Alliance

BEHAVIORAL HEALTHCARE

Community Needs Assessment and Gaps Analysis

September 2014

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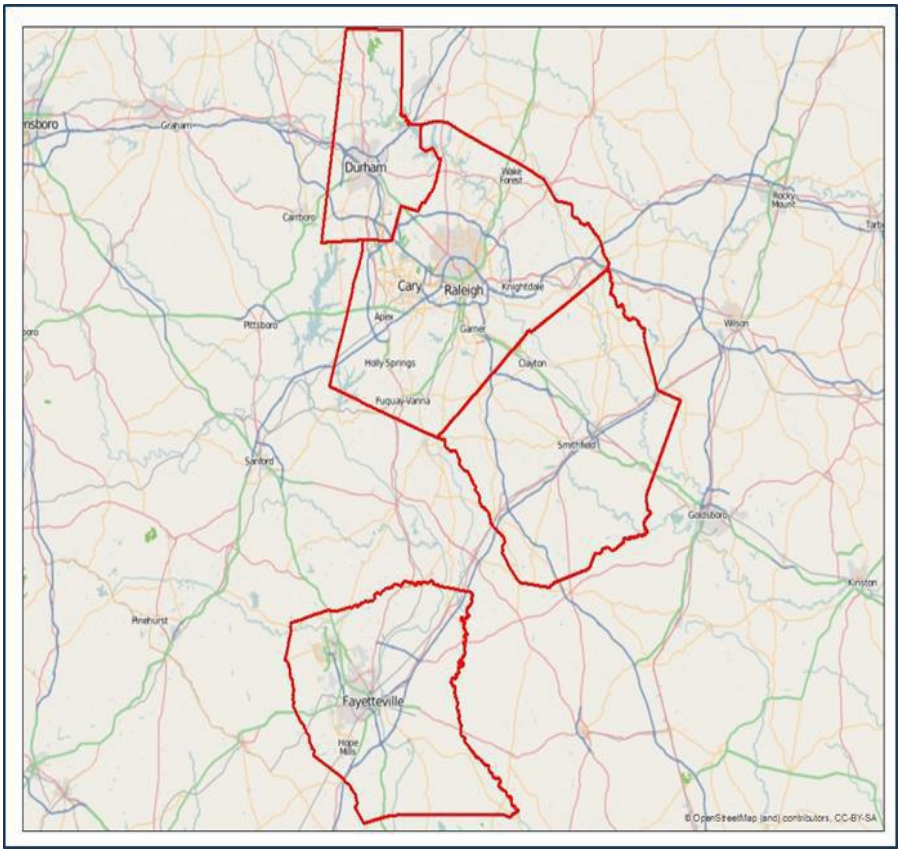
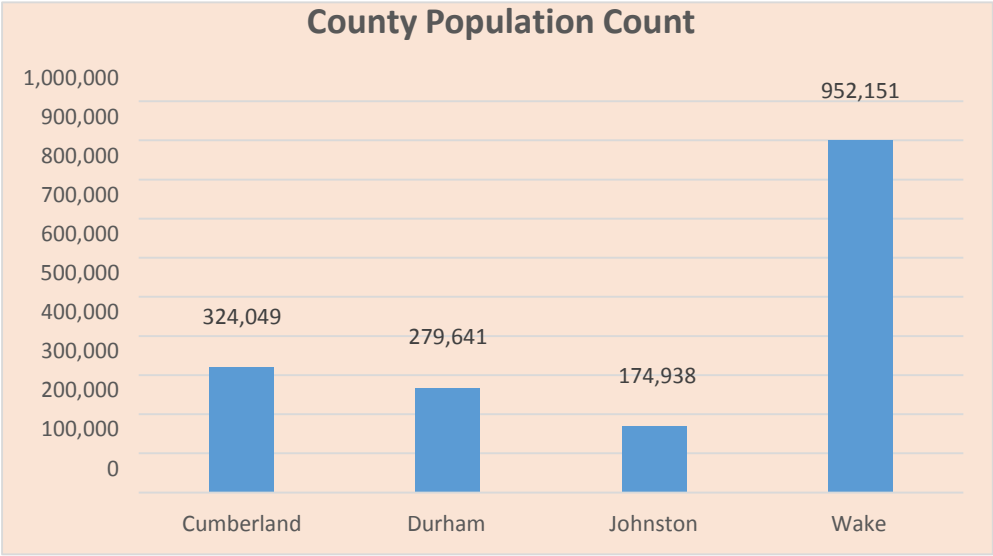
Alliance Behavioral Healthcare conducts a regular assessment of its provider network capacity in order to ensure adequacy to meet the needs of our enrollees. In April 2014 Alliance completed a Community Needs Assessment and Gaps Analysis covering the timeframe of February-June of 2013, the first six months of operation as a managed care organization. This is an update of that initial report, allowing for incorporation of more current information and a more comprehensive look at the data available to better inform network planning and development.

Description of Service Region and Demographics

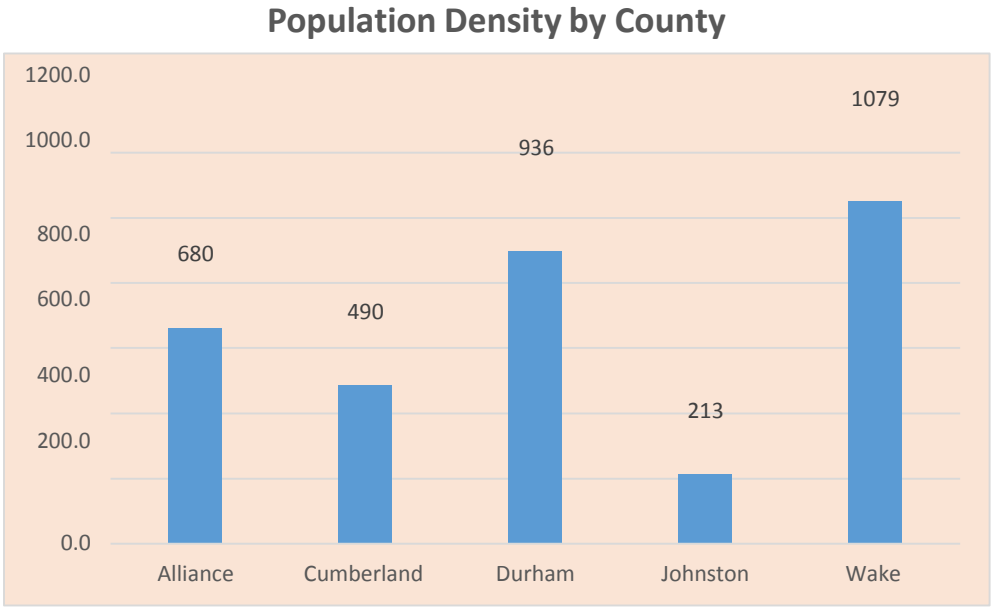


Alliance is comprised of Cumberland, Durham, Johnston and Wake Counties and covers roughly 2,589 square miles with a total population of 1,730,779. By far the largest county by population is Wake, exceeding the population of the other three counties combined. Wake and Durham are the most densely populated counties, reflecting their more urbanized settings. Johnston is the least densely populated county, which may create a challenge to recruit and engage providers to offer services in this area, particularly when there are more populous and urban areas nearby.



2012 U.S. Census Bureau Estimate

The service area includes both urban and rural areas but the majority of the population lives in urban areas. Johnston County is the most rural area although the population is divided between urban and rural areas.



2012 U.S. Census Bureau Estimates

County	Population	Square Miles	Rural/Urban	Persons per Square Mile
Cumberland	324,049	652	Mix	490
Durham	279,641	286	Urban	936
Johnston	174,938	791	Rural	213
Wake	952,151	860	Urban	1079
Total	**1,730,779**	**2589**	**Mix**	**2718 (average=680)**

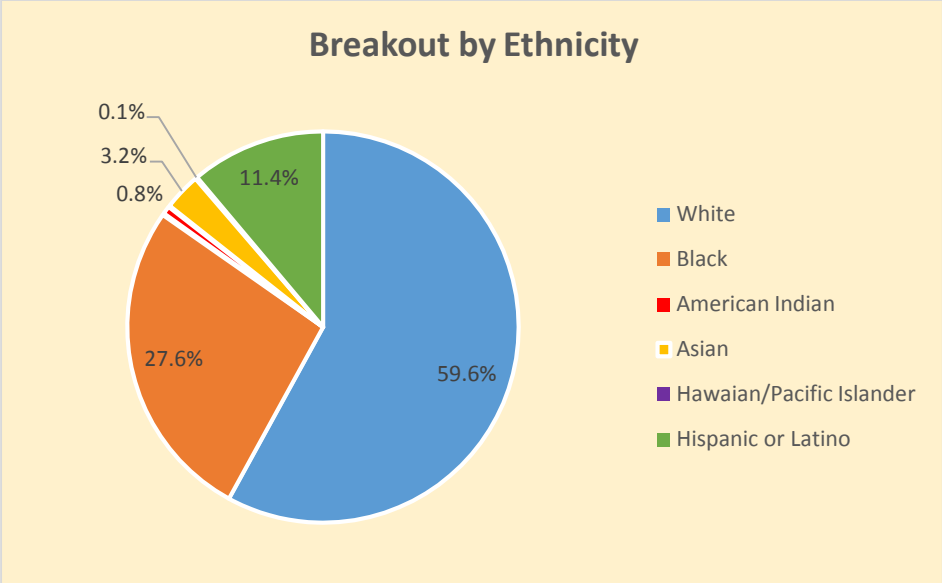
2012 U.S. Census Bureau Estimates

All Counties in the Alliance area anticipate growth over the next 4 years, particularly in Wake and Durham. This 5% growth will be a significant challenge for Alliance as population increases by nearly 100,000 individuals. Wake County in particular will see an increase in nearly 61,000 people.

County	July 14	July 15	July 16	July 17	Percentage Increase
Cumberland	334,466	336,340	338,213	340,086	1.7%
Durham	291,413	296,679	301,940	307,195	5.4%
Johnston	180,064	182,756	185,448	188,140	4.5%
Wake	985,146	1,005,322	1,025,498	1,045,673	6.1%
Alliance	**1,791,089**	**1,821,097**	**1,851,099**	**1,881,094**	**5.0%**

Data Source: Office of Management and Budget, State of North Carolina, County Population Projection Totals, 2010-2019 (www.osbm.state.nc.us/ncosbm/facts_and_figures/socioeconomic_data/population_estimates/demog/countytotals_2010_2019.html)

Across the Alliance area the primary ethnic group is Caucasian followed by Black and Hispanic/Latino. There is some variability across region, however. Johnston has a higher percentage of white population, with Black and Hispanic/Latino populations roughly the same percentage. Compared to the state average, Alliance has a significantly higher percentage of Hispanic/Latino population with Durham and Johnston having the highest percentage in the Alliance area. Alliance will need to focus on the development of adequate and culturally competent services to address the needs of this population.



2010 Census: Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States (http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml)

County	White	Black	Asian	American Indian	Hispanic/Latino
Cumberland	53.7%	37.0%	2.5%	1.7%	10.2%
Durham	53.0%	38.8%	4.9%	1.0%	13.4%
Johnston	80.9%	15.7%	.7%	.6%	13.0%
Wake	69.6%	21.4%	5.8%	.8%	10.0%
N. Carolina	71.9%	22.0%	2.5%	1.5%	8.7%

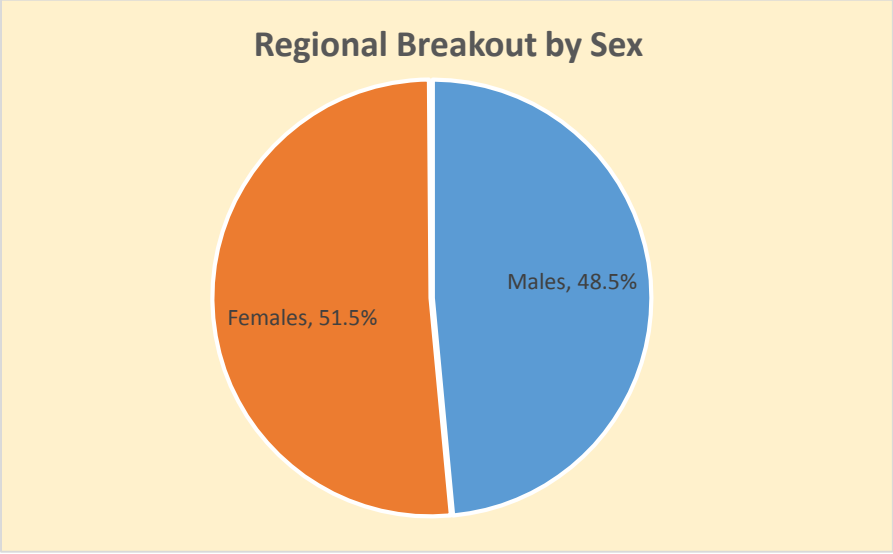
Will not equal 100% due to more than one race being reported Source: US Census Bureau, 2012 QuickFacts

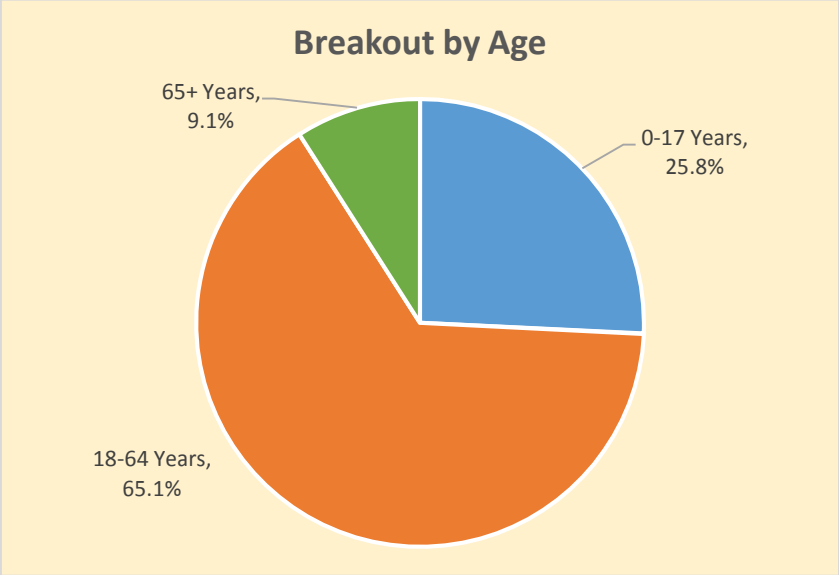
The primary language spoken across the Alliance area is English, followed by Spanish, most notably in Durham and Johnston Counties where the rate exceeds 10% of the population. It will be important for Alliance to assure adequate access to Spanish language services particularly in those two communities.

Top Languages Spoken in Service Area	United States	North Carolina	Alliance	Cumberla	Durham	Johnston	Wake
English	80.38%	89.66%	85.63%	89.36%	81.16%	87.97%	84.05%
Spanish	19.62%	6.93%	9.32%	6.45%	11.89%	10.73%	8.20%
Chinese	0.58%	0.23%	0.63%	0.16%	1.39%	0.11%	0.86%
Vietnamese	0.44%	0.24%	0.21%	0.22%	0.21%	0.02%	0.40%
Korean	0.38%	0.16%	0.36%	0.56%	0.38%	0.05%	0.43%
German	0.38%	0.27%	0.44%	0.94%	0.34%	0.16%	0.32%
French	0.44%	0.32%	0.46%	0.30%	0.73%	0.18%	0.62%
Other Western Germanic Languages			0.03%	0.03%	0.00%	0.03%	0.07%
Laotian		0.05%	0.02%	0.02%	0.04%	0.02%	0.00%
Other Asian Languages			0.31%	0.05%	0.46%	0.01%	0.72%
Hmong	0.07%	0.11%	0.01%	0.00%	0.00%	0.02%	0.00%

American Community Survey, 5-Year Estimates, 2006-2010 pulled through the Modern Language Association Database and Analytic Tools (http://www.mla.org/map_data)

Age and Sex demographics are fairly consistent across the Alliance area. The population is roughly even between males and females with the majority of individuals in the adult years of 18-64. The median age of the area is 33.7 which is somewhat younger compared with the 37.4 median age for the rest of North Carolina due to a lower percentage of individuals in the "65 and older category."





