North Carolina’s Medicaid Transformation: *Challenges and Opportunities*

Carrie L. Brown, MD, MPH  
Chief Medical Officer for Behavioral Health & IDD  
North Carolina Department of Health and Human Services

*Duke University School of Medicine*  
*Medical Alumni Weekend 2019*  
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Disclosures

I do not intend to discuss any unapproved or investigative use of commercial products or devices.
Educational Objectives

- Describe the phases of Medicaid Transformation between 2019 and 2021

- Explain the differences and similarities between Standard Plans and Tailored Plans

- Identify at least one challenge and one opportunity for psychiatrists in Medicaid Transformation
Agenda

• Review the **Background** for Medicaid Transformation

• Review the **Key Elements** of Medicaid Transformation
  o Healthy Opportunities Pilots
  o Managed Care Health Plan Types
    ➢ Standard Plans
    ➢ BH/IDD Tailored Plans
  o Care Management
  o Quality Measures

• Discuss **Challenges and Opportunities** of Medicaid Transformation

• Discuss **Role of Psychiatrists** in Medicaid Transformation
North Carolina by the Numbers

Population - 10,388,837 persons*

Uninsured Ages, 3-64 years old - 1,022,018*

Persons Enrolled in Medicaid – 2,033,773**


**Unduplicated count of Medicaid Eligibles reported from NC OSBM website https://linc.osbm.nc.gov/pages/social-human-services/. 
Unmet Health-related Social Needs

• More than **1.2M** North Carolinians cannot find affordable housing
• **1 in 28** of NC children under age 6 is homeless
• NC has **8th** highest rate of food insecurity in US
• **> 1 in 5** children live in food insecure households
• **47%** of NC women have experienced intimate partner violence
In **2015**, the North Carolina General Assembly enacted Session Law 2015-245 for the North Carolina Department of Health and Human Services (DHHS) to transition the Medicaid and NC Health Choice programs into Medicaid Managed Care - from fee-for-service to managed care.
Then in June 2018 . . .

Session Law 2018-48 directed DHHS to create two types of managed care products:

- **Standard Plans**
- **BH/IDD Tailored Plans**
Managed Medicaid is common across the US
Percent of Medicaid Population in Managed Care 2018

SOURCE: Kaiser Family Foundation’s State Health Facts.
CMS Waiver Required for Managed Medicaid

NC 1115 Medicaid Demonstration Waiver approved by the Centers for Medicare and Medicaid Services (CMS) allows for:

- Phased approach
- Geographically limited pilots for enhanced case management
- Mandatory enrollment in managed care
- Varying the amount, duration and scope of services offered to individuals in managed care

Other state 1115 Medicaid Demonstration waiver requests differ, e.g., Medicaid expansion, benefit restrictions, eligibility and enrollment restricts, work requirements, etc.
CMS 1115 Waivers Across the U.S.

Landscape of Approved vs. Pending Section 1115 Medicaid Demonstration Waivers, October 9, 2019

NOTES: Some states have multiple approved and/or multiple pending waivers, and many waivers are comprehensive and may fall into a few different areas. Therefore, the total number of pending or approved waivers across states cannot be calculated by summing counts of waivers in each category. Pending waiver applications are not included here until they are officially accepted by CMS and posted on Medicaid.gov. For more detailed information on each Section 1115 waiver, download the detailed approved and pending waiver tables posted on the tracker page.

"MLTSS" = Managed long-term services and supports.
NC 1115 Waiver Timeline

• **November 2017 NC applied** for the waiver to transition to Medicaid managed care and add innovative features to the managed care delivery system

• **Waiver approval October 2018**

• **Approval through October 31, 2024**
NC 1115 Waiver Key Elements

• Pilot program to address health determinants
  o Healthy Opportunities - NC Enhanced Case Management and Other Services Pilot Program

• Use of Mandatory Managed Care for most Medicaid beneficiaries

• BH/IDD Tailored Plans for populations with specific complex needs

• SUD Waiver updates NC’s policy on substance use to meet ASAM criteria and expand inpatient options by allowing treatment of SUD in institutions of mental disease (IMD)
Use of Evidence-based, Non-medical Interventions

• Healthy Opportunities Pilots will test and evaluate evidence-based, non-medical interventions in housing, food, transportation and interpersonal safety to high-needs Medicaid enrollees.

