is a state-supported effort for coalition building and mobilization around alcohol and drug issues. The state collaborates with Wake Forest University School of Medicine to coordinate technical assistance and training to emerging and established coalitions through a mini-grant process that supports 8 grantees statewide. Further technical assistance is provided by Community Anti-Drug Coalitions of America (CADCA). This initiative is contingent upon continued state funding. CADCA also provides national support to the Drug Free Community (DFC) grantee sites in NC. Four (4) new awards at $125,000 each for NC have been supported, in addition to ongoing support for others that have been previously awarded.

A sustainable comprehensive prevention infrastructure cannot be dependent on one source of funding. In order to support a sustainable prevention system at the local level, technical assistance and resources need to be available to local communities. It is important to utilize all

existing structure to maintain a sustainable infrastructure. The linkage, collaboration and coordination efforts identified in this plan will serve to support a sustainable prevention system that stands to affect the goal of reduction in substance use and abuse across the continuum of care.

Benefit and Savings

The pledge of the NC-SEOW members to continue to meet for an on-going dialogue and to share data will ensure a commitment to a data-driven process as it relates to substance abuse prevention and prevention of mental disorders. Together with the NCPOPS enhancements, a systematic, ongoing monitoring system of State substance-abuse related consumption patterns and consequences will allow the state to track progress on addressing prevention priorities, trends, and outcomes. Reviewing and utilizing this data will assist with deriving the benefits needed for prevention services. Cost indicators, types of prevention strategies and data elements all vary; but prevention science has demonstrated a 2 to 1 cost-benefit ratio for prevention services.

The benefits will be derived from choosing the most appropriate and cost effective strategy to address the identified priority areas. The Regional Evidence Based Workgroups will be charged with identifying the comparisons for particular types of programs implemented for universal, selective 0and indicated populations. We know that every $1 dollar spent on prevention directly, an estimated average of $60 is spent on public programs addressing the consequences of substance abuse. The benefits gained from intervening early demonstrates cost-savings that can be used by the prevention system to invest in sustained programs. As the Affordable Care Act supports more up-front preventive services, other federal dollars can contribute to supporting those services not covered. Emphasis on environmental strategies to address issues across the life span, at the community level, will demonstrate the benefits of reaching more people with a comprehensive approach.

The current prevention system utilizes the SAPTBG funds to contract with local LME/MCOs with disbursement of funds on a per capita basis. As the LME/MCOs increase their consumer base, it will be even more important to develop an equitable formula to reach those consumers in need. For prevention services, a formula that reaches "high risk" communities will be implemented on a competitive basis. The formula will take into account the data that reflects higher incidence and prevalence rates of the priorities identified by the state.

Cost-Savings.

Training and technical assistance to local communities to select the appropriate evidence-based strategies will save costs related to identifying and implementing the strategies that work. Local providers can document the costs related to implementing strategies and compare

savings based on analysis of social conditions affected if strategies were not implemented. Further training and technical assistance will be needed to assist with the development of an effective cost-savings matrix.
Collaboration and sharing of resources will create a cost savings as it reduces time each individual organization spends in research and decrease learning curve time. Surveys with each of the partners will assess increases in collaborations and determine the extent of the cost savings.

The NCPOPs enhancements will create savings in financial and human resources by decreasing the amount of time it takes to:

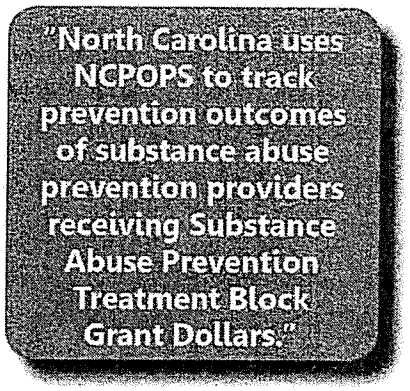
- report and enter data at the community level,
- generate reports on the local and state level, and
- compile data for state wide reports from multiple funding streams such as the block grants and discretionary awards, thus allowing data to be captured in the same system.

Cost savings will also occur in the reduction of local, regional, and state level staff time required to research resources and information. By enhancing the Centers for Prevention Resources (CPRs) online technologies enabling for free access to online prevention specific training hours, there will be a significant cost savings in workforce development trainings both in registration and travel expenses associated with training travel for all prevention professionals. The webinar and online meeting technologies will decrease the costs for travel time and coordination of logistics will represent cost savings for management of required meetings.

Cost savings occur as collaboration throughout the process and the maximizing of resource sharing increases as described above. The true impact of cost-savings occurs in the effective implementation of each of the elements of the comprehensive prevention system.

IX. PERFORMANCE AND EVALUATION

The need for an enhanced infrastructure is consistent with priorities of the state as stated in the North Carolina Department of Health and Human Service Goals to "expand awareness, understanding and use of information to enhance the health and safety of North Carolinians" and to "provide outreach, support and services to individuals and families identified as being at risk of compromised health and safety to eliminate or reduce those risks."



In addition, members of the Prevention Internal Management Team (IMT) have been participating in the development of the Healthy NC 2020 goals (www.nciom.org), which have aligned with addressing impact outcomes for substance abuse prevention. Alcohol and drug issues are identified in the top 5 initiatives for Healthy NC 2020. The proposed goals include:

- reduce the percentage of high school students that had alcohol on one or more of the past 30 days;
- reduce the percentage of traffic crashes that are alcohol-related; and
- reduce the percentage of individuals aged 12 years and older reporting any illicit drug use in the past 30 days.

During the SPE process, the IMT and Policy Consortium looked to integrate the progress and findings of the NC-2020 goals, align its strategies with the NCIOM Prevention Action Plan and work collaboratively with its community partners. The priorities identified by these processes serve as the initial focal points for priorities for the State. The periodic Community Profiles compiled by the SEOW help to focus efforts, assure strategies are in alignment with specific community needs and monitor progress.

Substance abuse prevention evaluation process and methodology. Local strategic plans were developed that reflect a data-driven system derived from county needs assessments or state-wide estimates from various data sources including the SEOW. A state-wide plan for infrastructure development is shared with the Local Management Entities (LMEs) to adopt as needed for local implementation. North Carolina uses the Prevention Outcomes Performance System (NCPOPS) to track prevention outcomes of substance abuse prevention providers receiving Substance Abuse Prevention Treatment Block Grant Dollars.

Table 8, Performance and Evaluation at a Glance—the Sustainable Perspective, indicates specific accomplishments and highlights action items needed over the next five years.

Table 8: Performance and Evaluation at a Glance—the Sustainable Perspective

Objective	Accomplishments to Date	5 Year Plan
5. To have a flexible response system that allows the prevention system to respond and adapt to changing needs.	☑ North Carolina Prevention Outcomes Performance System (NCPOPs) Database captures process outcomes ☑ Performance Evaluation Measures agreed upon	☐ Expand reporting features of NCPOPs to include impact outcomes and appropriate funding streams ☐ Provide training and technical assistance to LME/MCOs and providers on how to use available data to collect impact measures
6. To have decision making system in place that allows stakeholders to work together as an effective problem-solving group.	☑ SEOW data used for decision making ☑ Evidence Based Workgroups (EBW) Plan Developed ☑ Evaluation results shared with LME/MCOs in statewide systems performance report	☐ SEOW reviews state-wide and community profile to analyze trends and make recommendations for performance evaluation ☐ Develop Regional EBWs and identify performance measures ☐ Continuously evaluate status of capacity, service gaps and cost measures for appropriateness, alignment and reach
7. To adopt and utilize a comprehensive planning model.	☑ The Strategic Prevention Framework (SPF) has been adopted as the foundational tool for all prevention activities. ☑ Training and Technical Assistance Evaluation Logic Model Developed	☐ Use agreed upon measures to Develop Process and Impact Outcomes Monitoring Tool ☐ Review and revise as necessary training and technical assistance evaluation tool; disseminate results ☐ Track the completion of the Coordination of Services Plan, Data Collection and Reporting Plan, and Training and Technical Assistance plans and evaluate performance targets
8. To effectively use limited resources.	☑ NCPOPs Developed ☑ Community Social Indicator Study Developed ☑ State Epidemiological Profile Developed ☑ LME/MCOs gaps analysis completed	☐ Develop survey instrument to evaluate NCPOPs effectiveness. ☐ Develop impact evaluation on reaching overall goals and objectives ☐ Evaluate how communities are using local profiles and integrating with local priorities ☐ LME/MCOs conduct periodic updates on Gaps Analysis

Planning and Implementation

Success will be measured in terms of process and outcome:

- A process evaluation will be designed to examine the creation of the monitoring system and the extent to which providers use the monitoring system and how it impacts their job.
- An impact evaluation will be conducted to determine the impact on the capacity, service gaps, and cost.

Process Evaluation. The process evaluation will be used to determine the process involved in enhancing the NCPOPS monitoring system and any associated barriers as well as the effectiveness of the monitoring system for providers. To gather information related to the creation of the monitoring system, focus groups will be held with relevant stakeholders to determine the challenges, successes, and barriers to the creation of a statewide system. To collect information about providers' use of the system, we will conduct a survey of providers to determine their use of data monitoring tools developed during the grant. The survey will include questions that tap into items such as:

- Frequency of use of monitoring systems (e.g., daily, weekly, monthly);
- Helpfulness in doing current job;
- Usefulness in reaching target population;
- Helpfulness in aligning programs, practices, and policies with needs of target population;
- User friendliness of the system;
- Able to access needs assessment data in a way that is helpful in their community;
- Which data monitoring source is the most helpful? Are other community data sources used that are helpful?;
- Time and resource savings; and
- Overall impact.

We anticipate the survey will have about eight or nine questions and will take about ten minutes to complete. The survey will be administered to approximately thirty-five providers via the collaborative partnership with the Centers for Prevention Resources to use their email marketing system with a built in survey feature. The survey will be conducted every six months in order to assess changes in use of the monitoring systems.

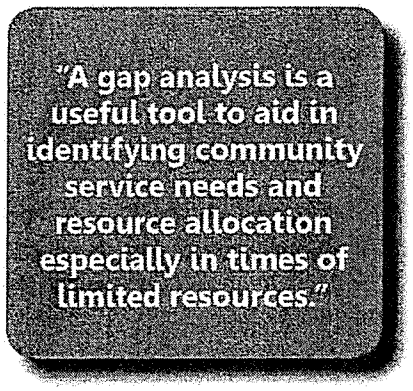
Impact Evaluation. The impact evaluation of prevention capacity efforts will examine three main outcomes: capacity, service gaps and costs.

Capacity-Several measures of capacity will be examined by:

- The number of partnerships and collaborations formed
    - Community survey data and collaboration mapping
- The increase in workforce development (i.e., the increase in prevention consultants certified)
- The number of technical assistance requests made

- The number of training opportunities provided
    - Satisfaction surveys will be conducted after the training sessions and will provide various indicators about the relevance, logistics and quality of the trainings offered.
- The number of people reached through mass communications and the type of communications used (e.g., email, website, social media). These communications have multiple goals. The first being the dissemination of information in a quick and timely manner to all parties in the state with a substance abuse prevention interest. The second goal focuses on creating the communication channels for each of the prevention organizations to communicate with one another, share ideas and resources. Enhanced communications will strengthen the unified prevention message across the state that will allow for each organization to clearly see their role in the prevention plan, increase buy in to the plan and ultimately create a foundation from which policies can be developed and implemented.
    - The number of people reached and engaged in the communication process will be tracked through online analytics of the email and social media channels.
    - Additional indicators of communication success will be documented by:
        - the completion of a unified 5-year strategic plan;
        - the number of organizations and partners that report knowledge of participation in the plan in satisfaction surveys; and
        - the number of policy changes that occur over the next five years.

Service Gaps-Two methods will be used to determine if service gaps have been bridged. First, the increase in the number of prevention professionals in provider organizations offering mental health and behavioral health services will be examined. These measures are collected in January and July each year for the North Carolina Substance Abuse Prevention Treatment Block Grant. As such, it will be determined if the number of prevention professionals in provider organizations offering such services increases.