2010 Census: Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States (http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml)

Multiple studies have documented the impact of social determinants on health and mental health. Addressing community risk factors can both mitigate the negative impact of these stressors and promote resiliency. Prevalence of these factors across the Alliance area tends to be comparable with the state average. The exception, however, is Cumberland County which has significantly higher rates of poverty, child abuse/neglect and homicide. Particularly in Cumberland it will be important to assure that providers have competence in trauma informed care and that collaborations with community partners at DSS, law enforcement and the court system are well developed.

Community Risk Indicators	Individual Poverty Rate	Family Poverty Rate	Disability Rate	Single Mother w/ Children under 18	Child Abuse/Neglect per 1000	Homicide Rate per 100,000	Suicide rate per 100,000	Unemployment Rate	Population without insurance
United States	26.4%	29.7%	12.2%	7.3%	41.0%	4.2%	12.4%	7.3%	37.2%
North Carolina	24.7%	28.7%	13.0%	7.8%	56.1	6.3%	12.1%	8.0%	18.9%
Cumberland	35.1%	35.5%	14.4%	11.0%	74.7	9.6%	13.5%	10.3%	18.4%
Durham	17.7%	26.2%	9.3%	7.8%	44.5	10.0%	8.3%	7.6%	18.1%
Johnston	17.5%	25.2%	13.3%	6.8%	30.9	4.6%	11.6%	8.4%	18.5%
Wake	21.5%	24.1%	7.0%	7.0%	34.1	3.1%	8.9%	7.5%	16.2%

Data Sources:
North Carolina Statewide and County Trends in Key Health Indicators. North Carolina DHHS, Division of Public Health;
State Center for Health Statistics. February 2013; Selected Social Characteristics in the US, Reports DP02 and S1701 2012 American Community Survey;
2013 Kids Count Data Book, Annie P Casey Foundation; 2013 North Carolina Health Rankings, University of Wisconsin Population Health

Penetration Rate

In service planning it is critical to determine expected service demand related to the number actually being served. Efforts should be made to improve the penetration rate in all areas but particularly in the area of substance abuse services.

Persons Served	FY14 Average
Unduplicated Count of Medicaid Members	177,651
# Persons Receiving MH Services	12,572
% of Members Receiving MH Services	7.1%
# Persons Receiving SA Services	969
% of Members Receiving SA Services	0.5%
# Persons Receiving DD Services	2,645
% of Members Receiving DD Services	1.5%
Unduplicated # that received MH/DD/SA Services	15,463
% of Members Receiving MH/DD/SA Services	8.7%

State/Block Grant Only

Persons Served	FY14 Average
Unduplicated Count of State Members	261,408
# Persons Receiving MH Services	3,460
% of Members Receiving MH Services	1.3%
# Persons Receiving SA Services	1,047
% of Members Receiving SA Services	0.4%
# Persons Receiving DD Services	1,021
% of Members Receiving DD Services	0.4%
Unduplicated # that received MH/DD/SA Services	5,369
% of Members Receiving MH/DD/SA Services	2.1%

Data Source: Alliance LME-MCO Monthly Monitoring Report, June 2014

Description of Provider Network

Alliance has a large network of providers. There are 2,372 credentialed providers in the network, represented in the following categories as of August 1, 2014:

- 2372 credentialed providers
- 1545 licensed professionals
- 362 agencies
- 42 Hospitals/Residential Treatment Facilities
- 423 outpatient practices
- 727 Medicaid and 139 State contracts.

Alliance assures 24/7 access to services by contracting for crisis facilities in each county. Durham and Wake Counties have 16 beds in each facility, and Cumberland County has eight beds with plans to increase to 16. Johnston County has 24/7 access via the local emergency department to crisis stabilization, assessment, and management (seven beds).

Provider agencies in the Alliance network support the range of populations served by Alliance. The largest proportion of providers offer service to individuals with mental health needs, reflecting the largest number of individuals served by diagnostic category.

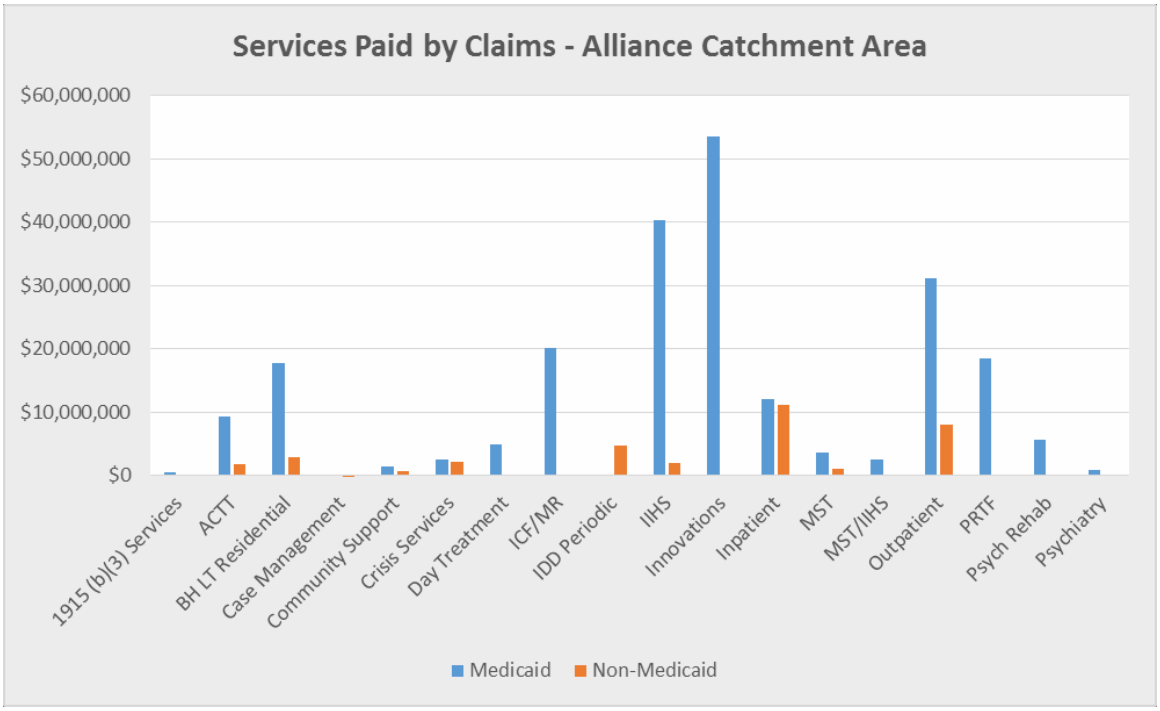
Diagnostic Populations Served by Provider Agencies	No.	Pct.
Intellectual/Developmental Disability ONLY	199	18.9%
Mental Illness ONLY	423	40.2%
Mental Illness AND Substance Abuse	92	8.7%
Mental Illness AND Intellectual/Developmental Disability	113	10.7%
Mental Health AND Intellectual/Developmental Disability AND Substance Abuse	53	5.0%
Substance Abuse ONLY	118	11.2%
Intellectual/Developmental Disability AND Substance Abuse	54	5.1%

Based on Claims Dates of Service from 07/01/2013-07/31/2014
Report Date: 08/21/2014

The top services provided based on cost are:

- Innovations (IDD Waiver)
- Intensive In-Home
- Outpatient
- ICF/MR
- PRTF
- BH Long-Term Residential

A number of these services are residential institutional type services. Alliance would benefit from a review of these services to determine whether additional lower cost service options could be developed.



Report Date: 08/19/2014

GeoMapping the network allows a visual review of the network to understand the location of providers offering particular services, the location of individuals needing that service, and the distance of those individuals to reach the services that need. As required by contract, Alliance seeks to offer access to services within 30 miles/minutes as well as choice of at least two providers. Appendix A includes GeoMaps for the Alliance four county area with the location of contracted providers and service recipient location for the enhanced MH/SA services of SAIOP, SACOT, ACCT, Mobile Crisis, Day Treatment, CST, Psychosocial Rehabilitation, Intensive In-home, and MST. The maps are evidence of the robustness of the Alliance provider network with choice of provider in all counties and service recipients within the 30 mile radius.

Access to professionals, especially psychiatrists, is a clear expectation to meet the needs of the populations served by Alliance providers. The US DHHS uses HRSA criteria to determine whether an area should be designated as having a shortage of mental health professionals. These criteria include ratios of population to psychiatrist (prescribers) that exceed 30:000:1 or that exceed a ratio of 9,000:1 for population to core (licensed) professionals. Based on these criteria, neither Alliance as a whole nor any of the individual counties can be considered as having a shortage of mental health professionals (see also Appendix A-Service Geomapping). Wake has the highest ratios but well below the ratio indicating a shortage.

DUPLICATED Prescribers per County (based on Prescribers serving in more than county)					
	Cumberland	Durham	Johnston	Wake	Total
MD/DO	82	92	61	136	371
Nurse Practitioner	28	44	25	44	141
Physician Assistant	17	3	8	16	44
Total	**127**	**139**	**94**	**196**	**556**
Ratio to Total Population	2,552:1	2,012:1	1,861:1	4,858:1	3,113:1
Licensed Professionals (non-prescribers)	652	893	468	1224	3237
Ratio to Total Population	497:1	313:1	374:1	778:1	535:1

Report Date: 9/23/2014

HRSA criteria also identify expected ratios to population by type of provider. Based on these criteria the following would be expected within the Alliance area. While Alliance has ample providers in many areas, the need to increase psychologists, marriage and family therapists, and addiction counselors is evident.

Practitioner Type	Number Required per 100,000	Number Required per 1,730,779 Population	Alliance (Unduplicated)
Psychiatrist	14	242	315
Psychologist	31	514	265
Social Worker	35	580	1193
Psychiatric Nursing (All)	7	116	164
Professional Counselors	49	812	886
Marriage and Family Therapists	17	282	118
Other Counselors (including SUD)	31	514	256
Total Clinicians	**184**	**3049**	**3197**

Report Date: 9/23/2014

Alliance strives to support the implementation of evidence based practices. These practices, when offered to fidelity, assure quality and have demonstrated treatment outcomes associated with the population served. Some services, such as intensive in-home, have been used as a platform to offer models of evidence based practice. Other services are themselves considered evidence base practices and often include independent reviews to assure fidelity.

Use of Specific Evidence-Based Practices per Provider 23 Intensive In-Home Providers		
Cognitive Behavioral Therapy	22	96%
Trauma Focused-CBT	8	35%
Seeking Safety	3	13%
Seven Challenges	3	13%
Brief Strategic Family Therapy	2	9%
Dialectical Behavioral Therapy	1	4%
Family Centered Treatment™	1	4%
Illness Management and Recovery	1	4%

Numbers of Providers Offering Evidence Based Practice and Reviewed for Fidelity by Independent Review	
ACTT	6
MST	6
Intensive Alternative Family Treatment: Pressley Ridge	1
Intensive Alternative Family Treatment: Together Facing the Challenge	2

Alliance also assures that special needs of service recipients are met.

Numbers of Providers Offering Specialty Services (Self-Report)					
	Cumberland	Durham	Johnston	Wake	Alliance
Spanish Language	22	20	5	39	86
Other Language	13	1	2	9	25
American Sign	5	1	1	4	11
Deaf and Hard of Hearing	1	2	-	2	5
Hearing Impaired	5	3	2	2	12
Vision Impaired	10	11	3	12	36
Sex Offender Treatment	12	4	2	8	26

Note: Other Languages (Provider Counts): Arabic (1), French (6), German (5), Hindi (3), Italian (2), Japanese (1), Korean (2), Portuguese (2), Russian (3); Report Date: 9/23/2014

Alliance has an out of network process for those instances where the specialty needs of an individual cannot be addressed by a contracted network provider. Alliance has 22 out of network providers, primarily inpatient hospitals, which is a small proportion of the total network of providers. Once a need has been identified as medically necessary an out of network contract is utilized on a short term basis until a full contract can be implemented.

An opportunity of operating within a managed care waiver environment is the ability to offer non-traditional services referred to as "b3" services. Alliance has moved forward to implement b3 services for child and adult IDD and MH/SA populations. Alliance has contracted with six providers to offer MH/Supported Employment/LTVS and two to offer Peer Support. These services should be available by the end of 2014.

B3 Service	# Providers with Claims for Service	Unduplicated Count of Consumers Served	Total Claims
H0045 HA - Respite Ind Child	16	119	$136,458.42
H0045 HQ HA- Respite Grp Child	3	31	$37,131.00
H0045HB - Respite Individual Adult	11	62	$60,619.15
H0045HBHQ - Respite Group Adult	2	15	$19,926.00
H2023 HQ U4 - Supported Employment Group B3	1	5	$24,062.83
H2023 U4-Supported Employment	1	4	$32,284.80
H2026 U4 -Supported Employment to Maintain Employment	8	117	$48,438.41
T1019 U4 - Individual Supports	1	1	$17,280.00
T1019 U4 HW - RHD Individual Supports	1	29	$151,740.98
T2041 U5 - Community Guide B3	6	94	$42,450.00
			$570,391.59

Claims 1/1/14-8/1/14

Process for Identification of Service Needs

In addition to the collection and review of data concerning the provider network, Alliance also seeks and reviews information from service recipients and stakeholders through surveys and from advisory committees.

The North Carolina Mental Health and Substance Abuse Consumer Perception of Care Survey provides information on the quality of care in each LME/MCO's catchment area, based on the perceptions of individuals and families who have received Medicaid or state-funded mental health and/or substance abuse services.

DMH/DD/SAS allocated surveys to Alliance Behavioral Healthcare for eligible providers in the network to distribute to service recipients. These were returned by July 12, 2013.

Three survey instruments were used in the FY2014 administration:

- The 2013 North Carolina Consumer Perception of Care Survey (Adults, all ages)
- The 2013 North Carolina Consumer Perception of Care Survey (12-17 years of age)
- The 2013 North Carolina Consumer Perception of Care survey for Families (YSS, families of children 0-11 years of age)

Surveys were distributed in both Spanish and English for each of the three instruments.

Each instrument included the following four sections:

I. **Background Information:** *consumer demographic information, primary reason for seeking services, length of time served by provider, help seeking practices (*Adults and Adolescents), *number of hospitalizations (*Adults and Adolescents), *height and weight* (Adults only)

II. **Perception of Care:** *consumer perception of care, provider staff, and quality of life outcomes related to services received*

III. **MCO/Network Provider:** *consumer perception of routine and emergent services provided by MCO staff*

IV. **Comments:** *additional consumer feedback and request for follow-up from DMH/DD/SAS*

Consumers 18 years and older were asked to respond to an additional section that addressed consumer physical health:

V. **Physical Health**: *general perception of health, recent routine physical and/or dental examinations, medical conditions, tobacco use, physical activity*

Consumers used a five-item Likert-type scale to demonstrate their level of agreement with the surveys' statements (e.g., "Strongly Agree," "Agree," "I am Neutral," "Disagree," "Strongly Agree," "N/A"). The survey instrument also included yes/no, multiple choice, and short answer

questions to best capture the consumers' background information, physical health, and perception of the MCO/network provider. 29 providers returned 563 completed consumer surveys during the designated collection period, with a 38.7% response rate.

