Transparency Report

JULY 1, 2024 - JUNE 30, 2025

Prepared for the North Carolina Department of Health and Human Services & Vaya Health

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

VAYAHEALTH

To our Valued Partners,

It is with deep gratitude that we present this transparency report, which reflects both the impact and promise of our shared work. The progress detailed in these pages would not be possible without the confidence, guidance, and partnership of the North Carolina Department of Health and Human Services (NCDHHS) and Vaya Health.

Together, we are navigating the changing landscape of Medicaid expansion, managed care, and the continued need for whole-person, integrated care. With your trust and collaboration, ABCCM has been able to expand access to healthcare, mental health treatment, recovery services, housing, and coordinated care across our communities. Most importantly, this partnership ensures that individuals and families in crisis are not left behind but are instead connected to the right care, at the right time, in the right way.

We remain grateful for the confidence you have placed in us and are committed to honoring that trust by continuing to innovate, collaborate, and serve the people of North Carolina with compassion and excellence.

Semper fidelis

Brandon Wilson,
Chief Operating Officer, ABCCM

Honoring Our Shared Commitment

The intent of this report is to provide a clear and comprehensive account of our work in partnership with the North Carolina Department of Health and Human Services and Vaya Health. Together, these collaborations make a measurable difference in the lives of North Carolinians by ensuring that care, stability, and support reach those who need them most.

In alignment with the Division of Mental Health's 2024–2029 Strategic Plan, and Vaya's Quality Management Improvement Program this report reflects our shared commitment to transparency and outcome measurement while advancing other key priorities. These include expanding access for justice-involved individuals, strengthening behavioral health services, ensuring timely delivery of care, reducing stigma, and streamlining access across the system.

None of this would be possible without the leadership, trust, and shared vision of both the Department and Vaya through these aligned goals and program offerings with ABCCM.

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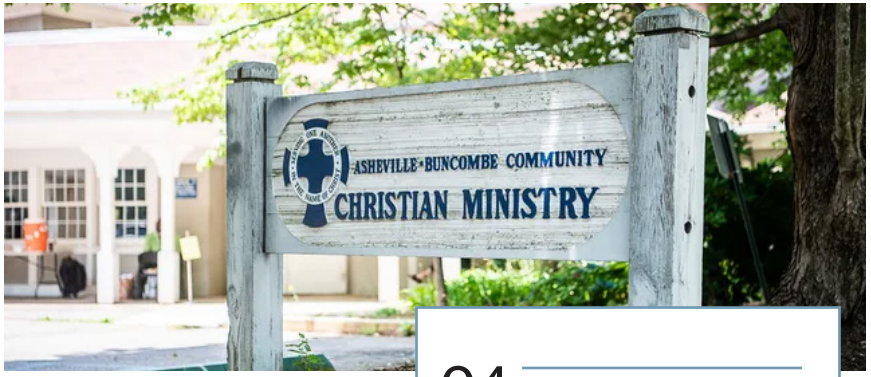


This ABCCM report presents the portfolio of programs supported by state funding.

While ABCCM offers a broader array of services, the programs highlighted here are central to ABCCM's model of care and play a vital role in its overall design. These include NCServes, the nation's first statewide coordinated care network and call center for Veterans and families, improving access to care and services; the free Medical Clinic with two pharmacies, delivering essential integrated care to uninsured adults; the Costello House, a peer-led recovery living program for men addressing substance use, mental health, and reentry; and Transformation Village, a 100-bed transitional program for women and children that provides comprehensive services ranging from emergency housing to mental health and substance use treatment.

In addition, two outreach initiatives—HOPE and PATH—leverage NC Certified Peer Support Specialists to reach NC's most vulnerable populations. Each program operates with defined eligibility and geographic criteria in alignment with state grant requirements.

Recovery Living Center

The Costello House, a 35-bed Peer-Led Recovery Living Program for men, provides a safe and structured transition from homelessness and treatment to long-term stability and healing. This program is built on an intentional recovery community model that fosters sustained recovery through the leadership of NC Certified Peer Support Specialists and Community Health Workers with lived experience.

63

Residents connected to Substance Use services

89%

Reduction in Recidivism

27

Residents connected to Mental Health services

Residents receive education on recovery, workforce development, and tools for building healthy relationships, all within a peer-supported environment that reinforces accountability and personal growth overseen by an LCSW. The program partners closely with VAYA Health, RHA, October Road, and MAHEC to ensure access to comprehensive mental health and substance use services. In addition, Costello House collaborates with Operation Gateway, a peer-led reentry program, to support men exiting incarceration and reduce cycles of relapse and recidivism. Together, these partnerships create a continuum of care that strengthens recovery, workforce readiness, and community reintegration.