Second, service gaps or unmet needs will be determined through a community needs assessment (i.e., gap analysis). A gap analysis is a useful tool to aid in identifying community service needs and resource allocation especially in times of limited resources. All Local Management Entities are required to conduct an assessment of their counties' needs every other year. To determine what service gaps exist in NC communities, the 2010 and 2014 community needs assessments will be examined to assess if service gaps have decreased during the capacity building efforts outlined in this plan.

Costs-Costs benefits savings will be achieved by increasing the communications and sharing of information and resources. Costs savings will occur in the reduction of staff time on the local, regional and state level it takes to research resources and information. By enhancing the Centers for Prevention Resources (CPRs) online technologies enabling for free access to online prevention specific training hours, there will be a significant cost savings workforce development trainings both in registration and travel expenses associated with training travel for all prevention professionals. The webinar and online meeting technologies also all for regional and statewide collaborative meetings of professionals. This service shared with the PACCs, PPA, CAAB and other partners decreases the travel time and expenses associated with collaborative meetings.

The development of the needs assessment tracking system that includes multiple data sources that is updated annually as outlined in the Data Collection, Analysis and Reporting Plan reduces the amount of time local providers and PACCs spend in researching local needs assessments and increases the effectiveness in aligning prevention services with the needs in the community.

Monitoring Outcome Measures. Over the next year, the NC Office of the Prevention will work collaboratively with the SEOW to identify key datasets across state and to select various outcome measures related to substance abuse, mental health, and behavioral health for inclusion in a statewide database. Additionally, as NCPOPs is enhanced, outcome level data will be collected from the sub-recipient communities and reported in seven common domains that are consistent with the NOMS. As outlined in the Data Collection, Analysis and Reporting Plan, this system will also be enhanced to include additional prevention partners including the Centers for Prevention Resources, Preventing Underage Drinking Collaboratives and North Carolina Coalition Initiative Sites. The addition of these measures in a statewide database will allow for continuous tracking of various measures which will enable the project to assess its progress and provide a continuum for communication and overall adjustments. The five year strategic plan will include the sustainability of these databases and the use of them for aligning effective prevention strategies with targeted populations and the evaluation of those outcomes.

The Internal Management Team will have overall responsibility for the collection and reporting of information related to performance assessment. Specifically, data for two GPRA measures will be collected.

Other supporting evaluation data will be collected and includes the following benchmarks:

- A summary of the progress and accomplishments made to date in meeting the goals and objectives outlined in the four mini plans that comprise the Capacity Building/Infrastructure Enhancement Plan.
- An explanation of how all remaining efforts to accomplish these mini plans will be implemented and sustained, including a timeline for their completion.

Evaluation of the Coordination of Services will include process data that:

- tracks the completion of each of the plan developments outlined in the timeline and
- will use satisfaction surveys to monitor the extent of and sense of inclusion by each of the partners.

X. IMPLEMENTATION PLAN and TIMELINE

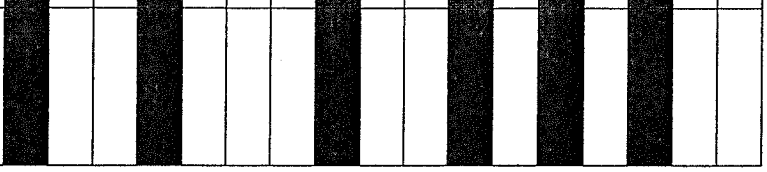
Data Collection, Analysis and Reporting Action Plan and Timeline																					
Task	Responsible Party	2012				2013				2014				2015		2016		2017	
		Jan – Mar	Apr - June	July - Sept	Oct – Dec	Jan – Mar	Apr - June	July - Sept	Oct – Dec	Jan – Mar	Apr - June	July - Sept	Oct – Dec	Jan - June	July - Dec	Jan - June	July - Dec	Jan - June	July - Dec
Revise Post surveys for trainings	CPRs					■													
Annual evaluation outcome report	IMT PUD							■				■			■		■		■
NCPOPS: Inclusion of NCCI Activity Tracking and Reporting	IMT NCCI					■													
NCPOPS: Submit contract amendment for Real Time Data	IMT				■														
NCPOPS: KIT Solutions customizes North Carolina Enhancements	IMT					■	■												
NCPOPS: Pilot Testing and debugging Enhancement of Local and State Reporting Features	IMT						■	■	■										
NCPOPS: Training and TA for LMES and providers	IMT					■		■			■			■		■		■	
NC POPS: LMEs and Providers begin using the new enhancements	IMT									■	■								
Social Indicator Study Additional Variable Selection	SEOW	■	■																
Social Indicator Study Enhancement Product Development	SEOW RTI			■															
Review and Evaluate Cost Benefit of Data Systems	SEOW					■	■	■											
Review NCPOPS data collection, reporting and analysis	IMT Policy Consortium SEW							■				■			■		■		■
Develop Evidence-Based Workgroup (EBW) Plan		■	■	■															
Finalize Policies and Procedures for the EBWs	SEOW Policy Consortium CPRs				■	■	■												
Implement EBWs on the Regional Level	SEOW CPRs							■	■	■									
Develop plan for further enhancements to data collection, analysis, and reporting.	IMT CPRs	■	■	■															

Coordination of Services Action Plan and Timeline

Task	Responsible Party	2012				2013				2014				2015		2016		2017	
		Jan – Mar	Apr - June	July - Sept	Oct – Dec	Jan – Mar	Apr - June	July - Sept	Oct – Dec	Jan – Mar	Apr - June	July - Sept	Oct – Dec	Jan - June	July - Dec	Jan - June	July - Dec	Jan - June	July - Dec
Policy Consortium Development: Finalize profile of pertinent partners outlining roles and responsibilities	CAAB IMT Consortium																		
Policy Consortium Development: Review memoranda of understanding between partners	CAAB IMT Consortium																		
Policy Consortium Meetings (Quarterly)	CAAB Consortium																		
Develop Interagency Coordination Plan	CAAB LME/MCO																		
Cooperative Agreement Advisory Board Meetings (Quarterly)	CAAB																		
Develop Cultural Responsiveness Plan	IMT																		
Develop Cultural Responsiveness Curriculum	IMT																		
PACC Leadership Team Meetings (Quarterly)	PACC LME/MCO																		
Prevention is the Answer and PACC Summit	PPA PACC NCSAPPA																		
Develop Cross Sector Communication Plan	CPRs Lead PACCs PPA CAAB																		

Technical Assistance and Training Action Plan and Timeline

Task	Responsible Party	2012				2013				2014				2015		2016		2017	
		Jan – Mar	Apr - June	July - Sept	Oct – Dec	Jan – Mar	Apr - June	July - Sept	Oct – Dec	Jan – Mar	Apr - June	July - Sept	Oct – Dec	Jan - June	July - Dec	Jan - June	July - Dec	Jan - June	July - Dec
Provide training to providers, PACCs and LMEs to meet the needs of the field and increase the number of credentialed professionals.	CPRs																		
Provide technical assistance and coaching to providers, PACCs, and LMEs on evidence- based programs, practices and policies to address targeted variables in their community.	CPRs EBW																		
Provide information technology and media to providers and PACCs to increase effective communication and access to resources.	CPRs																		
Webinar evaluation post event for ease of use, usefulness of topic content, additional training needs and overall satisfaction	CPRs																		
Annual training needs assessment to align topic content with participant need	CPRs																		
Retrospectives will be collected from training participants post training on knowledge or skills increased and intent to use information in the future	CPRs																		
Retrospective on participants attending classes geared toward improving credentialing outcomes to determine usefulness of training on successful completion of the exam process	CPRs																		
Webinar engagement data will be analyzed every month to determine participant engagement during training (provided by Web-ex systems)	CPRs																		
Retrospective on participant feedback will be analyzed every six months for quality assurances check	CPRs																		

of effectiveness and potential need for modification of strategies		
Number of NC Substance Abuse Professional Practice Board approved hours of training (CEUs) provided will be measured each year	CPRs	
Number of training events provided on evidence based programs, practices or polices will be measured each year	CPRs	
Number of certified substance abuse prevention consultants (CSAPCs) registered with the NCSAPPB will be measured each year		

Performances and Evaluation Plan and Timeline

Task	Responsible Party	2012				2013				2014				2015		2016		2017	
		Jan – Mar	Apr - June	July - Sept	Oct – Dec	Jan – Mar	Apr - June	July - Sept	Oct – Dec	Jan – Mar	Apr - June	July - Sept	Oct – Dec	Jan - June	July - Dec	Jan - June	July - Dec	Jan - June	July - Dec
NCPOPS reporting feature expansion	IMT																		
Annual evaluation outcome report	IMT PUD																		
LME/MCO Training on NCPOPS	IMT																		
Review of Statewide and Community Profiles	IMT SEOW																		
Develop Regional EBWs	SEOW Policy Consortium NC CPRs																		
Identify Performance Measures for EBWs	SEOW CPRs																		
Evaluate status of capacity and service gaps	IMT																		
Evaluate cost measures	IMT																		
Develop Process and Impact Outcomes Monitoring Tool	IMT																		
Review Technical Assistance Evaluation Results	IMT NC CPRs																		
Disseminate Technical Assistance and Training Evaluation Results	IMT NC CPRs																		
Review NCPOPS data collection, reporting and analysis	IMT Policy Consortium SEW																		
Develop Survey Instrument to Evaluate NCPOPS Effectiveness	IMT																		
Evaluate how communities are using local profiles and integrating with local priorities	SEOW IMT NC CPRs																		
Local Gaps Analysis	LMEs/MCOs IMT																		

XI. CONCLUSION

The Healthy NC 2020: A Better State of Health has set the stage to incorporate alcohol and substance use, mental health and tobacco use measures in analyzing overall health for North Carolina. The emphasis on the need for prevention services has increased within the state with an acknowledgement that prevention can be cost-effective, reduces health care costs, and improves productivity. The Strategic Prevention Framework/State Prevention Enhancement (SPF/SPE) cooperative agreement has afforded North Carolina, through the Division of MHDDSAS and its Office of Prevention, to develop a plan that addresses the impact of alcohol, substance use, tobacco and mental health issues. This plan will be inclusive of all stakeholders and partners to direct attention to the agreed upon measures. The objectives and goals that have been identified are for measuring progress and sustaining a comprehensive approach to addressing the issues of preventing substance abuse and some mental disorders. The measures are indicated in the grid below:

Table 9: Substance Abuse and Mental Health Focused Healthy NC 2020 Objectives

Healthy NC 2020 Objectives	Baseline	2020 Goal	Data Source
Substance Use			
Reduce the percentage of high school students who had alcohol on one or more of the past 30 days	35.0% *(2009)*	26.4%	YRBS
Reduce the percentage of traffic crashes that are alcohol related	5.7% *(2008)*	4.7%	HSRC
Reduce the percentage of individuals aged 12 years and older reporting any illicit drug use in the past 30 days	7.8% *(2007-08)*	6.6%	YRBS
Tobacco Use			
Decrease the percentage of adults who are current smokers	20.3% *(2009)*	13.0%	BRFSS
Decrease the percentage of high school students reporting current use of any tobacco product	25.8% *(2009)*	15.0%	CDC
Decrease the percentage of people exposed to second-hand smoke in the workplace in the past seven days	14.6% *(2008)*	0%	CDC
Mental Health			
Reduce the suicide rate (per 100,000 population)	12.4 suicides per 100,000 *(2008)*	8.3 suicides per 100,000	State Center for Health Statistics
Decrease the average number of poor mental health days among adults in the past 30 days	3.4 days *(2008)*	2.8 days	BRFSS
Reduce the rate of mental health-related visits to emergency departments (per 10,000 population)	92.0 visits per 10,000 *(2008)*	82.8 visits per 10,000	NC DETECT
Death			
Reduce unintentional poisoning mortality rate (per 100,000)	*11 deaths per 100,000 (2008)*	9.9 deaths per 100,000	Injury Prevention & Control

To address the goals, the comprehensive prevention plan focusing on the priority areas identified, has been divided into three (4) distance plans incorporating cultural responsiveness and sustainability components at every level. Those include:

- Coordination of Services
- Data Collection, Analysis and Reporting
- Technical Assistance and Training
- Performance Evaluation

The Implementation Plan and Timeline will guide the process for the measurement of process and impact outcomes that will be periodically reported into a monitoring system to give feedback for continued planning. The expectation of the SPF-SPE is to address several pertinent areas. A synopsis of those areas are highlighted as:

1. The NC State Epidemiology Outcomes Workgroup (NC-SEOW) has identified priority substance abuse prevention needs in the State Epi Report as well as identified community-level consumption and consequence data in the Social Indicator Study. The NC-SEOW continues to make on going recommendations to the Policy Consortium.