2013 MH/SA Consumer Perception of Care Survey (3/17/14 draft)

Adult Measure	Alliance Percent Positive Domain Scores	State Percent Positive Domain Scores
Access	85	90
Quality and Appropriateness	91	94
General Satisfaction	88	91
Outcomes	72	75
Treatment Planning	74	80
Social Connectedness	80	76
Functioning	76	76

Youth Measure	Alliance Percent Positive Domain Scores	State Percent Positive Domain Scores
Access	84	80
General Satisfaction	79	84
Outcomes	63	71
Treatment Planning	73	74
Cultural Sensitivity	93	92

Parent Measure	Alliance Percent Positive Domain Scores	State Percent Positive Domain Scores
Access	94	92
General Satisfaction	79	92
Outcomes	68	67
Treatment Planning	84	94
Cultural Sensitivity	100	98
Social Connectedness	94	93
Functioning	68	67

A high percentage of all respondents indicated satisfaction with services overall, and that they would continue with their current providers and refer to friends or family if asked. A high percentage also indicated feeling respected by and understood by their providers.

A moderate percentage of consumers are utilizing the ED for physical health care services. According to consumer self-report, 21% of children, 16% of adolescents, and 37% of adult participants have visited the ED at least once in the past 12-months primarily for physical health treatment. Adult consumers are also seeking ED treatment in large numbers for behavioral health problems. Sixteen percent (16%) of adult consumers reported receiving treatment for mental health symptoms within the past 12-months and 5% visited the ED for health problems around substance use. Both of these consumer groups visited the ED an average of 3 times in the past year. This suggests that Alliance should develop strategies to engage consumers in continuous and integrated treatment to reduce health care emergencies. Alliance may consider a collaboration effort with hospital emergency department staff to improve discharge planning in order to direct consumers to more appropriate levels of care as well as to reduce inappropriate hospital admissions.

The Provider Satisfaction Survey was conducted in partnership with The Division of Medical Assistance (DMA). Unfortunately, there was a low response rate by Alliance providers. During the time that the survey was administered, Alliance was in transition with providers, especially in Wake County. It is likely that this transition had an effect on the response rate of 92 agencies.

The following is a summary of the results:

Length of time as a Provider

83% indicated 5 or more years

Provider Type

92% were agencies and 7% were Licensed Individual Practitioners

Types of Services Provided*

Community	51
Outpatient	45
Residential	41
Inpatient	1
ICFM/R	6
Innovations	38

Priority Populations Served*

Adult I/DD	40
Child I/DD	28
Adult Mental Health	41
Child Mental Health	41
Adult SA	29
Child SA	15

* *These are actual numbers indicated by providers. Some providers serve more than one population.*

The strongest areas in which providers were satisfied were:

- Provider Network staff keeps providers informed of changes
- Provider Network staff are knowledgeable
- Provider Network meetings are informative and meet needs
- Claims are processed timely and are accurate
- Information Technology trainings are informative and meet needs
- LME staff are accessible for information, referrals, and appointments.

There were a few areas that needed attention:

- Responding more quickly to provider needs
- Responding to local community stakeholders
- Training on claims and billing
- Ensuring Provider Network staff give accurate information.

In early 2014 Alliance requested that the Alliance Consumer and Family Advisory Committee (CFAC) submit recommendations for needed service development across the Alliance four county area. Below is a summary of the recommendations received:

Durham

Mental Health

1) Hospital Bed Availability/3-way beds
2) Housing First – regardless of disability
3) Peer Support Services

Substance Use Disorder

1) Peer Support Services
2) Engagement
3) Prevention

Intellectual and Developmental Disabilities

1) Personal Assistance – IPRS
2) Transition Services for Children to Adulthood
3) Housing Options for Aging Consumers

Wake

All-Inclusive

1) Information Gap
2) Peer Support Services
3) Housing

Cumberland

Mental Health

1) Public Information/Advocacy
2) Mobile Crisis
3) Peer Support Services

Substance Use Disorders

1) Public Information/Advocacy
2) SAIOP Providers
3) Peer Support Services

(Honorable mention: B3 Services, SA Residential)

Intellectual and Developmental Disabilities

1) Public Information/Advocacy
2) Transition Services for Children to Adulthood
3) Services for Non-Innovation Consumers

Network Development Plan Process

In February 2014 Alliance staff began a multi-disciplinary, cross department, intensive review of demographics, network data, utilization, experience to identify service needs and priorities. The following priorities were identified and reviewed by both the CFAC and the Alliance Provider Advisory Committee (APAC). The Alliance Board of Directors endorsed these priorities at its April 2014 Board retreat.

Intellectual/Developmental Disabilities

- Developmental Therapy – While Alliance has many providers of Developmental Therapy, the focus will be on supporting the growth of professional Developmental Therapy services that are clinically sound and outcome focused and to develop a consistent benefit plan for this service across the Alliance service area.
- Specialized Consultative Services – Alliance will work with providers to develop clearer expectations for this service. Credentialed professionals such as psychologists are especially needed particularly in Cumberland and Durham.
- State-Funded Residential Services – Alliance will work to develop a uniform benefit package across all of our counties and develop clearer provider expectations for this service.
- Crisis – Alliance will seek to develop a Regional Team with professional level consultation provided by the NC START program. Particular focus will be on individuals with dual diagnosis IDD/MH.

- Uniform Benefit Packages – Study, develop and recommend a uniform benefit package across the four-county Alliance area for Developmental Therapy, Personal Assistance, and State funded Residential Services.

Adult MH/SA

- Outpatient Mental Health – Alliance will seek to expand psychiatric capacity in Cumberland County. In Johnston County Alliance will promote the Open Access model.
- Assertive Engagement – Alliance will seek to expand this capacity to identify and engage individuals transitioning from higher levels of service or who are difficult to engage in services. Expansion of Peer Support Services will be a priority as a way to offer assertive engagement.
- ACTT – Alliance will seek to develop capacity in Cumberland and Johnston Counties.
- Supported Employment/LTVS – Alliance will support the continued expansion of this capacity across all of our counties.
- Residential Continuum – Alliance will initiate a comprehensive review of residential capacity, quality and service expectations, and benefit package. Results of this review will guide future service development.
- Transitional Living – Alliance will develop a capacity for this 30-day housing option in all of our counties to assist with transition from hospital and crisis services.

Child MH/SA

- Outpatient – Alliance will promote models of evidence based practice, including trauma informed therapies, by supporting training on these models and creating a mechanism to verify and track training and experience.
- Child/Family Navigator – Alliance will seek to expand this capacity into Cumberland and Johnston counties.
- SAIOP – Alliance will work to expand this capacity in all of our counties.
- Day Treatment – Alliance will identify and promote evidence based models in all of our counties.
- Residential Continuum – Alliance will initiate a comprehensive review of residential capacity, quality, service expectations, and benefit package. Results of this review will guide service development.

Crisis Adult

- Mobile Crisis – Alliance will seek to develop additional capacity in Johnston and Wake Counties.
- Walk-in Psychiatric – Alliance will implement the Open Access model in Johnston counties. Will seek to expand walk in capacity for psychiatric and medication to weekend and after hours in all counties.
- Facility Based Crisis/Detox Beds – Alliance will seek to increase the number of beds in Wake County. Alliance will promote models of trauma-informed models of crisis care.

Crisis Child

- Rapid Response – Alliance will seek to establish Rapid Response capacity in all counties.

Homeless

- Peer Support Outreach – Alliance will develop a capacity across all counties to utilize peer support to provide assertive outreach to homeless individuals.
- SOAR – Alliance will seek to identify dedicated personnel/entities in each county to be trained and offer SOAR services.

Jail Transition

- Continuum of services – Alliance will see to identify agencies in each county to develop a continuum of post release services including a jail transition team, peer bridging, critical time intervention, and transportation.
- Interpretation services

Transition Age Youth

- Outpatient trauma informed care – Alliance will promote trauma informed care through training, provider collaboratives, and review activities across all counties.
- Independent living groups
- SE/LTVS

IDD/MH TBI

- Training for residential and group home providers on supports and interventions for dually diagnosed individuals.
- Training for providers on interventions and resources for TBI accommodating the special needs of individuals with co-occurring IDD/TBI.

Strategies Crossing Disability Areas designed to benefit all service recipients:

- Standardize the Benefit Package
    - Develop a uniform benefit package for Developmental Therapy.
    - Develop uniform benefit packages for Personal Assistance and IDD IRPS Residential as well as clearer provider expectations for these services.

- Enhanced Provider Training
    - Promote trauma-informed care and create ways to assure fidelity across all counties for child and adult outpatient services and for crisis services.
    - Identify training and training resources on interventions and resources for individuals with TBI.
    - Identify training and training resources on supports and interventions for dually-diagnosed individuals.

- Review of Residential Services
    - Conduct a comprehensive review of adult and child MH/SA residential capacity, quality and service expectations, and benefit packages.
    - Explore and plan to implement the Streets to Home model of housing and supports for homeless individuals.

Conclusion and Recommendations

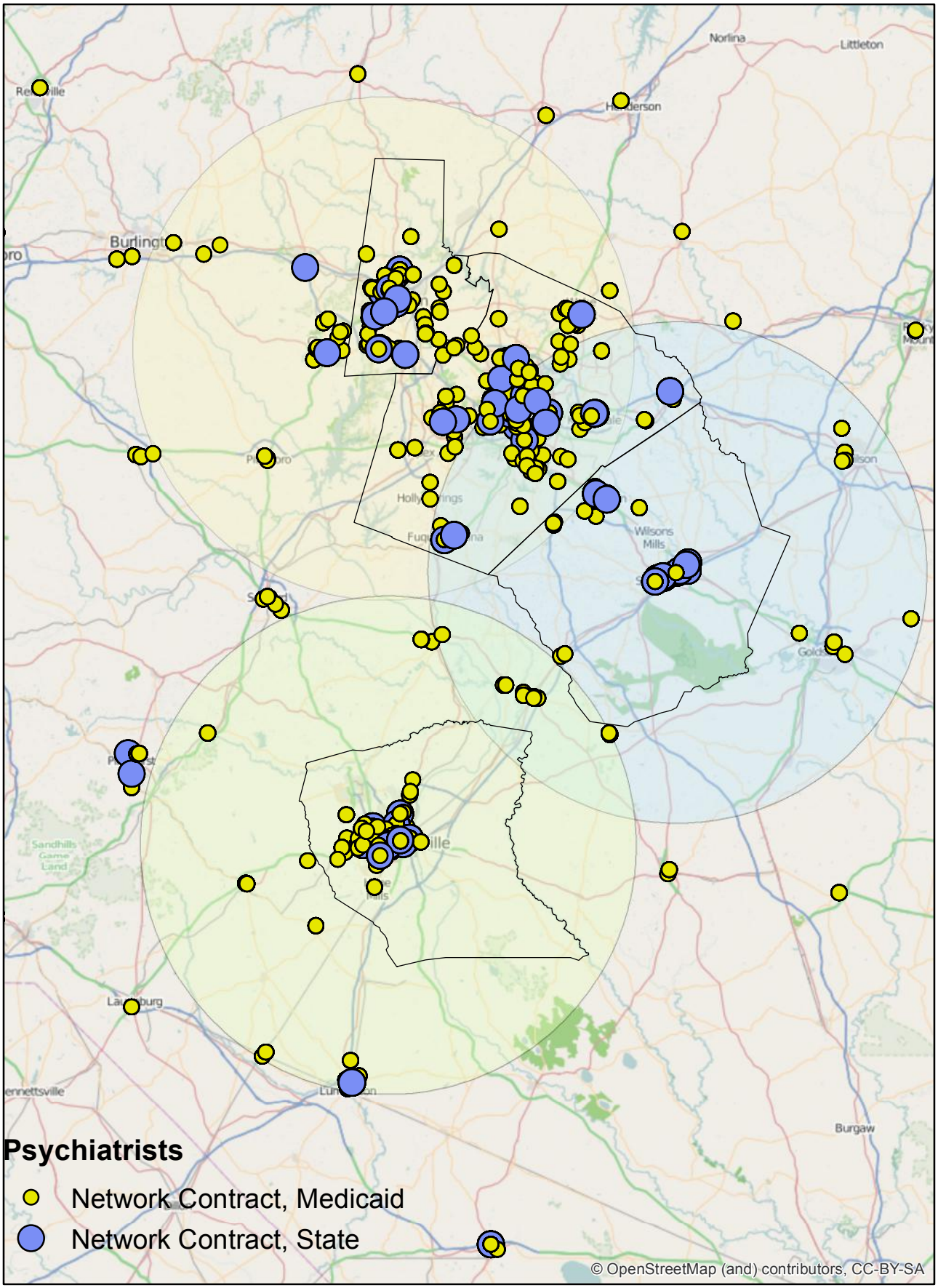
After a thorough review of data highlighting the characteristics and demographics of the individuals and communities within the Alliance area, a review of the characteristics of the current provider network, and input provided by service recipients and stakeholders a number of conclusions and recommendations concerning service needs and network development can be made:

- Alliance covers a large geographic and population area that is primarily urban with pockets of more rural areas especially in Johnston County. All areas are experiencing growth, especially Wake County, and Alliance will face a challenge to keep up with that growth to provide adequate access and capacity. Recruitment of providers in more rural areas may be a challenge given the proximity to urban areas that may be more attractive to providers.
- Alliance has a large and growing Hispanic/Latino population and will need to actively develop and recruit culturally competent services and providers to address the needs of this population.
- Cumberland Co. which has significantly higher rates of these risk factors in areas of poverty, child abuse/neglect, and homicide. Particularly in Cumberland it will be important to assure that providers have competence in trauma informed care and that collaborations

with community partners at DSS, law enforcement, and the court system are well developed.

- Efforts should be made to increase the penetration rate for all populations served but particularly for substance abuse services.
- While Alliance has ample licensed providers in many areas, there is a need to increase psychologists, marriage and family therapists, and addiction counselors.
- Alliance has a robust provider network with adequate numbers of provider to meet access standards across all four counties. Alliance may have excess capacity in some areas and should assess authorization and utilization of services to ensure a network that is "right sized" and can allow for financial stability of its network providers.
- While Alliance has a robust number of providers, concerns have been raised about the comparability and quality of some providers. Alliance should identify ways to standardize service expectations and offer training or provider collaboratives to enhance knowledge and improve quality.
- Alliance is building a strong base of providers offering evidence based practices. These treatments offer high quality and demonstrated outcomes. Alliance should develop ways to support and further develop these practices across the Alliance area.
- A number of the services for which Alliance is paying the most are residential institutional type services. Alliance would benefit from a review of these services to determine whether additional lower cost options should be developed.
- Alliance should develop strategies to engage consumers in continuous and integrated treatment to reduce health care emergencies. Alliance may consider a collaboration effort with hospital emergency department staff to improve discharge planning in order to direct consumers to more appropriate levels of care as well as to reduce inappropriate hospital admissions.
- In general, questions and concerns were identified about the continuum and availability of residential supports, the quality and comparability of residential services, and whether new or additional capacity, including potential new models of non-congregate options, should be considered. Alliance should engage in a comprehensive study of it residential and housing continuum to determine projected needs, capacity, and quality and to use results of this study to develop a plan to address needs across the network.
- The comprehensive network review completed by Alliance staff in early 2014 with input and review from stakeholders resulted in specific service need priorities across all counties and population groups. A plan should be developed to address these specific needs
- Alliance should update its Network Development Plan for FY 2015 to implement the conclusions and recommendations of this Needs Assessment and Gaps Analysis.