Costello House supports men with diagnosed substance use disorders who may be also experiencing homelessness and mental health disorders. The primary focus is on healing, education, and employment. Evidence-based practices such as Critical Time Intervention, Motivational Interviewing, and Trauma Informed modalities allows Peer Support Specialists, Community Health-workers, and Qualified Professionals to meet others where they are, without judgment, thus creating strong foundations for healthy boundaries and recovery skills. Through the use of an intentional community process, clients are able to eliminate shame, address trauma, and restore a sense of purpose and belonging in a healthy and safe environment.

“Because of Costello House I was given the time, space, and resources to allow me to repair my life and be the person my daughter deserves.”

- Seth Franklin

54

Men Secured Employment

21

Supportive Workforce Partners

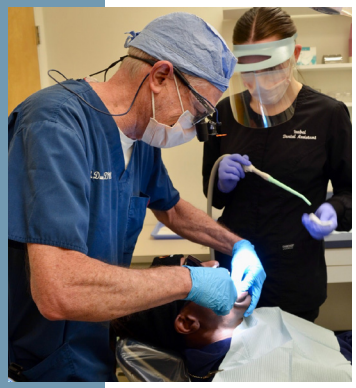
Medical Ministry

On September 22, 2023, North Carolina enacted Medicaid expansion, extending coverage to nearly all adults with incomes up to 138% of the Federal Poverty Level. While this historic legislation represents a tremendous step forward, the need for free clinics remains both realistic and essential. Free clinics continue to serve those who still face barriers to care, including the working poor, individuals transitioning out of homelessness, and those managing mental health and substance use challenges. Our clinic provides a vital bridge to primary care, whether through Medicaid or other pathways, ensuring no one is left without access to the care they need.

ACCESSIBILITY	2,963 Unduplicated patients	106 Dental patients
HEALTH OUTCOMES	66.5% Of diabetic patients obtained an A1C level of< 8%.	47% Of hypertensive patients have blood pressure controlled at <140/90.
BEHAVIORAL HEALTH	378 Unduplicated patients	778 Clinic Visits
PRESCRIPTIONS	349 Patients at 356 Pharmacy.	1,077 Prescriptions filled
REFERRALS	211 Clients received referrals through NCCARE360	382 Referrals addressing Social Determinants of Health

INTEGRATING CARE

ABCCM's free medical clinic uses an integrated care model that improves both physical and mental health, advancing whole-person wellbeing. By leveraging NCCARE360/NCServes, the clinic also addresses key social determinants of health—such as housing, transportation, and nutrition—strengthening workforce stability and community resilience.



KEY HIGHLIGHTS

The ABCCM Medical Ministry delivers urgent care, chronic disease management, and medication assistance to more than 3,000 Buncombe County residents each year. ABCCM participates in the Buncombe County Health Safety Net Committee which fosters pathways to stability and success for uninsured patients.

Our clinic provides critical healthcare, at no cost, to uninsured adults ages 18–65 living below 250% of the federal poverty line. ABCCM also operates two pharmacies, including one dedicated solely to mental health (356 Pharmacy), which together supplied over **$2.7 million in life-saving medications** in 2024, including **$520,000 in mental health prescriptions**. These services ensure uninsured residents receive essential treatment that improves health outcomes and stabilizes lives. Importantly, this care allows patients—two-thirds of whom are actively employed—to stay healthy enough to maintain their jobs. In 2024 alone, the clinic generated over **$16 million in avoided emergency room costs** through effective ER diversion, creating a measurable economic and community impact.

TOP 3 NEEDS IDENTIFIED

Food Assistance

Housing & Shelter

Mental & Behavioral Health

TOP 3 RECURRING NEEDS

Individual Family Support

2.5
CASES PER CLIENT

Clothing and Household Goods

1.4
CASES PER CLIENT

Transportation Services

1.3
CASES PER CLIENT

Transformation Village

In 2021, ABCCM opened Transformation Village, a 100-bed state-of-the-art center providing essential transitional housing for homeless women, mothers with children, and female Veterans. This transitional housing program, in consultation with industry experts, is now recognized as a best practice in the nation. This developmental, incentive-based program is designed to:

1) Aid residents in stabilization from isolation, depression, addiction, and interpersonal violence.

2) Children receive safe housing, stability, and wraparound support that fosters healing, growth, and a hopeful future .

3) Provide them with the life-skills to cope with challenges and develop self sufficiency.

4) Educate and train into living-wage jobs.

