



Thursday, November 04, 2021

AREA BOARD REGULAR MEETING

(virtual meeting via videoconference)
4:00-6:00 p.m.

MEMBERS PRESENT: Glenn Adams, Cumberland County Commissioner, JD; Heidi Carter, Durham County Commissioner, MPH, MS; Carol Council, MSPH; David Curro, BS; Vicki Evans; Lodies Gloston, Vice-Chair, MA; David Hancock, MBA, MPAff; D. Lee Jackson, BA; John Lesica, MD; Lynne Nelson, Chair, BS; Gino Pazzaglini, MSW LFACHE; Pam Silberman, JD, DrPH; and McKinley Wooten, Jr., JD

APPOINTED MEMBERS ABSENT: Maria Cervania, Wake County Commissioner, MPH; Ted Godwin, Johnston County Commissioner; Donald McDonald, MSW; and Samruddhi Thaker, PhD

GUEST(S) PRESENT: Denise Foreman, Wake County Manager’s office; Yvonne French, NC DHHS/DMH (Department of Health and Human Services/Division of Mental Health, Intellectual Disability, and Substance Abuse Services); Jason Phipps, Alliance CFAC; Pamela Wade; and Antwane Yelverton

ALLIANCE STAFF PRESENT: Joey Dorsett, Senior Vice-President/Chief Information Officer; Angel Felton-Edwards, Senior Vice-President/Population Health and Care Management; Cheala Garland-Downey, Executive Vice-President/Chief Human Resources Officer; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Veronica Ingram, Executive Assistant II; Wes Knepper, Senior Vice-President/Quality Management; Mehul Mankad, Chief Medical Officer; Shaw Mazyck, Senior Vice-President/Provider Network; Sara Pacholke, Senior Vice-President/Financial Operations; Brian Perkins, Senior Vice-President/Strategy and Government Relations; Monica Portugal, Chief Compliance Officer; Robert Robinson, Chief Executive Officer; Matt Ruppel, Senior Director of Program Integrity; Sean Schreiber, Executive Vice-President/Chief Operating Officer; Jennifer Stoltz, Administrative Assistant II; Tammy Thomas, Senior Vice-President/Business Evolution; Sara Wilson, Chief of Staff; Carol Wolff, General Counsel; Doug Wright, Director of Community and Member Engagement; and Ginger Yarbrough, NCQA Accreditation Manager

1. **CALL TO ORDER:** Board Chair Lynne Nelson called the meeting to order at 4:00 p.m.

AGENDA ITEMS:	DISCUSSION:
2. Agenda Adjustments	There were no adjustments to the agenda.
3. Public Comment	David Curro reviewed an inclusivity housing conference he attended. There were no other public comments.
4. Chair’s Report	There was no report.
5. CEO’s Report	Mr. Robinson introduced the Chief of Staff, Sara Wilson.
6. Consent Agenda	<p>A. Draft Minutes from October 7, 2021, Board Meeting – page 4</p> <p>B. Audit and Compliance Committee Report – page 8</p> <p>C. Client Rights/Human Rights Committee Report – page 20</p> <p>D. Executive Committee Report – page 113</p> <p>E. Finance Committee Report – page 115</p> <p>F. Quality Management Committee Report - 125</p> <p>The consent agenda was sent as part of the Board packet; it is attached to and made part of these minutes. There were no comments or discussions about the consent agenda.</p> <p>BOARD ACTION A motion was made by Vice-Chair Gloston to adopt the consent agenda; motion seconded by Mr. Curro. Motion passed unanimously.</p>

Thursday, November 04, 2021

AREA BOARD REGULAR MEETING

(virtual meeting via videoconference)
4:00-6:00 p.m.

AGENDA ITEMS:	DISCUSSION:
7. Committee Reports	<p>A. Consumer and Family Advisory Committee (5 minutes) – page 129 The Alliance Consumer and Family Advisory Committee (CFAC) is composed of consumers and/or family members from Durham, Wake, Cumberland or Johnston counties who receive mental health, intellectual/developmental disabilities or substance use/addiction services. This month’s report included minutes and documents from the October Steering, Durham, Wake, and Johnston Committee meetings.</p> <p>Jason Phipps, CFAC Chair, presented the report. Mr. Phipps provided an update from recent CFAC meetings, which included representatives from Mecklenburg and Orange County CFACs, pending changes to the CFAC by-laws, participation in the upcoming i2i Center for Integrative Care conference in December. He reviewed the importance of the continued relationship with current care managers, noting concerns over staffing changes, reassigning care managers, and additional notice regarding the transition of care managers. The CFAC report is attached to and made part of these minutes.</p> <p>BOARD ACTION The Board received the report.</p>
8. Lease of Suite 100A, at 201 Sage Road in Chapel Hill, NC (10 minutes) – page 215	<p>Carol Wolff, General Counsel, provided an overview of the lease assignment. The property includes approximately 3000 square feet of space on the first floor in Suite 100A. The term will commence on December 1, 2021, and expire on April 30, 2023. Per Alliance’s by-laws, this item required supermajority approval; a supermajority was present.</p> <p>BOARD ACTION A motion was made by Mr. Pazzaglini to accept the assignment of the lease from Cardinal Innovations for Suite 100A, at 201 Sage Road in Chapel Hill, NC; motion seconded by Dr. Silberman. Motion passed unanimously.</p>
9. Closed Session(s)	<p>BOARD ACTION A motion was made by Mr. Curro to enter closed session pursuant to NC General Statute 143-318.11 (a) (1) and (a) (6) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1 and to consider the qualifications, competence, and performance of an employee; motion seconded by Vice-Chair Gloston. Motion passed unanimously.</p>
10. Reconvene Open Session	<p>The Board returned to open session.</p>
11. Special Updates/Presentation(s)	<p>A. County Realignment Update Brian Perkins, Senior Vice-President/Strategy and Government Relations, presented the update. He noted the change in Mecklenburg and Orange counties realignment with Alliance; it will now be December 1, 2021. He shared that NC DHHS will notify members of the date change and Alliance will send notification closer to December 1. He also reviewed the agency’s multi-media campaign to boost public awareness to these new members.</p> <p>B. DEI Efforts as Hiring/Staffing Strategy – page 216 At the conclusion of the workforce demographic presentation at the October 7, 2021, meeting, the Board requested additional information regarding current DEI (diversity, equity, and inclusion) efforts and Alliance’s hiring/staffing strategy. Cheala Garland-Downey, Executive Vice-President/Chief Human Resources Officer, presented the update noting data from FY21 (fiscal year 2020-2021), current hiring and staffing strategies/goals to attract, retain and develop staff. The presentation is saved as part of the Board’s files.</p>

Thursday, November 04, 2021

AREA BOARD REGULAR MEETING

(virtual meeting via videoconference)
4:00-6:00 p.m.

AGENDA ITEMS:	DISCUSSION:
	<p>C. Medicaid Transformation Overview – page 217 Sara Wilson, Chief of Staff, provided an overview of Medicaid Transformation in NC, including a high-level summary of the NC DHHS Tailored Plan features. The Board also discussed current legislation regarding Medicaid expansion. The presentation is saved as part of the Board's files.</p> <p><u>BOARD ACTION</u> The Board accepted the updates/presentations.</p>
B. Adjournment	All business was completed; the meeting adjourned at 5:39 p.m.

Next Board Meeting
Thursday, December 02, 2021
4:00 – 6:00 pm

Minutes approved by Board on December 2, 2021.



**Alliance Health
BOARD OF DIRECTORS
Agenda Action Form**

ITEM: Draft Minutes from the October 7, 2021, Board Meeting

DATE OF BOARD MEETING: November 4, 2021

BACKGROUND: The Alliance Health (Alliance) Board of Directors (Board) per North Carolina General Statutes 122C is responsible for comprehensive planning, budgeting, implementing, and monitoring of community based mental health, developmental disabilities and substance use/addiction services to meet the needs of individuals in Alliance's catchment area. The minutes from the previous meeting is attached and submitted for review and approval by the Board.

SPECIFIC INFORMATION FOR BOARD REVIEW (if applicable/available): N/A

REQUEST FOR AREA BOARD ACTION: Approve the draft minutes from the October 7, 2021, meeting.

CEO RECOMMENDATION: Approve the draft minutes from the October 7, 2021, meeting.

RESOURCE PERSON(S): Lynne Nelson, Board Chair; Robert Robinson, CEO

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Thursday, October 07, 2021

AREA BOARD REGULAR MEETING

(virtual meeting via videoconference)
4:00-6:00 p.m.

MEMBERS PRESENT: Glenn Adams, Cumberland County Commissioner, JD; Heidi Carter, Durham County Commissioner, MPH, MS; Maria Cervania, Wake County Commissioner, MPH; Carol Council, MSPH; David Curro, BS; Vicki Evans; Lodies Gloston, MA; David Hancock, MBA, MPAff; John Lesica, MD; Donald McDonald, MSW; Lynne Nelson, Chair, BS; Gino Pazzaglini, MSW LFACHE; Pam Silberman, JD, DrPH; Samruddhi Thaker, PhD; and McKinley Wooten, Jr., JD

APPOINTED MEMBERS ABSENT: Ted Godwin, Johnston County Commissioner; D. Lee Jackson, BA; one vacancy representing Durham County; and two vacancies representing Wake County

GUEST(S) PRESENT: Denise Foreman, Wake County Manager's office; Yvonne French, NC DHHS/DMH (Department of Health and Human Services/Division of Mental Health, Intellectual Disability, and Substance Abuse Services); Mary Hutchings, Wake County Finance Department; and Pam Wade

ALLIANCE STAFF PRESENT: Brandon Alexander, Communications and Marketing Specialist II; Joey Dorsett, Senior Vice-President/Chief Information Officer; Angel Felton, Senior Vice-President/Population Health and Care Management; Cheala Garland-Downey, Executive Vice-President/Chief Human Resources Officer; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Veronica Ingram, Executive Assistant II; Wes Knepper, Senior Vice-President/Quality Management; Joshua Knight, Director of Internal Audit; Mehul Mankad, Chief Medical Officer; Shawn Mazyck, Senior Vice-President/Provider Network; Sara Pacholke, Senior Vice-President/Financial Operations; Brian Perkins, Senior Vice-President/Strategy and Government Relations; Monica Portugal, Chief Compliance Officer; Robert Robinson, CEO; Sean Schreiber, Executive Vice-President/Chief Operating Officer; Jennifer Stoltz, Administrative Assistant II; Tammy Thomas, Senior Vice-President/Business Evolution; Sara Wilson, Senior Director of Government Relations; Carol Wolff, General Counsel; Doug Wright, Director of Member and Community Engagement; and Ginger Yarbrough, NCQA Accreditation Manager

1. **CALL TO ORDER:** Board Chair Lynne Nelson called the meeting to order at 4:02 p.m.

AGENDA ITEMS:	DISCUSSION:
2. Agenda Adjustments	There were no agenda adjustments.
3. Public Comment	There were no public comments.
4. Chair's Report	Chair Nelson reported that two board members resigned, Angela Diaz and Duane Holder. She shared that the FY22 (fiscal year 2021-2022) board vice-chairperson position is vacant and the executive committee's recommendation will be presented during committee reports.
5. CEO's Report	<p>Mr. Robinson reminded Board members and attendees of the October 10 Walk for Hope, which is virtual this year. Alliance is a sponsor and Board/staff may join Alliance's team or make a donation on Alliance's behalf via Alliance's team link.</p> <p>Mr. Robinson reminded board members that i2i conference registration is open; they may contact Ms. Ingram by October 25 to register.</p> <p>He provided an update from a recent meeting of the Johnston Board of County Commissioners and expressed gratitude to Alliance board members: Lee Jackson and Commissioner Ted Godwin.</p> <p>Mr. Robinson and Sean Schreiber, Executive Vice-President/Chief Operating Officer, introduced new staff, Shawn Mazyck, Senior Vice-President/Provider Network. Cheala Garland-Downey, Executive Vice-President/Chief Human Resources Officer, provided a staffing update as the agency prepares for tailored plan implementation and Mecklenburg and Orange counties' realignment.</p>

AGENDA ITEMS:	DISCUSSION:
6. Consent Agenda	<p>A. Draft Minutes from September 2, 2021, Board Meeting – page 4 B. Audit and Compliance Committee Report – page 8 C. Network Development and Services Committee Report – page 16 D. Quality Management Committee Report – page 18</p> <p>The consent agenda was sent as part of the Board packet. There were no comments or discussion about the consent agenda.</p> <p><u>BOARD ACTION</u> A motion was made by Mr. Pazzaglini to adopt the consent agenda; motion seconded by Dr. Silberman. Motion passed unanimously.</p>
7. Committee Reports	<p>A. Consumer and Family Advisory Committee (5 minutes) – page 23 The Alliance Consumer and Family Advisory Committee (CFAC) is composed of consumers and/or family members from Durham, Wake, Cumberland or Johnston counties who receive mental health, intellectual/developmental disabilities or substance use/addiction services. This month’s report included CFAC’s annual report, draft minutes from the September steering committee, and draft minutes from the Durham, Wake, Johnston, and Cumberland subcommittee meetings.</p> <p>Doug Wright, Director of Member and Community Engagement, presented the report. He noted that the report was sent as part the packet and included the CFAC annual report, updates on the state budget, county realignments, updates to the CFAC by-laws and agreements with the agency and Alliance Board. Mr. Wright also noted an upcoming meeting with CFAC representatives in Mecklenburg and Orange counties. The CFAC report is attached to and made part of these minutes.</p> <p><u>BOARD ACTION</u> The Board received the report.</p> <p>B. Executive Committee Report (10 minutes) – page 98 The Executive Committee sets the agenda for Board meetings and acts in lieu of the Board between meetings. Actions by the Executive Committee are reported to the full Board at the next scheduled meeting. This report included draft minutes from the previous meeting and a recommendation to elect a Board member to the vacant FY22 Board Vice-Chairperson position.</p> <p>Chair Nelson reviewed the vacant vice-chair position, which was reviewed by the executive committee at its September 20, 2021, meeting. She shared that Lodies Gloston is willing to serve as FY22 Vice-Chair and the executive committee recommends her nomination and appointment. Chair Nelson opened the floor for additional nominations.</p> <p><u>BOARD ACTION</u> A motion was made by Mr. Wooten to close the nominations (for FY22 Vice-Chair) with the said name (Lodies Gloston); motion seconded by Mr. Pazzaglini. Motion passed unanimously.</p> <p>C. Finance Committee Report (10 minutes) – page 101 The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Board, including reviewing/recommending budgets, audit reports, and financial statements. This Committee also reviews and recommends policies and procedures for managing contracts and other purchase of service arrangements. This month’s report included documents and draft minutes from the previous meeting and a request to approve FY22 (2021-2022) committed funds and reinvestment plan.</p>

Thursday, October 07, 2021

AREA BOARD REGULAR MEETING

(virtual meeting via videoconference)
4:00-6:00 p.m.

AGENDA ITEMS:	DISCUSSION:
	<p><u>BOARD ACTION</u> A motion was made by Dr. Silberman to approve the one-year reinvestment plan of \$44,636,221.00 and to commit \$47,630,674.00 as of 6/30/21; motion seconded by Ms. Gloston. Motion passed unanimously.</p>
8. Closed Session(s)	<p><u>BOARD ACTION</u> A motion was made by Mr. Curro to enter closed session pursuant to NC General Statute 143-318.11 (a) (1) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1; motion seconded by Ms. Council. Motion passed unanimously.</p>
9. Reconvene Open Session	The Board returned to open session.
10. Special Updates/Presentation(s)	<p>A. County Realignment Update Brian Perkins, Senior Vice-President/Strategy and Government Relations, presented the update. Mr. Perkins stated that Orange and Mecklenburg counties realignment with Alliance is effective December 15, 2021. He shared about internal workgroups in place to prepare for the realignment and an external workgroup that includes NC DHHS and Alliance staff.</p> <p><u>BOARD ACTION</u> The Board received the update.</p> <p>B. FY21 Workforce Demographics (20 minutes) – page 109 Alliance’s Equal Employment Opportunity Policy (policy number HR-1) states the following: “Annually, the Chief Executive Officer shall provide an organizational workforce report to include the distribution of employees by age, race, ethnicity and gender to the Board.” Cheala Garland-Downey, Executive Vice-President/Chief Human Resources Officer, presented the report; the report included growth trends and current demographics.</p> <p>Chair Nelson requested DEI in hiring practices for the November board meeting. Commissioner Adams requested other slides with details by county. Commissioner Cervania requested DEI goals with metrics shared. Ms. Garland-Downey shared that the goal is to have staffing reflective of the communities served. Mr. Curro requested demographics of the aspiring leaders program. The presentation is saved as part of the board’s files.</p> <p><u>BOARD ACTION</u> The Board received the report.</p>
11. Adjournment	All business was completed; the meeting adjourned at 5:52 p.m.

Next Board Meeting
Thursday, November 04, 2021
4:00 – 6:00 pm

Minutes approved by Board on [Click or tap to enter a date..](#)



**Alliance Health
BOARD OF DIRECTORS
Agenda Action Form**

ITEM: Audit and Compliance Committee Report

DATE OF BOARD MEETING: November 4, 2021

BACKGROUND: The purpose of the Audit and Compliance Committee is to put forth a meaningful effort to review the adequacy of existing compliance systems and functions and to assist the Board in fulfilling its oversight responsibilities. This Committee also develops, reviews, and revises the By-Laws and Policies that govern Alliance.

This report includes draft minutes from the previous meeting.

SPECIFIC INFORMATION FOR BOARD REVIEW (if applicable/available): Proposed By-Laws included in the report as part of the Board's thirty-day notification. By-Laws will be presented for action at the Board's December 2, 2021, meeting.

REQUEST FOR AREA BOARD ACTION: Approve the report.

CEO RECOMMENDATION: Approve the report.

RESOURCE PERSON(S): David Curro, Committee Chair; Monica Portugal, Chief Compliance Officer

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Wednesday, October 20, 2021

BOARD AUDIT AND COMPLIANCE COMMITTEE - REGULAR MEETING
 (virtual meeting via videoconference)
 4:00-5:30 p.m.