Appendix A:
Service Geomapping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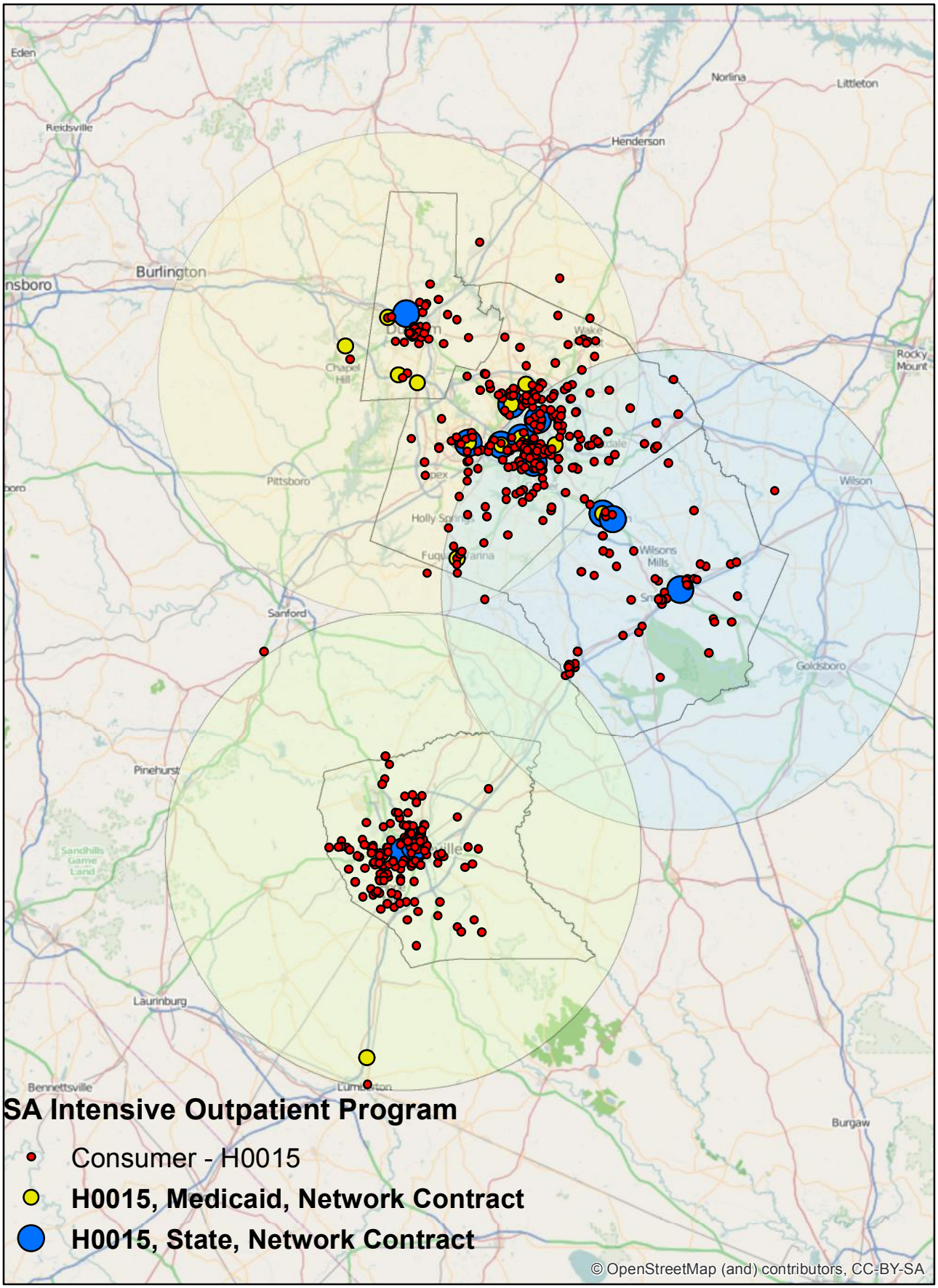
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H0015, State, Network Contract
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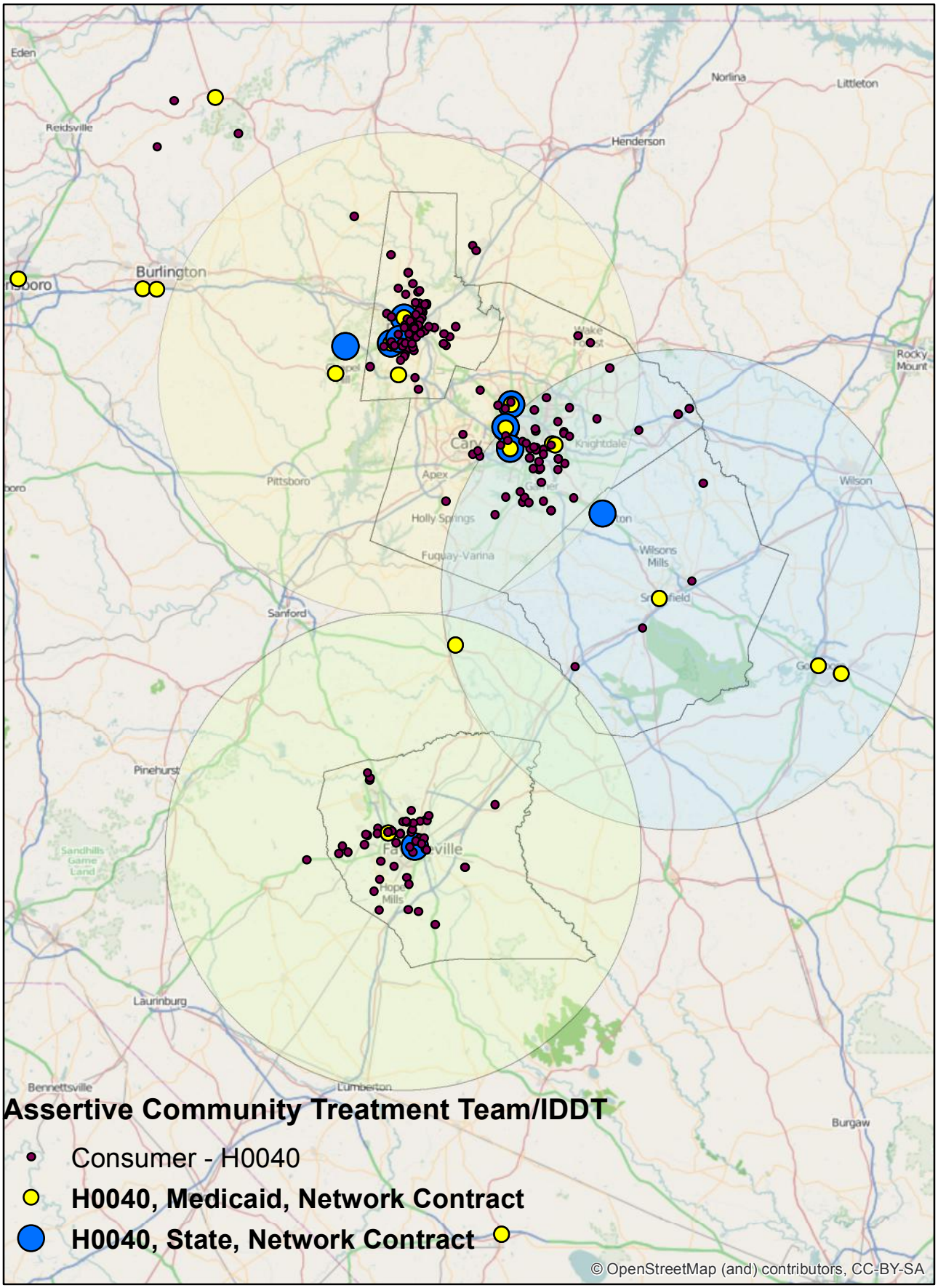
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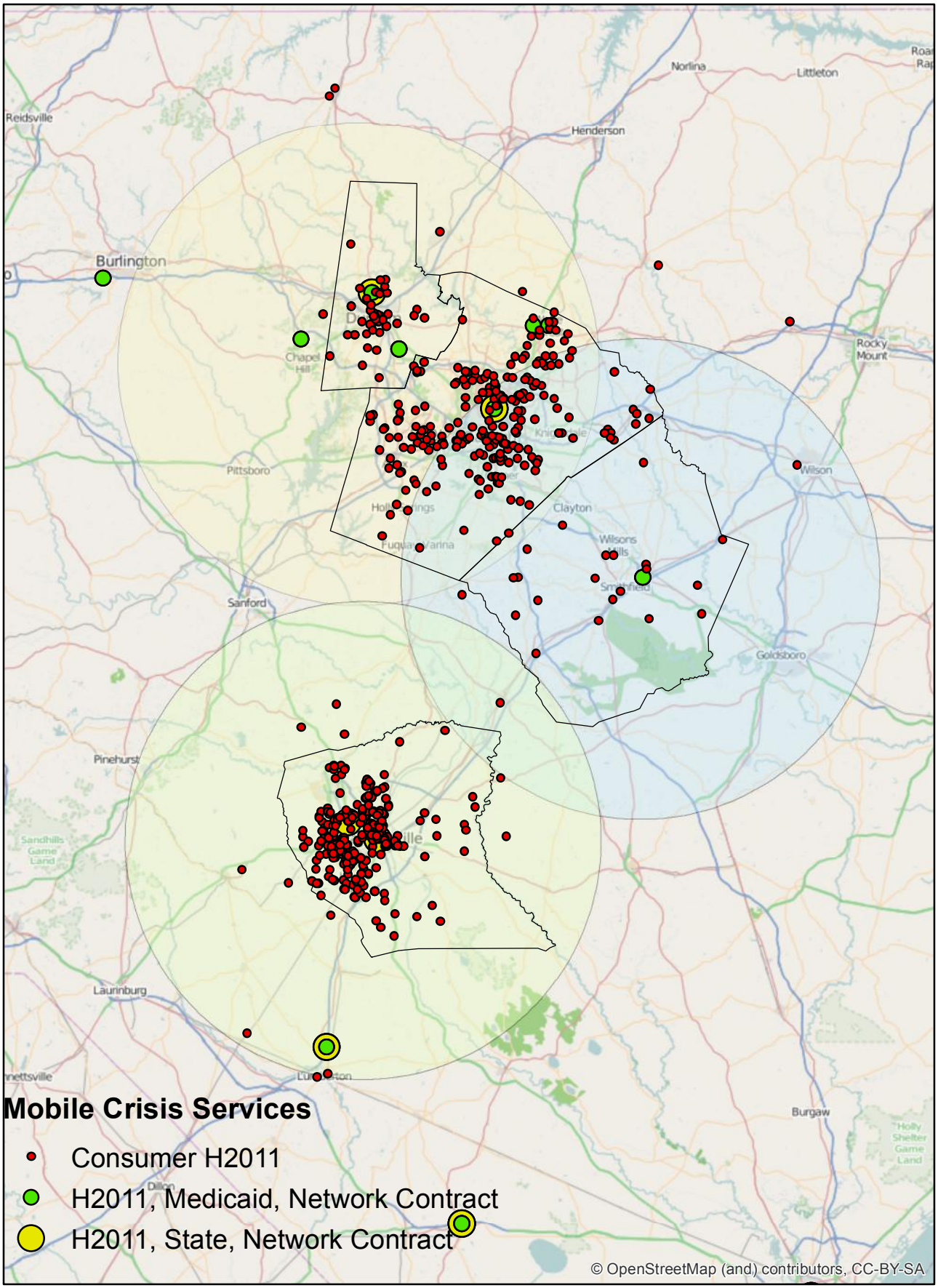
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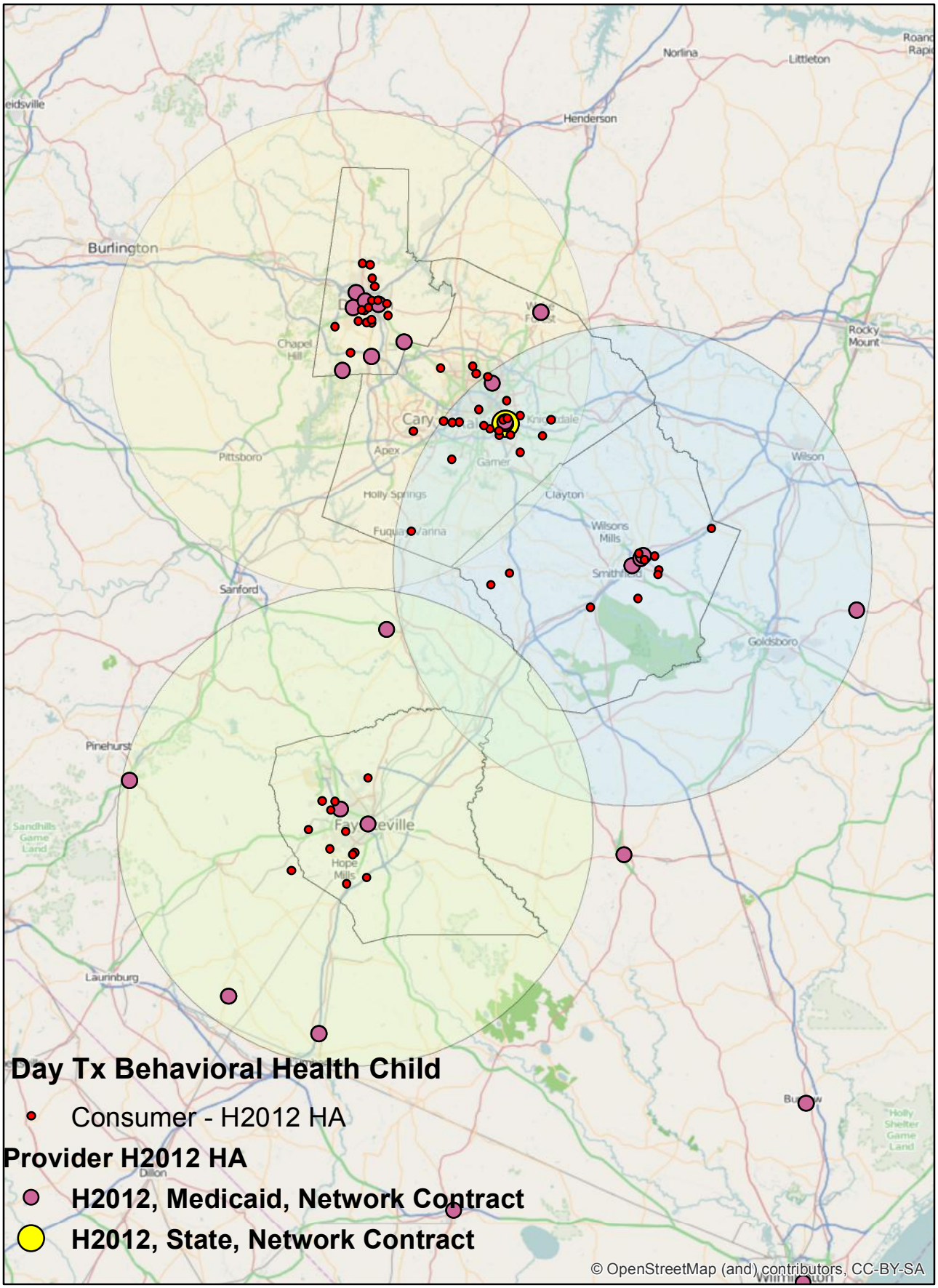
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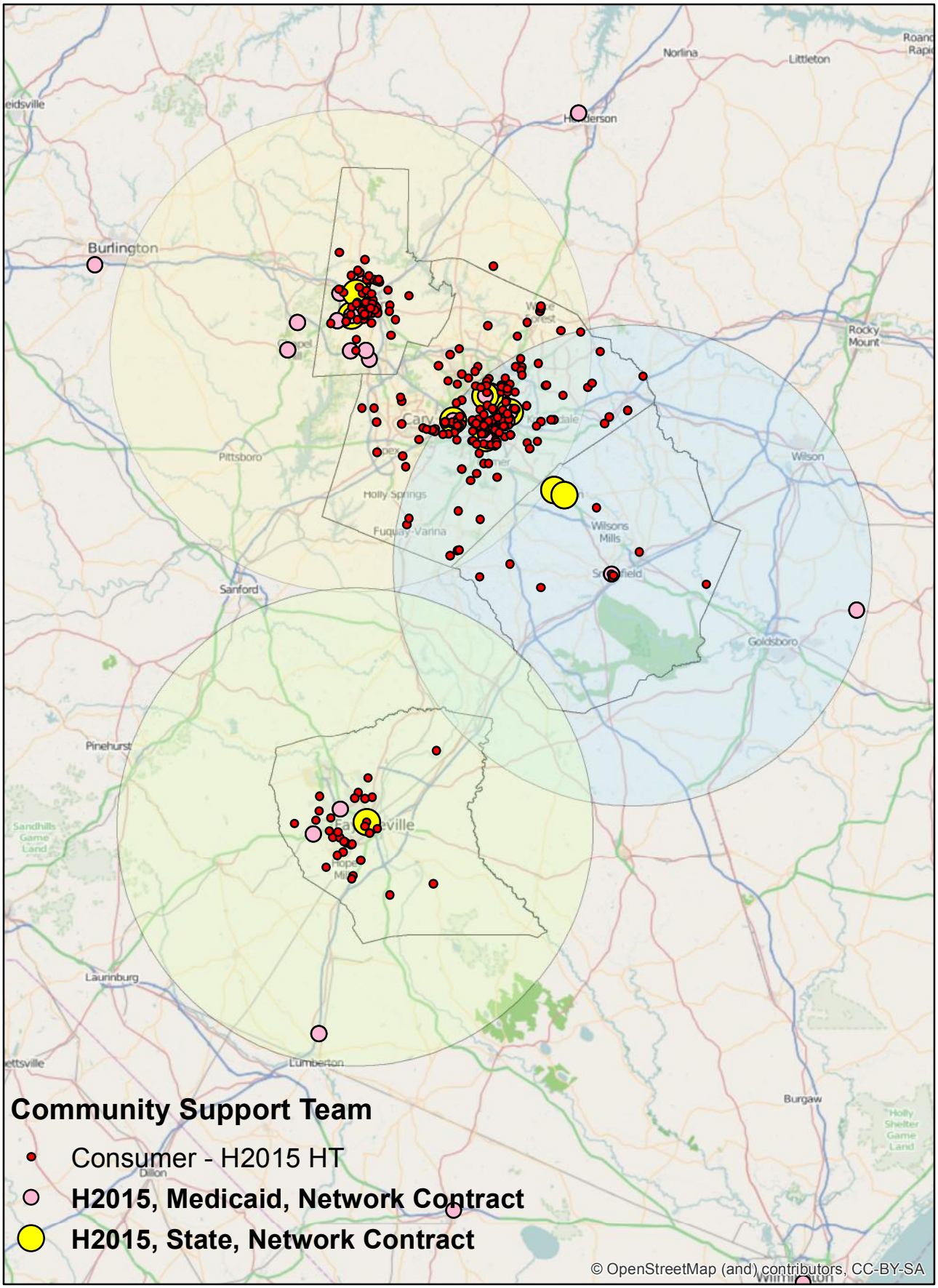