5) Equip them to sustain permanent housing with healthy supportive networks of faith, family, work, civic groups, and recreation.

CAMPUS EXPANSION

In May 2025, ABCCM held its ribbon-cutting ceremony for a 36-bed emergency shelter. It officially opened on August 4th, 2025, as Safe Haven and will serve women, children and intact families in crisis with immediate, trauma-informed shelter, case management, rapid housing and recovery support. Safe Haven stays can be up to 30 days, during which wraparound services are provided as residents identify the next steps towards stable living. Since opening, 30 total intakes have been conducted, including referral paperwork, screenings, and coordinated staff support. 116 individuals remain on the waitlist, including 46 parents with children.

Recovery Housing Pilot

KEY HIGHLIGHTS

Recovery Housing Pilot is a transitional living program that aims to work with women with limited financial resources who have successfully completed rehabilitation services at Alcohol and Drug Abuse Treatment Center (“ADATC”) to provide support for ongoing recovery. These ten contract beds work in partnership with VAYA Health. **The Program met or exceeded expectations across all performance outcome areas.** The program achieved universal compliance (100%) in screenings, care linkages, barrier reduction, and collaborative service delivery. Recidivism rates remained low (<20%), and families engaged with DSS services demonstrated measurable improvement. NCCARE360 partnerships ensured seamless community integration and holistic support.

PERFORMANCE OUTCOMES AT DISCHARGE

26 Clients Served

95%
Wellbeing & Engagement

100%
Recovery Stability

88%
Economic Independence

80%
Housing Stability

<20%
Returned to Jail/ Detox/Crisis Stabilization Within 6 Months Post-entry.

100%
Resident Participation

ALL TrV RESIDENTS

- Are assigned a treatment provider, and participate in joint case review. Weekly collaborative care plans strengthen trust and retention.
- Complete a substance use screening within 24 hours, linked to care within 30 days, and receive follow-up contacts post-referral.
- Are provided linkage or direct assistance to resolve barriers.
- Referred to community partners via NCCARE360.
- Demonstrate improved family functioning for DSS-involved clients.

HOPE

In 2018, ABCCM expanded its Veteran Outreach operations from Western NC into Eastern NC. Initiated through a pilot project called Healing Outreach Partnership for Empowerment (HOPE), a Veteran-specific program, HOPE models most aspects of the Federal Projects for Assistance in Transitioning from Homelessness (PATH). The HOPE program is deployed in 10 counties: Buncombe, Haywood, Henderson, Wake, Cumberland, Mecklenburg, Carteret, Onslow, Pender, and New Hanover.

KEY HIGHLIGHTS

- Mental Health & SOAR referrals rose significantly, pointing to escalating support needs and connection.
- Emergency food and employment referrals remained consistent, with a noticeable Q4 increase.
- Eastern region maintained consistent engagement, while the West experienced variability due to Hurricane Helene-related disruptions.
- Overall service utilization shows the growing complexity of Veteran and community needs.

PERMANENT SUPPORTIVE HOUSING SERVICES & EXITS BY REGION

SERVICES	47 Eastern Region	23 Western Region	70 Total	
EXITS	20 Eastern Region	11 Western Region	31 Total	70% Are stability housed with long term MH care

OVERALL INSIGHTS

- High initial engagement in Q1.
- Referrals for Mental Health and SOAR/benefits navigation increased each quarter.
- Exit rates improved quarter-over-quarter, suggesting strengthening housing stability and retention.

This pilot, funded through an internal Mental Health Block Grant from the NCDHHS, has grown by 50% since 2018, thanks to the Department's efforts to address Veteran homelessness, and focuses on extensive outreach, intensive peer support, and resource connection to address homeless Veterans' most acute and immediate needs.