APPOINTED MEMBERS PRESENT: David Curro, BS (Committee Chair); Vicki Evans (Board Member); D. Lee Jackson, BA; John Lesica, MD; Samruddhi Thaker, PhD

BOARD MEMBERS PRESENT: Lodies Gloston, Vice-Chair (Joined by Phone)

GUEST(S) PRESENT: None

STAFF PRESENT: Monica Portugal, Chief Compliance Officer; Josh Knight, Director of Internal Audit; Jamie Preslar, Administrative Assistant III; Carol Wolff, General Counsel

- 1. WELCOME AND INTRODUCTIONS** – The meeting was called to order at 4:15 pm by David Curro.
- 2. REVIEW OF THE MINUTES** – The minutes from the August 25, 2021, meeting will be reviewed at the next regular meeting of the Audit and Compliance Committee.

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
3. By-Laws Updates	Wolff reviewed details of each proposed revision to the By-Laws. Committee was allowed an opportunity to review revisions and ask questions. COMMITTEE ACTION: A motion was made by Ms. Evans to approve the By-Laws with the changes as discussed; motion seconded by Ms. Gloston. Motion passed unanimously.	Proposed changes to the By-Laws will be submitted via email to full Board for 30-day notification per the By-Laws. By-Laws with proposed changes will then go to Board for approval.	By October 28, 2021 December 2, 2021
4. Delegation Oversight Program	Not reviewed; to be moved to next regular meeting.	N/A	N/A
5. Work Plan/Audit Plan Dashboard	Not reviewed; to be moved to next regular meeting.	N/A	N/A
6. Compliance Dashboard	Not reviewed; to be moved to next regular meeting.	N/A	N/A
7. Quarterly Reports A. Network Compliance B. Overpayments C. Special Investigations D. Internal Investigations E. HIPAA Incidents	Not reviewed; to be moved to next regular meeting.	N/A	N/A

- 1. ADJOURNMENT:** The meeting adjourned at 4:29 pm; the next meeting will be December 15, 2021, from 4:00 p.m. to 5:30 p.m.

*Items shared during meeting are stored with these meeting minutes in the Audit & Compliance Committee folder.

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on [Click or tap to enter a date..](#)



BOARD OF DIRECTORS
POLICIES & PROCEDURES

TITLE:	By-Laws
BOARD POLICY #:	BL
LINES OF BUSINESS:	Governance
RESPONSIBILITY:	Board of Directors
REFERENCE(S):	N.C.G.S. 122C
URAC STANDARDS:	N/A
NCQA STANDARDS:	N/A
APPROVAL DATE:	5/3/2012
LATEST REVISION DATE:	8/1/2019
LATEST REVIEW DATE:	09/03/2020

BOARD OF DIRECTORS BY-LAWS

**ARTICLE I
PURPOSE**

The Alliance Health Board of Directors, also known as the Board of Directors, by virtue of powers contained in Chapter 122C of the North Carolina General Statutes is responsible for comprehensive planning, budgeting, implementing and monitoring of ~~community-based mental health, developmental disabilities and substance abuse health~~ services to meet the needs of ~~individuals~~ Medicaid members and eligible non-Medicaid recipients enrolled in with Alliance’s health plan catchment area as that term is defined in the contracts between NC Department of Health and Human Services (NCDHHS) and Alliance for Medicaid waiver management services. Any use of the term Board of Directors or CEO in these bylaws shall be deemed to include the Area Board, Area Authority, LME, Area Director and other such terms used in North Carolina General Statutes.

MISSION STATEMENT

To improve the health and well-being of the people we serve by ensuring highly effective, community-based support and care.

VISION STATEMENT

To be a leader in transforming the delivery of whole person care in the public sector.

VALUES STATEMENT

Accountability and Integrity: We keep the commitments we make to our stakeholders and to each other. We ensure high-quality services at a sustainable cost.

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Collaboration: We actively seek meaningful and diverse partnerships to improve services and systems for the people we serve. We value communication and cooperation between team members and departments to ensure that people receive needed services and supports.

Compassion: Our work is driven by dedication to the people we serve and an understanding of the importance of community in each of our lives.

Dignity and Respect: We value differences and seek diverse input. We strive to be inclusive and honor the culture and history of our communities and the people we serve.

Innovation: We challenge the way it's always been done. We learn from experience to shape a better future.

ARTICLE II STRUCTURE

A. AUTHORITY

1. The Alliance Board of Directors is accountable to the citizens of the Alliance Catchment Area. The Alliance Catchment Area refers to the geographical area served by Alliance Health under a contract(s) between NC Department of Health and Human Services (NCDHHS) and Alliance.
2. The powers and duties of the Board of Directors derive from General Statutes 122C-115.5 and 122C-117.
3. In addition to exercising those powers, duties, and functions set forth in 122C-115.5 and 122C-117, the Board of Director's primary responsibilities include:
 - a. Defining services to meet the needs of citizens (within the parameters of the law) through an annual needs assessment.
 - b. Governing the organization by adopting necessary and proper policies to carry out the obligations under its contracts ~~with NCDHHS as a Pre-paid Inpatient Health Plan (PHIP).~~
 - c. Evaluating quality and availability of services in meeting the needs of the population.
 - d. Providing Fiscal oversight.
 - e. Performing public relations and community advocacy functions.
 - f. Appointing a CEO in accordance with General Statute 122C-121 (d). The CEO is an employee of the Board of Directors and shall serve at the pleasure of the Board of Directors.
 - g. Evaluating annually the Chief Executive Officer for performance based on criteria established by the Secretary of NCDHHS and the Board of Directors.
 - h. Delegating responsibility to the Chief Executive Officer who shall be responsible for the appointment of employees, the implementation of the policies and programs of the Board of Directors, for compliance with the rules of the North Carolina Division for Mental Health, Developmental Disabilities and Substance Abuse Services, and NCDHHS, supervision of all employees and management of all contract providers.
 - i. Delegating to the Chief Executive Officer authority to execute contracts and agreements, where appropriate.
 - j. Maintaining open communication with the Consumer and Family Advisory Committee (CFAC).
 - k. Participate in strategic planning, including consideration of local priorities as determined by the County Commissioner Advisory Board;
 - l. Government affairs and advocacy.

B. COMPOSITION

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1. The Board of Directors shall consist of nineteen (19)-(20) members.
- 4.2. The membership of the Board shall reside within the Alliance catchment area and be composed in a manner consistent with NCGS §122C-118.1.
- 2.3. As of December 15, 2021, Board seats are allocated to the individual catchment area counties as follows and will be filled and vacated through attrition of current Board members:

CFAC	1
Cumberland County	3
Durham County	3
Johnston County	2
Mecklenburg County	4
Orange County	2
Wake County	4

- 3.4. The Board of Directors shall work in conjunction with the Durham, Wake, Johnston and Cumberland.
- 4.5. The Durham and Wake County Commissioners shall appoint seven (7) members respectively, the Cumberland County Board of Commissioners will appoint four (4) members, and the Johnston County Board of Commissioners will appoint two (2) members.
- 5.6. The CFAC seat will be filled by the Alliance CFAC Chairperson or their designee, who shall be sworn in by the Board's Executive Secretary.
- 6.7. Other than CFAC, appointments are made by the County Commissioners within the member's county of residence based on a recommendation from the Board of Directors.
- 7.8. Other than CFAC and County Commissioner appointees, the Board of Directors will advertise, accept applications, interview and recommend appointments to the respective Boards of Commissioners based on the appointee's county of residence.
- 8.9. The Board of Directors shall work in conjunction with the Durham, Wake, Johnston and Cumberland County Commissioners of the counties in the Alliance Catchment Area to ensure that Board members collectively reflect the membership categories set forth in 122C- 118.1 and the diversity of the individuals served by Alliance.
- Board of Directors membership may consist of the following:
- a. Consumer or family member representing the interest of individuals with mental illness, intellectual or other developmental disabilities or substance abuse
 - b. CFAC member
 - c. An individual with health care expertise and experience in the fields of mental health, intellectual or other developmental disabilities or substance abuse services.
 - d. Individual with financial expertise
 - e. Individual with provider experience in a managed care environment.
- The Board of Directors shall assure that there is at least one representative of each of the three disability categories, i.e., mental illness, intellectual/developmental disabilities and substance abuse, on the board.
- 9.10. No individual who contracts with the Board of Directors for the delivery of mental health, intellectual/developmental disabilities, or substance abuse services may serve on the Board of Directors during the period in which the contract for services is in effect.

Commented [CW1]: in 122C

C. TERMS AND CONDITIONS OF OFFICE

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1. Terms of membership shall be for three consecutive years except any member of the Board of Directors who is a county commissioner serves on the Board in an ex officio capacity at the pleasure of the initial appointing authority, for a term not to exceed the earlier of three years or the member's service as a County Commissioner.
2. Members shall not be appointed for more than three consecutive terms.
3. Members may be removed with or without cause by the appointing authority or upon recommendation to the appointing authority by the Executive Committee.
4. Board of Directors members may resign at any time, upon written notification to the Chairperson or the Executive Secretary of the Board of Directors.
5. Vacancies on the Board of Directors shall be filled by the County Commissioners before the end of the term of the vacated seat or within 90 days of the vacancy, whichever comes first. Appointments shall be for the remainder of the unexpired term.
6. Board of Directors members are responsible for disclosing and may not vote on any issue in which they have a direct or indirect financial interest or personal gain. All Board members are expected to exhibit high standards of ethical conduct, avoiding both actual conflict of interest and the appearance of a conflict of interest.
7. Neither Board of Directors members nor members of their families will receive preferential treatment through the Area Authority's services or operations.
- ~~10-11.~~ Board of Directors members must be current with all property taxes in their respective counties.
- ~~11-12.~~ Membership is based on the rules and regulations of the Board of Directors policies and all applicable North Carolina General Statutes.
- ~~12-13.~~ Board of Directors members are required to comply with the Alliance Board of Directors Code of Ethics, policies and all applicable North Carolina General Statutes.
- ~~13-14.~~ While Board members may be appointed because they represent a certain community, once on the Board, their responsibility is to all individuals served by Alliance.

D. OFFICERS

1. At each final regular Board meeting of the fiscal year, the Officers of the Board of Directors shall be elected for a one-year term to begin July 1. The Officers of the Board of Directors include:
 - a. Chairperson, and
 - b. Vice-Chairperson.
2. No officer shall serve in a particular office for more than two consecutive terms.
3. Each Board of Directors member, other than County Commissioners, shall be eligible to serve as an officer.
4. Duties of officers shall be as follows:
 - a. Chairperson – this officer shall preside at all meetings and generally perform the duties of a presiding officer. The Chairperson shall appoint all Board of Directors committees.
 - b. Vice Chairperson – this officer shall be familiar with the duties of the Chairperson and be prepared to serve or preside at any meeting on any occasion where the Chairperson is unable to perform his/her duties.
5. Executive Secretary – The CEO (or his/her designee) shall serve as the Executive Secretary. The CEO shall not be an official member of the Board of Directors nor have a vote. As Executive Secretary, the CEO shall:
 - a. Send Board of Directors packets of information.
 - b. Maintain a true and accurate account of all proceedings at Board of Directors meetings.
 - c. Maintain custody of Board of Directors minutes and other records.

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- d. Notify the County Commissioners of any vacancies on the Board of Directors or attendance compliance issues.

E. COMMITTEES

- 1. **STANDING COMMITTEES** - Annually, the Board of Directors Chairperson shall appoint the membership and the Chairperson of each of the Standing committees set forth below. These committees shall have the responsibility of making policy recommendations to the Board of Directors regarding matters within each committee’s designated area of concern. The composition of each committee shall comply with the applicable statute, regulation or contract requirements. The chair of any standing committee must be a member of the Board of Directors. All Standing Committees shall adopt a Charter, which shall be reviewed and revised as needed by the committee at least annually.

If a non-board member with a conflict of interest is appointed to a committee, they shall be a non-voting member of the committee and as such shall not count towards establishing quorum. The Chairperson and Vice Chairperson may serve as standing alternate voting committee members on any committee those officers do not serve on. Except when so serving, the Chairperson and Vice Chairperson have no voting rights on a committee to which they are not regularly appointed. The standing committees shall be as follows:

a. Finance Committee (NCGS 122C-119 (d))

- i. This committee shall be composed in a manner consistent with NCGS 122C-119, having at least 3 members, two of whom have expertise in budgeting and fiscal control. The Finance Officers of Durham, Cumberland, Johnston and Wake Counties or designee may serve as ex-officio members.
- ii. The Chief Financial Officer or CEO designee will serve as staff liaison to the Committee.
- iii. The Committee’s functions include:
 - 1) Recommending policies/practices on fiscal matters to the full Board of Directors.
 - 2) Reviewing and recommending budgets to the entire Board of Directors.
 - 3) Reviewing and recommending approval of audit reports (following a meeting by a designee of this committee with the auditor and receipt of the management letter) and assure corrective actions are taken as needed.
 - 4) Reviewing and recommending policies and procedures for managing contracts and other purchase of service arrangements.
 - 5) Reviewing financial statements at least quarterly.
 - 6) Reviewing the financial strength of the Area Authority.

b. Client Rights/Human Rights Committee (DMH/DD/SAS contract and NCGS 122C-64, 10A NCAC 27G.0504)

- i. The Client Rights/Human Rights Committee shall consist of at least 5 members, a majority of whom shall be non-Board members. Members should include consumers and family members representing mental health, developmental disabilities and substance abuse. The membership of the Client Rights/Human Rights Committee shall include a representative from each of the counties in the Catchment Area.
- ii. The CEO will designate a staff liaison to the Committee.
- iii. The Client Rights/Human Rights Committee functions include:
 - 1) Reviewing and evaluating Alliance’s Client Rights policies at least annually and recommending needed revisions to the Board of Directors.

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- 2) Overseeing the protection of client rights and identifying and reporting to the Board of Directors issues which negatively impact the rights of persons served.
 - 3) Reporting to the full Board of Directors at least quarterly.
 - 4) Submitting an annual report to the Board of Directors which includes, among other things, a review of Alliance's compliance with NCGS 122C, Article 3, DMHDDSAS Client Rights Rules (APSM 95-2) and Confidentiality Rules (APSM 45-1).
- iv. The Client Rights/Human Rights Committee shall meet at least quarterly.

c. Quality Management Committee (~~URAC~~) (NCOA)

- i. The Quality Management (QM) Committee shall consist of at least 5 members to include consumers or their family members plus at least 2 non-voting provider representatives. The QM Committee will meet at least 6 times a year.
- ii. The QM Director, or CEO designee, will be the staff liaison to the Committee.
- iii. The QM Committee shall review statistical data and provider monitoring reports and make recommendations to the Board of Directors or other Board committees.
- iv. The QM Committee serves as the Board's Monitoring and Evaluation Committee charged with the review of statistical data and provider monitoring reports. The goal of the QM Committee is to ensure quality and effectiveness of services and to identify and address opportunities to improve Alliance operations and local service system with input from consumers, providers, family members, and other stakeholders.

d. Executive Committee - The Board of Directors shall have an Executive Committee. All actions taken by the Executive Committee will be reported to the full Board of Directors at the next scheduled meeting.

- i. The Executive Committee shall be composed of the current Officers of the Board of Directors, Chairpersons of standing committees (who are Board of Directors members), the immediate past Board chairperson or an at-large member in the event the immediate past Board Chairperson is not available.
- ii. The Board of Directors Chairperson shall serve as the Chairperson of the Executive Committee.
- iii. The Chief Executive Officer, or designee will be the staff liaison to the Committee.
- iv. The Chairperson shall call the meetings of the Executive Committee. Any member of the Board of Directors may request that the Chairperson call an Executive Committee meeting.
- v. The Executive Committee shall be responsible for the following:
 - 1) Function as the grievance committee to hear complaints regarding board member conduct and make recommendations to the full Board of Directors.
 - 2) Establish agendas for full Board of Directors meetings.
 - 3) Act on matters that are time-sensitive between regularly scheduled board meetings.
 - 4) Provide feedback to the CEO concerning current issues related to services, providers, staff, etc.
 - 5) Fulfill other duties as set forth in these By-laws or as otherwise directed by the Board of Directors.
 - 6) Notice of the time and place of every Executive Committee meeting shall be given to the members of the Executive Committee in the same manner that notice is given of Board of Directors meetings.

ef. Audit, Compliance and Policy Committee

- i. The Audit, Compliance and Policy Committee will consist of at least five members of the Board of Directors. At least one member shall have financial expertise. The Chairperson

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of the Audit, Compliance and Policy Committee may not also be the Chairperson of the Finance Committee.

- ii. The Chief Compliance Officer or CEO designee will serve as staff liaison to the Committee.
- iii. The Committee shall meet at least four times a year, with authority to convene additional meetings, to adequately fulfill all the obligations outlined in this charter.
- iv. The purpose of the Audit, Compliance and Policy Committee is to put forth a meaningful effort to review the adequacy of existing compliance systems and functions. To assist the Board of Directors in fulfilling its oversight responsibilities for:
 - 1) The integrity of the organization's annual financial statements;
 - 2) The system of risk assessment and internal controls;
 - 3) The organization's compliance with legal and regulatory requirements;
 - 4) The independent auditor's qualifications and independence;
 - 5) The performance of the organization's internal audit function; and
 - 6) Providing an avenue of communication between management, the independent auditors, and the Board of Directors.

The Audit, Compliance and Policy Committee also develops, reviews, and revises Board of Directors By-Laws and Policies that Govern Alliance by:

- a. Recommending new or revised Board Policies to the Board of Directors.
- b. Reviewing Board Policies at least annually, within 12 months of policies' approval, to ensure compliance with applicable law, federal and state statutes, administrative rules, state policies, contractual agreements and accreditation standards.

fg. Network Development & Services Committee

- i. The Network Development and Services Committee shall consist of at least three members, a majority of whom shall be members of the Board of Directors and shall meet at least quarterly.
- ii. The Executive Vice President of Network & Community Health or CEO designee will serve as staff liaison to the Committee.
- iii. The Committee's functions include:
 - 1) To review service network development activities.
 - 2) Reviews progress on the network development plan and progress on fund balance spending on service development.
 - 3) Provides guidance and feedback on development of the needs and gaps assessment to meet state and agency requirements.
 - 4) Areas of focus may include:
 - Emerging needs and Challenges
 - Data related to the Needs and Gaps Analysis
 - Network Development Plan and Status
 - State and Federal Initiatives

2. AD HOC COMMITTEES

- a. Ad hoc committees may be appointed by the Chair of the Board of Directors with the approval of a majority of the Board members who are present at the meeting during which approval is given.
- b. Ad hoc committees shall carry out their duties as designated by the Board of Directors and shall report their findings to the Board or its committees.