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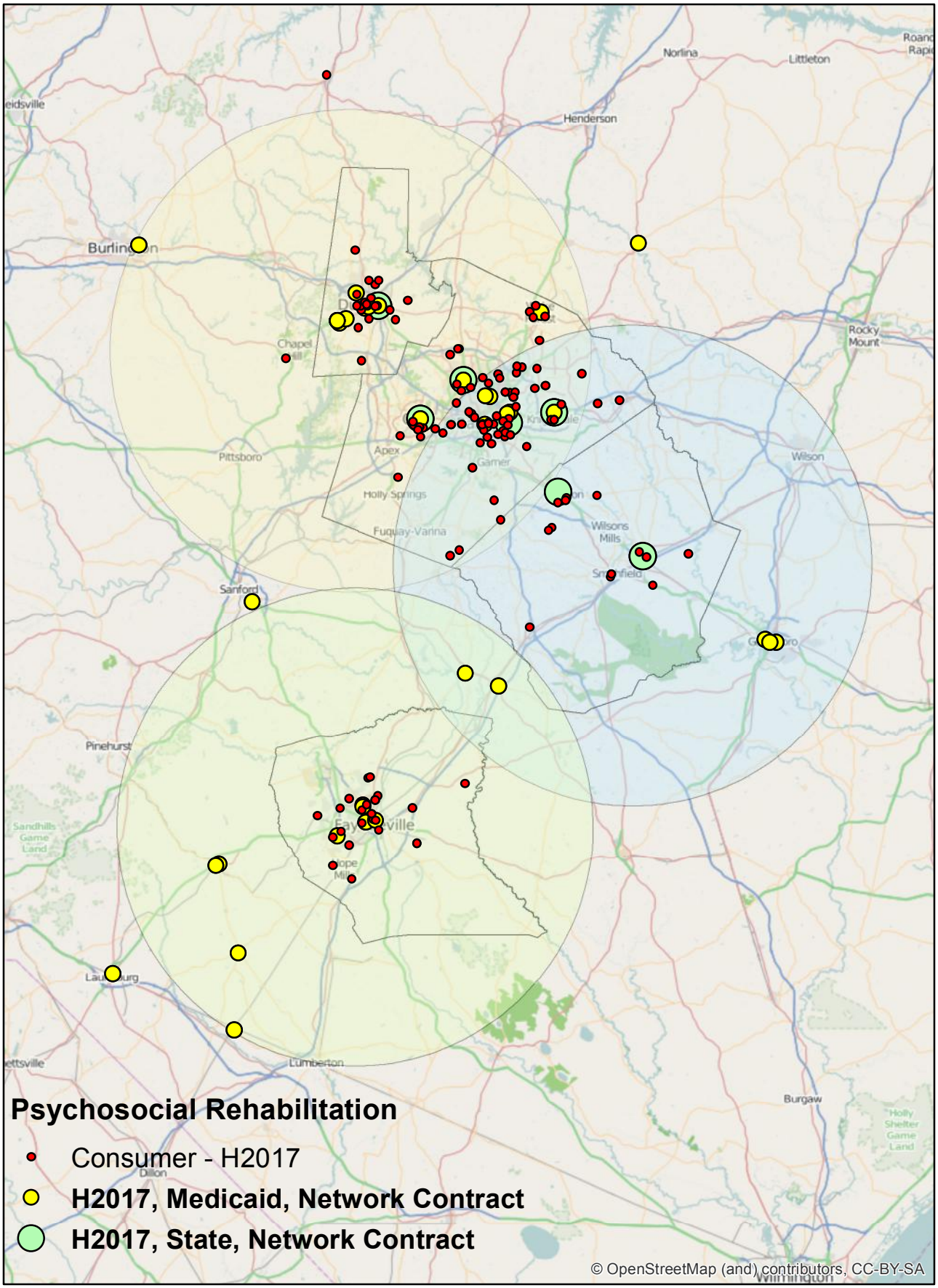
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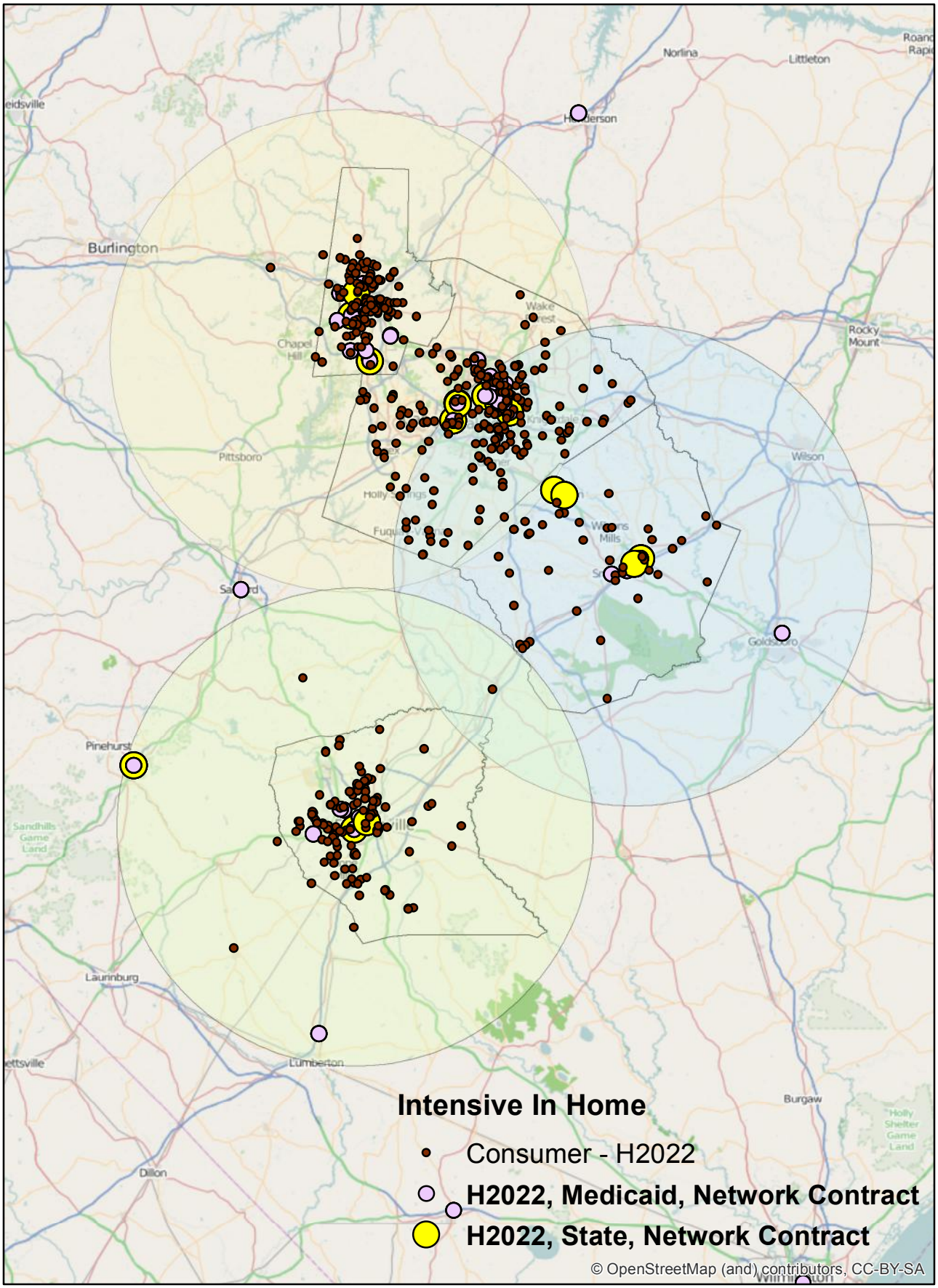
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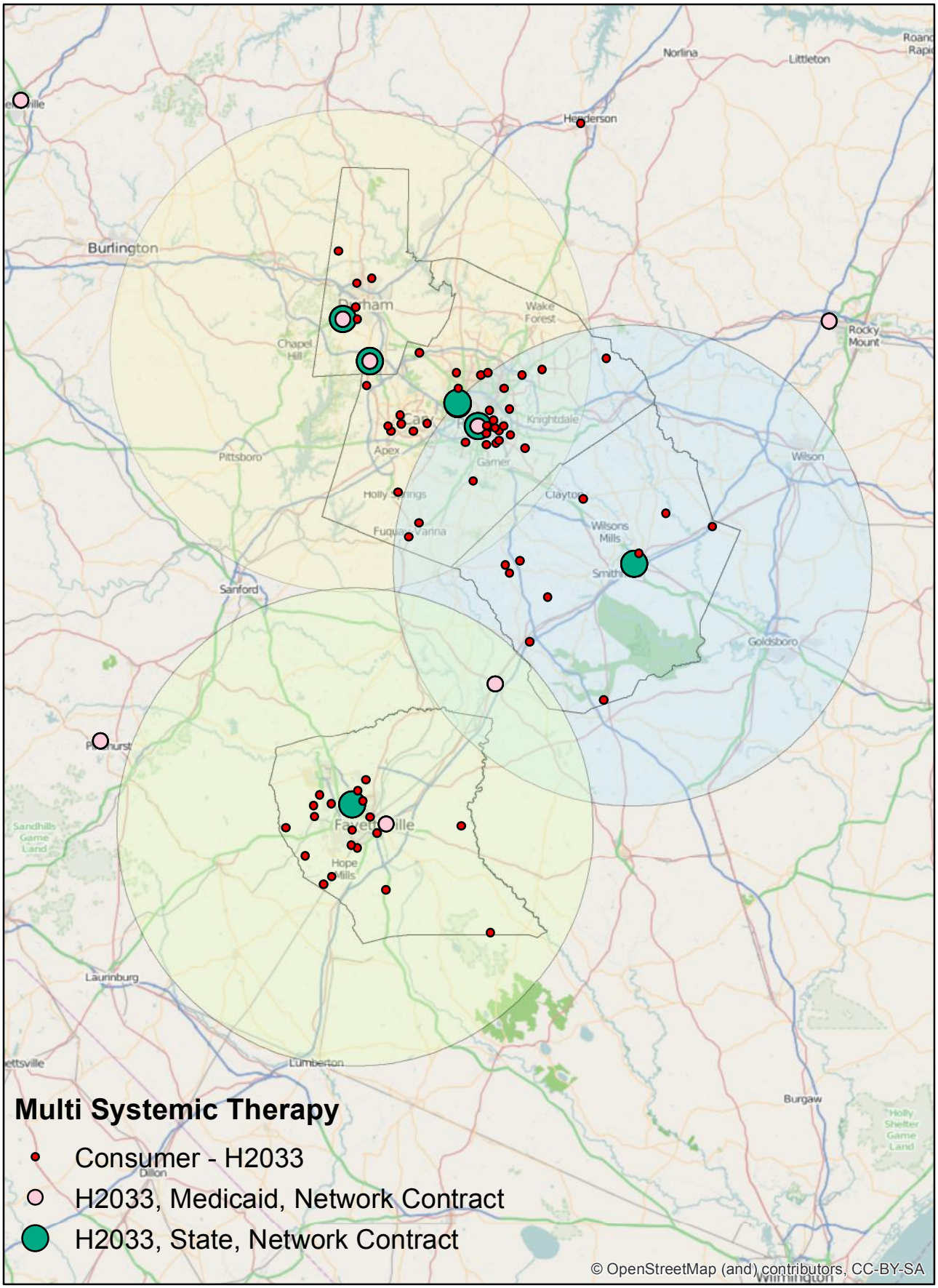
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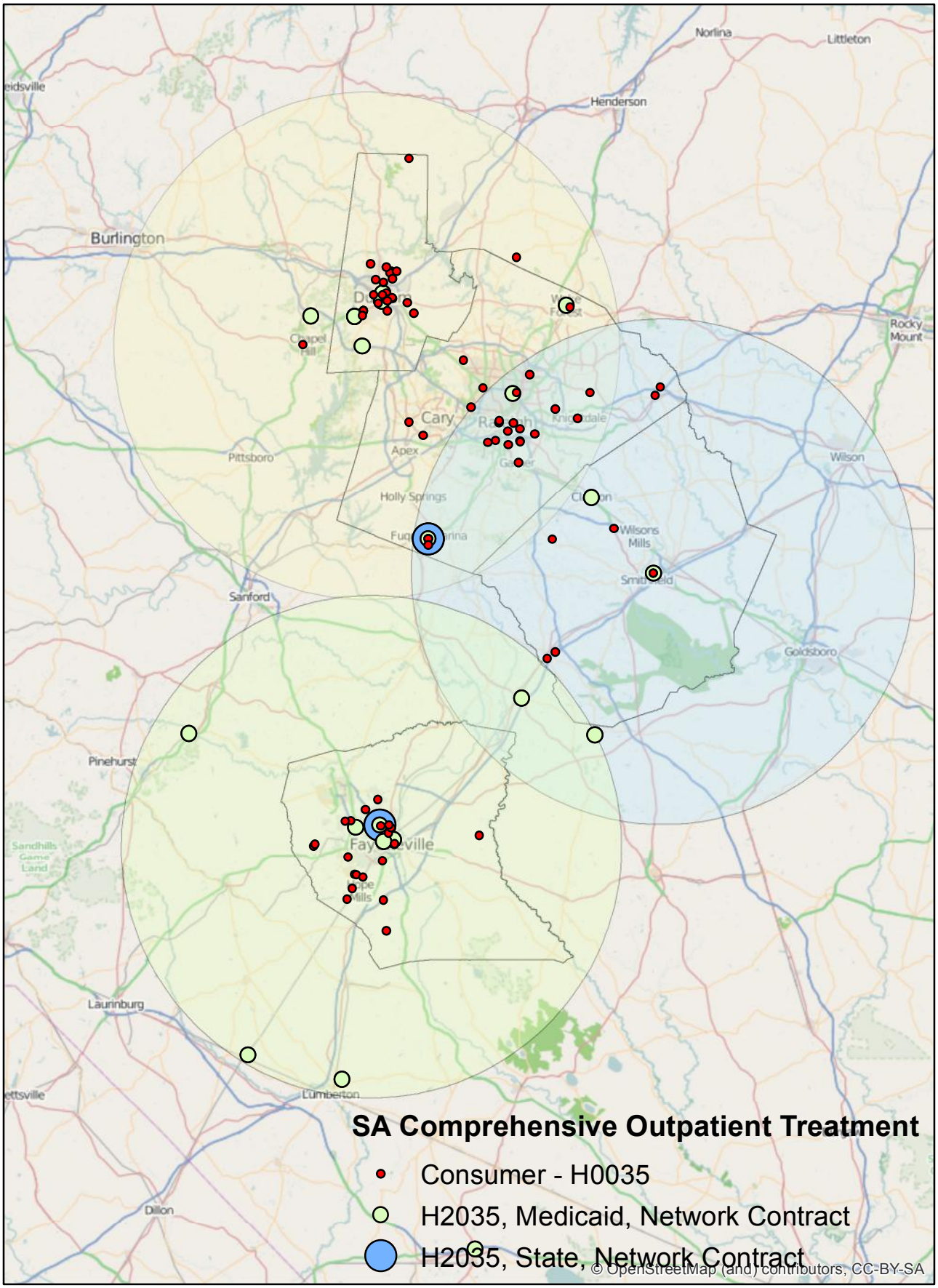
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H2035, Medicaid, Network Contract
H2035, State, Network Contract
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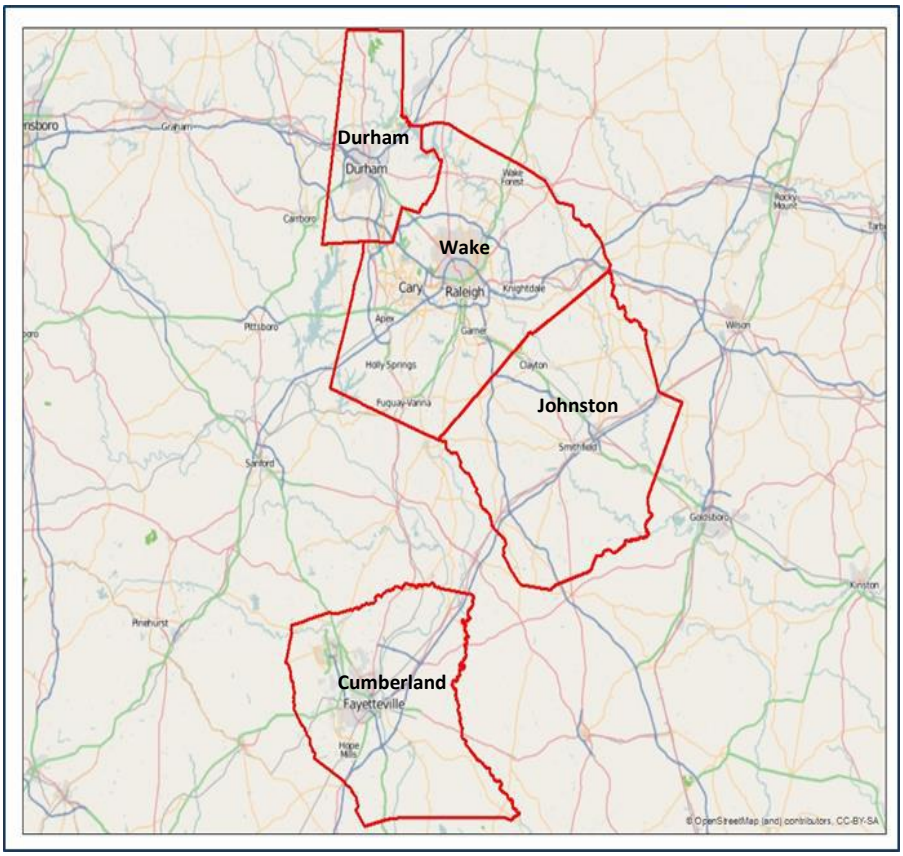
Appendix B:
FY13 Provider Network Profile