2. Data-driven goals and objectives taken from the Epidemiology Profile is identified and explained and will be quantified, monitored and evaluated for change over time.

3. Provides essential goals, objectives, and strategies for coordinating services with public and private service delivery systems, including primary health care.

4. The Policy Consortium developed and agreed to the Memorandum of Agreement that outlines their mission for the next five years. The Policy Consortium looked at the recommendations of the NC-SEOW, reviewed the current plans and documents for partners state organizations and decided upon the goals for the 5 Year Comprehensive Plan.

5. Communities are required to use the Strategic Prevention Framework to identify target audiences and contributing factors. The NC CPRs provide technical assistance to communities during the process. NC has also created the Regional Evidence Based Workgroups to ensure the most appropriate programs, policies and practices are selected to address the contributing factors in each community.

6. Funding formulas are derived from discussion with the SPE Policy Consortium, for allocating State substance abuse prevention resources to identified communities of greatest need according to data collected from Community Social Indicator Study.

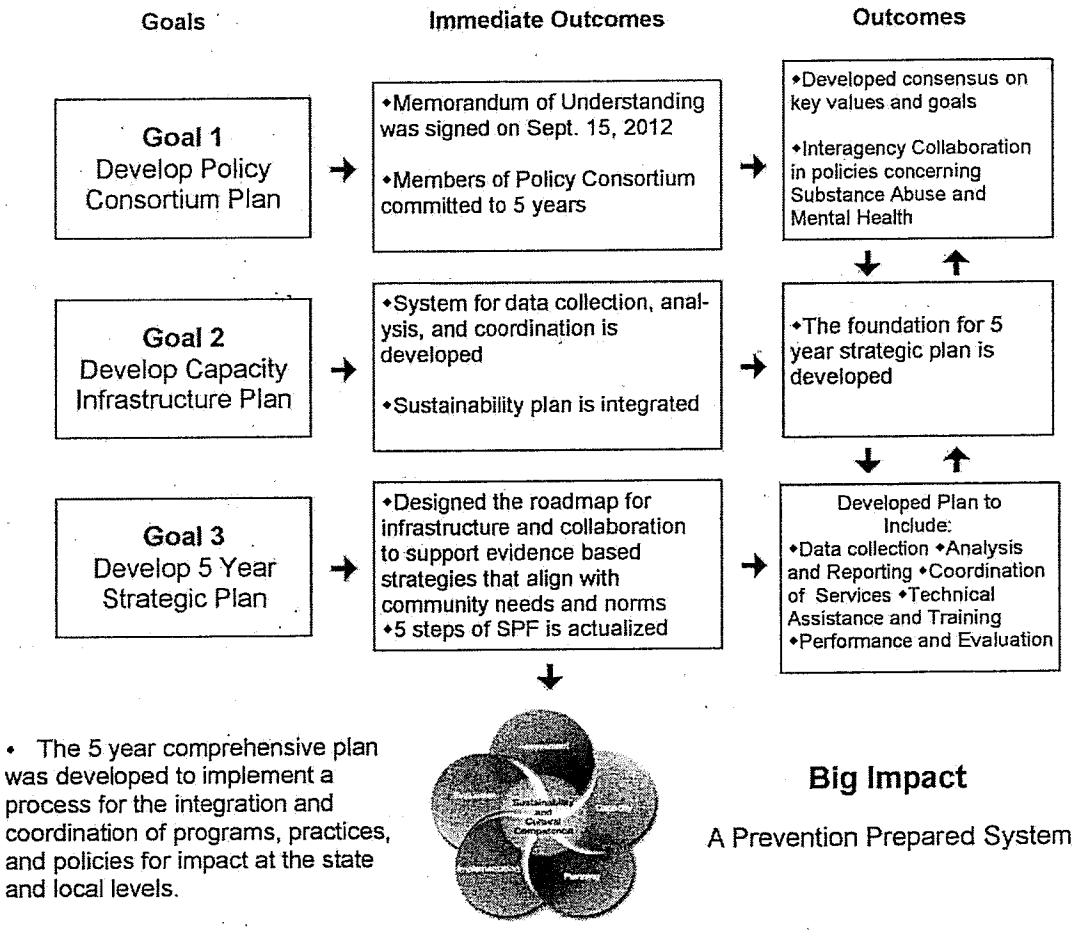
7. A comprehensive 5 year timeline outlines expected completion dates for each task and identifies those responsible for their completion.

8. The Performance and Evaluation section identifies baseline and outcomes measures as well as processes and procedures for conducting the evaluation.

9. The entire plan is built upon the foundation of the NC Keys to Sustainability. The Sustainability Section describes the primary strategies for sustaining the infrastructure and outcomes, and for implementing the plans developed as a result of this grant.

The proposed activities for the SPF/SPE comprehensive 5-Year Plan for Substance Abuse Prevention and Mental Health promotion will center on a solid board to drive enhancement, a structured system for building capacity, a formal framework to implement the 5-step SPF process, and an evaluation system implemented to track and analyze performance. See logic model below **(Figure 7).** The Policy Consortium will provide the avenue for stakeholders to come to consensus about operationalizing the plan and the mechanism to achieve the goals of enhancing the existing structure and maintaining a system to sustain needed elements. The 5-year plan contains all the elements needed to maintain "a good and modern system" for prevention services at the state and local levels. These activities are the structure of the proposed objectives for the SPE and are identified as the key activities for producing relevant outcomes related to moving the North Carolina prevention system down the right track.

Figure 7: Strategic Prevention Framework-State Enhancement Grant Logic Model



The 5 year strategic plan addresses infrastructure and collaboration to support evidence based strategies that align with community needs and workforce development for prevention professionals The SPE grant aligns itself with SAMHSA's Strategic Initiative # 1, focusing on goal # 1: Prevention of Substance Abuse and Mental Illness

XII. APPENDICES

Appendix A:	NC Healthy 2020 Plan Objectives
Appendix B:	NCIOM Taskforce Recommendations on Prevention
Appendix C:	LME/MCO List of Providers
Appendix D:	Policy Consortium List of Representatives
Appendix E:	Policy Consortium MOU
Appendix F:	SEOW Charter
Appendix G:	Professional and Provider Associations
Appendix H:	Content Strategy
Appendix I:	State Epi Profile
Appendix J:	Social Indicator Study
Appendix K:	Evidence-based Workgroup Concept Paper
Appendix L:	NC Centers for Prevention Resources Core Functions

HEALTHY NORTH CAROLINA 2020 OBJECTIVES

	Current	2020 Target
Tobacco Use		
1) 1. Decrease the percentage of adults who are current smokers	20.3% (2009)	13.0%
2) Decrease the percentage of high school students reporting current use of any tobacco product	25.8% (2009)	15.0%
3) Decrease the percentage of people exposed to secondhand smoke in the workplace in the past seven days	14.6% (2008)	0%
Physical Activity and Nutrition		
4) Increase the percentage of high school students who are neither overweight nor obese	72.0% (2009)	79.2%
5) Increase the percentage of adults getting the recommended amount of physical activity	46.4% (2009)	60.6%
6) Increase the percentage of adults who consume five or more servings of fruits and vegetables per day	20.6% (2009)	29.3%
Injury and Violence		
7) Reduce the unintentional poisoning mortality rate (per 100,000 population)	11.0 (2008)	9.9
8) Reduce the unintentional falls mortality rate (per 100,000 population)	8.1 (2008)	5.3
9) Reduce the homicide rate (per 100,000 population)	7.5 (2008)	6.7
Maternal and Infant Health		
10) Reduce the infant mortality racial disparity between whites and African Americans	2.45 (2008)	1.92
11) Reduce the infant mortality rate (per 1,000 live births)	8.2 (2008)	6.3
12) Reduce the percentage of women who smoke during pregnancy	10.4% (2008)	6.8%
Sexually Transmitted Disease and Unintended Pregnancy		
13) .Decrease the percentage of pregnancies that are unintended	39.8% (2007)	30.9%
14) Reduce the percentage of positive results among individuals aged 15 to 24 tested for chlamydia	9.7% (2009)	8.7%
15) Reduce the rate of new HIV infection diagnoses (per 100,000 population)	24.7 (2008)	22.2
Substance Abuse		
16) Reduce the percentage of high school students who had alcohol	35.0% (2009)	26.4%

on one or more of the past 30 days		
17) Reduce the percentage of traffic crashes that are alcohol-related	5.7% (2008)	4.7%
18) Reduce the percentage of individuals aged 12 years and older reporting any illicit drug use in the past 30 days	7.8% (2007-08)	6.6%
Mental Health		
19) Reduce the suicide rate (per 100,000 population)	12.4 (2008)	8.3
20) Decrease the average number of poor mental health days among adults in the past 30 days	3.4 (2008)	2.8
21) Reduce the rate of mental health-related visits to emergency departments (per 10,000 population)	92.0 (2008)	82.8
Oral Health		
22) Increase the percentage of children aged 1-5 years enrolled in Medicaid who received any dental service during the previous 12 months	46.9% (2008)	56.4%
23) Decrease the average number of decayed, missing, or filled teeth among kindergartners	1.5 (2008-09)	1.1
24) Decrease the percentage of adults who have had permanent teeth removed due to tooth decay or gum disease	47.8% (2008)	38.4%
Environmental Health		
25) Increase the percentage of air monitor sites meeting the current ozone standard of 0.075 ppm	62.5% (2007-09)	100.0%
26) Increase the percentage of the population being served by community water systems (CWS) with no maximum contaminant level violations (among persons on CWS)	92.2% (2009)	95.0%
27) Reduce the mortality rate from work-related injuries (per 100,000 equivalent full-time workers)	3.9 (2008)	3.5
Infectious Disease and Foodborne Illness		
28) Increase the percentage of children aged 19-35 months who receive the recommended vaccines	77.3% (2007)	91.3%
29) Reduce the pneumonia and influenza mortality rate (per 100,000 population)	19.5 (2008)	13.5
30) Decrease the average number of critical violations per restaurant/food stand	6.1 (2009)	5.5
Social Determinants of Health		
31) Decrease the percentage of individuals living in poverty	16.9% (2009)	12.5%
32) Increase the four-year high school graduation rate	71.8% (2008-09)	94.6%
33) Decrease the percentage of people spending more than 30% of their income on rental housing	41.8% (2008)	36.1%
Chronic Disease		

34) Reduce the cardiovascular disease mortality rate (per 100,000 population)	256.6 (2008)	161.5
35) Decrease the percentage of adults with diabetes	9.6% (2009)	8.6%
36) Reduce the colorectal cancer mortality rate (per 100,000 population)	15.7(2008)	10.1
Cross-cutting		
Increase average life expectancy (years)	77.5 (2008)	79.5
Increase the percentage of adults reporting good, very good, or excellent health	81.9% (2009)	90.1%
Reduce the percentage of non-elderly uninsured individuals (aged less than 65 years)	20.4% (2009)	8.0%
Increase the percentage of adults who are neither overweight nor obese	34.6% (2009)	38.1%

APPENDIX B

NCIOM Taskforce Recommendations on Substance Abuse Prevention from the Executive Summary of the NCIOM's Prevention Action Plan. For complete report, visit http://www.nciom.org/wp-content/uploads/NCIOM/projects/prevention/finalreport/PreventionReport-July2010.pdf .

Prevention for the Health of North Carolina:

Prevention Action Plan

October 2009

Prevent Substance Abuse and Improve Mental Health

Substance use and abuse is both a health problem in itself, as well as a health risk contributing to other health problems. People with substance abuse problems or dependence are at risk for premature death, co-morbid health conditions, and disability. In addition, the use of alcohol and other drugs can also lead to other health problems, including injuries, unintended pregnancies, and sexually transmitted diseases.