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3. CONSUMER AND FAMILY ADVISORY COMMITTEE – Consistent with NCGS 122C-170, Alliance shall have a committee made up of consumers and family members to be known as the Consumer and Family Advisory Committee (CFAC). The Consumer and Family Advisory Committee shall be self-governing and self-directed. The CFAC shall advise the Board of Directors on the planning and management of the local ~~mental health, intellectual/developmental disabilities and substance abuse~~ services system.

4. COUNTY COMMISSIONER ADVISORY BOARD
Per 122C-118.2, there is a County Commissioner Advisory Board. The County Commissioner Advisory Board is not a board or committee appointed by the Board of Directors. The CEO or designee will assist in facilitation of the County Commissioner Advisory Board meetings.

**ARTICLE III
MEETINGS**

A. REGULAR MEETINGS

Regular meetings shall be held at least six times each year at a location and time designated by the Board of Directors. The annual meeting for the election of Officers shall be the final meeting of each fiscal year. All meetings of the Board of Directors shall be conducted in accordance with provisions set forth in N.C.G.S. 143, Article 33C (the Open Meetings Statute).

B. SPECIAL MEETINGS

Special meetings may be called by the Board Chair or by three or more members of the Board of Directors after notifying the Board Chair in writing. Notice of special meetings shall be provided in a manner consistent with those utilized to notify Board of Directors members (and others) of regularly scheduled meetings.

C. EMERGENCY MEETINGS

Emergency meetings may be called for unexpected circumstances that require immediate consideration by the Board of Directors. Due to the urgent need to assemble a meeting as soon as possible, any requirements regarding advanced notice for regularly scheduled meetings may be waived and emergency meetings shall be held as soon as a quorum of the Board of Directors can be convened.

D. NOTICE OF MEETINGS

Notification of Board of Directors meetings shall be sent out no later than 48 hours before the regular meeting and in accordance with requirements set forth in the Open Meetings Statute, Chapter 143 Article 33C. The Board of Directors is scheduled to meet on the first Thursday of each month at the designated Alliance site. Notice of the date, time and place shall be sent to each Board member in the form of a Board of Directors agenda. Information concerning Board meetings shall also be made available to the local news media in accordance with Chapter 143 Article 33C. Notice for all Board meetings including the Board packet will be posted on the Alliance website.

E. CONDUCT OF MEETINGS

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Board of Directors meetings shall be conducted under parliamentary procedures. It is the policy of this Board that all deliberations and actions be conducted fairly, openly, and consistent with the applicable statutes of North Carolina. Participation in Board of Directors meetings via electronic means, e.g. telephone, video conferencing, is permissible to the extent allowed by law. Such participation includes the right to vote on issues that arise during the course of the meeting.

The following guidelines should be followed at all Board and committee meetings:

1. The Board/Committee must act as a body in the best interests of the consumers in the Alliance catchment area.
2. The Board/Committee should proceed in the most efficient manner possible.
3. The Board/Committee must act by at least a majority vote.
4. Every member must have an equal opportunity to participate in decision-making on the respective Board or committee they are participating on.
5. The Board/Committee must apply the rules of procedure consistently.

F. QUORUM

A majority of the actual membership of the Board or Committee, excluding vacant seats, shall constitute a quorum and shall be required for the transaction of business at all regular, special and emergency meetings. A majority is more than half.

G. APPROVAL OF CERTAIN ITEMS BY A SUPER MAJORITY

Significant actions by the Board of Directors require affirmative votes, from two-thirds of the actual membership of the Board, excluding vacant seats (referred to as a Super Majority). Significant actions shall include:

- (1) any action or decisions concerning the annual budget and amendments according to the Local Government Budget and Fiscal Control Act (NCGS 159),
- (2) the selection and dismissal of the Chief Executive Officer,
- (3) changes to the Board of Directors structure,
- (4) execution of contracts for sale, purchase or lease of real property,
- (5) approval or amendment of the Board of Director's by-laws, and,
- (6) any other matter so designated by the Board of Directors.

H. ABSENCES

1. Absence from three (3) consecutive regularly scheduled Board meetings without notification to the Executive Secretary shall constitute resignation from the Board.
2. Absence from four (4) or more ~~of the~~ regularly scheduled Board meetings during a 12 month period may also constitute resignation from the Board within the discretion of the Executive Committee.
3. In computing absences, absence from two (2) standing Board Committee meetings ~~may~~ constitutes one (1) absence from a regularly scheduled Board meeting.

ARTICLE IV GENERAL PROVISIONS

A. AMENDMENTS

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1. These By-Laws may be amended or repealed as necessary by a Super Majority.
2. Notice of proposed changes must be given to ~~the Board of Directors~~ members at least thirty (30) days prior to the change.

B. SUSPENSION OF BY-LAWS

The Board of Directors has the authority to suspend the By-Laws by an affirmative vote of a majority of Board members, ~~or a corresponding majority of Board members in the event the number of Board members changes or there are vacant seats on the Board,~~ with the exception of those items requiring a Super Majority set forth in Article III (G).

C. REVIEW OF BY-LAWS AND BOARD OF DIRECTORS GOVERNANCE POLICIES

These By-Laws and all Board of Directors governance policies shall be reviewed at least annually.



**Alliance Health
BOARD OF DIRECTORS
Agenda Action Form**

ITEM: Client Rights/Human Rights Committee Report

DATE OF BOARD MEETING: November 4, 2021

BACKGROUND: The Client Rights/Human Rights Committee is a Board Committee with at least 50% of its membership being either consumers or family members that are not Board members. This Committee's functions include the following: reviewing and evaluating Alliance's Client Rights policies at least annually and recommending needed revisions to the Board; overseeing the protection of client rights and identifying and reporting to the Board issues which negatively impact the rights of persons served; and reporting to the Board at least quarterly.

This report includes draft minutes from the previous meeting.

SPECIFIC INFORMATION FOR BOARD REVIEW (if applicable/available): N/A

REQUEST FOR AREA BOARD ACTION: Receive the report.

CEO RECOMMENDATION: Receive the report.

RESOURCE PERSON(S): Donald McDonald, Committee Chair; Doug Wright, Director of Community and Member Engagement

[\(Back to agenda\)](#)



Thursday, October 14, 2021

BOARD HUMAN RIGHTS COMMITTEE - REGULAR MEETING
 5200 W. Paramount Parkway, Morrisville, NC 27560
 4:00-5:30 p.m.

APPOINTED MEMBERS PRESENT: Angela Diaz, MBA, Board member, Marie Dodson, Sally Hunter, Donald McDonald, MSW, Board member (Committee Chair) , Lynne Nelson, BS, Board member, Dr. Michael Teague, Patricia Wells, Ira Wolfe, McKinley Wooten, Jr. JD, Board member

APPOINTED, NON-VOTING MEMBERS PRESENT:

BOARD MEMBERS PRESENT:

GUEST(S) PRESENT: Todd Parker, QM, Incident & Grievance Manager, William Cunningham

STAFF PRESENT: Doug Wright, Director of Community and Member Engagement, Starlett Davis, Member Engagement Specialist, Ramona Branch, Member Engagement Specialist, Erica Asbury, Member Engagement Specialist,

1. **WELCOME AND INTRODUCTIONS** – the meeting was called to order at 4:12pm
2. **REVIEW OF THE MINUTES** – The minutes from the June 8, 2021, meeting were reviewed; a motion was made by Mr. Wooten seconded by Dr. Teague to approve the minutes. Motion passed unanimously.

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
3. Charter Review	Doug Wright - reviewed with no changes recommended		
4. Grievance Review	Todd Parker, QM, Incident & Grievance Manager Presented the Grievance Review for Q4 FY 2021 Complaint Analysis <ul style="list-style-type: none"> • Categories- Complaints, Grievances, Internal Stakeholders Concern • Complaints and Grievances Overview- Q2 FY21 yielded 210 entries • Nature of Issues Definitions. • Nature of Issue/ Types- Quality of Services account for 32% of all Complaints/Grievances. Access to services is 17% • Who submitted the concerns- 83 (40%) were Grievances by Member or Legal Guardian; 94 (44%) were submitted by MCO staff; 29 (14%) External Stakeholder Concerns-Outside entities;4 (2%) Compliments • Service Breakdowns with the top 3 overall- 17% Outpatient Services;14% Crisis- inpatient Services; 13% Residential Services • Services with I/DD- 14% of all complaints and grievances were from IDD services/ 83% of IDD services were Innovations Services • MHSUD- 68% of all complaints and grievances were from MH/SUD services/ 43% of all complaints and grievances were from Basic Services 		

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on [Click or tap to enter a date..](#)

Thursday, October 14, 2021

BOARD HUMAN RIGHTS COMMITTEE - REGULAR MEETING
 5200 W. Paramount Parkway, Morrisville, NC 27560
 4:00-5:30 p.m.

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
	<ul style="list-style-type: none"> • Human Rights Issues: Abuse/Neglect/Exploitation:22; Clients rights:4; Basic needs: 2; Confidentiality/HIPPA: 1 		
5. Incidents Review	<p>Todd Parker, QM, Incident & Grievance Manager Presented the Incidents Trends Report for Q2 FY 2021</p> <ul style="list-style-type: none"> • Incident Report Breakdown- 724 Reports were entered in to NC-IRIS for 505 members, 492 children, 232 adults • LEVELS- 635 Level 2 reports /89 Level 3 • Incident Levels by County- Wake County submitted the largest number of Level 2 and Level 3 reports in the 2nd quarter of FY2021 • Adults Vs Children- A total of 466 Incidents were reported for children. A total of 232 Incidents were reported for Adults • Service Breakdown- PRTF service category remains the highest reporting service; 18% of all reports • Reports by Incident category • Restrictive Interventions- 148 Restrictive Interventions reported 73% of Restrictive Interventions were Physical Restraints • Physical Restraint- 73% from PRTF Programs • Injury Categories- 56 Total • Abuse/Neglect/Exploitation- 123 reported in this category (59% of all Incidents) Substantiated, 3 Exploitation, 3 Staff Abuse, 6 Staff Neglect • Member Deaths- A total of 40 deaths were reported during the 4th quarter • 14 (L2); 26 (L3) • 35% of reports due to Terminal Illnesses • 7 OCME Reports Reviewed. 1 confirmed suicide; 6 confirmed accidents • Incident Report Compliance, Process, and Late Incident Report Submission- Late submissions in the 4th quarter was same average as the 3rd quarter 		
6. Annual Training	Annual training completed.	N/A	N/A
7. Announcements	Would like to have Damali Alston present to the group on provider score cards at the next meeting.		

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on [Click or tap to enter a date..](#)

Thursday, October 14, 2021

BOARD HUMAN RIGHTS COMMITTEE - REGULAR MEETING
5200 W. Paramount Parkway, Morrisville, NC 27560
4:00-5:30 p.m.

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
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8. **ADJOURNMENT:** the meeting adjourned at 5:05pm; the next meeting will be February 17, 2021, from 4:00 p.m. to 5:30p.m.

DRAFT

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on [Click or tap to enter a date..](#)

SUBCHAPTER 26B – CONFIDENTIALITY RULES

SECTION .0100 – GENERAL RULES

10A NCAC 26B .0101 PURPOSE AND SCOPE

(a) The purpose of the rules in this Subchapter is to set forth requirements for those who collect, store and disseminate information on individuals who are served by facilities, AS DEFINED IN G.S. 122C-3. The rules shall be used in conjunction with the confidentiality requirements specified in G.S. 122C-51 through 122C-56. Area and State facilities shall comply with all Rules in this Subchapter; however, facilities, as defined in G.S. 122C-3, except Area and State facilities, shall comply only with Rules .0103(7) and .0111 of this Subchapter.

(b) Area and State facilities governed by these Rules include offices of the Division; regional psychiatric hospitals, mental retardation centers and alcohol and drug abuse treatment centers; State special care centers; schools for emotionally disturbed children; area programs and their contract agencies; and other public and private agencies, institutions or programs which are operated by or contract with the Division for Mental Health, Developmental Disabilities or Substance Abuse Services. All employees, students, volunteers or other individuals who have access to or control over confidential information in these facilities or programs shall abide by these Rules. However, local hospitals that are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) which contract with an area facility or provide services for a State facility shall be excluded from these Rules and the confidentiality policies of that accredited hospital shall apply. In addition, education records generated by Alcohol and Drug Education Traffic Schools (ADETS) and Drug Education Schools (DES) are excluded from these Rules since the records maintained by such schools are considered public records.

History Note: Authority G.S. 122C-52; 122C-55; 131E-67; 143B-147;
Eff. July 1, 1979;

Amended Eff. November 2, 1992; February 1, 1991; February 1, 1986; July 15, 1980.

10A NCAC 26B .0102 GENERAL PROVISIONS

(a) Area or state facilities or individuals with access to or control over confidential information shall take affirmative measures to safeguard such information.

(b) Confidential information may not be released or disclosed except in accordance with G.S. 122C-51 through 122C-56 and the rules in this Subchapter.

(c) Confidential information regarding substance abusers shall be released or disclosed in accordance with the federal regulations 42 C.F.R. Part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records", which are adopted by reference pursuant to G.S. 150B-14(c), unless the rules in this Subchapter are more restrictive in which case the rules in this Subchapter shall be followed.

(d) Confidential information regarding infants and toddlers receiving early intervention services who have or who are at risk for atypical development, developmental delay or developmental disability shall be released or disclosed in accordance with the federal regulations 34 C.F.R. Part 300, Subpart E, Sections 300.560 through 300.575, which are adopted by reference pursuant to G.S. 150B-14(c), unless the rules in this Subchapter are more restrictive in which case the rules in this Subchapter shall be followed.

(e) Questions regarding interpretation of these Rules shall be directed to the Client Records Consultant in the Institution Management Support Section of the Division.

History Note: Authority G.S. 122C-52; 131E-67; 143B-147; 150B-14;
Eff. July 1, 1979;

Amended Eff. February 1, 1991; March 1, 1990; February 1, 1986; January 1, 1984.

10A NCAC 26B .0103 DEFINITIONS

(a) The following terms shall have the meanings specified in G.S. 122C-3, 122C-4 and 122C-53:

- (1) "Area board",
- (2) "Area facility",
- (3) "Confidential information",
- (4) "Guardian",
- (5) "Internal client advocate",
- (6) "Legally responsible person",
- (7) "Next of kin",

- (8) "Provider of support services",
 - (9) "Secretary", and
 - (10) "State facility".
- (b) As used in this Subchapter, unless the context clearly requires otherwise, the following terms have the meanings specified:
- (1) "Client Record" means any documentation made of confidential information. For the purpose of the rules in this Subchapter, this also includes confidential information generated on an individual who was not admitted but received a service from an area or state facility.
 - (2) "Clinical Staff Member" means a mental health, developmental disabilities or substance abuse professional who provides active treatment/habilitation to a client.
 - (3) "Confidential information" as defined in G.S. 122C-3 includes but is not limited to photographs, videotapes, audiotapes, client records, reimbursement records, verbal information relative to clients served, client information stored in automated files, and clinical staff member client files.
 - (4) "Delegated Employee" means anyone designated by the facility head to carry out the responsibilities established by the rules in this Subchapter.
 - (5) "Disclosure of Information" means the dissemination of confidential information without consent.
 - (6) "Division" means Division of Mental Health, Developmental Disabilities and Substance Abuse Services.
 - (7) "Legitimate role in the therapeutic services offered" means next of kin or other family member who, in the judgment of the responsible professional as defined in G.S. 122C-3, and after considering the opinion of the client, currently provides, or within the past 12 months preceding the current hospitalization, provided substantial time or resources in the care of the client.
 - (8) "Minor Client" means a person under 18 years of age who has not been married or who has not been emancipated by a decree issued by a court of competent jurisdiction or is not a member of the armed forces.
 - (9) "Parent" means the biological or adoptive mother or father of a minor. Whenever "parents" are legally separated or divorced or have never been married, the "parent" legally responsible for the minor shall be the "parent" granted custody or either parent when joint custody has been granted.
 - (10) "Person Standing in Loco Parentis" means one who has put himself in the place of a lawful parent by assuming the rights and obligations of a parent without formal adoption.
 - (11) "Release of Information" means the dissemination of confidential information with consent.
 - (12) "Signature" means signing by affixing one's own signature; or by making one's mark; or impressing some other sign or symbol on the paper by which the signature may be identified.

History Note: Authority G.S. 122C-3; 122C-4; 122C-52; 122C-55; 131E-67; 143B-147;
 Eff. July 1, 1979;
 Amended Eff. November 2, 1992; February 1, 1991; March 1, 1990; February 1, 1986.

10A NCAC 26B .0104 LIABILITY OF PERSONS WITH ACCESS TO INFORMATION

- (a) Individuals employed in area and state facilities and employees governed by the State Personnel Act, G.S. Chapter 126, are subject to suspension, dismissal or disciplinary action for failure to comply with the rules in this Subchapter.
- (b) Individuals, other than employees but including students and volunteers, who are agents of the Department of Health and Human Services who have access to confidential information in an area or state facility who fail to comply with the rules in this Subchapter shall be denied access to confidential information by the facility.

History Note: Authority G.S. 122C-52; 131E-67; 143B-147(a)(6);
 Eff. July 1, 1979;
 Amended Eff. March 1, 1990; February 1, 1986; July 15, 1980.