Alliance

BEHAVIORAL HEALTHCARE

FY 2013 Provider Network Profile

CONTENTS



EXECUTIVE SUMMARY

The Alliance Behavioral Healthcare Local Management Entity/Managed Care Organization (LME/MCO) Provider Network Profile for Fiscal Year (FY) 2013 defines several aspects of the demographic and geographic community strengths and needs for the counties of Durham, Wake, Johnston and Cumberland. These counties represent Alliance's service catchment area.

Alliance Behavioral Healthcare was newly formed on July 1, 2012, to manage Medicaid behavioral health and developmental disability services. Building the provider network is a priority by credentialing providers that wish to serve consumers who reside in the Alliance Behavioral Healthcare service area. Information gathered for this report has been collected from various sources including:

- Perception of Care surveys conducted in FY11 and FY12
- Provider survey data from FY12
- Claims paid data describing the services that providers bill for services rendered in FY12 and FY13
- Population statistics for the 4 counties
- Projected numbers of individuals qualifying for Medicaid benefits
- Numbers served utilizing State of North Carolina funds for indigent individuals who have mental health, developmental disorders, or substance abuse needs
- Prior utilization of services funded by Alliance Behavioral Healthcare
- Providers contracted by the LME/MCO through June of 2013
- Geographic standards
- Quality Improvement Project (QIP) data
- Other secondary statistical data as referenced further in the report.

Alliance Behavioral Healthcare Strengths:

- Diverse Service Array Among Four Counties
- Low Rate per Capita of Emergency Room Admissions
- Availability of Crisis Facilities in Each County
- Local Community Inpatient Units in Each County
- Availability of Critical Access Behavioral Health Agencies
- Specialized Care Coordination for High Risk Individuals
- Recovery-Focused Programs
- Peer Support Training
- Respite Services
- Federal Housing Grants

Gaps/Needs:

- Enhance and Provide Additional Trauma Focused Care
- Increase Access to Affordable, Permanent Housing for Individuals At Risk of Homelessness
- Reduce admissions & Lengths of Stay in Emergency Rooms
- Enhance Discharge Planning from Inpatient or Crisis Facilities for Better Connection to Providers
- Provide additional Supportive Employment and Other Types of Employment and Education
- Reduce Hospitalizations of Individuals with Complex Physical and Mental Health Problems
- Enhance Crisis Diversion Services

DEMOGRAPHICS

The Medicaid eligibles listed in the table below include all Medicaid eligibles, including individuals who are not covered under the PIHP waiver program. The Medicaid population, as a percentage of the total population, varies from a low of 8.24% in Wake County to a high of 15.46% in Johnston. The average number of Medicaid eligibles is about 14% of the total Alliance population.

Estimated September 2012 Medicaid Eligibles for Alliance LME/MCO Catchment Area			
County	**Total Medicaid Eligible**	**Total Population 2012**	**Projected Medicaid Eligibles as % of Population**
Cumberland	48,092	324,049	16.6%
Durham	35,562	279,641	16.6%
Johnston	26,677	174,938	15.2%
Wake	76,651	952,151	10.1%
Alliance Total	**186,982***	**1,730,779****	**14.6%*****

* *Per DHHS Statistics, 2012-2013*
** *U.S. Census Bureau, 2012 Estimates*
*** *Per Projected FY14 Poverty Levels, U.S. Census Bureau*

Age

The total population for the Alliance LME/MCO catchment area for calendar year 2012 was estimated to be 1,730,779, with 562,255 (33%) under the age of 18, and 1,138,397 (67%) 18 years or age or older (US Census Bureau, 2013). Durham and Wake Counties both have fewer children than adults in the general population.

Race and Ethnicity

Based on the 2012 Census estimates for the counties in Alliance's catchment area, individuals who identified as white comprise 65.5% of the population or 1,114,127 people; individuals who identified as black are 26.5% of the population (450,452); and individuals who identified as being of Hispanic or Latino Origin are 10.8% of the population (184,487). However, within each county, the demographics vary. Johnston and Wake Counties both have a predominantly White population with 80% and 70% respectively. In addition, within Durham and Johnston Counties, the Hispanic population is higher than the catchment area average, with over 13% of the population identified as Hispanic or Latino. Lastly, both Wake and Durham Counties have a significant population of Asian persons.

Growth

Alliance is anticipating growth in the numbers of individuals needing behavioral health and intellectual/developmental disability services through 2020 due to the substantial general population growth in the four counties comprising the Alliance catchment area. According to NC State Data Center estimates, the population growth projections range from 7% in Cumberland County to 22% in Wake County. Assuming the estimated prevalence of behavioral health and developmental disabilities remains constant, then Alliance is projecting a 14.3% increase in number of individuals in need.

UTILIZATION OF SERVICES

Prior Utilization of Services

Alliance analyzed the Medicaid Paid Claims from February 1 through June 30, 2013 to determine baseline patterns of behavioral health and intellectual/developmental disability service utilization. For analysis purposes, the data below presents the number of unduplicated consumers served, claim counts, amounts paid, the amount paid per person served and utilization per 1,000 (population) during the period of February 1 through June 30, 2013. A summary of the utilization per 1000 population is shown in the following chart.

Utilization per 1000 for Medicaid Services by County				
Category of Service	**Cumberland**	**Durham**	**Johnston**	**Wake**
Crisis Services	38.27	45.35	27.15	40.05
Inpatient	12.30	7.12	5.93	7.99
ICF-MR	9.15	15.81	14.35	11.10
Residential	39.62	17.03	19.66	25.22
PRTF	3.75	5.39	5.62	8.61
Outpatient	645.26	566.29	691.42	592.22
Enhanced:				
ACTT	28.66	69.85	13.10	23.18
Day Tx	14.26	10.60	8.11	12.61
CST	13.51	23.98	7.18	20.42
IIH	49.07	85.84	61.78	91.20
MST	19.81	7.47	3.43	10.75
PSR	22.66	18.77	22.15	35.61
Other Enhanced - Psychiatry	3.15	6.43	30.27	9.59
Innovations	42.92	59.77	29.33	72.11
SACOT	4.80	12.68	8.11	3.64
SAIOP	15.76	30.76	14.04	16.25

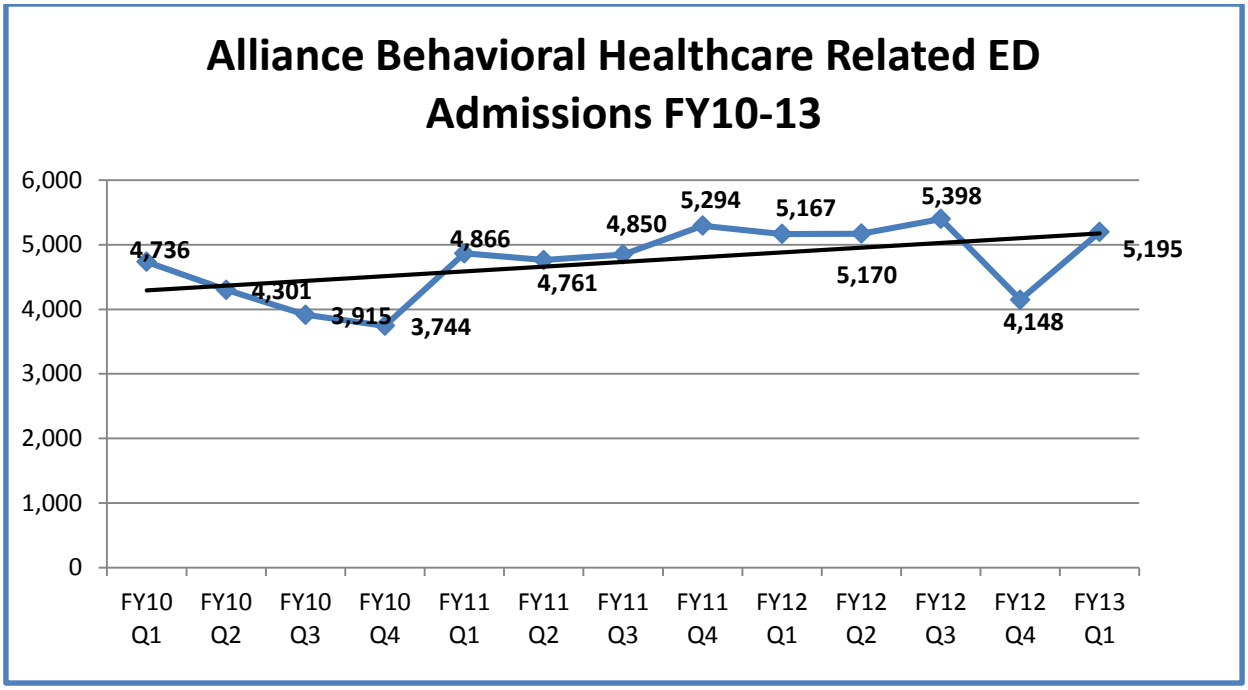
Claims for February 1, through June 30, 2013

The information in this chart indicates that outpatient services comprise the majority of services, with Intensive In-Home (IIH) coming in as second in utilization, and emergency room and inpatient services as the next highest (when separated out from Innovations services). This also shows that the Emergency Department utilization rate for Cumberland County is higher than the other catchment area counties, with Wake County close behind. Alliance Leadership, Care Coordination, and clinical staff are addressing this to ensure care coordinators are assigned to each individual admitted to a crisis or inpatient service.

Requests for Proposal are being considered for Cumberland County through October of 2013 for the next contract period, which will ensure improved provider network capacity for Cumberland in FY14. It is anticipated that the rates per thousand in Wake County will improve with an enhanced provider network that was effective July 1, 2013.