Substance abuse carries additional adverse consequences for an individual, his or her family, and society at large. People with addiction disorders are more likely than people with other chronic illnesses to end up in poverty, lose their jobs, or experience homelessness. Addiction to drugs or alcohol contributes to the state's .

crime rate, family upheaval, and motor vehicle fatalities. Approximately 90% of the criminal offenders who enter the prison system have substance abuse problems.[44]

More than two out of five youth in the state's juvenile justice system are in need of further assessment or treatment services for substance abuse.[45] Substance abuse is also one of the primary causes for motor vehicle fatalities, contributing to more than one-quarter (26.8%) of crash-related deaths.[46] Alcohol or drug use is also a major contributor to family disintegration.

Approximately 8% of North Carolinians ages 12 or older reported alcohol or illicit drug dependence or abuse.[47] Youth are particularly susceptible to the influence of drugs or alcohol, as these substances affect the developing brain. Almost 40% of North Carolina high school students reported having at least one drink in the last 30 days, more than 20% reported binge drinking, and almost as many reported using marijuana or taking prescription drugs without a prescription.[48]

Evidence-based prevention strategies have been shown to be effective in delaying initiation and reducing use of alcohol and other drugs. Many of these programs have also demonstrated other positive effects, such as an improved sense of well-being, reduced depression, reduced delinquency or violence among school aged children, reduced teen pregnancy or risky sexual behavior, and improved academic performance. The most effective prevention strategies are those that involve multifaceted interventions that include the individual, family, schools, and community and are reinforced by supportive public policies, including tax increases on alcohol. Communities can save four to five dollars for every one dollar spent on substance abuse prevention.[49]

Prevention should be the cornerstone of North Carolina's efforts to reduce inappropriate use, misuse, and dependence on alcohol and other drugs, and to prevent the incidence and severity of stress, depression, or other anxiety disorders. Evidence-based prevention programs have been shown to help reduce use and misuse of substances as well as reduce symptoms of depression. However, no prevention intervention will totally eliminate all harmful use of alcohol or other drugs, or feelings of isolation, depression, or stress. Thus, it is important to combine prevention with early intervention activities. Primary care practices are an optimal setting in which to provide early intervention services, including screening, motivational counseling, and referral into treatment for those who need more intensive treatment services for substance use or abuse or mental health problems. Additionally, the faith community may be an appropriate and ideal place for early intervention, especially for people who are uncomfortable seeking help, unaware of needing help, or unsure of how to begin the help process.

Recommendation 6.1: Develop and Implement a Comprehensive Substance Abuse Prevention Plan (PRIORITY RECOMMENDATION)

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should develop a comprehensive substance abuse prevention plan for use at the state and local levels. The plan should increase capacity at the state level and within local communities to implement a comprehensive substance abuse prevention system, prioritizing efforts to reach children, adolescents, young adults, and their parents. The plan should be pilot tested in six counties or multi-county areas, and if effective, should be implemented statewide. The North Carolina General Assembly

Environmental Factors and Plan

11. 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) Are you considering any of the following:

	Targeted services for veterans	(•) Yes ( ) No
	Expansion of services for:	
(1)	Adolescents	( ) Yes (•) No
(2)	Other Adults	( ) Yes (•) No
(3)	Medication-Assisted Treatment (MAT)	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 9. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Either directly or through and arrangement with public or private non-profit entities make pernatal care available to PWWDC receiving services? (●) 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 Are you considering 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, custody issue (●) 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

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	○ Yes ◉ No
b)	14-120 day performance requirement with provision of interim services	◉ Yes ○ No
c)	Outreach activities	◉ Yes ○ No
d)	Syringe services programs	◉ Yes ○ No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	◉ Yes ○ No

2. Are you considering 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 (military families, veterans, adolescents, older adults)	◉ Yes ○ No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

1. Review of mandatory reporting measures of LME-MCOs, including the requirement to treat individuals with an SUD as "urgent," therefore requiring appointments for care within 48 hours of a call coming in to the LME-MCO 24/7/365 helpline. LME-MCOs are also required to connect individuals being discharged from an inpatient setting within seven days of discharge.
2. Annual monitoring of all SABG-funded services.
3. Semi-Annual SABG Compliance Reports are completed by LME-MCOs and reviewed by Division staff to assure compliance.
4. Review of this and other SABG requirements annually during monthly calls with LME-MCO points of contact for SUD services.

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. Are you considering 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. Review of this and other SABG requirements annually during 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 maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery? ○ Yes ○ No

2. Are you considering any of the following:

a)	Establishment of EIS-HIV service hubs in rural areas	○ Yes ○ No
b)	Establishment or expansion of tele-health and social media support services	○ Yes ○ No
c)	Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS	○ Yes ○ No

Syringe Service Programs

1.	Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)?	(•) Yes ( ) No
2.	Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?	(•) Yes ( ) No
3.	Do any of the programs use SABG funds to support elements of a Syringe Services Program?	( ) Yes (•) No

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Syringe 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. Are you considering any of the following:

- **a)** Workforce development efforts to expand service access — ○ Yes ◉ No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ◉ Yes ○ No
- **c)** Establish a peer recovery support network to assist in filling the gaps — ◉ Yes ○ No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — ◉ Yes ○ No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ◉ Yes ○ No
- **f)** Explore expansion of service 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. Are you considering 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, e.g. 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. Are you considering any of the following:

- **a)** Notice to Program Beneficiaries — ○ Yes ◉ No
- **b)** Develop an organized referral system to identify alternative providers — ◉ Yes ○ No
- **a)** Develop 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. Are you considering 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. Are you considering any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — (●) Yes ( ) No

c) Updating written procedures which regulate and control access to records — (●) Yes ( ) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure — (●) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

During any given year, there are approximately 50 to 60 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, 8 to 10 programs participate in Independent Peer Review in NC, typically about 10% of contracted providers.

3. Are you considering 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) Develop 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, e.g., 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. Are you considering any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service (●) Yes ( ) No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ( ) Yes (●) No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opertunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state (●) Yes ( ) No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services (●) Yes ( ) No

c) Preformance-based accountability ( ) Yes (●) No

d) Data collection and reporting requirements (●) Yes ( ) No

2. Are you considering 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

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, which govern the Mental Health and Substance Use Disorder Programs.

Please see the attachments section for a document containing links to all applicable rules.

Footnotes:

*RULES 10A NCAC CHAPTER 27 RULES FOR COMMUNITY MH/DD/SAS FACILITIES AND SERVICES

***SUBCHAPTER 27A – FISCAL RULES**	
10A NCAC 27A .0203	EARLY INTERVENTION - STATE AND FEDERAL FUNDS
10A NCAC 27A .0205	FUNDING ALCOHOL AND DRUG EDUCATION TRAFFIC SCHOOLS
10A NCAC 27A .0209	COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT
10A NCAC 27A .0214	TREATMENT ALTERNATIVES FOR WOMEN
10A NCAC 27A .0216	SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
SUBCHAPTER 27G - RULES FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE FACILITIES AND SERVICES	
SECTIONS .0100 - .0900 – CORE MH/DD/SAS RULES APPLICABLE TO ALL PROGRAMS AND FACILITIES UNLESS OTHERWISE SPECIFIED	
Section .0100 General Information	
10A NCAC 27G .0101	SCOPE
10A NCAC 27G .0102	COPIES OF RULES
10A NCAC 27G .0103	GENERAL DEFINITIONS
10A NCAC 27G .0104	STAFF DEFINITIONS
SECTION .0200 - OPERATION AND MANAGEMENT RULES	
10A NCAC 27G .0201	GOVERNING BODY POLICIES
10A NCAC 27G .0202	PERSONNEL REQUIREMENTS
10A NCAC 27G .0203	COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS
10A NCAC 27G .0204	COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS
10A NCAC 27G .0205	ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN
10A NCAC 27G .0206	CLIENT RECORDS
10A NCAC 27G .0207	EMERGENCY PLANS AND SUPPLIES
10A NCAC 27G .0208	CLIENT SERVICES
10A NCAC 27G .0209	MEDICATION REQUIREMENTS
10A NCAC 27G .0210	RESEARCH REVIEW BOARD
10A NCAC 27G .0212	DISCLOSURE OF FINANCIAL INTEREST OF PROVIDERS OF MH/DD/SA SERVICES TO POTENTIAL CLIENTS
SECTION .0300 - PHYSICAL PLANT RULES	
10A NCAC 27G .0301	COMPLIANCE WITH BUILDING CODES
10A NCAC 27G .0302	FACILITY CONSTRUCTION/ALTERATIONS/ADDITIONS

10A NCAC 27G .0303	LOCATION AND EXTERIOR REQUIREMENTS
10A NCAC 27G .0304	FACILITY DESIGN AND EQUIPMENT
SECTION .0400 - LICENSING PROCEDURES	
10A NCAC 27G .0401	LICENSE REQUIRED
10A NCAC 27G .0402	LICENSE ISSUANCE
10A NCAC 27G .0403	DEEMED STATUS
10A NCAC 27G .0404	OPERATIONS DURING LICENSED PERIOD
10A NCAC 27G .0405	LICENSE DENIAL, AMENDMENT OR REVOCATION
10A NCAC 27G .0406	LETTER OF SUPPORT REQUIRED FOR LICENSURE OF RESIDENTIAL FACILITIES
SECTION .0500 - AREA PROGRAM REQUIREMENTS	
10A NCAC 27G .0501	REQUIRED SERVICES
10A NCAC 27G .0502	AREA PROGRAM/HOSPITAL AGREEMENT
10A NCAC 27G .0503	STAFF REQUIREMENTS
10A NCAC 27G .0504	CLIENT RIGHTS COMMITTEE
10A NCAC 27G .0505	NOTIFICATION PROCEDURES FOR PROVISION OF SERVICES
10A NCAC 27G .0506	COMMUNICATION PROCEDURES FOR OUT OF HOME COMMUNITY PLACEMENT
10A NCAC 27G .0507	AREA BOARD ANNUAL EVALUATION OF AN AREA DIRECTOR
SECTION .0600 – AREA AUTHORITY OR COUNTY PROGRAM MONITORING OF FACILITIES AND SERVICES	
10A NCAC 27G .0601	scope
10A NCAC 27G .0602	DEFINITIONS
10A NCAC 27G .0603	incident response requirements for CATEGORY a and b providers
10A NCAC 27G .0604	incident reporting requirements for category a and b providers
10A NCAC 27G .0605	LOCAL MANAGEMENT Entity MANAGEMENT OF INCIDENTS
10A NCAC 27G .0606	REFERRAL OF COMPLAINTS TO LOCAL MANAGEMENT ENTITIES PERTAINING TO CATEGORY A OR CATEGORY
10A NCAC 27G .0608	LOCAL MONITORING
10A NCAC 27G .0609	LOCAL MANAGEMENT ENTITY REPORTING REQUIREMENTS
10A NCAC 27G .0610	REQUIREMENTS CONCERNING THE NEED FOR PROTECTIVE SERVICES
SECTION .0800 - WAIVERS AND APPEALS	
10A NCAC 27G .0801	SUBMISSION OF REQUESTS FOR WAIVERS OF RULES