10A NCAC 26B .0105 OWNERSHIP OF RECORDS

- (a) All records, including those which contain confidential information which are generated in connection with the performance of any function of an area or state facility, are the property of the facility.
- (b) Original client records may be removed from an area or state facility premises only under the following conditions:

- (1) in accordance with a subpoena to produce document or object or other order of the court or when client records are needed for district court hearings held in accordance with Article 5 of Chapter 122C of the N.C. General Statutes;
 - (2) whenever client records are needed for treatment/habilitation or audit purposes, records may be transported within an area facility or between state facilities;
 - (3) in situations where the facility determines it is not feasible or practical to copy the client record or portions thereof, client records may be securely transported to a local health care provider, provided the record remains in the custody of a delegated employee;
 - (4) whenever a client expires at an area or state facility and an autopsy is to be conducted, the client record may be transported to the agency wherein the autopsy will be performed provided the agency complies with Rule .0108 of this Subchapter.
- (c) Area facilities shall develop written policies and procedures regarding fees for the reproduction of client records.
- (d) Except as otherwise provided in this Rule, state facilities shall charge uniform fees for the reproduction of client records which do not exceed the cost of reproduction, postage and handling. The uniform fee shall be five dollars (\$5.00) for up to three pages and fifteen cents (\$.15) for each additional page. State facilities shall not charge for the reproduction of client records in the following types of situations:
- (1) professional courtesy when records are requested by physicians, psychologists, hospital or other health care providers;
 - (2) third party payors when the state facility will derive direct financial benefits;
 - (3) providers of support services as defined in G.S. 122C-3;
 - (4) attorneys representing the Attorney General's office and Special Counsel;
 - (5) other situations determined by the state facility to be for good cause;
 - (6) when indigent clients request pertinent portions of their client records necessary for the purpose of establishing eligibility for SSI, SSADIB, Medicaid, or other legitimate aid; or
 - (7) whenever state facilities utilize private photocopy services wherein the photocopy service, rather than the state facility, bills the recipient of the information based on the usual and customary fee established by the copy service.

History Note: Authority G.S. 122C-52; 122C-54; 122C-224.3; 122C-268; 122C-286; 131E-67; 143B-147; Eff. July 1, 1979; Amended Eff. February 1, 1991; March 1, 1990; February 1, 1986.

10A NCAC 26B .0106 ALTERATIONS IN THE CLIENT RECORD

A client or a client's legally responsible person may contest the accuracy, completeness or relevancy of information in the client record and may request alteration of such information. Alterations shall be made as follows:

- (1) whenever a clinical staff member concurs that such alteration is justified, the area or state facility shall identify the contested portion of the record and allow the insertion of the alteration as an addendum to the contested portion of the client record; however, the original portion of the written record may not be deleted; or
- (2) whenever a clinical staff member does not concur that such alteration is justified, the area or state facility shall identify the contested portion of the record and allow a statement relative to the contested portion to be added to the client record which shall be recorded on a separate form and not on the original portion of the record which is being contested. Such statement shall be made a permanent part of the client's record and shall be released or disclosed along with the contested portion of the record.

History Note: Authority G.S. 122C-52; 122C-53; 131E-67; 143B-147(a)(6); Eff. July 1, 1979; Amended Eff. March 1, 1990; February 1, 1986.

10A NCAC 26B .0107 SECURITY OF CONFIDENTIAL INFORMATION

- (a) Each area or state facility that maintains records with confidential information shall provide a secure place for the storage of records and shall develop written policies and procedures regarding controlled access to those records.
- (b) Each area or state facility shall ensure that only authorized employees or other individuals authorized by the facility director have access to the records.

(c) Each area or state facility director shall ensure that a clinical staff member is present in order to explain and protect the record when a client or a client's legally responsible person comes to the facility to review the client record. A delegated employee shall document such review in the client's record.

(d) Each area or state facility that maintains confidential information in an automated data processing system shall develop written policies and procedures regarding the provision of safeguards to ensure controlled access to such information.

History Note: Authority G.S. 122C-52; 131E-67; 143B-147(a)(6);
Eff. July 1, 1979;
Amended Eff. February 1, 1986.

10A NCAC 26B .0108 ASSURANCE OF CONFIDENTIALITY

(a) The area or state facility director shall make known to all employees, students, volunteers and all other individuals with access to confidential information the provisions of the rules in this Subchapter and G.S. 122C-52 through 122C-56. The facility shall develop written policies and procedures in accordance with the rules of this Subchapter and applicable statutes and provide training to all individuals with access to confidential information.

(b) Such individuals shall indicate an understanding of the requirements governing confidentiality by signing a statement of understanding and compliance. Employees shall sign such statement upon employment and, again, whenever revisions are made in the requirements. Such statement shall contain the following information:

- (1) date and signature of the individual and his title;
- (2) name of area or state facility;
- (3) statement of understanding;
- (4) agreement to hold information confidential; and
- (5) acknowledgement of civil penalties and disciplinary action for improper release or disclosure.

History Note: Authority G.S. 122C-52; 131E-67; 143B-147;
Eff. July 1, 1979;
Amended Eff. March 1, 1990; February 1, 1986; July 15, 1980.

10A NCAC 26B .0109 REVIEW OF DECISIONS

Clients, clients' legally responsible persons or employees may request a review of any decisions made under the rules in this Subchapter by the area or state facility director, or, if elsewhere within the Division, by the Division director.

History Note: Authority G.S. 122C-52; 131E-67; 143B-147(a)(6);
Eff. February 1, 1986.

10A NCAC 26B .0110 INFORMATION RECEIVED FROM OTHER AGENCIES/INDIVIDUALS

Whenever an area or state facility receives confidential information from another facility, agency or individual, then such information shall be treated as any other confidential information generated by the area or state facility. Release or disclosure of such information shall be governed by the rules of this Subchapter.

History Note: Authority G.S. 122C-52; 131E-67; 143B-147;
Eff. February 1, 1986;
Amended Eff. March 1, 1990.

10A NCAC 26B .0111 INFORMATION PROVIDED TO FAMILY/OTHERS

Information shall be provided to the next of kin or other family member, who has a legitimate role in the therapeutic services offered, or other person designated by the client or his legally responsible person in accordance with G.S. 122C-55(j) through (l).

History Note: Authority G.S. 122C-52; 122C-55; 131E-67; 143B-147;
Eff. November 2, 1992.

SECTION .0200 – RELEASE OF CONFIDENTIAL INFORMATION WITH CONSENT

10A NCAC 26B .0201 CONSENT FOR RELEASE

Area or state facility employees may not release any confidential information until a Consent for Release form as described in Rules .0202 and .0203 of this Section has been obtained. Disclosure without authorization shall be in accordance with G.S. 122C-52 through 122C-56 and Section .0300 of this Subchapter.

*History Note: Authority G.S. 122C-52; 122C-53; 131E-67; 143B-147(a)(6);
Eff. July 1, 1979;
Amended Eff. February 1, 1986.*

10A NCAC 26B .0202 CONSENT FOR RELEASE FORM

(a) When consent for release of information is obtained by an area or state facility covered by the rules in this Subchapter, a Consent for Release form containing the information set out in this Paragraph shall be utilized. The consent form shall contain the following information:

- (1) client's name;
- (2) name of facility releasing the information;
- (3) name of individual or individuals, agency or agencies to whom information is being released;
- (4) information to be released;
- (5) purpose for the release;
- (6) length of time consent is valid;
- (7) a statement that the consent is subject to revocation at any time except to the extent that action has been taken in reliance on the consent;
- (8) signature of the client or the client's legally responsible person; and
- (9) date consent is signed.

(b) Unless revoked sooner by the client or the client's legally responsible person, a consent for release of information shall be valid for a period not to exceed one year except under the following conditions:

- (1) a consent to continue established financial benefits shall be considered valid until cessation of benefits; or
- (2) a consent for release of information to the Division, Division of Motor Vehicles, the Court and the Department of Correction for information needed in order to reinstate a client's driving privilege shall be considered valid until reinstatement of the client's driving privilege.

(c) A consent for release of information received from an individual or agency not covered by the rules in this Subchapter does not have to be on the form utilized by area or state facilities; however, the receiving area or state facility shall determine that the content of the consent form substantially conforms to the requirements set forth in this Rule.

(d) A clear and legible photocopy of a consent for release of information shall be considered to be as valid as the original.

(e) Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S. 130A-143. Whenever authorization is required for the release of this information, the consent shall specify that the information to be released includes information relative to HIV infection, AIDS or AIDS related conditions.

*History Note: Authority G.S. 122C-52; 122C-53; 130A-143; 131E-67; 143B-147;
Eff. July 1, 1979;
Amended Eff. July 1, 1993; February 1, 1991; March 1, 1990; February 1, 1986.*

10A NCAC 26B .0203 PERSONS WHO MAY SIGN CONSENT FOR RELEASE

The following persons may sign a consent for release of confidential information:

- (1) a competent adult client;
- (2) the client's legally responsible person;
- (3) a minor client under the following conditions:
 - (a) pursuant to G.S. 90-21.5 when seeking services for venereal disease and other diseases reportable under G.S. 130A-135, pregnancy, abuse of controlled substances or alcohol, or emotional disturbances;
 - (b) when married or divorced;
 - (c) when emancipated by a decree issued by a court of competent jurisdiction;
 - (d) when a member of the armed forces; or

- (4) personal representative of a deceased client if the estate is being settled or next of kin of a deceased client if the estate is not being settled.

History Note: Authority G.S. 28A-13.3; 90-21.5; 122C-52; 122C-53; 131E-67; 143B-147;
Eff. July 1, 1979;
Amended Eff. January 1, 1996; January 1, 1994; March 1, 1990; February 1, 1986.

10A NCAC 26B .0204 VERIFICATION OF AUTHORIZATION IN CASES OF DOUBT

Whenever the validity of an authorization is in question, an area or state facility employee shall contact the client or the client's legally responsible person to confirm that the consent is valid. Such determination of validity of the consent shall be documented in the client record.

History Note: Authority G.S. 122C-52; 122C-53; 131E-67; 143B-147(a)(6);
Eff. July 1, 1979;
Amended Eff. February 1, 1986.

10A NCAC 26B .0205 INFORMED CONSENT

Prior to obtaining a consent for release of confidential information, a delegated employee shall inform the client or his legally responsible person that the provision of services is not contingent upon such consent and of the need for such release. The client or legally responsible person shall give consent voluntarily.

History Note: Authority G.S. 122C-52; 122C-53; 131E-67; 143B-147(a)(6);
Eff. July 1, 1979;
Amended Eff. February 1, 1986; July 15, 1980.

10A NCAC 26B .0206 PERSONS DESIGNATED TO RELEASE CONFIDENTIAL INFORMATION

The area or state facility director shall be responsible for the release of confidential information but may delegate the authority for release to other persons under his supervision. The delegation shall be in writing.

History Note: Authority G.S. 122C-52; 131E-67; 143B-147;
Eff. July 1, 1979;
Amended Eff. March 1, 1990; February 1, 1986.

10A NCAC 26B .0207 DOCUMENTATION OF RELEASE

Whenever confidential information is released with consent, a delegated employee shall ensure that the release is placed in the client record.

History Note: Authority G.S. 122C-52; 122C-53; 131E-67; 143B-147(a)(6);
Eff. July 1, 1979;
Amended Eff. January 1, 2005; February 1, 1986.

10A NCAC 26B .0208 PROHIBITION AGAINST REDISCLOSURE

(a) Area or state facilities releasing confidential information shall inform the recipient that redisclosure of such information is prohibited without client consent.

(b) A stamp may be used to fulfill this requirement.

History Note: Authority G.S. 122C-52; 131E-67; 143B-147(a)(6);
Eff. July 1, 1979;
Amended Eff. February 1, 1986.

10A NCAC 26B .0209 RELEASE TO HUMAN RIGHTS COMMITTEE MEMBERS

(a) Human Rights Committee members may have access to confidential information only upon written consent of the client or the client's legally responsible person.

(b) A delegated employee shall release confidential information upon written consent to Human Rights Committee members only when such members are engaged in fulfilling their function as set forth in 10A NCAC 28A .0207, and when involved in or being consulted in connection with the training or treatment of the client.

History Note: Authority G.S. 122C-52; 122C-53; 122C-64; 131E-67; 143B-147(a)(6);
Eff. July 15, 1980;
Amended Eff. February 1, 1986.

10A NCAC 26B .0210 RELEASE TO AREA BOARD MEMBERS

Area board members may have access to confidential information only upon written consent of the client or the client's legally responsible person or pursuant to other exceptions to confidentiality as specified in G.S. 122C-53 through 122C-55. Area board members may have access to non-identifying client information.

History Note: Authority G.S. 122C-52; 122C-53; 131E-67; 143B-147;
Eff. February 1, 1991.

10A NCAC 26B .0211 RELEASE OF INFORMATION BY INTERNAL CLIENT ADVOCATES

Upon request by the Secretary, internal client advocates may disclose to the Secretary or his designee confidential information obtained while fulfilling monitoring and advocacy functions.

History Note: Authority G.S. 122C-53; 131E-67; 143B-147;
Eff. February 1, 1991.

SECTION .0300 – DISCLOSURE OF CONFIDENTIAL INFORMATION WITHOUT CONSENT

10A NCAC 26B .0301 NOTICE TO CLIENT

(a) Each area or state facility that maintains confidential information shall give written notice to the client or the legally responsible person at the time of admission that disclosure may be made of pertinent information without his expressed consent in accordance with G.S. 122C-52 through 122C-56. This notice shall be explained to the client or legally responsible person as soon as possible.

(b) The giving of notice to the client or legally responsible person shall be documented in the client record.

History Note: Authority G.S. 122C-52; 131E-67; 143B-147;
Eff. July 1, 1979;
Amended Eff. March 1, 1990; February 1, 1986; July 15, 1980.

10A NCAC 26B .0302 PERSONS DESIGNATED TO DISCLOSE CONFIDENTIAL INFORMATION

The area or state facility director shall be responsible for the disclosure of confidential information but may delegate the authority for disclosure to other persons under his supervision. Such delegation shall be in writing.

History Note: Authority G.S. 122C-52; 131E-67; 143B-147;
Eff. July 1, 1979;
Amended Eff. March 1, 1990; February 1, 1986; July 15, 1980.

10A NCAC 26B .0303 DOCUMENTATION OF DISCLOSURE

History Note: Authority G.S. 122C-52; 122C-55; 131E-67; 143B-147;
Eff. July 1, 1979;
Amended Eff. March 1, 1990; February 1, 1986; July 15, 1980;
Repealed Eff. January 1, 2005.

10A NCAC 26B .0304 PROHIBITION AGAINST REDISCLOSURE

(a) Agencies disclosing confidential information pursuant to G.S. 122C-52 through G.S. 122C-56 shall inform the recipient that redisclosure of such information is prohibited without client consent.

(b) A stamp may be used to fulfill this requirement.

History Note: Authority G.S. 122C-52; 131E-67; 143B-147(a)(6);
Eff. January 1, 1984;
Amended Eff. February 1, 1986.

CLIENT RIGHTS RULES IN COMMUNITY MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

10A NORTH CAROLINA ADMINISTRATIVE CODE 27C, 27D, 27E, 27F



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SUBCHAPTER 27C – PROCEDURES AND GENERAL INFORMATION**SECTION .0100 – GENERAL POLICIES AND PROCEDURES****10A NCAC 27C .0101 SCOPE**

(a) These Rules, 10A NCAC 27C, 27D, 27E and 27F, set forth procedures governing the protection of client rights in each public or private facility that provides mental health, developmental disabilities and substance abuse services, with the exception of a state-operated facility. In addition to these Rules, the governing body shall comply with the provisions of G.S. 122C, Article 3, regarding client rights.

(b) A facility that is certified by the Centers for Medicare and Medicaid Services (CMS) as an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or a Medicare/Medicaid Hospital or a Psychiatric Residential Treatment Facility (PRTF) is deemed to be in compliance with the rules in Subchapters 27C, 27D, 27E and 27F, with the exception of Rules 27C .0102; 27D .0101; .0303; 27E .0104; .0105; .0108 and .0109.

(c) A facility that is certified as specified in Paragraph (b) of this Rule shall comply with the following:

- (1) use of the definition of physical restraint as specified in Rule .0102 Subparagraph (b)(19) of this Section;
- (2) documentation requirements as specified in 10A NCAC 27D .0303 and 10A NCAC 27E .0104; .0105; .0108 and .0109;
- (3) debriefing requirements as specified in 10A NCAC 27D .0101 and 10A NCAC 27E .0104; and
- (4) training requirements as specified in 10A NCAC 27E .0108 and .0109.

*History Note: Authority G.S. 122C-51; 131E-67; 143B-17; 143B-147;
Eff. February 1, 1991;
Amended Eff. January 1, 1992;
Temporary Amendment Eff. January 1, 2001;
Temporary Amendment Expired October 13, 2001;
Amended Eff. April 1, 2003.*

10A NCAC 27C .0102 DEFINITIONS

(a) The definitions contained in this Rule, and the terms defined in G.S. 122C-3, G.S. 122C-4 and G.S. 122C-53(f) also apply to all rules in Subchapters 27C, 27D, 27E and 27F.

(b) As used in these Rules, the following terms have the meanings specified:

- (1) "Abuse" means the infliction of mental or physical pain or injury by other than accidental means, or unreasonable confinement, or the deprivation by an employee of services which are necessary to the mental or physical health of the client. Temporary discomfort that is part of an approved and documented treatment plan or use of a documented emergency procedure shall not be considered abuse.
- (2) "Anti-psychotic medication" means the category of psychotropic drugs which is used to treat schizophrenia and related disorders. Examples of neuroleptic medications are Chlorpromazine, Thioridazine and Haloperidol.
- (3) "Basic necessity" means an essential item or substance needed to support life and health which includes, but is not limited to, a nutritionally sound balanced diet consisting of three meals per day, access to water and bathroom facilities at frequent intervals, seasonable clothing, medications prescribed by a physician, time for sleeping and frequent access to social contacts.
- (4) "Client advocate" means the term as defined in G.S. 122C-3. For the purpose of these Rules, a client advocate may be a facility employee who is not directly involved in the treatment/habilitation of a specific client, but who is assigned, in addition to other duties, to act as an advocate for that client.
- (5) "Consent" means acceptance or agreement by a client or legally responsible person following receipt of information from the qualified professional who will administer the proposed treatment or procedure. Consent implies that the client or legally responsible person was provided with sufficient information, in a manner that the client or legally responsible person can understand, concerning proposed treatment, including both benefits and risks, in order to make a decision with regard to such treatment.
- (6) "Day/night facility" means a facility wherein a service is provided on a regular basis, in a structured environment, and is offered to the same individual for a period of three or more hours within a 24-hour period.
- (7) "Director of Clinical Services" means Medical Director, Director of Medical Services, or other qualified professional designated by the governing body as the Director of Clinical Services.