• Over 5 years, pilots will provide up to $650M in Medicaid funding for services in non-medical interventions that impact health outcomes and health care costs of enrollees.

Reference: Healthy Opportunities Pilot, NC Department of Health and Human Services
https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots
Healthy Opportunity Pilots

- **First** time CMS approved an Enhanced Case Management Pilot

- Pilots operate in **2 to 4 geographic areas** and all Medicaid Managed Care Plans must participate

- Pilots will be operated by **Lead Pilot Entities (LPE)** that are responsible for coordinating community service organizations, e.g., food banks

- LPEs will be announced in Spring 2020 and **operate until October 2024**
Medicaid Beneficiary Pilot Eligibility

To be eligible for pilot services, Medicaid managed care enrollees must have:

- **At least one Needs-Based Criterion:**
  - Physical/behavioral health condition criteria vary by population:
    - Adults (e.g., 2 or more chronic conditions)
    - Pregnant Women (e.g., multifetal gestation)
    - Children, ages 0-3 (e.g., Neonatal intensive care unit graduate)
    - Children 0-21 (e.g., Experiencing three or more categories of adverse childhood experiences)

- **At least one Social Risk Factor:**
  - Homeless and/or housing insecure
  - Food insecure
  - Transportation insecure
  - At risk of, witnessing or experiencing interpersonal violence
Evidence-Based Services Will be Provided

<table>
<thead>
<tr>
<th>Priority Domain</th>
<th>Overview of Approved Services</th>
</tr>
</thead>
</table>
| **Housing**     | • Targeted tenancy support and sustaining services  
                     • Housing quality and safety improvements  
                     • One-time payments to secure housing (e.g., first month’s rent and security deposit)  
                     • Short-term post hospitalization housing |
| **Food**        | • Linkages to community-based food services (e.g., Supplemental Nutrition Assistance Program (SNAP)/Women, Infants and Children (WIC) application support, food bank referrals)  
                     • Nutrition and cooking coaching/counseling  
                     • Healthy food boxes  
                     • Medically tailored meal delivery |
| **Transportation** | • Linkages to transportation resources  
                            • Payment for transit to support access to Pilot services, including:  
                                o Public transit  
                                o Taxis, in areas with limited public transit infrastructure |
| **Interpersonal Violence/Toxic Stress** | • Linkages to legal services for interpersonal violence (IPV) related issues  
                                               • Services to help individuals leave a violent environment and connect with behavioral health resources  
                                               • Evidence-based parenting support programs  
                                               • Evidence-based home visiting services |
Health Influenced by Social and Environmental Factors

- **ALL Medicaid beneficiaries screened** for social determinants of health
- **NCCARE360** connects beneficiaries with identified needs to community resources with a feedback loop on outcome of the connection

<table>
<thead>
<tr>
<th>S</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>Within the past 12 months, did you worry that your food would run out before you got money to buy more?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Within the past 12 months, did the food you bought just not last and you didn’t have money to get more?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing/Utilities</td>
<td>Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else’s home (i.e. couch-surfing)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are you worried about losing your housing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal Safety</td>
<td>Do you feel physically or emotionally unsafe where you currently live?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Within the past 12 months, have you been humiliated or emotionally abused by anyone?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optional: Immediate Need</td>
<td>Are any of your needs urgent? For example, you don’t have food for tonight, you don’t have a place to sleep tonight, you are afraid you will get hurt if you go home today.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Would you like help with any of the needs that you have identified?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Health Opportunities Screening Questions, NC DHHS https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions
## NCCARE360 Status Update (as of 10/21/19)

<table>
<thead>
<tr>
<th>Count</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Counties launched (Alamance, Beaufort, Bertie, Brunswick, Chowan, Durham, Edgecombe, Franklin, Guilford, Granville, Hertford, Johnston, Martin, New Hanover, Pender, Person, Pitt, Rockingham, Vance, Wake and Warren)</td>
</tr>
<tr>
<td>29</td>
<td>Counties started on implementation</td>
</tr>
<tr>
<td>1619</td>
<td>Organizations engaged in socialization process</td>
</tr>
<tr>
<td>396</td>
<td>Organizations with NCCARE360 licenses</td>
</tr>
<tr>
<td>1634</td>
<td>Active Users</td>
</tr>
<tr>
<td>1118</td>
<td>Referrals Sent</td>
</tr>
</tbody>
</table>