10A NCAC 27G .0802	CONTENTS OF WAIVER REQUESTS
10A NCAC 27G .0803	PROCEDURE FOR WAIVERS BY COMMISSION
10A NCAC 27G .0804	WAIVERS REQUESTED BY COMMISSION
10A NCAC 27G .0805	PROCEDURE FOR WAIVERS BY DIVISION DIRECTOR
10A NCAC 27G .0806	WAIVERS REQUESTED BY DIVISION DIRECTOR
10A NCAC 27G .0807	RESERVED FOR FUTURE CODIFICATION
10A NCAC 27G .0808	APPEALS PROCEDURES FOR CONTRACT PROVIDERS
10A NCAC 27G .0809	RESERVED FOR FUTURE CODIFICATION
10A NCAC 27G .0810	state mh/dd/sa appeals PANEL administrative review PROCEDURES
10A NCAC 27G .0811	STATE MH/DD/SA APPEALS PANEL HEARING PROCEDURES
10A NCAC 27G .0812	STATE MH/DD/SA APPEALS PANEL HEARING DECISIONS
10A NCAC 27G .0813	WAIVER OF LICENSURE RULES
SECTION .0900 - GENERAL RULES FOR INFANTS AND TODDLERS	
10A NCAC 27G .0901	SCOPE
10A NCAC 27G .0902	DEFINITIONS
10A NCAC 27G .0903	GENERAL REQUIREMENTS FOR INFANTS AND TODDLERS
10A NCAC 27G .0904	SURROGATE PARENTS
10A NCAC 27G .0905	PROCEDURAL REQUIREMENTS
SECTIONS .1000 - .1900 MENTAL HEALTH PROGRAM RULES **SECTION .1100 - PARTIAL HOSPITALIZATION FOR INDIVIDUALS WHO ARE ACUTELY MENTALLY ILL**	
10A NCAC 27G .1101	SCOPE
10A NCAC 27G .1102	STAFF
10A NCAC 27G .1103	OPERATIONS
SECTION .1200 - PSYCHOSOCIAL REHABILITATION FACILITIES FOR INDIVIDUALS WITH SEVERE AND PERSISTENT MENTAL ILLNESS	
10A NCAC 27G .1201	SCOPE
10A NCAC 27G .1202	STAFF
10A NCAC 27G .1203	OPERATIONS
SECTION .1300 - RESIDENTIAL TREATMENT FOR CHILDREN OR ADOLESCENTS	
10A NCAC 27G .1301	SCOPE

10A NCAC 27G .1302	STAFF
10A NCAC 27G .1303	OPERATIONS
10A NCAC 27G .1304	PHYSICAL PLANT
SECTION .1400 - DAY TREATMENT FOR CHILDREN AND ADOLESCENTS WITH EMOTIONAL OR BEHAVIORAL DISTURBANCES	
10A NCAC 27G .1401	SCOPE
10A NCAC 27G .1402	STAFF
10A NCAC 27G .1403	OPERATIONS
SECTION .1700 - RESIDENTIAL TREATMENT STAFF SECURE FOR CHILDREN OR ADOLESCENTS	
10A NCAC 27G .1701	SCOPE
10A NCAC 27G .1702	REQUIREMENTS OF qualified professionals
10A NCAC 27G .1703	Requirements for associate professionals
10A NCAC 27G .1704	Minimum staffing requirements
10A NCAC 27G .1705	Requirements of licensed professionals
10A NCAC 27G .1706	OPERATIONS
10A NCAC 27G .1707	PERSONS PERMITTED IN THE FACILITY
10A NCAC 27G .1708	TRANSFER OR DISCHARGE
SECTION .1800 – INTENSIVE RESIDENTIAL TREATMENT FOR CHILDREN or ADOLESCENTS	
10A NCAC 27G .1801	SCOPE
10A NCAC 27G .1802	Requirements of licensed professionals
10A NCAC 27G .1803	REQUIREMENTS OF qualified professionals
10A NCAC 27G .1804	Minimum staffing requirements
10A NCAC 27G .1805	OPERATIONS
10A NCAC 27G .1806	TRANSFER OR DISCHARGE
SECTION .1900 - PSYCHIATRIC RESIDENTIAL TREATMENT FOR CHILDREN AND ADOLESCENTS	
10A NCAC 27G .1901	SCOPE
10A NCAC 27G .1902	STAFF
10A NCAC 27G .1903	OPERATIONS
10A NCAC 27G .1904	TRANSFER OR DISCHARGE

*RULES 10A NCAC CHAPTER 27 RULES FOR COMMUNITY MH/DD/SAS FACILITIES AND SERVICES

SECTIONS .2000 - .2900 DEVELOPMENTAL DISABILITIES PROGRAM RULES **SECTION .2100 - SPECIALIZED COMMUNITY RESIDENTIAL CENTERS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES**	
10A NCAC 27G .2101	SCOPE
10A NCAC 27G .2102	STAFF
10A NCAC 27G .2103	OPERATIONS
10A NCAC 27G .2104	PHYSICAL PLANT
SECTION .2200 - BEFORE/AFTER SCHOOL AND SUMMERD EVELOPMENTAL DAY SERVICES FOR CHILDREN WITH OR AT RISK FOR DEVELOPMENTAL DELAYS, DEVELOPMENTAL DISABILITIES, OR ATYPICAL DEVELOPMENT	
10A NCAC 27G .2201	SCOPE
10A NCAC 27G .2202	STAFF
10A NCAC 27G .2203	OPERATIONS
10A NCAC 27G .2204	PHYSICAL PLANT
SECTION .2300 - ADULT DEVELOPMENTAL AND VOCATIONAL PROGRAMS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES	
10A NCAC 27G .2301	SCOPE
10A NCAC 27G .2302	DEFINITIONS
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*RULES 10A NCAC CHAPTER 27 RULES FOR COMMUNITY MH/DD/SAS FACILITIES AND SERVICES

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The Commission for Mental Health, Development Disabilities, and Substance Abuse Services: Creation and Rulemaking Authority

The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services was established in 1973 as part of the Executive Organization Act pursuant to N.C.G.S. § 143B-147, *Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services – creation, power, and duties*. While some of its authority stems from N.C.G.S. § 143B-147, its authority is also reflected throughout N.C.G.S. § 122C as noted in the citations below. N.C.G.S. § 90-88 grants the Commission authority to adopt rules relating to controlled substances.

The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services is granted statutory authority to adopt rules for the following purposes:

1. Adopt rules establishing definitions
    a. Qualified Personnel [122C-3(31)]
    b. High Risk Consumer [122C-115.4(f)(1)]
    c. High Cost Consumer [122C-115.4(f)(2)]
    d. "Legitimate Role" for confidentiality purposes [122C-55(m)]
2. Adopt rules establishing requirements and standards
    a. Professional Requirements for staff of licensed facilities. [143B-147(a)(6), 122C-26(5)(a)]
    b. Qualifications of facility administrators or directors [122C-26(5)(b)]
    c. Standards of public services for mental health, developmental disabilities, and substance abuse services. [143B-147(a)(1)(f)]
    d. Requirements of a qualified public or private provider as the term is used in 122C-141. [122C-114(b)(4)]
    e. Requirement that years of experience for Qualified Professional be earned before or after earning required educational degree [S.L. 2017-32]
3. Adopt rules for procedural matters and appeals
    a. Adopt rules specifying procedures for waiver of rules adopted by the Commission. [143B-147(a)(8); 122C-26(4)]
    b. Adopt rules establishing an appeals process for non-Medicaid mh/dd/sa service clients to appeal decisions made by the LME. [143B-147(a)(9)]
    c. Adopt rules regarding hearings and appeals of mh/dd/sa area facilities. [143B-147(a)(1)(c)]
    d. Handle appeals by area authorities or county programs regarding rules of the Commission or rules under dual jurisdiction of the Commission and the Secretary, and adopt rules for such hearings. [122C-151.2(a)]
    e. The Commission may order a report into areas of concern over which it has rulemaking authority. [143B-17]
    f. Adopt rules governing appeals of decisions to approve or deny licensure [122C-26(3)]
4. Adopt rules for State facilities
    a. Admission to State facilities. [143B-147(a)(1)(a)]

b. Admission, care and discharge of those individuals admitted for research purposes only. [122C-210.2(d)(4)]

5. Adopt rules for licensed facilities
    a. Adopting rules for the licensing of facilities for the mentally ill, developmentally disabled, and substance abusers. [143B-147(a)(2)]
    b. Developing rules establishing procedure for deeming licensure from national accreditation. [122C-22]
    c. Developing rules waiving licensure requirements, including the authority to conduct hearings in contested cases regarding the same. [122C-24; 122C-26; 122C-23(f)]
    d. Adopt rules regarding requirements for death reporting, including confidentiality provisions. [122C-26(5)(c)]
    e. Adopt rules establishing requirements for patient advocates. [122C-26(5)(d)]
    f. Adopt rules compelling the facility personnel to disclose financial conflicts of interest when referring clients to provider agencies. [122C-26(5)(e)]
    g. Adopt rules developing the standards for use of electronic supervision devices during client sleep hours and personnel for the same for facilities licensed under Rules 10A NCAC 27G, Section .1700. [143B-147(a)(2)]
    h. Adopt rules establishing standardized procedures for facilities in training and record keeping of the measures taken to inform employees and volunteers of the duties imposed by G.S. 122C-66 [122C-26(5)(f)]
6. Adopt rules regarding Local Management Entities (LMEs) [defined by 122C-3(20b); functions set out in 122C-115.4]
    a. Operation of services, including education, prevention, intervention, treatment, rehabilitation and other related services, by area authorities, county programs and all providers of public services. [143B-147(a)(1)(b)]
    b. Adopt rules regarding notice and procedural requirements for removing one or more LME functions, as set out in the statute. [122C-115.4(f)(3)]
    c. Development of the process for screening, triage and referral including a uniform portal process which shall be implemented by the Secretary. [122C-114(b)(1)]
    d. Develop rules regarding LME provision of technical assistance to providers of mh/dd/sa services. [122C-114(b)(3)]
    e. Develop rules regarding LME monitoring of providers of mh/dd/sa services [122C-114(b)(2)]
    f. Develop rules regarding LME personnel and training in order the needs of members of the active and reserve components for military and their families. [122C-115.4(g)]
7. Adopt rules governing 24 hour facilities [defined by 122C-3(14)(g)]
    a. Adopt rules to implement the transfers of voluntary clients, minors, and incompetent adults between 24 hour facilities. [122C-206(g)]
    b. Adopt rules governing procedures for admission to 24 hour facilities for minors into facilities for the mentally ill or substance abusers not falling into the category where freedom of movement is restricted, ensuring no

minor is improperly admitted or improperly remains at the facility. [122C-221(b)]

c. Adopt rules governing procedures for admission to 24 hour facilities for incompetent adults into facilities for the mentally ill or substance abusers not falling into the category where freedom of movement is restricted, ensuring no incompetent adult is improperly admitted or improperly remains at the facility. [122C-232(a)]

8. Adopt rules relating to controlled substances, including registration and control of the manufacture, distribution, security and dispensing of the same. [143B-147(a)(5); 90-88]
9. Adopt rules and curriculum for Alcohol and Drug Education Traffic ("ADET") schools. [122C-142.1(d)], including placement of individuals into a substance abuse treatment program. [122C-142.1(h)]
10. Adopt rules providing for the licensure and accreditation of residential treatment facilities that provide services to person with traumatic brain injuries. [122C-26(6)]
11. General rulemaking authority to implement N.C.G.S. 122C, Article 3, Clients' Rights and Advance Instruction [N.G.C.S. 143B-147(a)(7)], including:
    a. Adopting rules for the establishment, composition and duties of human rights committees at each State facility, LME, and provider agency. [122C-64]
    b. Developing rules to provide procedures when voluntarily admitted clients refuse treatment. [122C-57(d)]
    c. Adopting rules specifying which therapeutic and diagnostic procedures require express written consent (in addition to the statutorily required electroshock therapy and all surgeries unless emergency surgery). [122C-57(f)]
    d. Adopting rules regarding the use of restraint and seclusion, including staff training and competence, as well as matters relating to the use of physical restraint or seclusion of clients necessary to ensure the safety of clients and others. [122C-60(b)]
    e. Adopting rules implementing restriction of statutorily enumerated rights by a physician in twenty-four hour facilities. [122C-62(e)]
    f. Adopting rules implementing restriction of statutorily enumerated rights for clients in 24 hour facilities by the qualified professional responsible for the formulation of the clients treatment or habilitation plan. [122C-62(f)]
    g. Adopting rules implementing restriction of statutorily enumerated rights for clients being held to determine capacity for fitness for criminal trial or clients in a facility of substance abuse, if the restrictions are necessary and reasonable in order to protect the health, safety, and welfare of that client or other clients. [122C-62(g)]
    h. Developing programmatic rules for assuring the continuity of care for the mentally retarded. [122C-63(h)]
    i. Adopting rules to protect clients in facilities from being exploited, abused or neglected. [122C-67]

Environmental Factors and Plan

12. 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 2016-FFY 2017? (●) Yes ( ) No

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

Keeping those we serve at the center of service design and delivery the Division's Quality Management structure provides the focus for ongoing attention to the clinical quality and effectiveness of the service system. The Division's Quality Management Steering Committee brings together staff from across the Division to plan, monitor and evaluate initiatives to improve the clinical quality of the service system and the effective use of state and federal funds. Please see the NC DMHDDSAS Quality Management Plan SFY18 in the Attachments section.