Utilization of Emergency Rooms

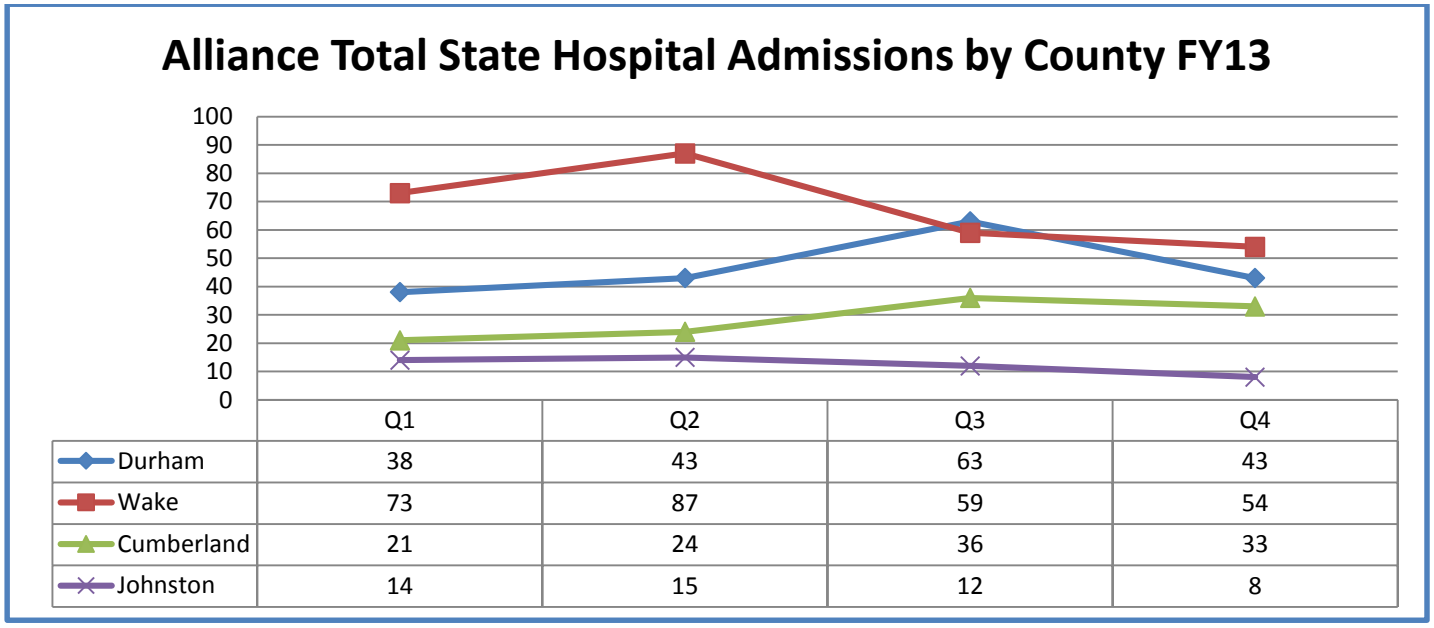
Several trends emerged from reviewing paid claims data. Emergency room usage greatly varies between the four counties in Alliance's catchment area. Cumberland County utilization (per capita) continues to exceed the other counties. The higher rate of emergency room utilization is due in part to the limited capacity of facility-based crisis services in the community, particularly bed availability after regular business hours and beds for youth. Alliance has collaborated with Cumberland County to develop a local crisis facility that will be operational in FY 2014. In addition, The University of North Carolina is operating the crisis facility in Wake County once operated by Wake Behavioral Health, and is opening an additional 16 bed inpatient unit on that campus this fall. Utilization of beds at The Durham Center Access crisis facility has not been at capacity; therefore, a study is underway to determine how best to fully utilize these beds to divert hospitalizations in Durham County.



The chart above shows a trend line for all counties comprising the Alliance geographic area from FY 2010 through the first quarter of FY 2013 (latest NC-DETECT data available). Overall, there has been an approximate 9% increase in utilization of the EDs; however, this is not statistically significant—meaning that the trend could be due to increases in population over the 3 years analyzed, and not due to a true increase in the rate of admissions. Alliance staff will continue to monitor ED admissions and analyze claims data reported for FY 2013 in order to trend ED costs and compare to admissions numbers.

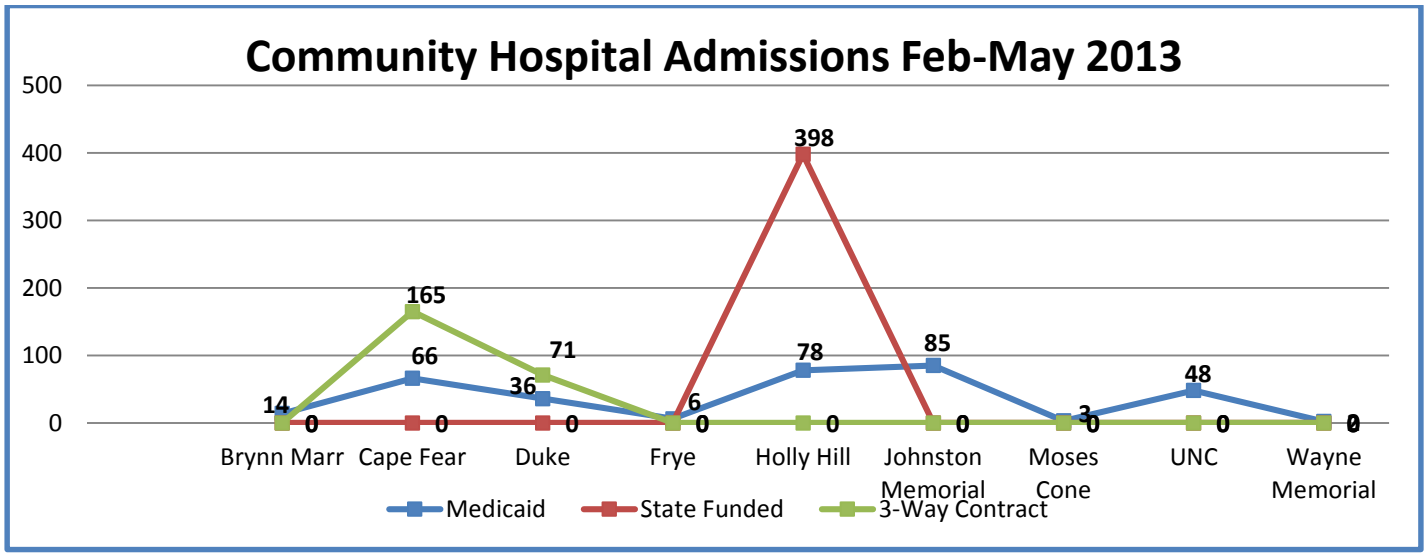
Inpatient Utilization

Inpatient utilization has been fairly consistent across all Alliance counties, until Quarter 3 (January through March, 2013) of FY 2013. State Psychiatric Hospital admissions increased in the 3rd Quarter for Cumberland and Durham Counties. This increase is being studied to determine if it is a trend that requires further review. Durham tends to have a higher utilization per capita of Central Regional Hospital (CRH) than the other counties. This may be due in part to few Three-Way Contract beds in Durham (5 at Duke), which leaves CRH as the only longer term inpatient resource in that county.



	Q1	Q2	Q3	Q4
Durham	38	43	63	43
Wake	73	87	59	54
Cumberland	21	24	36	33
Johnston	14	15	12	8

Efforts are in place to reduce unnecessary admissions to the State Psychiatric Hospitals; including building more facility based crisis capacity in Wake and Cumberland Counties. There was a reduction of admissions in quarter 4 and this will continue to be monitored.



Data based on authorizations during the months of February through May of 2013

Community hospital admissions for the period of February through June of 2013 are being tracked for trends, as well as to establish baseline data to determine benchmarks for FY14. Duke University and Cape Fear Valley Hospitals have 3-Way Contracts with the Division of MH/DD/SAS and LME/MCOs, and Holly Hill Hospital has an exclusive contract to cover Wake County psychiatric admissions. Cost analyses are being conducted, with reviews of lengths of stay and discharge planning. Readmissions within 30 days at the community hospital level range from 3 to 29 percent, with the highest readmission rate corresponding to Holly Hill Hospital (29%), with 15% of these being Medicaid recipients, and 14% being state and Wake County funded individuals per the contract with Holly Hill.

Residential and Outpatient Services

Alliance is tracking the use of residential and outpatient services to ensure capacity is adequate to stabilize individuals recently discharged from crisis facilities and to prevent others from experiencing crisis episodes. Enhanced, intensive community services are critical elements of Alliance's network. Medicaid paid claims data indicated varying use of these intensive services in the Alliance catchment area. For example, each community has experienced a large increase in the use of intensive in-home services for youth since the elimination of the community support service. The service for youth was designed to add comprehensive, best practice services for youth with chronic behavioral health conditions and at risk of out-of-home placement. According to the Medicaid paid claims data, intensive in-home is utilized more than any service other than outpatient services. Utilization is very high in Durham and significantly elevated in Wake County.

County	Total Adult Facilities	Total Adult Beds	Adult Beds per 10K Adult Population	Total Child Facilities	Total Child Beds	Child Beds per 10K Child Population	Total Beds	Overall Beds per 10K	Family Care Home Beds	Adult Care Beds	Family Care Facilities	Adult Care Facilities
Durham	85	650	32.29	8	41	6.32	691	25.69	177	808	33	12
Wake	158	746	11.08	24	99	4.52	845	9.31	253	2,737	45	32
Cumberland	71	381	16.2	12	47	5.47	428	13.33	40	176	9	13
Johnston	21	105	8.4	7	28	6.46	133	7.82	42	550	8	21
Alliance	335	1882	67.97	51	215	22.77	2097	56.15	512	4271	95	78

Data as of August 2012 from the Division of Health Services Regulation (DHSR)

Residential services remain a highly utilized service in the four counties. A total of 987 enrollees received residential services in FY12. Currently, 386 facilities are licensed by the NC Division of Health Service Regulation to provide residential services in the Alliance catchment area. Of these facilities 335 serve adults and 51 serve child. Across the catchment area, almost 31,500 bed days were paid with Medicaid funds. The highest utilization has been in Johnston County where individuals resided in residential for an average of 140 days compared to less than 23 days in the other three counties. While the utilization is anticipated to decrease through utilization management, a large number of residential facilities are still needed to meet the current demand for services. Services that are available for adults with intellectual/development disabilities is currently over 90% of existing capacity in Durham and Cumberland. Alliance will be reviewing the standards for residential services during the first year of operations to augment the requirements beyond geographic access to better gauge capacity and need.

PROVIDER CAPACITY

Nearly two-thirds of enrollees with behavioral health or developmental disabilities receive some type of basic outpatient service, such as assessment, group therapy, and individual therapy. Alliance has credentialed over 2,000 providers associated with the following number of provider types:

Service Type or Practitioner	Contracted as of June 30, 2013
Agencies	352
Hospitals	27
CABHAs	39
LIPs	489
PRTFs	15
Total	922

The Number of Network Providers Who Are Not Accepting New Referrals

Alliance is committed to ensuring new enrollees have timely access to care. Alliance tracks availability of new intake slots through an online scheduler. Providers are required to input times and dates that are available for new intakes in the system. At the time of writing this report (July 2013) there are no waiting lists for outpatient care.

Geographic Standards

Alliance ensures that Medicaid Enrollees have a choice of at least two providers within 30 miles or 30 minutes' drive time for services. If active consumers reside outside of the geographic standard, then Alliance will create a plan to add capacity to fit the needs of the individuals served. Exceptions may be requested by Alliance to DMA for specialty services, where appropriate.

According to an analysis of geo-access maps, Alliance meets the geographic standards detailed in the evaluation section above. The entire four county area is within a 30 mile radius of all contracted provider agencies or LIPs and a 20 mile radius of contracted CABHA agencies.

PERFORMANCE MEASURES STATUS

Following is a summary of the status of Alliance Behavioral Healthcare DHHS Performance Measures at the end of FY2012:

Many of the North Carolina Department of Health and Human Services (DHHS) contract performance indicators were met during this reporting year, and include:

- State Psychiatric Hospitalizations were at or below the state goal of 20 or less.
- Readmissions within 180 days to the State Psychiatric Hospitals averaged 24%, which met the state requirement of 30% or less.
- Consumers and families who completed the Perception of Care surveys indicated a 90% satisfaction with services overall.

Areas that are determined to need improvement are:

- Services for children with Intellectual/Developmental Disorders (I/DD) need to reach more children in this population (minimum of 37%).
- Individuals with substance abuse disorders are not being retained in services as long as they should be (at least 55% should have 4 or more visits within 45 days).
- Improvements in supported employment are needed.
- Reductions in emergency room and inpatient psychiatric admissions need to be continued.
- Improved engagement rates across the continuum of care for best practice services.
- Fewer inpatient readmissions (both community and State facilities).
- Improve access to care timelines.
- Improve crisis and inpatient discharge planning practices and follow-up care.
- Better coordination between jails and behavioral health care.

NEXT STEPS

Alliance is working on a 3 year Local Business Plan that focuses on several initiatives. Five of the initiatives are DHHS mandated, and 3 have determined from performance indicators not being met at this time. The initiatives are as follows:

- Transition to Community Living (Department of Justice Mandate)
- Assertive Community Treatment Team Enhancements and Improvements in Supported Employment
- Crisis Services Enhancement
- Closer to Home Care for Youth (Psychiatric Residential Treatment Facilities (PRTF's)
- Reduce Waitlists for Individuals with Intellectual or Development Disabilities
- Improve Care of Individuals with Complex Physical and Behavioral Health Issues
- Open Access (improve access to care with more timely appointments)
- Improve Diversions from Jail and Post Jail Linkages

The timeline for beginning these improvements is robust and planning teams are already meeting to develop strategies. Performance measures are being created that will be monitored and tracked over the next 3 years.

Other areas to consider based on the Alliance Behavioral Healthcare Consumer and Family Advisory Committee (CFAC), the following are noted for further consideration as funds allow:

- Focus on Recovery Oriented Services
- Focus on Veterans and Military
- Inclusion of Peer Support in Evidence Based Practices
- Other Housing Options (in addition to what is included in DOJ requirements)

Any questions or comments can be directed to: QMHelp@Alliancebhc.org.

ATTACHMENTS: Medicaid Utilization by Unduplicated Served and Claims Paid

Data is from February 2013 through June 2013 (Source: Alpha)

CUMBERLAND

Category of Service	Unduplicated Served	Claim Count	Amount Paid	Paid per Consumer	Utilization/1,000
Crisis Services	255	4,711	$322,106	$1,263.16	38.27
Inpatient	82	809	$569,663	$6,947.11	12.30
ICF-MR	61	4,553	$2,354,652	$38,600.85	9.15
Residential	264	22,759	$2,135,142	$8,087.66	39.62
PRTF	25	1,638	$738,741	$29,549.64	3.75
Outpatient	4300	39,595	$2,485,626	$578.05	645.26
Enhanced:					
ACTT	191	2,090	$615,144	$3,220.65	28.66
Day Tx	95	3,367	$580,449	$6,109.99	14.26
CST	90	1,152	$138,664	$1,540.71	13.51
IIH	327	10,984	$2,835,212	$8,670.37	49.07
MST	132	3,184	$1,014,725	$7,687.31	19.81
PSR	151	8,054	$524,185	$3,471.42	22.66
Other Enhanced(Psychiatry)	21	183	$14,038	$668.48	3.15
Innovations	286	33,934	$3,435,351	$12,011.72	42.92
SACOT	32	1,196	$216,954	$6,779.81	4.80
SAIOP	105	1,252	$164,199	$1,563.80	15.76
All Categories	6,664	139,765	$18,218,813		

DURHAM

Category of Service	Unduplicated Served	Claim Count	Amount Paid	Paid per Consumer	Utilization/1,000
Crisis Services	261	3,863	$279,586	$1,071.21	45.35
Inpatient	41	696	$765,609	$18,673.39	7.12
ICF-MR	91	7,381	$3,808,247	$41,848.87	15.81
Residential	98	8,355	$979,367	$9,993.54	17.03
PRTF	31	2,201	$1,030,640	$33,246.45	5.39
Outpatient	3,259	40,721	$2,282,028	$700.22	566.29
Enhanced:					
ACTT	402	5,284	$1,530,670	$3,807.64	69.85
Day Tx	61	2,614	$367,107	$6,018.15	10.60
CST	138	2,260	$213,590	$1,547.75	23.98
IIH	494	16,793	$4,335,062	$8,775.43	85.84
MST	43	728	$174,601	$4,060.49	7.47
PSR	108	5,415	$302,497	$2,800.90	18.77
Other Enhanced (Psychiatry)	37	241	$17,318	$468.05	6.43
Innovations	344	37,601	$4,058,945	$11,799.26	59.77
SACOT	73	2,730	$492,199	$6,742.45	12.68
SAIOP	177	3,033	$394,800	$2,230.51	30.76
All Categories	5,755	140,039	$21,075,207		

JOHNSTON

Category of Service	Unduplicated Served	Claim Count	Amount Paid	Paid per Consumer	Utilization/1,000
Crisis Services	87	1,053	$64,839	$745.28	27.15
Inpatient	19	247	$135,635	$7,138.68	5.93
ICF-MR	46	2,229	$1,234,355	$26,833.80	14.35
Residential	63	5,617	$644,996	$10,238.03	19.66
PRTF	18	1,237	$619,886	$34,438.11	5.62
Outpatient	2,216	22,820	$1,055,554	$476.33	691.42
Enhanced:					
ACTT	42	468	$138,167	$3,289.69	13.10
Day Tx	26	1,194	$194,986	$7,499.46	8.11
CST	23	293	$34,075	$1,481.52	7.18
IIH	198	7,740	$1,998,032	$10,091.07	61.78
MST	11	587	$175,542	$15,958.36	3.43
PSR	71	3,524	$224,837	$3,166.72	22.15
Other Enhanced (Psychiatry)	97	560	$28,625	$295.10	30.27
Innovations	94	8,191	$770,248	$8,194.13	29.33
SACOT	26	805	$143,896	$5,534.46	8.11
SAIOP	45	752	$97,651	$2,170.02	14.04
All Categories	3,205	57,458	$7,587,901		

WAKE

Category of Service	Unduplicated Served	Claim Count	Amount Paid	Paid per Consumer	Utilization/1,000
Crisis Services	451	5,335	$335,466	$743.83	40.05
Inpatient	90	1,020	$543,063	$6,034.03	7.99
ICF-MR	125	9,042	$4,597,547	$36,780.38	11.10
Residential	284	23,744	$3,166,006	$11,147.91	25.22
PRTF	97	7,031	$3,109,565	$32,057.37	8.61
Outpatient	6,669	80,405	$4,607,080	$690.82	592.22
Enhanced:					
ACTT	261	3,144	$925,634	$3,546.49	23.18
Day Tx	142	5,859	$910,710	$6,413.45	12.61
CST	230	3,800	$375,252	$1,631.53	20.42
IIH	1,027	36,197	$9,344,226	$9,098.56	91.20
MST	121	1,241	$272,767	$2,254.27	10.75
PSR	401	18,996	$1,203,415	$3,001.03	35.61
Other Enhanced (Psychiatry)	108	916	$46,054	$426.43	9.59
Innovations	812	84,320	$8,857,298	$10,908.00	72.11
SACOT	41	1,373	$237,649	$5,796.32	3.64
SAIOP	183	2,562	$336,412	$1,838.32	16.25
All Categories	11,261	285,258	$38,948,499		

Appendix C:
FY15 Network Development Plan

Alliance
Network Development Plan

Alliance believes that the services available through its network of providers should reflect its commitment to support outcomes of recovery, resiliency and self-determination for the individuals we serve.