### Engaged Organizations by Service

- **Health Care**: 24%
- **Housing**: 11%
- **Employment**: 8%
- **Food Assistance**: 16%
- **Interpersonal Violence**: 14%
- **Transportation**: 6%
- **Other**: 21%
- **Employment**: 8%
- **Food Assistance**: 16%
- **Interpersonal Violence**: 14%
- **Transportation**: 6%
- **Other**: 21%
NCCARE360 State Coverage
October 16, 2019
MANAGED CARE
Medicaid Beneficiaries and Prepaid Health Plans

- Standard Plan: 76%
- Medicaid Direct: 19%
- Tailored Plan: 5%
## Medicaid Transformation Timeline

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2018</td>
<td>1115 waiver approved</td>
</tr>
<tr>
<td>February 2019</td>
<td>Standard Plan contracts awarded</td>
</tr>
<tr>
<td>June - July 2019</td>
<td>Enrollment Broker (EB) sends enrollment packages to individuals in initial regions</td>
</tr>
<tr>
<td>Summer 2019</td>
<td>Standard Plans contract with providers and meet network adequacy</td>
</tr>
<tr>
<td>Fall 2019</td>
<td>Statewide <strong>Open Enrollment began October 14, 2019</strong></td>
</tr>
<tr>
<td>February 2020</td>
<td><strong>Managed Care Standard Plans launch in ALL REGIONS</strong></td>
</tr>
<tr>
<td>Tentatively July 2021</td>
<td>Behavioral Health and Intellectual/Developmental Disability (BH I/DD) Tailored Plans Launch</td>
</tr>
</tbody>
</table>
4 Statewide Prepaid Health Plans (PHPs)
Carolina Complete Health in Regions 3, 4, and 5
All will go live in February 2020
Potential BH/IDD Tailored Plan Regions

Legislation requires 5 to 7 BH/IDD Tailored Plan Contracts
LME/MCOs will bid through Request for Application (RFA) process
## Benefits in Both Standard and Tailored Plans

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Specific Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient and Outpatient</td>
<td>Emergency Department care, on-hospital clinic services, and telemedicine</td>
</tr>
<tr>
<td>EPSDT</td>
<td></td>
</tr>
<tr>
<td>Selected Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Prescription Drugs</td>
</tr>
<tr>
<td>Labs/X-rays</td>
<td></td>
</tr>
<tr>
<td>Physicians</td>
<td></td>
</tr>
<tr>
<td>Nursing Facilities</td>
<td>Up to 90 days (then transition to Medicaid Direct)</td>
</tr>
<tr>
<td>Ancillary</td>
<td>PT, OT, ST, Respiratory, Dietary Counseling</td>
</tr>
<tr>
<td>Ambulance</td>
<td></td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Hospice, Personal Care, DME, Home Infusion</td>
</tr>
<tr>
<td>Vision</td>
<td></td>
</tr>
<tr>
<td>Services EXCLUDED from managed care: PACE, School Services, CDSA services, Dental, Glasses</td>
<td></td>
</tr>
</tbody>
</table>
## Behavioral Health in Standard and Tailored Plans

<table>
<thead>
<tr>
<th>Behavioral Health Services</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>Includes current IMD option</td>
</tr>
<tr>
<td>Crisis</td>
<td>Mobile Crisis, Facility Based Crisis (Adult and Youth)</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Clinic and ED</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td></td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td>Ambulatory Detox, Non-Hospital Detox, Medical Detox, ADATC, Opioid Treatment</td>
</tr>
<tr>
<td>Research-based Intensive Behavioral Therapy</td>
<td>ABA, TEACCH</td>
</tr>
<tr>
<td>EPSDT</td>
<td></td>
</tr>
<tr>
<td>Peer Supports</td>
<td></td>
</tr>
</tbody>
</table>
## BH/IDD Tailored Plan Services Only

<table>
<thead>
<tr>
<th>Service</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most enhanced/residential services for youth with SED</td>
<td>Day Treatment, IIH, MST, Child Residential (all levels), PRTF</td>
</tr>
<tr>
<td>Most enhanced services for adults with SMI</td>
<td>ACTT, CST, PSR</td>
</tr>
<tr>
<td>Most enhanced/residential services for those with serious SUDs</td>
<td>SAIOP, SACOT ASAM 3.1, 3.5, and 3.7 (except ADATCs that are in both plan types)</td>
</tr>
<tr>
<td>Specialty/Waiver Services</td>
<td>For IDD/TBI: ICF-IID, Innovations Waiver, TBI Waiver, most current (b)(3) services</td>
</tr>
<tr>
<td></td>
<td>For BH: Most current (b)(3) services</td>
</tr>
<tr>
<td>State Single Stream &amp; Federal Block Grant funded services</td>
<td></td>
</tr>
</tbody>
</table>
## CARE MANAGEMENT

<table>
<thead>
<tr>
<th>STANDARD PLANS</th>
<th>BH/IDD TAILORED PLANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primarily uses existing primary care practices who are designated Tier 3 Advanced Medical Homes (AMH’s)</td>
<td>Provided through designated BH/IDD AMH+’s, Care Management Agencies, BH/IDD TP’s directly</td>
</tr>
<tr>
<td>Minimal care management provided at the plan level</td>
<td>Care management available to essentially all enrollees</td>
</tr>
<tr>
<td>Addresses physical, behavioral, and social determinants of health</td>
<td>Ultimately anticipate 20% of Care Management remaining at the plan level</td>
</tr>
<tr>
<td></td>
<td>Addresses physical, behavioral, and social determinants of health</td>
</tr>
<tr>
<td></td>
<td>Meets Federal definition for Health Home care management</td>
</tr>
</tbody>
</table>

### AUTO-ENROLLED in BH/IDD Tailored Plan

NC DHHS will review claims and other available data, using a rolling 18-month lookback period, to identify beneficiaries who meet BH I/DD Tailored Plan eligibility.

#### IDD/TBI Identifiers
- Qualifying IDD diagnosis code in any position
- Innovations Waiver/Waitlist
- “Children with Complex Needs” list
- TBI Waiver/Waitlist

#### Crisis System Use Identifiers
- 1+ state psychiatric/ADATC hospital admissions
- 2+ psychiatric inpatient admissions
- 2+ ED admissions with a qualifying diagnosis code in the primary position.
- Use of 2+ BH crisis services

#### BH/IDD TP-only Service Use Identifier
- Use of Medicaid or State-funded service that will only be available through a BH I/DD Tailored Plan

#### SMI/SED/Severe SUD Identifiers
- Qualifying BH/SUD diagnosis plus use of an enhanced service
- Use of clozapine
- Use of any Long Acting Injectable Antipsychotic (LAI)
- Use of ECT
- Psychotic disorder in any position and is under age 18

*Prior to BH I/DD Tailored Plan launch, beneficiaries will be auto-enrolled in Fee-For-Service/LME-MCO. They will have the option to move to a Standard Plan if they are not in a 1915 (c) Waiver and are otherwise Managed Care eligible.*
### Requesting BH/IDD Tailored Plan

**Questions?** Go to ncmedicaidplans.gov. Use the “chat” tool on the website or call 1-833-870-5500, 7 am to 8 pm, 7 days a week. The call is free. You will need your Medicaid ID number.

#### Request to Stay in NC Medicaid Direct (Fee for Service) and LME-MCO: Provider Form

1. **Beneficiary Demographic Information**
   - **Beneficiary Name:** (Last, First, M.I.)
   - **Date of Birth:**
   - **NC Medicaid ID Number:**
   - **Guardian/Legally Responsible Person:**
   - **Guardian/Legally Responsible Person Phone Number:**

2. **Provider Submitting this Form**
   - **Provider Name:** (Last, First, M.I.)
   - **Telephone Number:**
   - **Provider Agency:** (If Applicable)
   - **NPI/Provider Identifier:**
   - **Provider Email:**

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**Questions?** We can help. Go to ncmedicaidplans.gov. Use the “chat” tool on the website or call 1-833-870-5500, 7 am to 8 pm, 7 days a week.
QUALITY
Quality Strategy

• Quality Program supports **PHP’s in:**
  – Quality improvement
  – Operational effectiveness
  – Advancement of initiatives on addressing unmet resource needs
  – Telemedicine and accreditation
  – AMH Tier 3 contracting goals

• PHPs will **collect and publicly report on all Quality Measures**

• Measures will be collected annually and **validated by the External Quality Review Organization (EQRO)**
NC Medicaid Standard Plan Quality Measures: Overview

- SP’s must report all of these measures to DHHS annually.
- SPs could include any of these measures in provider incentive programs.
- DHHS will hold SPs financially accountable for these measures starting in Year 3 (July 2021).

- 64 Measures: Quality and Select Administrative Measures Aligned with National, State and Prepaid Health Plan (PHP) Reporting
- 31 Measures: Priority Measures Aligned with DHHS Policies
- 6 Measures: Quality Withhold Measures

SP’s must report all of these measures to DHHS annually.
SPs could include any of these measures in provider incentive programs.
DHHS will hold SPs financially accountable for these measures starting in Year 3 (July 2021).
Quality Strategy: Use of Priority Measures

• **31 of the 64** quality measures are **Priority Measures** for:
  - Provider Incentive Programs
  - Prepaid Health Plan (PHP) performance improvement projects
  - Quality withhold program for financial penalties

• **Prepaid Health Plans** (PHPs) will be given:
  - Historical baseline data
  - **Benchmarks** for optimal performance levels for all Priority Measures
  - **Targets** to represent the *level PHPs must achieve to receive some or all of their quality withhold amount*

Proposed Year 1 Quality Withhold Measures

<table>
<thead>
<tr>
<th>SIX Withhold Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both Prenatal and Postpartum Care Rates</td>
</tr>
<tr>
<td>Live Births Weighing Less than 2,500 Grams</td>
</tr>
<tr>
<td>Well-Child Visits in 3rd, 4th, 5th, and 6th Years of Life</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: HbA1c Poor Control (&gt;9.0%)</td>
</tr>
<tr>
<td>Follow-Up After Emergency Department Visit for Mental Illness or Alcohol/Other Drug Abuse</td>
</tr>
<tr>
<td>Rates for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
</tr>
</tbody>
</table>
Tailored Plan Quality Metrics

Principles for BH/IDD Tailored Plan Quality Metrics:

− Build upon the Standard Plan quality model

− Incorporate Federal Health Home measurements

− Prioritize measurement of improved functioning, quality of life, and successful deinstitutionalization

− Have physical health measures specific to BH/IDD population
SMART SPENDING: Value-Based Purchasing under Managed Care

• Value-Based Purchasing ties provider payments to improved performance by health care providers

• Payment report form holds health care providers accountable for both cost and quality of care

• Strives to reduce inappropriate care and identify and reward the best-performing providers

• NC Medicaid will link provider payment to value achieved or produced

• Support for PHPs and provider contracting flexibility helps providers deliver care in new ways

• PHPs play a critical role in driving forward Medicaid’s Value-Based Purchasing goals
Managed Care Payment Models

- **Bundled Payments**
  - Based on an episode of care
  - Payer and provider mutually decide on cost
  - Reimbursement is shared among providers
  - Can reduce unnecessary services

- **Accountable Care - Shared Savings**
  - Still paid on fee-for-service basis with the additional incentive to participate in shared savings if cost is less than target
  - Can be used in conjunction with other delivery payments
  - Expensive information technology outlay and have to calculate individual payments to multiple providers
  - Payments can be prospective or retrospective

- **Population Health Management**
  - Reimburses providers based on a specific condition and the cost savings associated with the population - i.e. diabetes

- **Value-Based Purchasing**
  - Targeted at quality but can also reimburse for patient satisfaction, safety, care coordination, or adoption of electronic health records
  - Aligns incentives across both payers and providers
  - Administratively complex and expensive to implement
CHALLENGES AND OPPORTUNITIES
BIG CHALLENGES

• **Transitions** of Care between plans: mitigating with guardrails on turn around time

• **Multiple payers** (contracting, rates): mitigating with centralized credentialing and contracting guardrails

• Provide the **uninsured** with **integrated care**: partially mitigated by developing state-funded care management for targeted populations
But Bigger Opportunities

• Fully integrated, whole-person care!!

• Opportunity to **purchase specific health outcomes** rather than specific health services

• Address and pay for **unmet social needs/non-medical drivers of health**, e.g., housing, transportation
Psychiatrists Can Maximize Opportunities

• Increase residency training
• Change the way we train
• Expand skills for consultation and practice in primary care and specialty practices
• Encourage team-based care, collaborative care, and population health management
• Adopt evolving technologies to track, monitor and communicate with individuals
Physicians with a primary area of practice of Psychiatry, General per 10,000 Population by County, North Carolina, 2018

State Rate: 1.01

Number of Counties

Rate per 10,000 Population

Physicians with a primary area of practice of Psychiatry, General include the following: Forensic Psychiatry, Geriatric Psychiatry, Hypnosis, Internal Medicine, Psychiatry, Psychiatric Medicine, Psychiatric specialty. Notes: Data include active, licensed physicians in practice in North Carolina as of October 31 of each year who are not residents-in-training and are not employed by the Federal government. Physician data are derived from the North Carolina Medical Board. County estimates are based on primary practice location. Population census data and estimates are downloaded from the North Carolina Office of State Budget and Management via NC LINC and are based on US Census data. Source: North Carolina Health Professions Data System, Program on Health Workforce Research and Policy, Credi G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Created October 28, 2019 at https://nchealthworkforce.unc.edu/supply/. 
### NC Psychiatry Residency Programs by Location*

<table>
<thead>
<tr>
<th>Institution</th>
<th>Program</th>
<th>Location</th>
<th>Positions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duke Univ Med Ctr</td>
<td>Global Health</td>
<td>Durham</td>
<td>1</td>
</tr>
<tr>
<td>Duke Univ Med Ctr</td>
<td>Internal Med/Psych</td>
<td>Durham</td>
<td>11</td>
</tr>
<tr>
<td>Vidant Health</td>
<td>Internal Med/Psych</td>
<td>Durham</td>
<td>10</td>
</tr>
<tr>
<td>Carolina Medical Ctr</td>
<td>Psychiatry</td>
<td>Charlotte</td>
<td>3</td>
</tr>
<tr>
<td>Duke Univ Med Ctr</td>
<td>Psychiatry</td>
<td>Durham</td>
<td>38</td>
</tr>
<tr>
<td>MAHEC/Mission Health Sys</td>
<td>Psychiatry</td>
<td>Asheville</td>
<td>4</td>
</tr>
<tr>
<td>UNC Health Care</td>
<td>Psychiatry</td>
<td>Chapel Hill</td>
<td>53</td>
</tr>
<tr>
<td>Vidant Health</td>
<td>Psychiatry</td>
<td>Greenville</td>
<td>30</td>
</tr>
<tr>
<td>Wake Forest Baptist Med Ctr</td>
<td>Psych-CH Adoles Psych</td>
<td>Winston-Salem</td>
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</tr>
<tr>
<td>Wake Forest Baptist Med Ctr</td>
<td>Psychiatry-Psych</td>
<td>Winston-Salem</td>
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<tr>
<td>UNC Health Care</td>
<td>Psych/Child</td>
<td>Chapel Hill</td>
<td>10</td>
</tr>
<tr>
<td>CUSOM/Cape Fear Valley Hosp</td>
<td>Psychiatry</td>
<td>Wilmington</td>
<td>16</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td><strong>208</strong></td>
</tr>
</tbody>
</table>

*Omits Psychiatry Fellowships; Source: Program on Health Workforce and Policy, Sheps Center for Health Services Research, University of North Carolina at Chapel Hill with data gathered from individual programs, 2017 (Addendum 2019)
Active, Licensed Psychiatrists Practicing in North Carolina by Primary Practice Location Facility Type, 2018

Notes: Data include active, licensed physicians in practice in North Carolina as of October 31, 2018 who are not residents-in-training and are not employed by the Federal government. Physician data are derived from the North Carolina Medical Board and include physicians with a self-reported primary area of practice of Child & Adolescent Psychiatry, Pediatrics - Psychiatry, Addiction Medicine, Addiction Psychiatry, Forensic Psychiatry, Geriatric Psychiatry, Hypnosis, Internal Medicine - Psychiatry, Psychiatry, Psychiatry - Family Practice, Psychoanalysis, Psychosomatic Medicine.

Source: North Carolina Health Professions Data System, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill
Be in the Right Place at the Right Time

• Chance to participate in truly integrated care

• Chance to affect the health of entire populations

• Opportunity to lead
  – Telepsychiatry
  – Collaborative Care
  – Population Health
  – Workforce multipliers (e.g., NC PALS, NC MATTERS)
“In a world where there is so much to be done. I felt strongly impressed that there must be something for me to do.” - Dorothea Dix
CONTACT

Carrie L. Brown, MD, MPH

Chief Medical Officer for Behavioral Health & IDD
North Carolina Department of Health and Human Services
(919) 733-7011 and (919) 855-4700
Carrie.Brown@dhhs.nc.gov