- (8) "Emergency" means a situation in which a client is in imminent danger of causing abuse or injury to self or others or when substantial property damage is occurring as a result of unexpected and severe forms of inappropriate behavior and rapid intervention by the staff is needed.
- (9) "Exploitation" means the use of a client's person or property for another's profit or advantage or breach of a fiduciary relationship through improper use of a client's person or property including situations where an individual obtains money, property or services from a client from undue influence, harassment, deception or fraud.
- (10) "Facility" means the term as defined in G.S. 122C-3. For the purpose of these Rules, when more than one type of service is provided by the facility, each service shall be specifically addressed by required policy and procedures when applicable.
- (11) "Governing body" means, in the case of a corporation, the board of directors; in the case of an area authority, the area board; and in all other cases, the owner of the facility.
- (12) "Governor's Advocacy Council for Persons with Disabilities (GACPD)" means the council legislatively mandated to provide protection and advocacy systems and promote employment for all persons with disabilities in North Carolina.
- (13) "Intervention Advisory Committee" means a group established by the governing body in a facility that utilizes restrictive interventions as specified in Rule .0104 of Subchapter 27E.
- (14) "Involuntary client" means an individual who is admitted to a facility in accordance with G.S. 122C, Article 5, Parts 6 through 12.
- (15) "Isolation time-out" means the removal of a client for a period of 30 minutes or more to a separate room from which exit is barred by staff, but not locked, and where there is continuous supervision by staff, for the purpose of modifying behavior.
- (16) "Minor client" means a person under 18 years of age who has neither been married nor been emancipated by a decree issued by a court of competent jurisdiction.
- (17) "Neglect" means the failure to provide care or services necessary to maintain the mental or physical health and well-being of the client.
- (18) "Normalization" means the utilization of culturally valued resources to establish or maintain personal behaviors, experiences and characteristics that are culturally normative or valued.
- (19) "Physical Restraint" means the application or use of any manual method of restraint that restricts freedom of movement; or the application or use of any physical or mechanical device that restricts freedom of movement or normal access to one's body, including material or equipment attached or adjacent to the client's body that he or she cannot easily remove. Holding a client in a therapeutic hold or other manner that restricts his or her movement constitutes manual restraint for that client. Mechanical devices may restrain a client to a bed or chair, or may be used as ambulatory restraints. Examples of mechanical devices include cuffs, ankle straps, sheets or restraining shirts, arm splints, posey mittens, and helmets. Excluded from this definition of physical restraint are physical guidance, gentle physical prompting techniques, escorting a client who is walking; soft ties used solely to prevent a medically ill client from removing intravenous tubes, indwelling catheters, cardiac monitor electrodes, or similar medical devices; and prosthetic devices or assistive technology which are designed and used to increase client adaptive skills. Escorting means the temporary touching or holding of the hand, wrist, arm, shoulder or back for the purpose of inducing a client to walk to a safe location.
- (20) "Protective device" means an intervention that provides support for a medically fragile client or enhances the safety of a self-injurious client. Such devices may include geri-chairs or table top chairs to provide support and safety for a client with a physical handicap; devices such as seizure helmets or helmets and mittens for self-injurious behaviors; prosthetic devices or assistive technology which are designed to increase client adaptive skills; or soft ties used to prevent a medically ill client from removing intravenous tubes, indwelling catheters, cardiac monitor electrodes, or similar medical devices. As provided in Rule .0105(b) of Subchapter 27E, the use of a protective device for behavioral control shall comply with the requirements specified in Rule .0104 in Subchapter 14R.
- (21) "Privileged" means authorization through governing body procedures for a facility employee to provide specific treatment or habilitation services to clients, based on the employee's education, training, experience, competence and judgment.
- (22) "Responsible professional" means the term as defined in G.S. 122C-3 except the "responsible professional" shall also be a qualified professional as defined in Rule .0104 of Subchapter 27G.
- (23) "Restrictive intervention" means an intervention procedure which presents a risk of mental or physical harm to the client and, therefore, requires additional safeguards. Such interventions include the emergency or planned use of seclusion, physical restraint (including the use of protective devices for the purpose or with the intent of controlling unacceptable behavior), isolation time-out, and any combination thereof.

- (24) "Seclusion" means isolating a client in a separate locked room for the purpose of controlling a client's behavior.
- (25) "Treatment" means the process of providing for the physical, emotional, psychological and social needs of a client through services.
- (26) "Treatment/habilitation plan" means the term as defined in 10A NCAC 27G .0103.
- (27) "Treatment or habilitation team" means an interdisciplinary group of qualified professionals sufficient in number and variety by discipline to assess and address the identified needs of a client and which is responsible for the formulation, implementation and periodic review of the client's treatment/habilitation plan.
- (28) "24-Hour Facility" means a facility wherein service is provided to the same client on a 24-hour continuous basis, and includes residential and hospital facilities.
- (29) "Voluntary client" means an individual who is admitted to a facility upon his own application or that of the legally responsible person, in accordance with G.S. 122C, Article 5, Parts 2 through 5.

History Note: Authority G.S. 122C-3; 122C-4; 122C-51; 122C-53(f); 122C-60; 143B-147; Eff. February 1, 1991; Amended Eff. January 1, 1992; Temporary Amendment Eff. January 1, 2001; Amended Eff. August 1, 2002.

SUBCHAPTER 27D – GENERAL RIGHTS

SECTION .0100 – GENERAL POLICIES AND PROCEDURES

10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS

- (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66.
- (b) The governing body shall develop and implement policy to assure that:
 - (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and
 - (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications.
- (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies:
 - (1) any restrictive intervention that is prohibited from use within the facility; and
 - (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client.
- (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify:
 - (1) the permitted restrictive interventions or allowed restrictions;
 - (2) the individual responsible for informing the client; and
 - (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions.
- (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes:
 - (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E);
 - (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and
 - (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.
- (f) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policies which require that:
 - (1) positive alternatives and less restrictive interventions are considered and are used whenever possible prior to the use of more restrictive interventions; and

- (2) consideration is given to the client's physical and psychological well-being before, during and after utilization of a restrictive intervention, including:
 - (A) review of the client's health history or the comprehensive health assessment conducted upon admission to a facility. The health history or comprehensive health assessment shall include the identification of pre-existing medical conditions or any disabilities and limitations that would place the client at greater risk during the use of restrictive interventions;
 - (B) continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of physical restraint throughout the duration of the restrictive intervention by staff who are physically present and trained in the use of emergency safety interventions;
 - (C) continuous monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being during the use of manual restraint; and
 - (D) continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention; and
- (3) following the utilization of a restrictive intervention, staff shall conduct debriefing and planning with the client and the legally responsible person, if applicable, as specified in 10A NCAC 27E .0104, to eliminate or reduce the probability of the future use of restrictive interventions. Debriefing and planning shall be conducted, as appropriate, to the level of cognitive functioning of the client.

*History Note: Authority G.S. 122C-51; 143B-147;
Eff. February 1, 1991;
Amended Eff. January 1, 1992;
Temporary Amendment Eff. January 1, 2001;
Temporary Amendment Expired October 13, 2001;
Amended Eff. April 1, 2003.*

10A NCAC 27D .0102 SUSPENSION AND EXPULSION POLICY

- (a) Each client shall be free from threat or fear of unwarranted suspension or expulsion from the facility.
- (b) The governing body shall develop and implement policy for suspension or expelling a client from a service. The policy shall address the criteria to be used for an suspension, expulsion or other discharge not mutually agreed upon and shall establish documentation requirements that include:
 - (1) the specific time and conditions for resuming services following suspension;
 - (2) efforts by staff of the facility to identify an alternative service to meet the client's needs and designation of such service; and
 - (3) the discharge plan, if any.

*History Note: Authority G.S. 122C-51; 143B-147;
Eff. February 1, 1991;
Amended Eff. January 1, 1992.*

10A NCAC 27D .0103 SEARCH AND SEIZURE POLICY

- (a) Each client shall be free from unwarranted invasion of privacy.
- (b) The governing body shall develop and implement policy that specifies the conditions under which searches of the client or his living area may occur, and if permitted, the procedures for seizure of the client's belongings, or property in the possession of the client.
- (c) Every search or seizure shall be documented. Documentation shall include:
 - (1) scope of search;
 - (2) reason for search;
 - (3) procedures followed in the search;
 - (4) a description of any property seized; and
 - (5) an account of the disposition of seized property.

*History Note: Authority G.S. 122C-51; 143B-147;
Eff. February 1, 1991;
Amended Eff. January 1, 1992.*

10A NCAC 27D .0104 PERIODIC INTERNAL REVIEW

- (a) The governing body shall assure the conduct, no less than every three years, of a compliance review in each of its facilities regarding the implementation of Client Rights Rules as specified in 10A NCAC 27C, 27D, 27E and 27F.
- (b) The review shall assure that:
- (1) there is compliance with applicable provisions of the federal law governing advocacy services to the mentally ill, as specified in the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (Public Law 99-319) and amended by Public Law 100-509 (1988); and
 - (2) there is compliance with applicable provisions of the federal laws governing advocacy services to the developmentally disabled, the Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. 6000 et. seq.
- (c) The governing body shall maintain the three most recent written reports of the findings of such reviews.

*History Note: Authority G.S. 122C-51; 143B-147;
Eff. February 1, 1991;
Amended Eff. January 1, 1992.*

SECTION .0200 -INFORMING CLIENTS AND STAFF OF RIGHTS**10A NCAC 27D .0201 INFORMING CLIENTS**

- (a) A written summary of client rights as specified in G.S. 122C, Article 3 shall be made available to each client and legally responsible person.
- (b) Each client shall be informed of his right to contact the Governor's Advocacy Council for Persons with Disabilities (GACPD), the statewide agency designated under federal and State law to protect and advocate the rights of persons with disabilities.
- (c) Each client shall be informed regarding the issues specified in Paragraph (d) and, if applicable in Paragraph (e), of this Rule, upon admission or entry into a service, or
- (1) in a facility where a day/night or periodic service is provided, within three visits; or
 - (2) in a 24-hour facility, within 72 hours. Explanation shall be in a manner consistent with the client's or legally responsible person's level of comprehension.
- (d) In each facility, the information provided to the client or legally responsible person shall include;
- (1) the rules that the client is expected to follow and possible penalties for violations of the rules;
 - (2) the client's protections regarding disclosure of confidential information, as delineated in G.S. 122C-52 through G.S. 122C-56;
 - (3) the procedure for obtaining a copy of the client's treatment/habilitation plan; and
 - (4) governing body policy regarding:
 - (A) fee assessment and collection practices for treatment/habilitation services;
 - (B) grievance procedures including the individual to contact and a description of the assistance the client will be provided;
 - (C) suspension and expulsion from service; and
 - (D) search and seizure.
- (e) In addition, for the client whose treatment/habilitation is likely to include the use of restrictive interventions, or for the client in a 24-hour facility whose rights as specified in G.S. 122C-62 (b) or (d) may be restricted, the client or legally responsible person shall also be informed:
- (1) of the purposes, goals and reinforcement structure of any behavior management system that is allowed;
 - (2) of potential restrictions or the potential use of restrictive interventions;
 - (3) of notification provisions regarding emergency use of restrictive intervention procedures;
 - (4) that the legally responsible person of a minor or incompetent adult client may request notification after any occurrence of the use of restrictive intervention;
 - (5) that the competent adult client may designate an individual to receive notification, in accordance with G.S. 122C-53(a), after any occurrence of the use of restrictive intervention; and
 - (6) of notification provisions regarding the restriction of client rights as specified in G.S. 122C-62(e).
- (f) There shall be documentation in the client record that client rights have been explained.

*History Note: Authority G.S. 122C-51; 143B-147;
Eff. February 1, 1991;
Amended Eff. January 1, 1992.*

10A NCAC 27D .0202 INFORMING STAFF

The governing body shall develop and implement policy to assure that all staff are kept informed of the rights of clients as specified in 122C, Article 3, all applicable rules, and policies of the governing body. Documentation of receipt of information shall be signed by each staff member and maintained by the facility.

History Note: Authority G.S. 122C-51; 143B-147;
Eff. February 1, 1991;
Amended Eff. January 1, 1992.

SECTION .0300 - GENERAL CIVIL, LEGAL AND HUMAN RIGHTS**10A NCAC 27D .0301 SOCIAL INTEGRATION**

Each client in a day/night or 24-hour facility shall be encouraged to participate in appropriate and generally acceptable social interactions and activities with other clients and non-client members of the community. A client shall not be prohibited from such social interactions unless restricted in writing in the client record in accordance with G.S. 122C-62(e).

History Note: Authority G.S. 122C-51; 122C-62; 143B-147;
Eff. February 1, 1991;
Amended Eff. January 1, 1992.

10A NCAC 27D .0302 CLIENT SELF-GOVERNANCE

In a day/night or 24-hour facility, the governing body shall develop and implement policy which allows client input into facility governance and the development of client self-governance groups.

History Note: Authority G.S. 122C-51; 122C-58; 143B-147;
Eff. February 1, 1991;
Amended Eff. January 1, 1992.

10A NCAC 27D .0303 INFORMED CONSENT

(a) Each client, or legally responsible person, shall be informed, in a manner that the client or legally responsible person can understand, about:

- (1) the alleged benefits, potential risks, and possible alternative methods of treatment/habilitation; and
- (2) the length of time for which the consent is valid and the procedures that are to be followed if he chooses to withdraw consent. The length of time for a consent for the planned use of a restrictive intervention shall not exceed six months.

(b) A consent required in accordance with G.S. 122C-57(f) or for planned interventions specified by the rules in Subchapter 27E, Section .0100, shall be obtained in writing. Other procedures requiring written consent shall include, but are not limited to, the prescription or administration of the following drugs:

- (1) Antabuse; and
- (2) Depo-Provera when used for non-FDA approved uses

(c) Each voluntary client or legally responsible person has the right to consent or refuse treatment/habilitation in accordance with G.S. 122C-57(d). A voluntary client's refusal of consent shall not be used as the sole grounds for termination or threat of termination of service unless the procedure is the only viable treatment/habilitation option available at the facility.

(d) Documentation of informed consent shall be placed in the client's record.

History Note: Authority G.S. 122C-51; 122C-57; 143B-147;
Eff. February 1, 1991;
Amended Eff. January 4, 1993; January 1, 1992;
Temporary Amendment Eff. January 1, 2001;
Amended Eff. August 1, 2002.

10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION

- (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66.
- (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter.
- (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy.
- (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.
- (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.

History Note: Authority G.S. 122C-59; 122C-65; 122C-66; 143B-147;
 Eff. February 1, 1991;
 Amended Eff. April 1, 1994; January 1, 1992.

SUBCHAPTER 27E – TREATMENT OR HABILITATION RIGHTS**SECTION .0100 – PROTECTIONS REGARDING INTERVENTIONS PROCEDURES****10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE**

- (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include:
 - (1) using the least restrictive and most appropriate settings and methods;
 - (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others;
 - (3) providing choices of activities meaningful to the clients served/supported; and
 - (4) sharing of control over decisions with the client/legally responsible person and staff.
- (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include:
 - (1) using the intervention as a last resort; and
 - (2) employing the intervention by people trained in its use.

History Note: Authority G.S. 122C-51; 122C-53; 143B-147;
 Eff. February 1, 1991;
 Amended Eff. January 1, 1992;
 Temporary Amendment Eff. January 1, 2001;
 Amended Eff. August 1, 2002.

10A NCAC 27E .0102 PROHIBITED PROCEDURES

In each facility the following types of procedures shall be prohibited:

- (1) those interventions which have been prohibited by statute or rule which shall include:
 - (a) any intervention which would be considered corporal punishment under G.S. 122C-59;
 - (b) the contingent use of painful body contact;
 - (c) substances administered to induce painful bodily reactions, exclusive of Antabuse;
 - (d) electric shock (excluding medically administered electroconvulsive therapy);
 - (e) insulin shock;

- (f) unpleasant tasting foodstuffs;
 - (g) contingent application of any noxious substances which include but are not limited to noise, bad smells or splashing with water; and
 - (h) any potentially physically painful procedure, excluding prescribed injections, or stimulus which is administered to the client for the purpose of reducing the frequency or intensity of a behavior.
- (2) those interventions determined by the governing body to be unacceptable for or prohibited from use in the facility.

History Note: Authority G.S. 122C-51; 122C-57; 122C-59; 131E-67; 143B-147;
 Eff. February 1, 1991;
 Amended Eff. January 1, 1992.

10A NCAC 27E .0103 GENERAL POLICIES REGARDING INTERVENTION PROCEDURES

(a) The following procedures shall only be employed when clinically or medically indicated as a method of therapeutic treatment:

- (1) planned non-attention to specific undesirable behaviors when those behaviors are health threatening;
- (2) contingent deprivation of any basic necessity; or
- (3) other professionally acceptable behavior modification procedures that are not prohibited by Rule .0102 of this Section or covered by Rule .0104 of this Section

(b) The determination that a procedure is clinically or medically indicated, and the authorization for the use of such treatment for a specific client, shall only be made by either a physician or a licensed practicing psychologist who has been formally trained and privileged in the use of the procedure.

History Note: Authority G.S. 122C-51; 122C-53; 122C-60; 122C-62; 131E-67; 143B-147;
 Eff. February 1, 1991;
 Amended Eff. January 1, 1992.

10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL

(a) This Rule governs the use of restrictive interventions which shall include:

- (1) seclusion;
- (2) physical restraint;
- (3) isolation time-out
- (4) any combination thereof; and
- (5) protective devices used for behavioral control.

(b) The use of restrictive interventions shall be limited to:

- (1) emergency situations, in order to terminate a behavior or action in which a client is in imminent danger of abuse or injury to self or other persons or when property damage is occurring that poses imminent risk of danger of injury or harm to self or others; or
- (2) as a planned measure of therapeutic treatment as specified in Paragraph (f) of this Rule.