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

Footnotes:

Please see the NC DMHDDSAS Quality Management Plan SFY18 in the Attachments section.

North Carolina Department of Health and Human Services

Quality Management Plan SFY: 2017 - 2018

For

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Revised

August 2017

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Appendix

Values and Guiding Principles of the Quality Management Program

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS or Division) Quality Management Plan weaves together the mission and vision of the NC Department of Health and Human Services and DMH/DD/SAS and with the National Behavioral Health Quality Framework(NBFQF), the Federal Centers for Medicare and Medicaid Services Quality Framework and a Total Quality Management philosophy to formulate a structure and a process to achieving a high quality MH/DD/SA service system.

The mission of the NC Department of Health and Human Services (NC DHHS) is, in collaboration with our partners, DHHS provides essential services to improve the health, safety and well-being of all North Carolinians. This mission is driven by a vision that Advancing innovative solutions that foster independence, improve health and promote well-being for all North Carolinians.

It is the mission of the Division to, ***provide people with, or at risk of, mental illness, developmental disabilities, and substance abuse problems and their families the necessary prevention, intervention, treatment services and supports they need to live successfully in communities of their choice.***

The Division's Quality Management plan outlines the Division's Quality Management Program, its values and guiding principles, approach, structure, responsibilities, and improvement initiatives.

North Carolina's Service System

The Division's organizational structure is designed to implement North Carolina's public mental health, developmental disability and substance use service system. Our programs are governed by rules created by the MH/DD/SA Commission and we are advised by the State Consumer and Family Advisory Committee. MH/DD/SAS services are managed by Local Management Entities-Managed Care Organizations (LME-MCO) that oversee comprehensive provider networks that *provide the necessary MH/DD/SA services and supports that North Carolinian's need to live successfully in communities of their choice* (See Appendix A: Local Management Entities Map).

Quality Management Infrastructure

Keeping those we serve at the center of service design and delivery the Division's Quality Management structure provides the focus for ongoing attention to the clinical quality and effectiveness of the service system. The Division's Quality Management Steering Committee brings together staff from across the Division to plan, monitor and evaluate initiatives to improve the clinical quality of the service system and the effective use of state and federal funds (See Appendix B: Division Quality Management Infrastructure).

A Culture of Quality
Customer focused quality management is championed at the Division by Executive Operations team to promote a collaborative, accountable and results-based organization. The Division goals supports our workforce development model that includes:

- Promote access to evidence-based or promising practices and quality mental health services, substance use disorder services, and supports to persons with intellectual/developmental disabilities and to persons who have experienced traumatic brain injury;
- Advance knowledge and innovative solutions to mental health, intellectual/developmental disabilities, and substance use disorders services challenges;
- Promote economic and social well-being, community integration, and self-determination for individuals and families;
- Promote prevention and well-being across the life span;
- Ensure efficiency, transparency, and accountability of Division programs and initiatives; and
- Develop strategies to ensure continuity of work processes and products in the workplace.

Fiscal Resources
It is the Division's responsibility to provide a cost efficient publicly funded behavioral health care system while supporting quality service delivery. The Division will monitor compliance, efficiency and accountability within NC DMH/DD/SAS programs by detecting and preventing fraud, waste, program abuse, and by ensuring that State and Block Grant dollars are utilized appropriately, in accordance with laws and regulations, and in support of programmatic goals through the DMH/DD/SAS Service System Integrity Plan.

Performance Monitoring

To ensure the needs of those we serve are being met the Division monitors key indicators to help assure that the system is working as intended, opportunities for improvement area identified and acted upon, desired improvements are recognized and efforts to sustain successful practices are implemented and monitored to maintain achievements, as priorities change.

A process for periodic monitoring of key indicators is coordinated by the Steering Committee. Monitoring of indicators will include:

- Reviewing valid and reliable performance and outcome data
- Determining significance of trends and patterns
- Implementing improvement initiatives
- Evaluating improvement initiatives
- Raising the bar on measures when appropriate
- Evaluating and revising the Quality Management plan annually

The Division supports a statewide Incident Response Improvement System for reporting and documenting responses to emergency and critical incidents with a focus on future prevention. Contract requirements address reporting and resolution requirements related to complaints and grievances and establishes standards for resolution timeframe (See Appendix C: Performance Contract Reporting).

Regular and ongoing feedback within the Division and to Local Management Entities-Managed Care Organizations and system stakeholders is a key to ensuring and sustaining improvements in quality. The guidelines for critical outcomes and performance measures are described in the North Carolina LME-MCO Performance Measurement and Reporting Guide. Measurement is based on valid and reliable data, consistent with the NBHQF and describe the health and functioning of the MH/DD/SA system (See Appendix D: Performance Measurement and Reporting Guide). Quality Management and Performance Expectations for LME-MCOs are established per contract. Regular monitoring against performance targets or standards provides information on how the system is doing. The SFY18 contract includes penalty

measures for under performance and the implementation of plans of correction by the LME/MCOs who fall short of the performance standard expectations. Additional technical assistance will be supplied by the Division to the LME/MCOs when performance standards are not met for measures identified as Critical Performance Measures.

The Division continuously measures the effectiveness of the Local Management Entities-Managed Care Organization and their network through the review of administrative functions, compliance with reporting requirements, through statewide measures of service quality, input from stakeholders via surveys and outcome measurement systems, analysis of emergency and critical incidents, and review and follow-up of complaints and grievances.

Performance Measurement & Sustainability

The Steering Committee is charged with the overall implementation and success of the Division's quality management plan. It oversees all quality management committees and monitors Division initiatives. The Steering Committee is responsible for promoting excellence and assisting with identifying potential issues and opportunities for improvement and ensuring that they are referred to and addressed at the appropriate level.

Reports will be based on consistent and credible data and will be examined to determine if changes have produced the desired results, or if further adjustments are needed to achieve success. On an annual basis, the Steering Committee will oversee the review of reporting requirements, data sources and reporting formats to ensure that reporting elements remain relevant and support the desired system outcomes.

The Steering Committee ensures improvement actions and quality initiatives are followed-up for successful resolution and sustainability. The Steering Committee champion information sharing when change actions result in demonstrable improvements; those actions will be recognized and spot-lighted. Additionally, communication on system performance will occur throughout the quality improvement process using the Centers for Medicare and Medicaid Services Quality Framework to promote strategic and solution focused initiatives. (See Appendix E: Quality Framework)

Involvement of Stakeholders

Success of our service system is dependent on the collaboration between the Division, Local Management Entities-Managed Care Organizations, direct service providers, consumers and families and other community stakeholders. The Executive Operations Team continues to ensure regular communication and feedback through communication bulletins, websites, forums, trainings and conference participation. The Executive Operations Team will ensure coordination with standing advisory and stakeholder committees with responsibilities for quality of the service system including, but not limited to:

- DMH/DD/SAS External Advisory Team
- State Consumer & Family Advisory Committee
- DHHS LME-MCO Director Meetings
- DHHS LME-MCO Clinical Director Meetings
- DHHS LME-MCO Medical Director Meetings
- DHHS LME-MCO Quality Management Directors Forum
- Joint Clinical Policy Collaborative
- Block Grant Planning Council
- Departmental Waiver Advisory Committee
- Service Advocacy Organizations

Division Leadership will foster collaborative efforts with the Division of Medical Assistance to ensure coordinated oversight of the Medicaid Waivers, Partnership for Healthy North Carolina, and the Division of Medical Assistance Quality Strategy for the North Carolina Behavioral Health Prepaid Inpatient Healthcare Plans. Division staff will be a part of the Intra-departmental monitoring teams responsible for the monitoring the operations and services related to the waivers, block grants and state funded services.

Communication

Communication is critical to the success of any quality improvement effort. The Division's Leadership will communicate priorities, a directional vision and goals for the MH/DD/SA service system. The Steering Committee will monitor and communicate progress and performance related to Division initiatives and quality improvement projects in relation to the priorities and goals.

The Division's Leadership will support a culture conducive to open communication, information sharing and champion data driven decision making at the State and local levels. Report results and highlights will be communicated on the Division website, in memos and other communiqués so that together as a system we can learn from each other. Sharing information and data will encourage innovation and enable replication of successful practices.

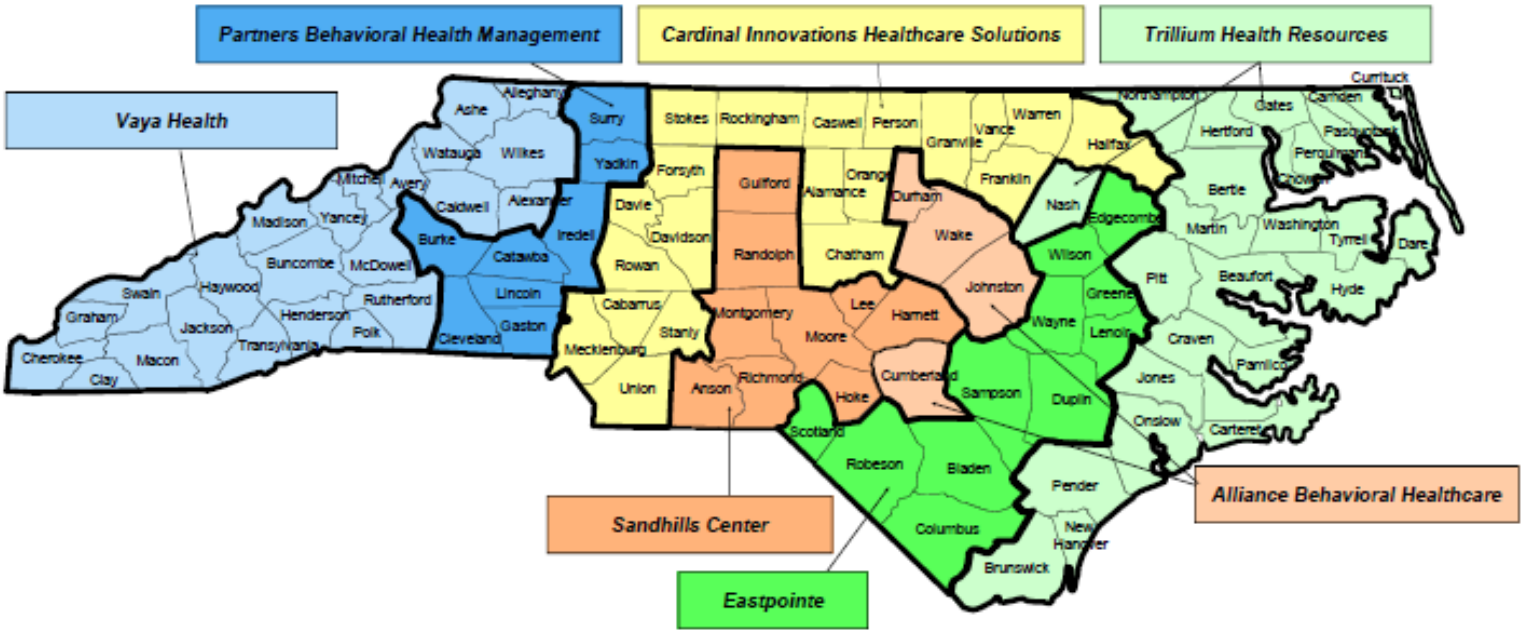
DMH/DD/SAS engages in a systematic effort to include consumers, individuals with lived experience, and family members in the development of mental health, intellectual/developmental disabilities, substance use disorders, and traumatic brain injury services and supports. DMH/DD/SAS worked in collaboration with identified stakeholders and partners to develop a State Strategic Plan with five priority areas, all directed toward improving the overall services and supports. The Quality management infrastructure will help to support the measurement of the initiatives identified in the State Strategic Plan.