Alliance must seek not only to develop a continuum of services that support these outcomes, but must assure that best practice and evidence-based models are offered, that adequate capacity is available, and that providers are fiscally-viable.

Within each disability area, this Plan identifies what Alliance considers to be an optimal collection of services and supports, then focuses on priority focus areas for Fiscal Year 2015, and finally enumerates a list of additional capacity needs targeted for attention in subsequent years.

This plan was informed by a gaps analysis study which included data review and input from stakeholders. Alliance staff also participated in a series of planning meetings reviewing data, clinical and network experience across all counties in the Alliance catchment area.

Intellectual and Developmental Disabilities (IDD)

Alliance seeks to develop a continuum of support services for individuals with IDD that includes the following:

Respite

- Innovations (individual, group, facility)
- Hourly Respite (State-funded)
- Respite Care Nursing
- B3 Respite (group, individual, child, adult)
- Out-of-Home Respite
- Adult Day Activity

Developmental Therapy

- Paraprofessional, Professional

Community Connections

Community Guide

- Innovations (B3)

Vocational Supports

- ADVP/Adult Day Activity
- CAET (individual, group)
- Day Supports (individual, group)
- Supported Employment (individual, group, innovations, B3, State)
- LTVS

Assistive Technology

Vehicle Adaptations

Home Modifications

Specialized Consultative Services

Behavioral Plan Development Monitoring

In-Home Intensive Support

Community Networking (group, classes)

In-Home Skill Building (Innovations individual, group)

Natural Supports Education

Residential Supports

- Supervised Living Low
- Group Living Low, Moderate, High
- Supervised Living Level 1,2,3, and 4
- Residential Supports Level 1,2,3,4
- Residential Support AFL Level 1,2,3,4
- Specialized Service Wrap around supports for transition from institutions

Crisis

- Primary Crisis Response
- Out of Home Crisis Respite
- Crisis Behavioral Consultation
- Professional Level Consult
- NC Start (adult, child)

Transitional ICF (adult, child)

ICF

- ICF Therapeutic Leave

FY 15 Priorities

A review of data and experience associated with the Alliance provider network suggests areas in which service capacity needs to be developed. In addition, there is a recognition that in some cases capacity deficits are due to a need to provide greater clarity regarding service expectations and quality parameters and associated provider training and technical assistance.

Alliance will address these service capacity needs over the next several years, focusing on areas of highest need in fiscal year 2015.

Developmental Therapy

While Alliance has many providers of Developmental Therapy, the focus will be on supporting the growth of professional Developmental Therapy services that are clinically sound and outcome focused and to develop a consistent benefit plan for this service across the Alliance service area.

Specialized Consultative Services

Alliance will work with providers to develop clearer expectations for this service. Credentialed professionals such as psychologists are especially needed particularly in Cumberland and Durham.

IPRS Residential Services

Alliance will work to develop a uniform benefit package across all of our counties and develop clearer provider expectations for this service.

Crisis

Alliance will see to develop a Regional Team with professional level consultation provided by the NC START program. Particular focus will be on individuals with dual diagnosis IDD/MH.

Uniform Benefit Packages

Study, develop and recommend a uniform benefit package across the four-county Alliance area for Developmental Therapy, Personal Assistance, and State funded Residential Services.

Remaining capacity needs to be addressed in subsequent years are:

- Hourly Respite
- Community Guide
- Community Connections
- CAET (both individual and group, in all counties)
- Expand service capacity for Day Supports in all of our counties
- Promotion and expansion of the use of group services
- Provider training to improve the quality of Residential supports services
- Creation of out-of-home ICF Respite option
- Crisis Training for providers of Residential, DT and Mobile Crisis

Adult MH/SA

Alliance seeks to develop a continuum of support services for adults with MH/SA needs that includes the following:

Outpatient MH

Outpatient SA

Assertive Engagement

Hospital Transition

SAIOP

SACOT

PSR

CST

ACTT

Partial Hospital

Supported Employment

Residential Continuum

Inpatient

FY 15 Priorities

A review of data associated with the Alliance provider network suggests areas where service capacity needs to be developed. In addition, there is a recognition that in some cases capacity deficits are due to a need to provide greater clarity regarding service expectations and quality parameters and associated provider training and technical assistance. Alliance will address these service capacity needs over the next several needs, focusing on areas of highest need in fiscal year 2015.

Outpatient Mental Health

Alliance will seek to expand psychiatric capacity in Cumberland County. In Johnston County Alliance will promote the Open Access model.

Assertive Engagement

Alliance will seek to expand this capacity to identify and engage individuals transitioning from higher levels of service or who are difficult to engage in services. Expansion of **Peer Support Services** will be a priority as a way to offer assertive engagement.

ACTT

Alliance will seek to develop capacity in Cumberland and Johnston Counties.

Supported Employment/LTVS

Alliance will support the continued expansion of this capacity across all of our counties.

Residential Continuum

Alliance will initiate a comprehensive review of residential capacity, quality and service expectations, and benefit package. Results of this review will guide future service development.

Transitional Living

Alliance will develop a capacity for this 30-day housing option in all of our counties to assist with transition from hospital and crisis services.

Remaining capacity needs to be addressed in subsequent years are:

- Study the need to expand pharmacy services in all counties
- Partial Hospital
- Outpatient sex offender treatment
- Outpatient Substance Abuse- Alliance will study creation of a uniform benefit package for services across all counties
- CST – Identify models and quality standards
- PSR – Identify models and quality standards

Child MH/SA

Alliance seeks to develop a continuum of support services for children with MH/SA needs that includes the following:

Outpatient MH and SA Services

Child/Family navigator

Substance Abuse Prevention

SAIOP

Respite

Intensive In-Home

Day Treatment

MST

Crisis

Residential Continuum

- Therapeutic Foster Care
- IAFT
- Partial Hospital
- Group Homes
- Short-term PRTF
- PRFT

Inpatient

FY 15 Priorities

A review of data associated with the Alliance provider network suggests areas where service capacity needs to be developed. In addition, there is a recognition that in some cases capacity deficits are due to a need to provide greater clarity regarding service expectations and quality parameters and associated provider training and technical assistance. Alliance will address these service capacity needs over the next several needs, focusing on areas of highest need in fiscal year 2015.

Outpatient

Alliance will promote models of evidence based practice, including trauma informed therapies, by supporting training on these models and creating a mechanism to verify and track training and experience.

Child/Family Navigator

Alliance will seek to expand this capacity into Cumberland and Johnston counties.

SAIOP

Alliance will work to expand this capacity in all of our counties.

Day Treatment

Alliance will identify and promote evidence based models in all of our counties.

Residential Continuum

Alliance will initiate a comprehensive review of residential capacity, quality, service expectations, and benefit package. Results of this review will guide service development.

Remaining capacity needs to be addressed in subsequent years are:

- Transportation
- Bilingual therapists
- Substance abuse prevention
- Planned Respite

Crisis Services, Adult

Alliance seeks to develop a continuum of support services for adults in crisis that includes the following:

Respite

Walk-In Psychiatric/Medication

Mobile Crisis

Facility Based Crisis

Crisis Assessment (CEO)

Detox

Inpatient

FY 15 Priorities

A review of data associated with the Alliance provider network suggests areas where service capacity needs to be developed. In addition, there is a recognition that in some cases capacity deficits are due to a need to provide greater clarity regarding service expectations and quality parameters and associated provider training and technical assistance. Alliance will address these service capacity needs over the next several needs, focusing on areas of highest need in fiscal year 2015.

Mobile Crisis

Alliance will seek to develop additional capacity in Johnston and Wake Counties.

Walk-in Psychiatric

Alliance will implement the Open Access model in Johnston counties. Will seek to expand walk in capacity for psychiatric and medication to weekend and after hours in all counties.

Facility Based Crisis/Detox Beds

Alliance will seek to increase the number of beds in Wake County. Alliance will promote models of **trauma-informed models** of crisis care.

Remaining capacity needs to be addressed in subsequent years are:

- Respite – Study effective models
- Facility based crisis/detox in Johnston County
- Standardize billing practices for facility based crisis and detox services
- Study FBC models and outcomes to guide and inform service development
- Pilot community para-medicine wellness checks in Durham and Wake Counties

Crisis Services, Child

Alliance seeks to develop a continuum of support services for children in crisis that includes the following:

Respite

Rapid Response

Mobile Crisis

Facility Based Crisis

Inpatient

FY 15 Priorities

A review of data associated with the Alliance provider network suggests areas where service capacity needs to be developed. In addition, there is a recognition that in some cases capacity deficits are due to a need to provide greater clarity regarding service expectations and quality parameters and associated provider training and technical assistance. Alliance will address these service capacity needs over the next several needs, focusing on areas of highest need in fiscal year 2015.

Rapid Response

Alliance will seek to establish Rapid Response capacity in all counties.

Remaining capacity needs to be addressed in subsequent years are:

- Facility Based Crisis – study feasibility of regional child facility based crisis center.
- Mobile Crisis – develop training for current mobile crisis teams to better respond to the needs of children.

Special Populations – Homeless

Alliance seeks to develop a continuum of support services for homeless adults that includes the following:

Outreach

- Peer Support
- Assertive Engagement

Intensive Case Management

Critical Time Intervention

Vocational

SE/LTVS

Integrated Medical Care

SOAR

Housing First/Plus

FY 15 Priorities

A review of data associated with the Alliance provider network suggests areas where service capacity needs to be developed. In addition, there is a recognition that in some cases capacity deficits are due to a need to provide greater clarity regarding service expectations and quality parameters and associated provider training and technical assistance. Alliance will address these service capacity needs over the next several needs, focusing on areas of highest need in fiscal year 2015.

Peer Support Outreach

Alliance will develop a capacity across all counties to utilize peer support to provide assertive outreach to homeless individuals.

SOAR

Alliance will seek to identify dedicated personnel/entities in each county to be trained and offer SOAR services

Remaining capacity needs to be addressed in subsequent years are:

- Identify intensive case management agencies and train on Critical Time Intervention Model.
- Study implementation of the Streets to Home model of housing and supports for homeless individuals.

Special Populations – Jail Transition

Alliance seeks to develop a continuum of support services for adults transitioning from jail that includes the following:

Outreach

- Peer Support
- Assertive Engagement

Immediate Psychiatric Access

Peer Bridging/Support

Drop-in Center/Wellness City

Intensive Case Management

Critical Time Intervention

Vocational

SE/LTVS

Integrated Medical Care

SOAR

Transportation

Forensic ACTT

Housing First/Plus

FY 15 Priorities

A review of data associated with the Alliance provider network suggests areas where service capacity needs to be developed. In addition, there is a recognition that in some cases capacity deficits are due to a need to provide greater clarity regarding service expectations and quality parameters and associated provider training and technical assistance. Alliance will address these service capacity needs over the next several needs, focusing on areas of highest need in fiscal year 2015.

Continuum of Services

Alliance will see to identify agencies in each county to develop a continuum of post release services including a jail transition team, peer bridging, critical time intervention, and transportation.

Interpretation Services

Remaining capacity needs to be addressed in subsequent years are:

- Forensic ACTT Wake/Cumberland
- Peer Bridge
- Transportation

Special Populations – Transition Age Youth

Alliance seeks to develop a continuum of support services for transition age youth that includes the following:

Outpatient

- Trauma Informed
- Independent Living Groups

Intensive Case Management

Vocational SE/ LTVS

Housing

- Respite/Rapid Response
- Supported Congregate
- Group Homes
- Level II

Integrated Medical Care

ACTT

FY 15 Priorities

A review of data associated with the Alliance provider network suggests areas where service capacity needs to be developed. In addition, there is a recognition that in some cases capacity deficits are due to a need to provide greater clarity regarding service expectations and quality parameters and associated provider training and technical assistance. Alliance will address these service capacity needs over the next several needs, focusing on areas of highest need in fiscal year 2015.

Outpatient trauma informed care
Alliance will promote trauma informed care through training, learning collaboratives, and review activities across all counties.

Independent living groups

SE/LTVS

Remaining capacity needs to be addressed in subsequent years are:

- Promote implementation of trauma informed care
- Study potential of piloting **Milwaukee wrap-around model,** a comprehensive evidence based practice model for at-risk youth
- Supported/congregate housing
- Level II Specialized Homes
- ACTT

Special Populations – IDD/MH and Traumatic Brain Injury (TBI)

While these special populations access existing service continuums their unique needs require greater clarity around interventions, support resources, service expectations and quality parameters. These are most immediately addressed through provider training and technical assistance.

Alliance will address these needs over the next several years, focusing on areas of highest need in fiscal year 2015.

Training for residential and group home providers on supports and interventions for dually diagnosed individuals

Training for providers on interventions and resources for TBI accommodating the special needs of individuals with co-occurring IDD/TBI

Remaining capacity needs to be addressed in subsequent years are:

- Assistive Technology
- NC START Expansion to children
- Case management specific to TBI

Strategies Crossing Disability Areas

The Plan provides for a number of strategies designed to benefit all consumers:

Standardize the Benefit Package

- Develop a uniform benefit package for Developmental Therapy.
- Develop uniform benefit packages for Personal Assistance and IDD IRPS Residential as well as clearer provider expectations for these services.

Enhanced Provider Training

- Promote trauma-informed care and create ways to assure fidelity across all counties for child and adult outpatient services and for crisis services.
- Identify training and training resources on interventions and resources for individuals with TBI.
- Identify training and training resources on supports and interventions for dually-diagnosed individuals.

Review of Residential Services

- Conduct a comprehensive review of adult and child MH/SA residential capacity, quality and service expectations, and benefit packages.
- Explore and plan to implement the Streets to Home model of housing and supports for homeless individuals.