(c) Restrictive interventions shall not be employed as a means of coercion, punishment or retaliation by staff or for the convenience of staff or due to inadequacy of staffing. Restrictive interventions shall not be used in a manner that causes harm or abuse.

(d) In accordance with Rule .0101 of Subchapter 27D, the governing body shall have policy that delineates the permissible use of restrictive interventions within a facility.

(e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions:

- (1) the requirement that positive and less restrictive alternatives are considered and attempted whenever possible prior to the use of more restrictive interventions;
- (2) consideration is given to the client's physical and psychological well-being before, during and after utilization of a restrictive intervention, including:
 - (A) review of the client's health history or the client's comprehensive health assessment conducted upon admission to a facility. The health history or comprehensive health assessment shall include the identification of pre-existing medical conditions or any disabilities and limitations that would place the client at greater risk during the use of restrictive interventions;

- (B) continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention by staff who are physically present and trained in the use of emergency safety interventions;
- (C) continuous monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being during the use of manual restraint; and
- (D) continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention;
- (3) the process for identifying, training, assessing competence of facility employees who may authorize and implement restrictive interventions;
- (4) the duties and responsibilities of responsible professionals regarding the use of restrictive interventions;
- (5) the person responsible for documentation when restrictive interventions are used;
- (6) the person responsible for the notification of others when restrictive interventions are used; and
- (7) the person responsible for checking the client's physical and psychological well-being and assessing the possible consequences of the use of a restrictive intervention and, in such cases there shall be procedures regarding:
 - (A) documentation if a client has a physical disability or has had surgery that would make affected nerves and bones sensitive to injury; and
 - (B) the identification and documentation of alternative emergency procedures, if needed;
- (8) any room used for seclusion or isolation time-out shall meet the following criteria:
 - (A) the room shall be designed and constructed to ensure the health, safety and well-being of the client;
 - (B) the floor space shall not be less than 50 square feet, with a ceiling height of not less than eight feet;
 - (C) the floor and wall coverings, as well as any contents of the room, shall have a one-hour fire rating and shall not produce toxic fumes if burned;
 - (D) the walls shall be kept completely free of objects;
 - (E) a lighting fixture, equipped with a minimum of a 75 watt bulb, shall be mounted in the ceiling and be screened to prevent tampering by the client;
 - (F) one door of the room shall be equipped with a window mounted in a manner which allows inspection of the entire room;
 - (G) glass in any windows shall be impact resistant and shatterproof;
 - (H) the room temperature and ventilation shall be comparable and compatible with the rest of the facility; and
 - (I) in a lockable room the lock shall be interlocked with the fire alarm system so that the door automatically unlocks when the fire alarm is activated if the room is to be used for seclusion.
- (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum:
 - (A) notation of the client's physical and psychological well-being;
 - (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior;
 - (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used;
 - (D) a description of the intervention and the date, time and duration of its use;
 - (E) a description of accompanying positive methods of intervention;
 - (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions;
 - (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and
 - (H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.
- (10) The emergency use of restrictive interventions shall be limited, as follows:
 - (A) a facility employee approved to administer emergency interventions may employ such procedures for up to 15 minutes without further authorization;
 - (B) the continued use of such interventions shall be authorized only by the responsible professional or another qualified professional who is approved to use and to authorize the use of the restrictive intervention based on experience and training;

- (C) the responsible professional shall meet with and conduct an assessment that includes the physical and psychological well-being of the client and write a continuation authorization as soon as possible after the time of initial employment of the intervention. If the responsible professional or a qualified professional is not immediately available to conduct an assessment of the client, but concurs that the intervention is justified after discussion with the facility employee, continuation of the intervention may be verbally authorized until an on-site assessment of the client can be made;
 - (D) a verbal authorization shall not exceed three hours after the time of initial employment of the intervention; and
 - (E) each written order for seclusion, physical restraint or isolation time-out is limited to four hours for adult clients; two hours for children and adolescent clients ages nine to 17; or one hour for clients under the age of nine. The original order shall only be renewed in accordance with these limits or up to a total of 24 hours.
- (11) The following precautions and actions shall be employed whenever a client is in:
- (A) seclusion or physical restraint, including a protective device when used for the purpose or with the intent of controlling unacceptable behavior: periodic observation of the client shall occur at least every 15 minutes, or more often as necessary, to assure the safety of the client, attention shall be paid to the provision of regular meals, bathing and the use of the toilet; and such observation and attention shall be documented in the client record;
 - (B) isolation time-out: there shall be a facility employee in attendance with no other immediate responsibility than to monitor the client who is placed in isolation time-out; there shall be continuous observation and verbal interaction with the client when appropriate; and such observation shall be documented in the client record; and
 - (C) physical restraint and may be subject to injury: a facility employee shall remain present with the client continuously.
- (12) The use of a restrictive intervention shall be discontinued immediately at any indication of risk to the client's health or safety or immediately after the client gains behavioral control. If the client is unable to gain behavioral control within the time frame specified in the authorization of the intervention, a new authorization must be obtained.
- (13) The written approval of the designee of the governing body shall be required when the original order for a restrictive intervention is renewed for up to a total of 24 hours in accordance with the limits specified in Item (E) of Subparagraph (e)(10) of this Rule.
- (14) Standing orders or PRN orders shall not be used to authorize the use of seclusion, physical restraint or isolation timeout.
- (15) The use of a restrictive intervention shall be considered a restriction of the client's rights as specified in G.S. 122C-62(b) or (d). The documentation requirements in this Rule shall satisfy the requirements specified in G.S. 122C-62(e) for rights restrictions.
- (16) When any restrictive intervention is utilized for a client, notification of others shall occur as follows:
- (A) those to be notified as soon as possible but within 24 hours of the next working day, to include:
 - (i) the treatment or habilitation team, or its designee, after each use of the intervention; and
 - (ii) a designee of the governing body; and
 - (B) the legally responsible person of a minor client or an incompetent adult client shall be notified immediately unless she/he has requested not to be notified.
- (17) The facility shall conduct reviews and reports on any and all use of restrictive interventions, including:
- (A) a regular review by a designee of the governing body, and review by the Client Rights Committee, in compliance with confidentiality rules as specified in 10A NCAC 28A;
 - (B) an investigation of any unusual or possibly unwarranted patterns of utilization; and
 - (C) documentation of the following shall be maintained on a log:
 - (i) name of the client;
 - (ii) name of the responsible professional;
 - (iii) date of each intervention;
 - (iv) time of each intervention;
 - (v) type of intervention;
 - (vi) duration of each intervention;
 - (vii) reason for use of the intervention;
 - (viii) positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used;

- (ix) debriefing and planning conducted with the client, legally responsible person, if applicable, and staff, as specified in Parts (e)(9)(F) and (G) of this Rule, to eliminate or reduce the probability of the future use of restrictive interventions; and
 - (x) negative effects of the restrictive intervention, if any, on the physical and psychological well-being of the client.
- (18) The facility shall collect and analyze data on the use of seclusion and physical restraint. The data collected and analyzed shall reflect for each incident:
- (A) the type of procedure used and the length of time employed;
 - (B) alternatives considered or employed; and
 - (C) the effectiveness of the procedure or alternative employed.
- The facility shall analyze the data on at least a quarterly basis to monitor effectiveness, determine trends and take corrective action where necessary. The facility shall make the data available to the Secretary upon request.
- (19) Nothing in this Rule shall be interpreted to prohibit the use of voluntary restrictive interventions at the client's request; however, the procedures in this Rule shall apply with the exception of Subparagraph (f)(3) of this Rule.
- (f) The restrictive intervention shall be considered a planned intervention and shall be included in the client's treatment/habilitation plan whenever it is used:
- (1) more than four times, or for more than 40 hours, in a calendar month;
 - (2) in a single episode in which the original order is renewed for up to a total of 24 hours in accordance with the limit specified in Item (E) of Subparagraph (e)(10) of this Rule; or
 - (3) as a measure of therapeutic treatment designed to reduce dangerous, aggressive, self-injurious or undesirable behaviors to a level which will allow the use of less restrictive treatment or habilitation procedures.
- (g) When a restrictive intervention is used as a planned intervention, facility policy shall specify:
- (1) the requirement that a consent or approval shall be considered valid for no more than six months and that the decision to continue the specific intervention shall be based on clear and recent behavioral evidence that the intervention is having a positive impact and continues to be needed;
 - (2) prior to the initiation or continued use of any planned intervention, the following written notifications, consents and approvals shall be obtained and documented in the client record:
 - (A) approval of the plan by the responsible professional and the treatment and habilitation team, if applicable, shall be based on an assessment of the client and a review of the documentation required by Subparagraph (e)(9) and (e)(14) of this Rule if applicable;
 - (B) consent of the client or legally responsible person, after participation in treatment planning and after the specific intervention and the reason for it have been explained in accordance with 10A NCAC 27D .0201;
 - (C) notification of an advocate/client rights representative that the specific intervention has been planned for the client and the rationale for utilization of the intervention; and
 - (D) physician approval, after an initial medical examination, when the plan includes a specific intervention with reasonably foreseeable physical consequences. In such cases, periodic planned monitoring by a physician shall be incorporated into the plan.
 - (3) within 30 days of initiation of the use of a planned intervention, the Intervention Advisory Committee established in accordance with Rule .0106 of this Section, by majority vote, may recommend approval or disapproval of the plan or may abstain from making a recommendation;
 - (4) within any time during the use of a planned intervention, if requested, the Intervention Advisory Committee shall be given the opportunity to review the treatment/habilitation plan;
 - (5) if any of the persons or committees specified in Subparagraphs (h)(2) or (h)(3) of this Rule do not approve the initial use or continued use of a planned intervention, the intervention shall not be initiated or continued. Appeals regarding the resolution of any disagreement over the use of the planned intervention shall be handled in accordance with governing body policy; and

- (6) documentation in the client record regarding the use of a planned intervention shall indicate:
 - (A) description and frequency of debriefing with the client, legally responsible person, if applicable, and staff if determined to be clinically necessary. Debriefing shall be conducted as to the level of cognitive functioning of the client;
 - (B) bi-monthly evaluation of the planned by the responsible professional who approved the planned intervention; and
 - (C) review, at least monthly, by the treatment/habilitation team that approved the planned intervention.

History Note: Authority G.S. 122C-51; 122C-53; 122C-60; 122C-62; 131E-67; 143B-147; Eff. February 1, 1991; Amended Eff. January 4, 1993; January 1, 1992; Temporary Amendment Eff. January 1, 2001; Temporary Amendment Expired October 13, 2001; Amended Eff. April 1, 2003.

10A NCAC 27E .0105 PROTECTIVE DEVICES

(a) Whenever a protective device is utilized for a client, the governing body shall develop and implement policy to ensure that:

- (1) the necessity for the protective device has been assessed and the device is applied by a facility employee who has been trained and has demonstrated competence in the utilization of protective devices;
- (2) the use of positive and less restrictive alternatives have been reviewed and documented and the protective device selected is the appropriate measure;
- (3) the client is frequently observed and provided opportunities for toileting, exercise, etc. as needed. When a protective device limits the client's freedom of movement, the client shall be observed at least every hour. Whenever the client is restrained and subject to injury by another client, a facility employee shall remain present with the client continuously. Observations and interventions shall be documented in the client record;
- (4) protective devices are cleaned at regular intervals; and
- (5) for facilities operated by or under contract with an area program, the utilization of protective devices in the treatment/habilitation plan shall be subject to review by the Client Rights Committee, as required in 10A NCAC 27G .0504. Copies of this Rule and other pertinent rules are published as Division publication RULES FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES, APSM 30-1, and may be purchased at a cost of five dollars and seventy-five cents (\$5.75) per copy.

(b) The use of any protective device for the purpose or with the intent of controlling unacceptable behavior shall comply with the requirements of Rule .0104 of this Section.

History Note: Authority G.S. 122C-51; 122C-53; 122C-60; 143B-147; Eff. February 1, 1991; Amended Eff. January 4, 1993; January 1, 1992; Temporary Amendment Eff. January 1, 2001; Amended Eff. August 1, 2002.

10A NCAC 27E .0106 INTERVENTION ADVISORY COMMITTEES

(a) An Intervention Advisory Committee shall be established to provide additional safeguards in a facility that utilizes restrictive interventions as planned interventions as specified in Rule .0104(g) of this Section.

(b) The membership of the Intervention Advisory Committee shall include at least one person who is or has been a consumer of direct services provided by the governing body or who is a close relative of a consumer and:

- (1) for a facility operated by an area program, the Intervention Advisory Committee shall be the Client Rights Committee or a subcommittee of it, which may include other members;
- (2) for a facility that is not operated by an area program, but for which a voluntary client rights or human rights committee has been appointed by the governing body, the Intervention Advisory Committee shall be that committee or a subcommittee of it, which may include other members; or
- (3) for a facility that does not meet the conditions of Subparagraph (b)(1) or (2), the committee shall include at least three citizens who are not employees of, or members of the governing body.

- (c) The Intervention Advisory Committee specified in Subparagraphs (b)(2) or (3) shall have a member or a regular independent consultant who is a professional with training and expertise in the use of the type of interventions being utilized, and who is not directly involved in the treatment or habilitation of the client.
- (d) The Intervention Advisory Committee shall:
- (1) have policy that governs its operation and requirements that:
 - (A) access to client information shall be given only when necessary for committee members to perform their duties;
 - (B) committee members shall have access to client records on a need to know basis only upon the written consent of the client or his legally responsible person as specified in G.S. 122C-53(a); and
 - (C) information in the client record shall be treated as confidential information in accordance with G.S. 122C-52 through 122C-56;
 - (2) receive specific training and orientation as to the charge of the committee;
 - (3) be provided with copies of appropriate statutes and rules governing client rights and related issues;
 - (4) be provided, when available, with copies of literature about the use of a proposed intervention and any alternatives;
 - (5) maintain minutes of each meeting; and
 - (6) make an annual written report to the governing body on the activities of the committee.

*History Note: Authority G.S. 122C-51 through 122C-56; 143B-147;
Eff. February 1, 1991;
Amended Eff. January 1, 1992.*

10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS

- (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.
- (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented.
- (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.
- (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
- (e) Formal refresher training must be completed by each service provider periodically (minimum annually).
- (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.
- (g) Staff shall demonstrate competence in the following core areas:
- (1) knowledge and understanding of the people being served;
 - (2) recognizing and interpreting human behavior;
 - (3) recognizing the effect of internal and external stressors that may affect people with disabilities;
 - (4) strategies for building positive relationships with persons with disabilities;
 - (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;
 - (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;
 - (7) skills in assessing individual risk for escalating behavior;
 - (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and
 - (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).
- (h) Service providers shall maintain documentation of initial and refresher training for at least three years.
- (1) Documentation shall include:
 - (A) who participated in the training and the outcomes (pass/fail);
 - (B) when and where they attended; and
 - (C) instructor's name;
 - (2) The Division of MH/DD/SAS may review/request this documentation at any time.
- (i) Instructor Qualifications and Training Requirements:
- (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.
 - (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.

- (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
- (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.
- (5) Acceptable instructor training programs shall include but are not limited to presentation of:
 - (A) understanding the adult learner;
 - (B) methods for teaching content of the course;
 - (C) methods for evaluating trainee performance; and
 - (D) documentation procedures.
- (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.
- (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.
- (8) Trainers shall complete a refresher instructor training at least every two years.
- (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.
 - (1) Documentation shall include:
 - (A) who participated in the training and the outcomes (pass/fail);
 - (B) when and where attended; and
 - (C) instructor's name.
 - (2) The Division of MH/DD/SAS may request and review this documentation any time.
- (k) Qualifications of Coaches:
 - (1) Coaches shall meet all preparation requirements as a trainer.
 - (2) Coaches shall teach at least three times the course which is being coached.
 - (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.
- (l) Documentation shall be the same preparation as for trainers.

*History Note: Authority G.S. 143B-147;
 Temporary Adoption Eff. February 1, 2001;
 Temporary Adoption Expired October 13, 2001;
 Eff. April 1, 2003.*

10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT

- (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually.
- (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated.
- (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions.
- (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
- (e) Formal refresher training must be completed by each service provider periodically (minimum annually).
- (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.
- (g) Acceptable training programs shall include, but are not limited to, presentation of:
 - (1) refresher information on alternatives to the use of restrictive interventions;
 - (2) guidelines on when to intervene (understanding imminent danger to self and others);
 - (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);
 - (4) strategies for the safe implementation of restrictive interventions;
 - (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;
 - (6) prohibited procedures;
 - (7) debriefing strategies, including their importance and purpose; and
 - (8) documentation methods/procedures.

- (h) Service providers shall maintain documentation of initial and refresher training for at least three years.
- (1) Documentation shall include:
 - (A) who participated in the training and the outcomes (pass/fail);
 - (B) when and where they attended; and
 - (C) instructor's name.
 - (2) The Division of MH/DD/SAS may review/request this documentation at any time.
- (i) Instructor Qualification and Training Requirements:
- (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.
 - (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out.
 - (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
 - (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
 - (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule.
 - (6) Acceptable instructor training programs shall include, but not be limited to, presentation of:
 - (A) understanding the adult learner;
 - (B) methods for teaching content of the course;
 - (C) evaluation of trainee performance; and
 - (D) documentation procedures.
 - (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule.
 - (8) Trainers shall be currently trained in CPR.
 - (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach.
 - (10) Trainers shall teach a program on the use of restrictive interventions at least once annually.
 - (11) Trainers shall complete a refresher instructor training at least every two years.
- (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.
- (1) Documentation shall include:
 - (A) who participated in the training and the outcome (pass/fail);
 - (B) when and where they attended; and
 - (C) instructor's name.
 - (2) The Division of MH/DD/SAS may review/request this documentation at any time.
- (l) Qualifications of Coaches:
- (1) Coaches shall meet all preparation requirements as a trainer.
 - (2) Coaches shall teach at least three times, the course which is being coached.
 - (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.
- (m) Documentation shall be the same preparation as for trainers.