CRITICAL NEEDS ADDRESSED

19
Substance Use Services

382
Mental Health Services

341
Housing Services

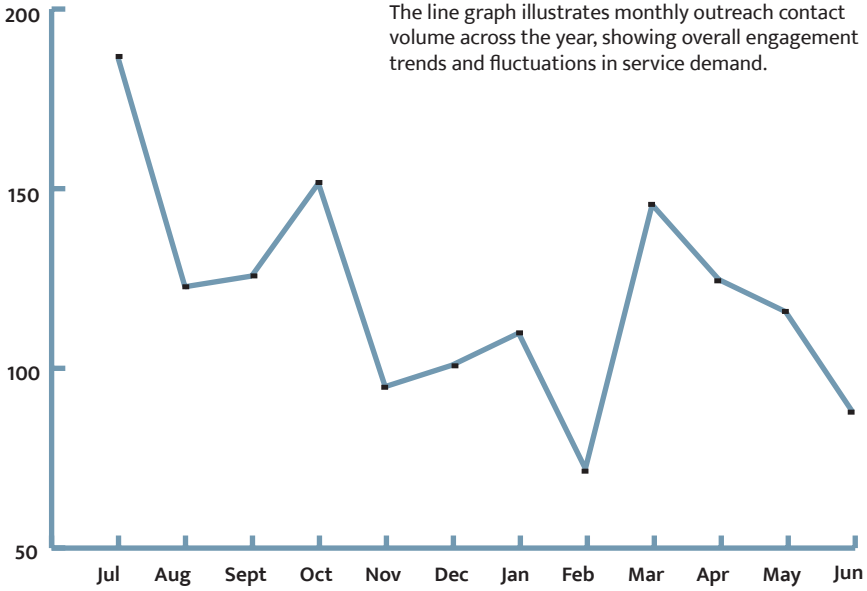
244
SOAR/BN Services

114
Employment Services

186
Emergency Food Services

MONTHLY OUTREACH ENGAGEMENT

First Time Contacts



The line graph illustrates monthly outreach contact volume across the year, showing overall engagement trends and fluctuations in service demand.

The success of the HOPE program has promoted the expansion of outreach services to the civilian sector. With the award of the NC SAMHSA PATH program in 2022, ABCCM deployed North Carolina certified peer support specialists across the state to engage in outreach to both Veterans and non-Veterans. This program addresses systemic barriers to include transportation and navigating health and benefits systems, while also prioritizing survival needs for those who are unsheltered.

PATH

Projects for Assistance in Transition from Homelessness

PATH delivers trauma-informed, person-centered care for individuals in North Carolina with serious mental illness and co-occurring substance use disorders, integrating clinical outreach, housing support, case management, and other social determinants of health services.
A primary goal of the PATH program is to identify key obstacles to achieving stability and recovery; by working to address those needs and eliminate barriers, PATH's holistic service framework aims to end homelessness among people with severe mental health and substance use challenges.

STRATEGIC REENTRY SERVICES

The Path team works collaboratively with the Department of Adult Corrections and Detention Facility Staff to promote smoother transitions for those previously unsheltered with SMIs who have entered the justice system. By providing case management, peer support, clinical services, connections to housing, mental health, and substance use services outside of the facility, PATH helps reduce the risk of homelessness and promotes successful reintegration while reducing recidivism. This collaboration ensures that those returning from incarceration have connection to the resources they need for stability, recovery, and long-term community reintegration.

PERMANENT SUPPORTIVE HOUSING SERVICES & EXITS BY REGION

SERVICES	54 Eastern Region	46 Western Region	100 Total	
EXITS	26 Eastern Region	27 Western Region	53 Total	70% Are stability housed with long term MH care