Appendix A

Local Management Entity – Managed Care Organization Map

SFY 17-18 Configuration

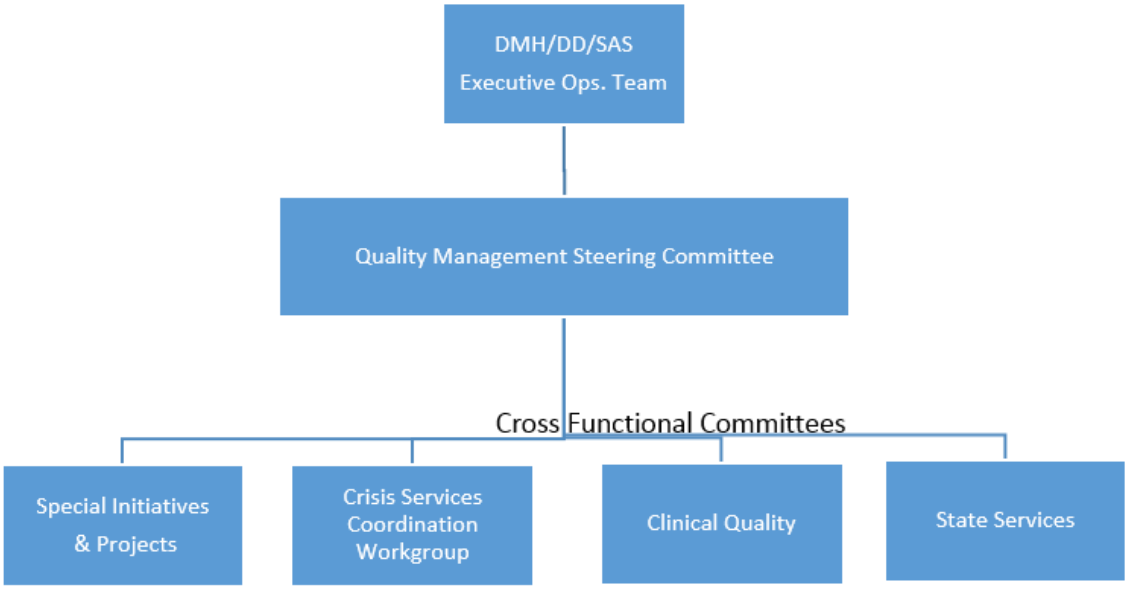
Local Management Entity - Managed Care Organizations (LME-MCOs)
DHHS currently has -- Seven- LME-MCOs operating under the 1915 b/c Waiver



- *Reflects LME-MCOs as of 7/1/17.*
- *Includes the move of Nash County to Trillium Health Resources on 7/1/17.*

Appendix B

Division Quality Management Infrastructure



The Quality Management (QM) Steering Committee

Ultimate responsibility for a comprehensive and sustainable quality management program at the Division is delegated to the Division's QM Steering Committee. The QM Steering Committee is charged with the overall success of the Division's quality management activities. It oversees all quality management responsibilities in the Division and serves as the hub receiving information and recommendations from the Quality Cross-Functional Committees and Special Initiatives/Projects, and it serves as the link to other DHHS quality initiatives.

On an annual basis, the QM Steering Committee reviews and approves the QM Plan and Steering Committee membership for the upcoming year. The QM Steering Committee membership will comprise the Cross-Functional Committee chairs, the LME-MCO liaisons, the project management supervisor, the medical director, key quality management and finance staff, the deputy directors and chaired by the division director.

The QM Steering Committee meets at least quarterly and is responsible for promoting excellence and for identifying potential problems and opportunities for improvement and ensuring that they are referred to and addressed at the appropriate level within the organization. The QM Steering Committee ensures that corrective action and quality initiatives are followed-up on for successful resolution and keep the Executive Operations

Team informed.

The QM Steering Committee's Responsibilities Include:

1. Development of the Division's Quality Management Plan, which will be reviewed and updated annually. The Quality Management Plan will identify performance measures and procedures for monitoring state established block grants, waivers, and Division priorities.

2. Oversight of the Quality Cross-Functional Committees Analysis of reports related to LME-MCO operations to gain broader perspective of statewide service system and performance. LME-MCO Reports may include:
    - Local Business Plan
    - Gap Analysis and Community Needs Assessment
    - Network Development Plans
    - Performance Improvement Projects
    - Intra-departmental Monitoring Reviews
    - Block Grant & Clinical Monitoring Reviews
    - Monthly Monitoring Reports
    - DMA & DMH Performance Measures
    - Performance Contract Reports/Data Requirements
    - Stakeholder Satisfaction Surveys
    - Service Utilization and Financial Analysis
    - Consumer Functional Outcome Data
    - Reports regarding emergencies, critical incidents, complaints and grievances

3. Review reports and recommendations from the Cross Functional Committees including Clinical Quality, State Services and Crisis Services Coordination Workgroup for service system impacts.

4. Review Special Initiative/Project progress, trends and monitor for impact on other parts of the service system.

5. Identify the need for special studies, initiatives or technical assistance and refer to the appropriate committee or team for implementation and monitoring.

6. Identify methods for communicating service system performance and improvement initiatives with Division staff and external advisory and stakeholder committees who share responsibility for the quality of the service system.

7. Ensure annual review of Division required LME-MCO reporting tools and requirements, to ensure reporting requirements accurately assess service system performance and that data is used to support decision making and performance monitoring; and to ensure that required data reporting is reviewed and communicated in a timely manner with system stakeholders.

Quality Cross-Functional Committees

The Steering Committee delegates priority quality improvement initiatives to specialized Quality Cross-Functional Committees with expertise in clinical quality, data analytics and state service implementation. Committees may also have workgroups that address specific topics within the purview of the Committee. Each committee regularly reports to the Steering Committee its activities, any areas of concern and success it has identified, and provides recommendations for action to improve the service system. Each committee monitors the results of corrective action and quality initiatives within its purview to ensure successful resolution and keeps the Steering Committee and Executive Operations Team informed.

Cross Functional Committees Responsibilities Include:

1. Responsible for monitoring and providing oversight of specific areas within its charge and identifying potential problems or opportunities for improvement.

2. Committee determines most effective way to provide technical assistance or implement improvement actions and provides ongoing monitoring.

Time Limited Workgroups & Special Initiatives/Projects

Time-limited workgroups and special initiatives/projects will be established as needed to address a specific issue, formulate a recommendation for an appropriate course of action, or implement a particular initiative. Membership will be drawn from staff with relevant experience and skills. Each group will identify a charge, a facilitator, responsible staff persons, deliverables, timelines and routes of communication. Workgroups and Special Initiative/Projects will regularly report to a Cross-Functional Committee or to the Steering Committee on activities, any areas of concern and success identified, and provides recommendations for improvement actions.

Appendix C

Performance Contract Reporting

The DHHS-LME Performance Contract requires LME-MCOs to submit reports and data in accordance with contractual requirements[1]. Monitoring of the fiscal requirements helps to ensure essential data integrity and provides reliable information needed for Federal reporting and for the oversight of specific program spending.

The direct outcome of the report reviews and the follow-up actions taken by LME-MCOs for Complaints, SAJJ, TBI, Work First, NC-TOPPS, CDW and NCSNAP result in improvements in program access for individuals served and their families. These reports also directly impact increases in the accountability and effectiveness of LME-MCO and provider systems associated with improved client identification, participation, quality of care and service outcomes.

LME-MCOs routinely review their individual results within their quality management committees for quality assurance and improvement, as well as with their area boards and CFACs. CEOs have used these reports for LME-MCO self-monitoring, and these reports have been instrumental in the adoption and implementation of local improvement projects to enhance LME-MCO performance.

[1] A schedule of reports is posted on the DMHDDSAS website's Performance Contracts page at: http://www2.ncdhhs.gov/mhddsas/statspublications/Contracts/Performancecontracts/fy14/lmeperformancerequirements6-14.pdf.

Copy of LME Performance require

[1] A schedule of reports is posted on the DMHDDSAS website's Performance Contracts page at: http://www2.ncdhhs.gov/mhddsas/statspublications/Contracts/Performancecontracts/fy14/lmeperformancerequirements6-14.pdf.

Appendix D

Performance Measurement & Reporting Guide

The performance Measurement and Reporting Guide set forth monthly, quarterly, semi-annual and annual reporting requirements for LME-MCOs contracted with the North Carolina Division of Medical Assistance (DMA) and the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). The technical specifications, described within this guide will be used as a standard way of reporting performance measures. The primary objective of the guide is to establish consistency and uniformity in reporting of the specific performance measures contained within this document. All data shall be submitted as outlined in LME-MCO contracts with DMA and DMH/DD/SAS. The data submitted is used by DMA and DMH/DD/SAS to monitor the quality, access, timeliness and care management operations of the Medicaid contracted PIHPs. Current reporting of the performance measures is self-report by the LME-MCOs. Once encounter and shadow claim information is successfully transmitting through NC-TRACKS, DHHS will re-evaluate the method for how performance measure reporting requirements are obtained. A quality improvement initiative is currently underway to validate the method of pulling data from the claims in NC-TRACKS.

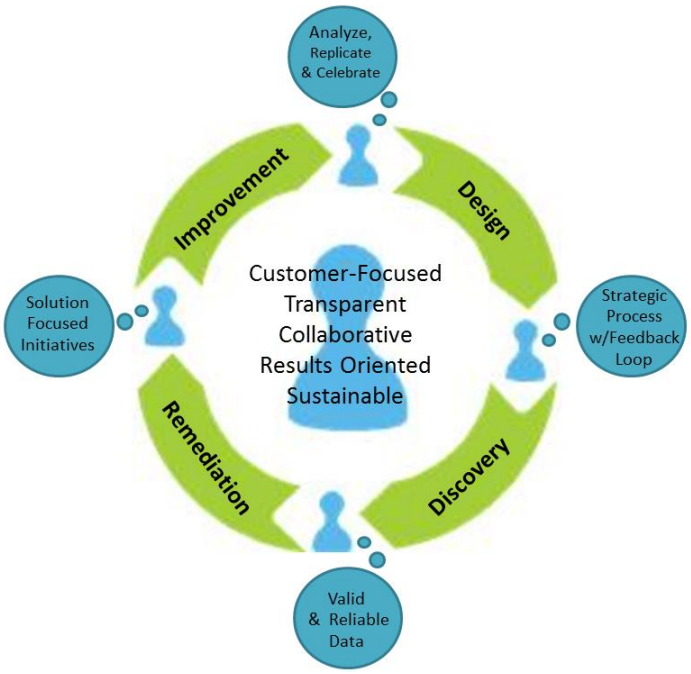
A number of the performance measures in this guide are based on the 2012 Healthcare Effectiveness Data and Information Set (HEDIS). The HEDIS measures were created through the National Committee for Quality Assurance's (NCQA) Committee on Performance Measurement. The performance measures will be reviewed in part by DHHS's External Quality Review contractor for the 1915 (b)(c) Medicaid Waiver.

Performance Measures Reporting

Appendix E

Quality Framework

The Federal Centers for Medicare and Medicaid Services promote a comprehensive framework for managing waiver plans. The Division has adopted and promoted this framework since 2003; it consists of four distinct, but related, activities that form a continuous, interdependent process. The framework is applied to clinical and performance outcome measures to assist with communicating and monitoring quality improvement initiatives.



Design: The design function refers to strategies for building quality assurance and quality improvement into the conception and design of the system. It includes mechanisms such as effective information systems, communication channels, feedback loops.

Discovery: The discovery function refers to the collection, analysis and reporting of information to make certain that people, processes and products are meeting basic requirements of quality and to evaluating progress toward goals. It includes compliance monitoring and audit activities, collection and analysis of trend data on services, consumer perceptions and outcomes, recurring management reports and dashboards and targeted evaluation studies.

Remediation: Remediation refers to strategies used to identify, analyze and correct problems quickly and effectively. Mechanisms vary based on the situation and can include consultation and technical assistance, training, development of new initiatives,

plans of correction, repayment of funds, loss of certification and redirection of resources.

Improvement: Improvement refers to systematic strategies to make incremental enhancements to operations and procedures that move the system toward achieving specified goals.