*History Note: Authority G.S. 143B-147;
 Temporary Adoption Eff. February 1, 2001;
 Temporary Adoption Expired October 13, 2001;
 Eff. April 1, 2003.*

SECTION .0200 - PROTECTIONS REGARDING MEDICATIONS

10A NCAC 27E .0201 SAFEGUARDS REGARDING MEDICATIONS

(a) The use of experimental drugs or medication shall be considered research and shall be governed by G.S. 122C-57(f), applicable federal law, licensure requirements codified in 10A NCAC 27G .0209, or any other applicable licensure requirements not inconsistent with state or federal law.

(b) The use of other drugs or medications as a treatment measure shall be governed by G.S. 122C-57, and G.S. 90, Articles 1, 4A and 9A.

History Note: Authority G.S. 122C-51; 122C-57; 131E-67; 143B-147;
Eff. February 1, 1991;
Amended Eff. January 1, 1992.

SUBCHAPTER 27F - 24-HOUR FACILITIES

SECTION .0100 - SPECIFIC RULES FOR 24-HOUR FACILITIES

10A NCAC 27F .0101 SCOPE

Article 3, Chapter 122C of the General Statutes provides specific rights for each client who receives a mental health, developmental disability, or substance abuse service. This Subchapter delineates the rules regarding those rights that apply in a 24-hour facility.

History Note: Authority G.S. 122C-51; 122C-62; 143B-147;
Eff. February 1, 1991;
Amended Eff. January 1, 1992.

10A NCAC 27F .0102 LIVING ENVIRONMENT

(a) Each client shall be provided:

- (1) an atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of clients being served; and
- (2) accessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team.

(b) Each client shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles, and with respect for the physical structure. Any restrictions on this freedom shall be carried out in accordance with governing body policy.

History Note: Authority G.S. 122C-51; 122C-62; 143B-147;
Eff. February 1, 1991;
Amended Eff. January 1, 1992.

10A NCAC 27F .0103 HEALTH, HYGIENE AND GROOMING

(a) Each client shall be assured the right to dignity, privacy and humane care in the provision of personal health, hygiene and grooming care. Such rights shall include, but need not be limited to the:

- (1) opportunity for a shower or tub bath daily, or more often as needed;
- (2) opportunity to shave at least daily;
- (3) opportunity to obtain the services of a barber or a beautician; and
- (4) provision of linens and towels, toilet paper and soap for each client and other individual personal hygiene articles for each indigent client. Such other articles include but are not limited to toothpaste, toothbrush, sanitary napkins, tampons, shaving cream and shaving utensil.

- (b) Bathtubs or showers and toilets which ensure individual privacy shall be available.
- (c) Adequate toilets, lavatory and bath facilities equipped for use by a client with a mobility impairment shall be available.

*History Note: Authority G.S. 122C-51; 122C-62; 143B-147;
Eff. February 1, 1991;
Amended Eff. January 1, 1992.*

10A NCAC 27F .0104 STORAGE AND PROTECTION OF CLOTHING AND POSSESSIONS

Facility employees shall make every effort to protect each client's personal clothing and possessions from theft, damage, destruction, loss, and misplacement. This includes, but is not limited to, assisting the client in developing and maintaining an inventory of clothing and personal possessions if the client or legally responsible person desires.

*History Note: Authority G.S. 122C-62; 143B-147;
Eff. February 1, 1991;
Amended Eff. January 1, 1992.*

10A NCAC 27F .0105 CLIENT'S PERSONAL FUNDS

(a) This Rule applies to any 24-hour facility which typically provides residential services to individual clients for more than 30 days.

(b) Each competent adult client and each minor above the age of 16 shall be assisted and encouraged to maintain or invest his money in a personal fund account other than at the facility. This shall include, but need not be limited to, investment of funds in interest-bearing accounts.

(c) If funds are managed for a client by a facility employee, management of the funds shall occur in accordance with policy and procedures that:

- (1) assure to the client the right to deposit and withdraw money;
- (2) regulate the receipt and distribution of funds in a personal fund account;
- (3) provide for the receipt of deposits made by friends, relatives or others;
- (4) provide for the keeping of adequate financial records on all transactions affecting funds on deposit in personal fund account;
- (5) assure that a client's personal funds will be kept separate from any operating funds of the facility;
- (6) provide for the deduction from a personal fund account payment for treatment or habilitation services when authorized by the client or legally responsible person upon or subsequent to admission of the client;
- (7) provide for the issuance of receipts to persons depositing or withdrawing funds; and
- (8) provide the client with a quarterly accounting of his personal fund account.

(d) Authorization by the client or legally responsible person is required before a deduction can be made from a personal fund account for any amount owed or alleged to be owed for damages done or alleged to have been done by the client:

- (1) to the facility;
- (2) an employee of the facility;
- (3) to a visitor of the facility; or
- (4) to another client of the facility.

*History Note: Authority G.S. 122C-51; 122C-58; 122C-62; 143B-147;
Eff. February 1, 1991;
Amended Eff. January 1, 1992.*



BOARD OF DIRECTORS
POLICIES & PROCEDURES

TITLE:	By-Laws
BOARD POLICY #:	BL
LINES OF BUSINESS:	Governance
RESPONSIBILITY:	Board of Directors
REFERENCE(S):	N.C.G.S. 122C
URAC STANDARDS:	N/A
APPROVAL DATE:	5/3/2012
LATEST REVISION DATE:	8/1/2019
LATEST REVIEW DATE:	09/05/2019

BOARD OF DIRECTORS BY-LAWS

**ARTICLE I
PURPOSE**

The Alliance Health Board of Directors, also known as the Board of Directors, by virtue of powers contained in Chapter 122C of the North Carolina General Statutes is responsible for comprehensive planning, budgeting, implementing and monitoring of community based mental health, developmental disabilities and substance abuse services to meet the needs of individuals in Alliance’s Catchment Area as that term is defined in the contract between NC Department of Health and Human Services (NCDHHS) and Alliance for Medicaid waiver management services. Any use of the term Board of Directors or CEO in these bylaws shall be deemed to include the Area Board, Area Authority, LME, Area Director and other such terms used in North Carolina General Statutes.

MISSION STATEMENT

To improve the health and well-being of the people we serve by ensuring highly effective, community-based support and care.

VISION STATEMENT

To be a leader in transforming the delivery of whole person care in the public sector.

VALUES STATEMENT

Accountability and Integrity: We keep the commitments we make to our stakeholders and to each other. We ensure high-quality services at a sustainable cost.

Collaboration: We actively seek meaningful and diverse partnerships to improve services and systems for the people we serve. We value communication and cooperation between team members and departments to ensure that people receive needed services and supports.

Compassion: Our work is driven by dedication to the people we serve and an understanding of the importance of community in each of our lives.

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Dignity and Respect: We value differences and seek diverse input. We strive to be inclusive and honor the culture and history of our communities and the people we serve.
Innovation: We challenge the way it’s always been done. We learn from experience to shape a better future.

ARTICLE II STRUCTURE

A. AUTHORITY

1. The Alliance Board of Directors is accountable to the citizens of the Alliance Catchment Area.
2. The powers and duties of the Board of Directors derive from General Statutes 122C-115.5 and 122C-117.
3. In addition to exercising those powers, duties, and functions set forth in 122C-115.5 and 122C-117, the Board of Director’s primary responsibilities include:
 - a. Defining services to meet the needs of citizens (within the parameters of the law) through an annual needs assessment.
 - b. Governing the organization by adopting necessary and proper policies to carry out the obligations under its contract as a Pre-paid Inpatient Health Plan (PIHP).
 - c. Evaluating quality and availability of services in meeting the needs of the population.
 - d. Providing Fiscal oversight.
 - e. Performing public relations and community advocacy functions.
 - f. Appointing a CEO in accordance with General Statute 122C-121 (d). The CEO is an employee of the Board of Directors and shall serve at the pleasure of the Board of Directors.
 - g. Evaluating annually the Chief Executive Officer for performance based on criteria established by the Secretary of NCDHHS and the Board of Directors.
 - h. Delegating responsibility to the Chief Executive Officer who shall be responsible for the appointment of employees, the implementation of the policies and programs of the Board of Directors, for compliance with the rules of the North Carolina Division for Mental Health, Developmental Disabilities and Substance Abuse Services, and NCDHHS, supervision of all employees and management of all contract providers.
 - i. Delegating to the Chief Executive Officer authority to execute contracts and agreements, where appropriate.
 - j. Maintaining open communication with the Consumer and Family Advisory Committee (CFAC).
 - k. Participate in strategic planning, including consideration of local priorities as determined by the County Commissioner Advisory Board;
 - l. Government affairs and advocacy.

B. COMPOSITION

1. The Board of Directors shall consist of twenty (20) members.
2. The Board of Directors shall work in conjunction with the Durham, Wake, Johnston and Cumberland County Commissioners.
3. The Durham and Wake County Commissioners shall appoint seven (7) members respectively, the Cumberland County Board of Commissioners will appoint four (4) members, and the Johnston County Board of Commissioners will appoint two (2) members.

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4. The Board of Directors will advertise, accept applications, interview and recommend appointments to the respective Boards of Commissioners.
5. Board of Directors membership may consist of the following:
 - a. Consumer or family member representing the interest of individuals with mental illness, intellectual or other developmental disabilities or substance abuse
 - b. CFAC member
 - c. An individual with health care expertise and experience in the fields of mental health, intellectual or other developmental disabilities or substance abuse services.
 - d. Individual with financial expertise
 - e. Individual with provider experience in a managed care environment.
6. The Board of Directors shall assure that there is at least one representative of each of the three disability categories, i.e., mental illness, intellectual/developmental disabilities and substance abuse, on the board.
7. No individual who contracts with the Board of Directors for the delivery of mental health, intellectual/developmental disabilities, or substance abuse services may serve on the Board of Directors during the period in which the contract for services is in effect.

C. TERMS AND CONDITIONS OF OFFICE

1. Terms of membership shall be for three years except any member of the Board of Directors who is a county commissioner serves on the Board in an ex officio capacity at the pleasure of the initial appointing authority, for a term not to exceed the earlier of three years or the member's service as a County Commissioner.
2. Members shall not be appointed for more than three consecutive terms.
3. Members may be removed with or without cause by the appointing authority, upon recommendation by the Executive Committee.
4. Board of Directors members may resign at any time, upon written notification to the Chairperson or the Executive Secretary of the Board of Directors.
5. Vacancies on the Board of Directors shall be filled by the County Commissioners before the end of the term of the vacated seat or within 90 days of the vacancy, whichever comes first. Appointments shall be for the remainder of the unexpired term.
6. Board of Directors members are responsible for disclosing and may not vote on any issue in which they have a direct or indirect financial interest or personal gain. All Board members are expected to exhibit high standards of ethical conduct, avoiding both actual conflict of interest and the appearance of a conflict of interest.
7. Neither Board of Directors members nor members of their families will receive preferential treatment through the Area Authority's services or operations.
8. Board of Directors members must be current with all property taxes in their respective counties.
9. Membership is based on the rules and regulations of the Board of Directors policies and all applicable North Carolina General Statutes.
10. Board of Directors members are required to comply with the Board of Directors Code of Ethics, policies and all applicable North Carolina General Statutes.
11. While Board members may be appointed because they represent a certain community, once on the Board, their responsibility is to all individuals served by Alliance.

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D. OFFICERS

1. At each final regular Board meeting of the fiscal year, the Officers of the Board of Directors shall be elected for a one-year term to begin July 1. The Officers of the Board of Directors include:
 - a. Chairperson, and
 - b. Vice-Chairperson.
2. No officer shall serve in a particular office for more than two consecutive terms.
3. Each Board of Directors member, other than County Commissioners, shall be eligible to serve as an officer.
4. Duties of officers shall be as follows:
 - a. Chairperson – this officer shall preside at all meetings and generally perform the duties of a presiding officer. The Chairperson shall appoint all Board of Directors committees.
 - b. Vice Chairperson – this officer shall be familiar with the duties of the Chairperson and be prepared to serve or preside at any meeting on any occasion where the Chairperson is unable to perform his/her duties.
 - c. Executive Secretary – The CEO (or his/her designee) shall serve as the Executive Secretary. The CEO shall not be an official member of the Board of Directors nor have a vote. As Executive Secretary, the CEO shall:
 - i. Send Board of Directors packets of information.
 - ii. Maintain a true and accurate account of all proceedings at Board of Directors meetings.
 - iii. Maintain custody of Board of Directors minutes and other records.
 - iv. Notify the County Commissioners of any vacancies on the Board of Directors or attendance compliance issues.

E. COMMITTEES

1. **STANDING COMMITTEES** - Annually, the Board of Directors Chairperson shall appoint the membership and the Chairperson of each of the Standing committees set forth below. These committees shall have the responsibility of making policy recommendations to the Board of Directors regarding matters within each committee’s designated area of concern. The composition of each committee shall comply with the applicable statute, regulation or contract requirements. The chair of any standing committee must be a member of the Board of Directors. If a non-board member having a conflict of interest is appointed to a committee, they shall be a non-voting member of the committee and as such shall not count towards establishing quorum. The Chairperson and Vice Chairperson may serve as standing alternate voting committee members on any committee those officers do not serve on. Except when so serving, the Chairperson and Vice Chairperson have no voting rights on a committee to which they are not regularly appointed. The standing committees shall be as follows:
 - a. **Finance Committee (NCGS 122C-119 (d))**
 - i. This committee shall be composed in a manner consistent with NCGS 122C-119, having at least 3 members, two of whom have expertise in budgeting and fiscal control. The Finance Officers of Durham, Cumberland, Johnston and Wake Counties or designee may serve as ex-officio members.
 - ii. The Chief Financial Officer or CEO designee will serve as staff liaison to the Committee.
 - iii. The Committee’s functions include:

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- 1) Recommending policies/practices on fiscal matters to the full Board of Directors.
- 2) Reviewing and recommending budgets to the entire Board of Directors.
- 3) Reviewing and recommending approval of audit reports (following a meeting by a designee of this committee with the auditor and receipt of the management letter) and assure corrective actions are taken as needed.
- 4) Reviewing and recommending policies and procedures for managing contracts and other purchase of service arrangements.
- 5) Reviewing financial statements at least quarterly.
- 6) Reviewing the financial strength of the Area Authority.

b. Client Rights/Human Rights Committee (DMH/DD/SAS contract and NCGS 122C-64, 10A NCAC 27G.0504)

- i. The Client Rights/Human Rights Committee shall consist of at least 5 members, a majority of whom shall be non-Board members. Members should include consumers and family members representing mental health, developmental disabilities and substance abuse. The membership of the Client Rights/Human Rights Committee shall include a representative from each of the counties in the Catchment Area.
- ii. The CEO will designate a staff liaison to the Committee.
- iii. The Client Rights/Human Rights Committee functions include:
 - 1) Reviewing and evaluating Alliance’s Client Rights policies at least annually and recommending needed revisions to the Board of Directors.
 - 2) Overseeing the protection of client rights and identifying and reporting to the Board of Directors issues which negatively impact the rights of persons served.
 - 3) Reporting to the full Board of Directors at least quarterly.
 - 4) Submitting an annual report to the Board of Directors which includes, among other things, a review of Alliance’s compliance with NCGS 122C, Article 3, DMHDDSAS Client Rights Rules (APSM 95-2) and Confidentiality Rules (APSM 45-1).
- iv. The Client Rights/Human Rights Committee shall meet at least quarterly.

c. Quality Management Committee (URAC)

- i. The Quality Management (QM) Committee shall consist of at least 5 members to include consumers or their family members plus at least 2 non-voting provider representatives. The QM Committee will meet at least 6 times a year.
- ii. The QM Director, or CEO designee, will be the staff liaison to the Committee.
- iii. The QM Committee shall review statistical data and provider monitoring reports and make recommendations to the Board of Directors or other Board committees.
- iv. The QM Committee serves as the Board’s Monitoring and Evaluation Committee charged with the review of statistical data and provider monitoring reports. The goal of the QM Committee is to ensure quality and effectiveness of services and to identify and address opportunities to improve Alliance operations and local service system with input from consumers, providers, family members, and other stakeholders.

d. Executive Committee - The Board of Directors shall have an Executive Committee. All actions taken by the Executive Committee will be reported to the full Board of Directors at the next scheduled meeting.

- i. The Executive Committee shall be composed of the current Officers of the Board of Directors, Chairpersons of standing committees (who are Board of Directors members), the immediate past Board chairperson or an at-large member in the event the immediate past Board Chairperson is not available.