CRITICAL NEEDS ADDRESSED

65
Substance Use Services

35
Mental Health Services

161
Housing Services

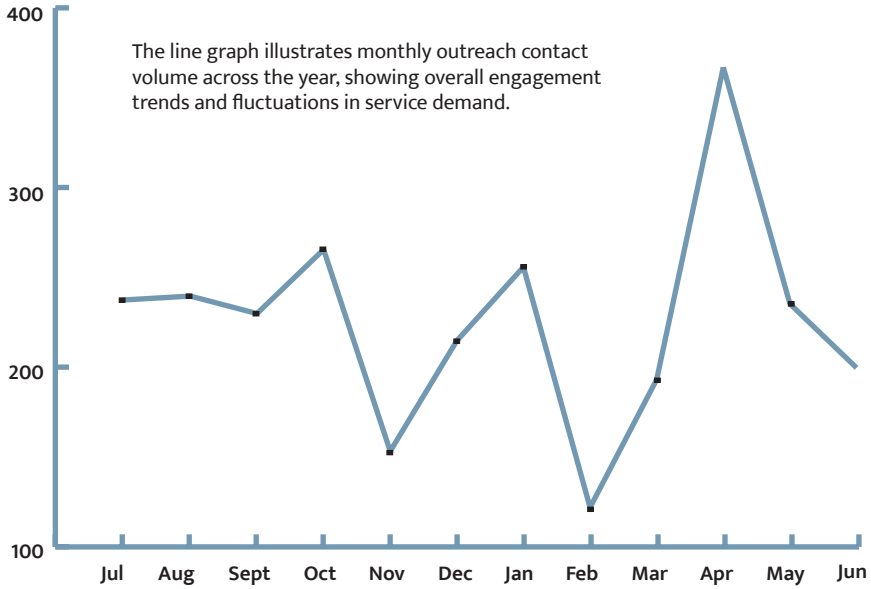
49
Income Assistance

47
Employment Services

65
Primary/Dental Services

MONTHLY OUTREACH ENGAGEMENT

First Time Contacts



DRIVING SUSTAINABLE ACCESS TO CARE

The PATH-funded outreach van has become a critical component of sustainable service delivery, ensuring that vital resources reach individuals where they are. By removing barriers such as transportation and accessibility, the van extends the reach of clinical staff and peer support specialists. Our team uses the PATH van for carrying both essential resources such as food, water, medical supplies, and cold-weather gear. The van also transports participants in need of community services, especially in our most rural areas across North Carolina. Most importantly, it provides safe passage to housing opportunities, medical appointments, and other critical services. Recently, the van was used to transport a mother and her five children to the Safe Haven shelter, a ride that was essential to ensuring their safety and well-being.

NCServes

Now entering its 11th year of service to North Carolina's Veterans and military families, NCServes stands as the nation's only statewide coordinated care network with a centralized call center dedicated to addressing the social determinants of health. Through this model, those in need are seamlessly connected to critical resources across every human service domain-from housing and healthcare to employment, benefits, and family support.

This work is made possible through an innovative public-private partnership that leverages the nation's most advanced closed-loop technology platform. By connecting nonprofits, state programs, federal grantees, and corporate partners, NCServes creates intentional, coordinated communities of care designed to honor and support our nation's warriors and their families.

KEY HIGHLIGHTS

- Became a critical component of Crisis response operations during Hurricane Helene.
- Record call volume: 12,198 calls in Q2 (Hurricane Helene Response).
- Northwestern University published white-paper on intentional outreach developed by NCServes that significantly shortens take-up gap of Veterans benefits.
- Implementation of the Columbia-Suicide Severity Rating Scale (C-SSRS) addressing Veterans suicide and mental health.

PERFORMANCE TRENDS

CLIENT VOLUME

+21%

In the second half of the year.

CALL VOLUME

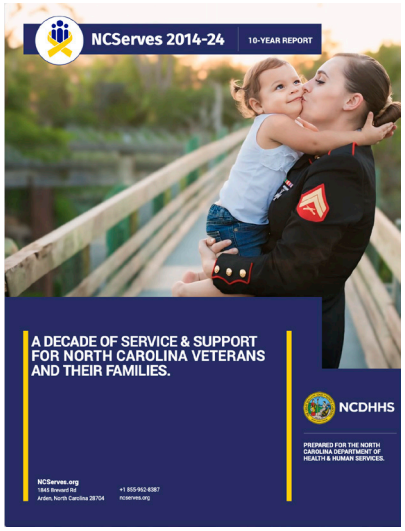
+28.4%

Indicating stronger engagement.

C-SSRS IMPLEMENTATION

3,405

Screenings, improving behavioral health risk identification.



PUBLICATIONS

As NCServes celebrates a decade of addressing the Social Determinant of Health needs for North Carolina's Veterans and their Families, remaining data informed in the delivery of that care is at the forefront of the model pioneered by NCServes. NCServes continues to pilot a unique predictive analytics project which includes a proprietary blend of both current data sets and public data. This project is being used to create upstream strategies that address prevention of Veterans homelessness and mental health challenges. ABCCM worked in partnership with both Northwestern University and Syracuse University for measurement and evaluation; these studies were published in the summer of 2024.

CLIENT ENGAGEMENT & COORDINATION CENTER ACTIVITY

KPI	Q1	Q2	Q3	Q4	Total/Avg
Clients Served	2,131	1,699	1,881	2,079	**7,790**
Calls Received	8,936	12,198	6,822	7,352	**35,308**
Cases Facilitated	758	432	677	1,098	2,965
Avg Time to Acceptance	1.6 Days	1.6 Days	1.6 Days	1.7 Days	1.625 Days
CSSRS Screenings Completed	0	0	1,752	1,653	3,405

UTILIZATION OVERVIEW

518

Receiving partners accepted referrals.

202

Referring organizations sent referrals into the Coordination Center.

- The network demonstrated agility in disaster response during crises.
- Q4 saw a significant case increase due to the pause of the Healthy Opportunities Pilot, highlighting food insecurity and housing instability.
- Data shifts occurred due to Unite Us platform upgrades, moving from org-level to program-level reporting.
- Publication highlight: Project DeLorean (Northwestern University) on closing the Veteran benefits take-up gap.

*The findings in this report are based on data documented throughout the designated reporting period of July 1, 2024 - June 30, 2025.

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