Total Quality Management Framework

The Division's long–term success will be achieved through a Total Quality Management approach that promotes a customer-focused atmosphere that involves all employees in continual improvement efforts. Our customers include persons receiving services and their families, our funders, all DHHS divisions, Local Management Entities-Managed Care Organizations and their provider networks, State and local Consumer and Family Advisory Committees (CFACs) and other state and local stakeholders. A culture of quality requires DMH/DD/SAS to effectively communicate and champion service delivery and project improvement initiatives.

To be effective, quality management requires integrated structures and processes that permeate all levels of every organization within the service system and works toward the objectives of:

- **Safeguarding** the health, safety and rights of persons served
- **Improving customer services** through collaboration with or input from persons served and family involvement
- Ensuring **timely access** to services
- Supporting the achievement of desired **outcomes and satisfaction** for persons served
- Ensuring the **integrity, effectiveness and continuous quality improvement** of services through review of consistent and credible data
- Ensuring **compliance** and guiding improvements of the services provided under state and federal funding and Medicaid waivers
- **Cultural competence**
- **Collaboration with other agencies**

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma [60] 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 behavioral health 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 behavioral health. 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 behavioral health 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 behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[61] paper.

60 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.*

61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health 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 behavioral health providers? ○ Yes ○ No

3. Does the state have a plan to build the capacity of behavioral health 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.

Footnotes:

Environmental Factors and Plan

14. 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.[62]

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.[63]

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 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.

[62] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. **OJJDP Model Programs Guide**

[63] **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 behavioral health 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, behavioral health 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 behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health 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 behavioral health 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?

• Approximately 45% of all NC law enforcement officers are CIT certified;
• All juvenile court counselors and adult probation/parole officers are Mental Health First Aid certified;
• The statewide TASC program served more than 24,000 people on probation/parole supervision, with at 61% program completion rate.

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

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? (●) Yes ( ) No

- **a)** [x] Methadone
- **b)** [x] Buprenophine, Buprenorphine/naloxone
- **c)** [ ] Disulfiram
- **d)** [ ] Acamprosate
- **e)** [x] Naltexone (oral, IM)
- **f)** [x] 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?

Please see North Carolina's needs assessment and strategic plan specific to the opioid epidemic in the Attachments section.

Please indicate areas of technical assistance needed to this section.

The DMHDDSAS recently submitted a request for technical assistance in reviewing our current regulations and statutes and establishing more specific rules and policies related to opioid treatment programs.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

Environmental Factors and Plan

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.[64] 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 behavioral health conditions and their families.

According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[65],

"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 behavioral health 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. Please check those that are used in your state:

[64] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[65] Practice Guidelines: Core Elements for Responding to Mental Health Crisis. 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 respond to the following items:

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)** ☐ WRAP Post-Crisis
- **b)** ☐ Peer Support/Peer Bridges
- **c)** ☐ Follow-up Outreach and Support
- **d)** ☐ Family to Family Engagement

e) ☐ Connection to care coordination and follow-up clinical care for individuals in crisis

f) ☐ Follow-up crisis engagement with families and involved community members

g) ☐ Recovery community coaches/peer recovery coaches

h) ☐ 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 to this section.

Footnotes:

Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health 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 behavioral health 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, 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. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

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

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.

Peer Support Services are available to support adults with Severe Mental Illness throughout North Carolina at all levels of care. The state recently bid out a contract for a pilot program for Peer Operated Respite Services, using the Georgia Mental Health Consumer Network's model. This pilot will initiate in the western region of North Carolina, with a goal to increase the number of Peer Operated Respite programs throughout the state.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Please see the document titled Recovery Supports and Services in NC in the attachments section.

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

Please see the document titled Recovery Supports and Services in NC in the attachments section.

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

Footnotes:
Please see the document titled Recovery Supports and Services in NC in the attachments section.

RECOVERY SUPPORTS AND SERVICES IN NC

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

The state has integrated recovery oriented principles and values into the North Carolina Substance Abuse Prevention and Treatment Block Grant plan and into the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services' 2016-2019 State Strategic Plan. Recovery principles are integrated into state contracts as well as in many training events statewide. The state of North Carolina adopted Person Centered Planning in 2006 and has promoted the use of "person first" language since then.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services created a new position in 2015 to ensure that recovery oriented principles are integrated into state policies. This position is the Consumer Policy Advisor and this staff person serves on the Executive Leadership Team. This individual identifies as a person in long-term recovery from mental health concerns and substance use disorder, and has a thorough understanding of the recovery movement as well as long-term recovery supports. In this role, He works closely with the Consumer and Family Advisory Councils throughout the state, as well as stakeholders and advocates throughout the state to promote recovery-oriented principles and ensure the "voice" of individuals in recovery is heard at high levels of policy development.

The state also provides financial support to a recovery organization formed in 2013, Recovery Communities of North Carolina. This is a statewide recovery community organization that provides leadership and support to other recovery community organizations statewide. They have also managed the Access to Recovery grant for the state for the since 2014 to present. Recovery Communities of North Carolina has taught recovery community messaging to individuals, families, stakeholders and treatment providers since 2014. Recovery messaging teaches those who wish to tell their stories of recovery in a manner that enhances listening and promotes the societal benefits of recovery; thus reducing discrimination. Reduced discrimination can lead to enhanced access to care, as those in need of treatment are more likely to ask for help when further shame is not a factor. The state also encourages treatment providers to learn about recovery messaging and to teach the individuals going through treatment about recovery messaging and advocacy for better health care while in treatment.

Training events focusing on the connection and intersection between substance use disorder prevention and recovery have been conducted at the North Carolina Foundation for Alcohol and Drug Studies conference July 27, 2015 and at the North Carolina Opioid Misuse and Prevention Summit in June 27, 2017. The focus of this training is to emphasize a reduction in silos between prevention and recovery, recognizing that addiction is a chronic condition that may require multiple treatment episodes with an emphasis on wellness promotion as a key component to supporting an individual's recovery. The fields of study between Certified Substance Abuse Prevention Consultants and Recovery Coaches and Peer Support Specialists should include both prevention and recovery content. An existing goal of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services is to enhance North Carolina's substance use disorder prevention and

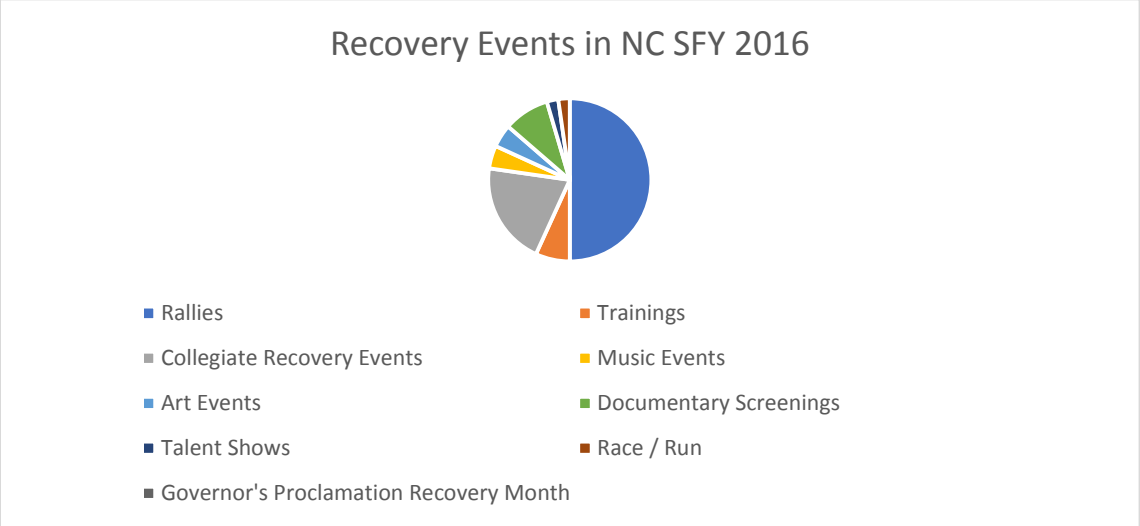
recovery system's capacity to address nonmedical prescription drug use by increasing working partnerships between prevention and recovery among state agencies and local communities to promote healthy communities, address risk and protective factors and promote recovery initiatives. Both systems share many common goals.

The state recognizes the need to mentor and develop future leaders who identify as being in recovery from mental health concerns and substance use disorders and in response, developed a six-month Leadership Development Academy in January 2017 through the University of North Carolina Chapel Hill.

A summary of recovery events around the state are tracked each year; with a summary of SFY 2016 and SFY 2017 below:

During state fiscal year 2015-2016; the state had a total of 45 recovery-related events. A breakdown of the recovery events are shown in Table 1.

Table 1.



During state fiscal year 2016-2017; the state had a total of 40 recovery-related events. A breakdown of the recovery events are shown in Table 2.

Table 2.

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

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services creates policies and oversees programs that support prevention, treatment and recovery for individuals with substance use disorders. Within that framework, the state can support long-term recovery for individuals with a substance use disorder. Evidence shows that addressing non-clinical needs and clinical needs simultaneously enhances long-term recovery.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services has implemented the Law Enforcement Assisted Diversion (LEAD) program; initiated a Peer Operated Respite Services program for individuals in recovery from mental health concerns; enhanced the Peer Support Specialist Curriculum to meet national standards and has trained 2,660 Peer Support Specialists statewide. Among those, 1163 identify as being in recovery from substance use disorders; 914 identify as being in recovery from mental health concerns; and 583 identify as being in recovery from co-occurring mental health and substance use disorder concerns. Peer Support Specialists have lived experience and complete 40 hours of state-approved training and an additional 20 hours of content-specific training to become certified. They are can engage with individuals in need of treatment at every level of care, from crisis to recovery. The state has supported and partnered with Recovery Communities of North Carolina and the Alcohol and Drug Council of North Carolina to deliver CCAR's Recovery Coach Academy trainings, resulting in 150 Recovery Coaches trained since 2015.

The state also supports the promotion of Recovery Community Centers, with over five supported by funds through a state contract, and an additional four initiated after modeling their centers after the other five. An "Artists Recovery Movement" has been sponsored by Recovery Communities of North Carolina through a contract with the state, and this initiative provides peer run workshops

centered on creative expression in various centers throughout Charlotte and Greensboro. The Artists Recovery Movement empowers individuals to traverse, discover, and create beauty in their lives and the lives of others.

North Carolina also funds six collegiate recovery programs throughout the state. These include programs at the University of North Carolina at Wilmington; East Carolina University; the University of North Carolina at Chapel Hill; the University of North Carolina A&T; the University of North Carolina at Greensboro; and the University of North Carolina at Charlotte.

Environmental Factors and Plan

18. 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 behavioral health 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 behavioral health 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.

Please respond to the following items

1. Does the state's Olmstead plan include :

housing services provided.	○ Yes ○ No
home and community based services.	○ Yes ○ No
peer support services.	○ Yes ○ No
employment services.	○ Yes ○ No

2. Does the state have a plan to transition individuals from hospital to community settings? ○ Yes ○ No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

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.

Footnotes:

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health 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[66]. 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[67]. 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[68].

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[69]. 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[70].

According to data from the 2015 Report to Congress[71] 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 behavioral health 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).

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

[67]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593?602.

[68]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

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

[70]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010**

[71] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? ○ Yes ○ No

b) The recovery and resilience of children and youth with SUD? ○ Yes ○ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health 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 behavioral health 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.

Footnotes:

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

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

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

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)		
Family Members of Individuals in Recovery* (to include family members of adults with SMI)		
Parents of children with SED*		
Vacancies (Individuals and Family Members)		
Others (Not State employees or providers)		
Total Individuals in Recovery, Family Members & Others	**0**	
State Employees		
Providers		
Federally Recognized Tribe Representatives		
Vacancies		
Total State Employees & Providers	**0**	
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations		
Providers from Diverse Racial, Ethnic, and LGBTQ Populations		
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Persons in recovery from or providing treatment for or advocating for substance abuse services		

* 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?

Footnotes:

Environmental Factors and Plan

23. 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
c)	Other (e.g. public service announcements, print media)	○ Yes ◉ No

If yes, provide URL:

Footnotes: