



Behavioral Health as Public Infrastructure

Executive Summary

Behavioral health is deeply personal. But the system that makes behavioral health care possible is public infrastructure.

Across North Carolina, people rely on a complex network of mental health, substance use disorder, intellectual and developmental disability, and traumatic brain injury services and supports. Some need outpatient treatment close to home. Others require highly specialized services, crisis intervention, residential supports, assistance with housing or employment, or long-term services that make it possible to live independently in their communities.

Behind each of those services is something larger: a system that must exist before a person needs it. Providers must be available. A workforce must be developed. Crisis services must be ready. Specialized capacity must be sustained even when the number of people who need it is small. Resources must reach rural as well as urban communities. Hospitals, first responders, counties, schools, justice partners, social services, housing organizations, providers, and families must be able to work together.

North Carolina's LME/MCOs are part of this public infrastructure. Their role includes financing and managing care, but it extends beyond the transactions traditionally associated with health insurance. LME/MCOs help translate public resources and statewide priorities into local systems of care.

This role can be summarized in two commitments: Every Dollar and Every Community. Every dollar reflects an obligation to steward public resources responsibly and turn those resources into access, capacity, stability, coordination, and measurable outcomes. Every community reflects an obligation to build a system that works across North Carolina's diverse geography and local needs.

The defining question is not only "What service did we purchase?" but "What did this investment make possible?"

This responsibility reflects five ideas: Every Person. Every Dollar. Every Community. Every Connection. Every Outcome. Together, they offer a framework for understanding behavioral health not simply as a collection of programs or expenditures, but as essential public infrastructure.



1. Every Person

A System Built Around Lives, Not Programs

People do not experience their lives in programs. They do not organize their needs according to funding streams, eligibility categories, agency responsibilities, or organizational boundaries.

A person experiencing serious mental illness may simultaneously need behavioral health treatment, physical health care, medication, stable housing, transportation, employment support, and help navigating public benefits. A child with an intellectual or developmental disability may interact with health care providers, schools, social services, community organizations, and family-support systems. Someone with a substance use crisis may encounter EMS, an emergency department, law enforcement, treatment providers, peer-support specialists, courts, housing organizations, and other community services within a short period of time.

The challenge of public behavioral health is to make separate systems work as though they were designed around the person. That is particularly important for people with significant disabilities, serious mental illness, complex substance use disorders, co-occurring conditions, or needs that require intensive community-based support.

Public infrastructure must be capable of serving the uncommon need reliably, not only the average need efficiently. It must get people where they need to go directly, like a well-paved highway, but also pay attention to the rural, gravel road that needs more care.

2. Every Dollar

Stewardship That Creates More Than Transactions

Every public dollar carries a responsibility: pay appropriately for services, maintain strong financial controls, prevent waste, measure performance, and direct resources toward the needs of the people and communities the system exists to serve.

But stewardship also requires understanding what a dollar can accomplish beyond a single transaction. Public behavioral health resources can support direct treatment while also helping sustain specialized providers, expand workforce capacity, establish crisis services, strengthen rural access, support community transitions, address gaps in care, and connect organizations that otherwise operate independently.



A transactional view asks, “Where was the dollar spent?” An infrastructure view asks, “What did the dollar make possible?” Responsible stewardship requires both questions.

Some behavioral health services operate within strong markets. Others do not. Specialized services may serve relatively small populations. Rural areas may lack sufficient volume to attract providers. Workforce shortages may make certain services difficult to sustain. In those circumstances, stewardship may require creating capacity, not merely purchasing what already exists.

Behavioral health needs also do not disappear when appropriate services are unavailable; the need often moves to emergency departments, hospitals, law enforcement, jails, institutions, homelessness systems, or families. The value of infrastructure therefore includes the capacity it creates and the escalation it helps prevent. A dollar spent on public behavioral health expands exponentially on the community impact it generates.

Public Infrastructure in Action

Alliance Health’s King’s Ridge

In Wake County, Alliance Health invested \$1 million in King's Ridge, a 100-unit supportive housing community developed by CASA for individuals and families moving out of homelessness. Seven units are set aside for Alliance members. The City of Raleigh and Wake County also invested in the development; UNC and WakeMed provide on-site medical services; and Alliance oversees behavioral health support services. The investment illustrates the multiplier effect of a public behavioral health dollar: it can attract partners, create a durable community asset, and connect housing with physical and behavioral health care.

3. Every Community

Statewide Responsibility Requires Local Understanding

North Carolina is one state. It is not one behavioral health market. The needs and resources of a large metropolitan community may be substantially different from those of a rural county. Workforce availability differs. Transportation differs. Provider capacity differs. Housing resources differ. Hospital access differs. Community institutions differ.

A statewide behavioral health strategy therefore cannot simply replicate the same solution everywhere. Equity does not always mean making every community look identical. It means ensuring every community has a pathway to the care and supports its residents need.



In communities with significant provider capacity, stewardship may focus on coordination, quality, specialization, and navigation. In communities with limited capacity, the work may begin earlier: recruiting providers, developing services, building partnerships, addressing transportation barriers, creating regional approaches, or finding ways to sustain services despite limited volume.

LME/MCOs operate across multiple counties while remaining connected to local communities. That position makes it possible to see both local conditions and regional patterns: a provider shortage may be a regional workforce problem; repeated emergency department use may reveal a crisis-capacity gap; difficulty with community transitions may point to shortages in housing or specialized services. Infrastructure stewardship means seeing the gap before it becomes the norm.

Public Infrastructure in Action

Trillium Health Resources's THRIVE Local Local Voices. Local Priorities. Local Solutions.

Communities understand their needs in ways that data alone cannot. Trillium's approach to regional stewardship therefore begins with listening, creating formal pathways for members and families, county leaders, providers, clinicians, and other community partners to identify needs, surface gaps, establish priorities, and shape solutions.

That community voice is built into Trillium's structure. Five Regional Advisory Boards, five Consumer and Family Advisory Committees (CFAC), Provider Council, and Council on Health Disparities maintain a direct connection between local communities and governance. Each appoints a representative to Trillium's Governing Board. Community and member voices are complemented by advice from the Clinical Advisory Committee, Member Advisory Committee, Long-Term Services and Supports Member Advisory Committee, Innovation Waiver Workgroup, and Community Listening Sessions. Together, these forums bring lived experience, local government perspective, provider knowledge, clinical expertise, and member and family priorities into decisions about needs, services, quality, and system improvement.

Listen → Identify → Prioritize → Invest → Measure → Listen Again

THRive Local shows what this community-informed model can make possible. The county-focused endeavor combines flexible county dollars with strategic investments to address needs that may not fit neatly within Medicaid or limited state funding. For example Trillium's reported investments includes: 12 mobile

clinic units operated by six provider organizations across 21 rural counties; School Substance Use Prevention Programs that reached more than 4,200 students, caregivers, educators, and community professionals through school-based education, with outcomes spanning from 2,463 students completing the NC State Science House Vaping STEM Lab with nearly 100% recognizing vaping health risks, 1,659 participants increasing knowledge through Poe Center trainings, and 30 professionals certified in Teen Intervene (SBIRT); Crisis Intervention Team training for 3,810 law enforcement officers and first responders, 43 inclusive playgrounds opened or announced, and enhancements to mobile crisis and co-responder approaches.

Every community does not need the same solution. Every community needs a voice in shaping it. Statewide responsibility and local decision-making are not competing ideas; strong public behavioral health infrastructure connects them.

4. Every Connection

The Value Between the Systems

Some of the most important work in behavioral health occurs in spaces no single organization owns: between a hospital and home, between a jail and treatment, between a school and a family, between Medicaid and other public resources, between a provider and housing, between a crisis call and the service capable of responding, and between state policy and local implementation.

These are the seams of the system, and seams are often where people fall through. Public behavioral health infrastructure must therefore do more than operate individual programs well. It must create connections between programs, organizations, and systems.

The LME/MCO can be understood not simply as another organization in the ecosystem, but as part of the connective infrastructure between its components. Coordination can sound administrative; in practice, it can determine outcomes.

When a provider closes or reduces services, who assesses the regional impact? When a county identifies an emerging need, who can bring funding and provider partners together? When a person leaves a hospital or justice setting, is there a pathway to the next right service? Those are not merely communication questions. They are infrastructure questions.



The goal is a simpler experience for the person: wherever I enter, the system gives me a map to help me find the next right place. Achieving that simplicity requires significant coordination behind the scenes.

Public Infrastructure in Action

VAYA Health (Effective 10/1/26 VAYA/Partners) + Public Safety

Vaya Health identified a transition gap among people returning from prison to western North Carolina: during one three-month period, only 22% attended their initial behavioral health appointments. Vaya and the N.C. Department of Public Safety strengthened coordination among prison social workers, probation and parole officers, Vaya, and community treatment. During the following three months, attendance increased to 48% (28 of 58 individuals). The lesson is larger than the program: sometimes the missing service is a connection between systems.

5. Every Outcome

Measuring What Matters

Public infrastructure should be accountable. For behavioral health, accountability begins with financial stewardship but cannot end there.

A system can process transactions efficiently and still fail to create access. It can maintain a large network on paper while people struggle to find appointments. It can fund crisis services without reducing repeated cycles of crisis. It can pay for community services without knowing whether people are able to remain in their communities.

Accountability therefore requires moving from inputs to activities, outputs, outcomes, and impact. The system should ask not only how much was invested or how many services were delivered, but what changed for people and communities because the system was there.

Success can include access; crisis prevention and resolution at the least restrictive appropriate level; successful transitions from hospitals or institutions; opportunities for independence, employment, housing, and community life; stronger provider capacity; rural access; better cross-system coordination; positive member and family experience; and responsible stewardship of public resources.

The central measurement question is simple: What became better because the system was there?



The System Behind the Service

Understanding the Role of the LME/MCO

Viewed through these five ideas, the role of an LME/MCO becomes clearer. It is a payer, but not only a payer. It is a managed care organization, but its public responsibility extends beyond conventional health plan functions. It is connected to state government, but it works through relationships with local communities. It works with providers but must also consider the health of the broader provider ecosystem. It serves individual members but must simultaneously understand population and community needs.

Its role sits at the intersection of financing, care, infrastructure, and community. Some of the system's greatest value lies in the infrastructure surrounding individual transactions: the capacity that already exists when a crisis occurs, the provider that remains available in a difficult market, the transition that succeeds because organizations communicated, and the partnership that solves a problem before it becomes a larger public cost.

When public behavioral health infrastructure works well, it may be almost invisible. A person gets an appointment rather than joining a waiting list. A family finds support before reaching exhaustion. A crisis is resolved in the community instead of an emergency department. A person leaves a hospital with somewhere safe to go. A rural county gains access to a service that could not have survived there independently. A state investment becomes local capacity.

Finance	Care	Infrastructure	Community
• Steward resources • Pay for care • Manage risk • Ensure accountability	• Support access • Coordinate services • Improve quality • Address complex needs	• Develop capacity • Identify gaps • Strengthen providers • Maintain readiness	• Understand local needs • Build partnerships • Connect systems • Respond locally



A Shared Responsibility

Behavioral health infrastructure does not belong to one organization. It belongs to North Carolina. State government establishes policy and invests resources. Counties understand local conditions. Providers deliver care. Hospitals respond to urgent needs. Schools support children and families. First responders encounter people in moments of crisis. Housing organizations create stability. Community organizations build relationships. Families provide care and advocacy. People with lived experience understand the system in ways no institution can. LME/MCOs help connect many of these resources into regional systems capable of responding to individual and community needs.

No single participant can create a strong behavioral health system independently. Infrastructure is inherently shared. Its success depends upon shared responsibility, shared information, shared accountability, and a willingness to solve problems across organizational boundaries.

The Opportunity Ahead

North Carolina has an opportunity to think differently about behavioral health: not simply as a collection of programs, a health care benefit, or expenditures within separate funding streams, but as infrastructure.

That perspective demands high expectations. Public resources should be managed carefully. Organizations should be accountable. Performance should be transparent. Outcomes should be measurable. Services should continuously improve. Ineffective investments should change. Gaps should be identified rather than accepted. And the system should remain focused on the people it exists to serve.

But accountability should ultimately answer a larger question than whether money was spent correctly. It should tell us whether North Carolina is building the behavioral health capacity its people and communities need.

What Happens When the System Works?

1. A person gets an appointment rather than joining a waiting list.
2. A family finds support before reaching exhaustion.
3. A provider exists because a gap was recognized early.
4. A crisis is resolved in the community instead of an emergency department.
5. A person leaves a hospital with somewhere safe to go.
6. A sheriff's deputy has an alternative to jail.
7. A rural community gains meaningful access to a needed service.
8. A state investment becomes local capacity.



Conclusion

Behavioral health is personal. The infrastructure behind it is shared. North Carolina's public behavioral health system exists to transform resources into something people can experience: access to care, support during crisis, stability at home, opportunities for independence, stronger families, and healthier communities.

Doing that well requires more than paying for individual services. It requires building and maintaining the capacity that makes those services possible. It requires understanding communities rather than assuming they are all the same. It requires connecting systems that were not necessarily designed to work together. It requires recognizing needs that markets alone may not meet. It requires measuring outcomes rather than activity alone. And it requires responsible stewardship of every public resource entrusted to the system.

The ultimate measure of public behavioral health infrastructure is not simply what it spends. It is what every dollar makes possible in every community.

Source Notes

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