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- ii. The Board of Directors Chairperson shall serve as the Chairperson of the Executive Committee.
- iii. The Chief Executive Officer, or designee will be the staff liaison to the Committee.
- iv. The Chairperson shall call the meetings of the Executive Committee. Any member of the Board of Directors may request that the Chairperson call an Executive Committee meeting.
- v. The Executive Committee shall be responsible for the following:
 - 1) Function as the grievance committee to hear complaints regarding board member conduct and make recommendations to the full Board of Directors.
 - 2) Establish agendas for full Board of Directors meetings.
 - 3) Act on matters that are time-sensitive between regularly scheduled board meetings.
 - 4) Provide feedback to the CEO concerning current issues related to services, providers, staff, etc.
 - 5) Fulfill other duties as set forth in these By-laws or as otherwise directed by the Board of Directors.
 - 6) Notice of the time and place of every Executive Committee meeting shall be given to the members of the Executive Committee in the same manner that notice is given of Board of Directors meetings.

e. Policy/By-Law Committee

- i. The Policy/By-law Committee shall consist of at least 3 Board members and shall meet at least 1 time a year.
- ii. The Chief Compliance Officer or CEO designee will be the staff liaison to the Committee.
- iii. The Policy/By-law Committee’s functions include:
 - 1) Developing, reviewing and revising Board of Directors By-Laws and Policies that Govern Alliance.
 - 2) Recommending policies to the full Board of Directors to include all functions and lines of business of Alliance.
 - 3) Reviewing Board Policies at least annually, within 12 months of policies’ approval. The Policy/By-law Committee reviews a number of Policies each quarter in order to meet the annual review requirement.
 - 4) Revising Policies to ensure compliance with applicable law, federal and state statutes, administrative rules, state policies, contractual agreements and accreditation standards.
 - 5) Ensure that a master Policy Index is kept current indicating Policy names, original approval dates, all revision dates, all review dates, accreditation standards, and references to applicable law, federal and state rules and regulations and state policies.

f. Audit and Compliance Committee

- i. The Audit and Compliance Committee will consist of at least three members of the Board of Directors. At least one member shall have financial expertise. The Chairperson of the Audit and Compliance Committee may not also be the Chairperson of the Finance Committee.
- ii. The Chief Compliance Officer or CEO designee will serve as staff liaison to the Committee.
- iii. The Committee shall meet at least three times a year, with authority to convene additional meetings, to adequately fulfill all the obligations outlined in this charter.
- iv. The purpose of the Audit and Compliance Committee is to put forth a meaningful effort to review the adequacy of existing compliance systems and functions. To assist the Board of

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Directors in fulfilling its oversight responsibilities for:

- 1) The integrity of the organization’s annual financial statements;
- 2) The system of risk assessment and internal controls;
- 3) The organization’s compliance with legal and regulatory requirements;
- 4) The independent auditor's qualifications and independence;
- 5) The performance of the organization’s internal audit function; and
- 6) To provide an avenue of communication between management, the independent auditors, and the Board of Directors.

g. Network Development & Services Committee

- i. The Network Development and Services Committee shall consist of at least three members, a majority of whom shall be members of the Board of Directors and shall meet at least quarterly.
- ii. The Executive Vice President of Network & Community Health or CEO designee will serve as staff liaison to the Committee.
- iii. The Committee’s functions include:
 - 1) To review service network development activities.
 - 2) Reviews progress on the network development plan and progress on fund balance spending on service development.
 - 3) Provides guidance and feedback on development of the needs and gaps assessment to meet state and agency requirements.
 - 4) Areas of focus may include:
 - Emerging needs and Challenges
 - Data related to the Needs and Gaps Analysis
 - Network Development Plan and Status
 - State and Federal Initiatives

2. AD HOC COMMITTEES

- a. Ad hoc committees may be appointed by the Chair of the Board of Directors with the approval of a majority of the Board members who are present at the meeting during which approval is given.
- b. These committees shall carry out their duties as designated by the Board of Directors and shall report their findings to the Board or its committees.

3. CONSUMER AND FAMILY ADVISORY COMMITTEE – Consistent with NCGS 122C-170, Alliance shall have a committee made up of consumers and family members to be known as the Consumer and Family Advisory Committee (CFAC). The Consumer and Family Advisory Committee shall be self-governing and self-directed. The CFAC shall advise the Board of Directors on the planning and management of the local mental health, intellectual/developmental disabilities and substance abuse services system.

4. COUNTY COMMISSIONER ADVISORY BOARD

Per 122C-118.2, there is a County Commissioner Advisory Board. The County Commissioner Advisory Board is not a board or committee appointed by the Board of Directors. The CEO or designee will assist in facilitation of the County Commissioner Advisory Board meetings.

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ARTICLE III MEETINGS

A. REGULAR MEETINGS

Regular meetings shall be held at least six times each year at a location and time designated by the Board of Directors. The annual meeting for the election of Officers shall be the final meeting of each fiscal year. All meetings of the Board of Directors shall be conducted in accordance with provisions set forth in N.C.G.S. 143, Article 33C (the Open Meetings Statute).

B. SPECIAL MEETINGS

Special meetings may be called by the Board Chair or by three or more members of the Board of Directors after notifying the Board Chair in writing. Notice of special meetings shall be provided in a manner consistent with those utilized to notify Board of Directors members (and others) of regularly scheduled meetings.

C. EMERGENCY MEETINGS

Emergency meetings may be called for unexpected circumstances that require immediate consideration by the Board of Directors. Due to the urgent need to assemble a meeting as soon as possible, any requirements regarding advanced notice for regularly scheduled meetings may be waived and emergency meetings shall be held as soon as a quorum of the Board of Directors can be convened.

D. NOTICE OF MEETINGS

Notification of Board of Directors meetings shall be sent out no later than 48 hours before the regular meeting and in accordance with requirements set forth in the Open Meetings Statute, Chapter 143 Article 33C. The Board of Directors is scheduled to meet on the first Thursday of each month at the designated Alliance site. Notice of the date, time and place shall be sent to each board member in the form of a Board of Directors agenda. Information concerning Board meetings shall also be made available to the local news media in accordance with Chapter 143 Article 33C. Notice for all Board meetings including the Board packet will be posted on the Alliance website.

E. CONDUCT OF MEETINGS

Board of Directors meetings shall be conducted under parliamentary procedures. It is the policy of this Board that all deliberations and actions be conducted fairly, openly, and consistent with the applicable Statutes of North Carolina. Participation in Board of Directors meetings via electronic means, e.g. telephone, video conferencing, is permissible to the extent allowed by law. Such participation includes the right to vote on issues that arise during the course of the meeting.

The following guidelines should be followed at all Board and committee meetings:

1. The Board/Committee must act as a body in the best interests of the consumers in the Alliance catchment area.
2. The Board/Committee should proceed in the most efficient manner possible.
3. The Board/Committee must act by at least a majority vote.
4. Every member must have an equal opportunity to participate in decision-making.
5. The Board/Committee must apply the rules of procedure consistently.

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F. QUORUM

A majority of the actual membership of the Board, excluding vacant seats, shall constitute a quorum and shall be required for the transaction of business at all regular, special and emergency meetings. A majority is more than half.

G. APPROVAL OF CERTAIN ITEMS BY A SUPER MAJORITY

Significant actions by the Board of Directors require affirmative votes, from-two-thirds of the actual membership of the Board, excluding vacant seats. Significant actions shall include:

- (1) any action or decisions concerning the annual budget and amendments according to the Local Government Budget and Fiscal Control Act (NCGS 159),
- (2) the selection and dismissal of the Chief Executive Officer,
- (3) changes to the Board of Directors structure,
- (4) execution of contracts for sale, purchase or leases of real property,
- (5) approval or amendment of the Board of Director’s by-laws, and,
- (6) any other matter so designated by the Board of Directors.

H. ABSENCES

- 1. Absence from three (3) consecutive Board meetings without notification to the Executive Secretary shall constitute resignation from the Board.
- 2. Absence from four (4) or more of the regularly scheduled Board meetings during a 12 month period may also constitute resignation from the Board within the discretion of the Executive Committee.
- 3. In computing absences, absence from two Board Committee meetings may constitute one absence from a regularly scheduled Board meeting.

**ARTICLE IV
GENERAL PROVISIONS**

A. AMENDMENTS

- 1. These By-Laws may be amended or repealed as necessary.
- 2. Notice of proposed changes must be given to the Board of Directors members at least thirty (30) days prior to the change.

B. SUSPENSION OF BY-LAWS

The Board of Directors has the authority to suspend the By-Laws by an affirmative vote of a majority of Board members, or a corresponding majority of Board members in the event the number of Board members changes or there are vacant seats on the Board, **with the exception of those items requiring a Super Majority set forth in Article III (G).**

C. REVIEW OF BY-LAWS AND BOARD OF DIRECTORS GOVERNANCE POLICIES

These By-Laws and all Board of Directors governance policies shall be reviewed at least annually.



Human Rights Committee Training

Human Rights Committee

- Responsible for protection of human rights
- Implemented in accordance to NC General Statute, Administrative Code and Alliance Board by-laws
- Alliance staff provide support to the committee



Committee Responsibility

- Assure human rights protections are reviewed routinely
- Compliance with human rights and advance instruction
- Assure confidentiality
- Review complaint and appeal data
- Report system issues to the Board
- Work with state and local agencies
- Report to the Board at least quarterly



Committee Demographics

- Members appointed by the Alliance Board Chair
 - Committee chaired by a Board member
- Majority of the members must not be Board Members
- 50% of members must be individuals or family members of individuals served
- Representation from each county
- Alliance staff members do not vote



Conflict of Interest & Confidentiality

Members must disclose a conflict or the appearance of a conflict

Members may not represent themselves independent

Members may not act independent on behalf of the committee

If conflict is not resolved, the Chair will submit to Board Chair for final decision



Meeting Structure

- Held quarterly
- Emergency meetings can be called
- Quorum is required to conduct meetings
 - Chair plus 50% of members
 - If quorum is not met, informal discussions may be held with unanimous consent of members present

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"Quorum? We don't even have a pair!"

Meeting Structure

- Minutes are taken
- No individual is identified in minutes or reports
- Provider-specific discussion must comply with Alliance Provider Confidentiality procedure



Sample Meeting Agenda

- Call to order
- Agenda review & approval
- Review & approve previous minutes
- Call for motions & voting as appropriate
- Adjournment



Attendance

Absence from three (3) consecutive meetings without notification to the Chair or from 25% of meetings within a 12-month period are grounds for dismissal

Attendance



Required Training

New Member Training

- NC Statues and Administrative Rules
- Conflict of Interest and Confidentiality
- Duties of the State and Alliance CFAC
- Principles of Advocacy, Self Determination & Recovery
- Customer Service Strategies

All members are trained annually on human rights issues

NC Statutes & Administrative Rules

LME/MCO Board has ultimate responsibility for assurance of human rights

Each Board establishes at least one Human Rights Committee

Each Governing Contract Agency required to establish Human Rights Committee

Board must implement policy

Committee oversees Client Rights Protections for contracted services

NC Statutes & Administrative Rules

- Nothing herein precludes authority of:
 - A county DSS to investigate abuse, neglect, or exploitation
 - Disability Rights of North Carolina to conduct investigations regarding alleged violations of member rights
- Human Right Committees established by contract agencies shall carry out the provisions of this Rule



Duties of CFAC

Alliance CFAC

- Review and comment on Alliance Program Budget
- Participate in Quality Improvement Measures & Performance Indicators
- Submit to the State, CFAC findings and recommendations to improve MH/SUD/IDD service delivery

State CFAC

- Provide input and conduct oversight of the Division's operations and efforts toward strategic outcomes
- Advises DHHS and General Assembly on planning and management of the State's public MH/SUD/IDD service system

Five Components of Self Advocacy

Personal
Responsibility

Knowledge of
the law &
other rules

Fact finding
and
documentation

Negotiating

Believing in
oneself



Responsibility of the Self Advocate

Be clear on what you need & want

Always go to meetings

Ask who is at the meeting & why

Keep all your papers

Never sign blank forms or copies

Document what happens

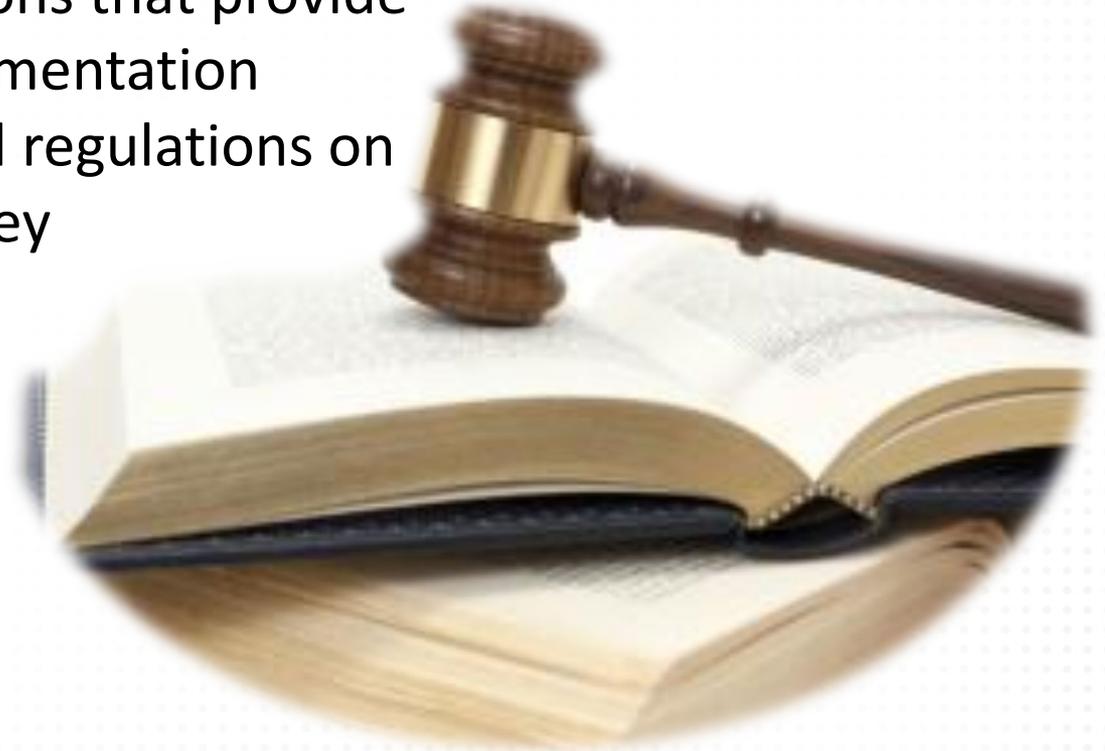
If you need help, take someone with you

Know the laws that regulate your services



State and Federal Laws

- Include definitions for eligibility and services
- Laws have regulations that provide guidance for implementation
- There are rules and regulations on how to spend money



Working with Providers

Find out if your provider has the needed specialized training

Evidence Best Practices help to justify request for services

Request written information on what your grievances/appeal rights are

Documentation and Fact Finding

Document what happens

Note times, dates and who you talked to

Write down if services aren't provided



Is it working????

Ask questions

- When, where and how often services will happen

Keep a log

- Write down when services happen

Know who to call

- If services don't occur, know your point of contact

Get it in writing

- Always ask for decisions/changes in writing

Use Communication skills

- Use telephone and meetings to gather information



Expressing Dissatisfaction



Tips for Negotiating



Self-Determination

The recognition of the right and need of individuals and their families to have the freedom to make their own choices and decisions



The Nation

- Holistic approach
- Individuals have reclaimed their lives, are productive and active members of society

RECOVERY

Alliance Service System

Managed care organization for public
MH/DD/SUD services

Services delivered by a network of Providers

Serves the citizens of Cumberland, Durham,
Johnston and Wake counties

Ensures that individuals who seek help receive
quality services and supports



Alliance Service System

Services respect & support individuals

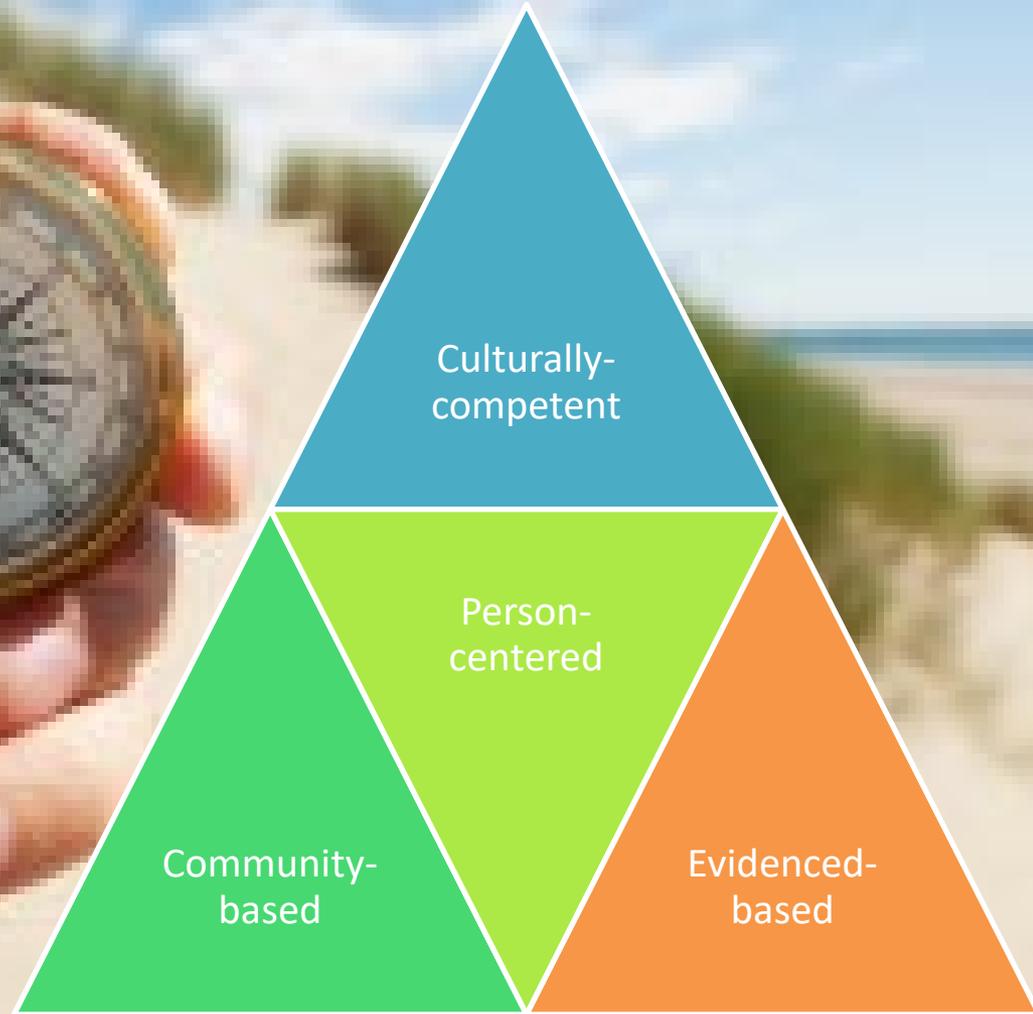
Services respond to real life needs

Services are effective

Based on a System of Care philosophy



SOC Core Values



Provider HR Committees

- Providers are required to establish HR committees
- Multiple providers can form joint committees
- Responsibilities mirror LME/MCO HR Committee



thank you



Q4 FY21
Complaint Analysis

CATEGORIES

Complaint: *(Internal and External Stakeholders)*

An expression of dissatisfaction about any matter other than decisions regarding requests for Medicaid services

Grievance:

A member or legal guardian's expression of dissatisfaction about any matter other than decisions regarding requests for Medicaid services

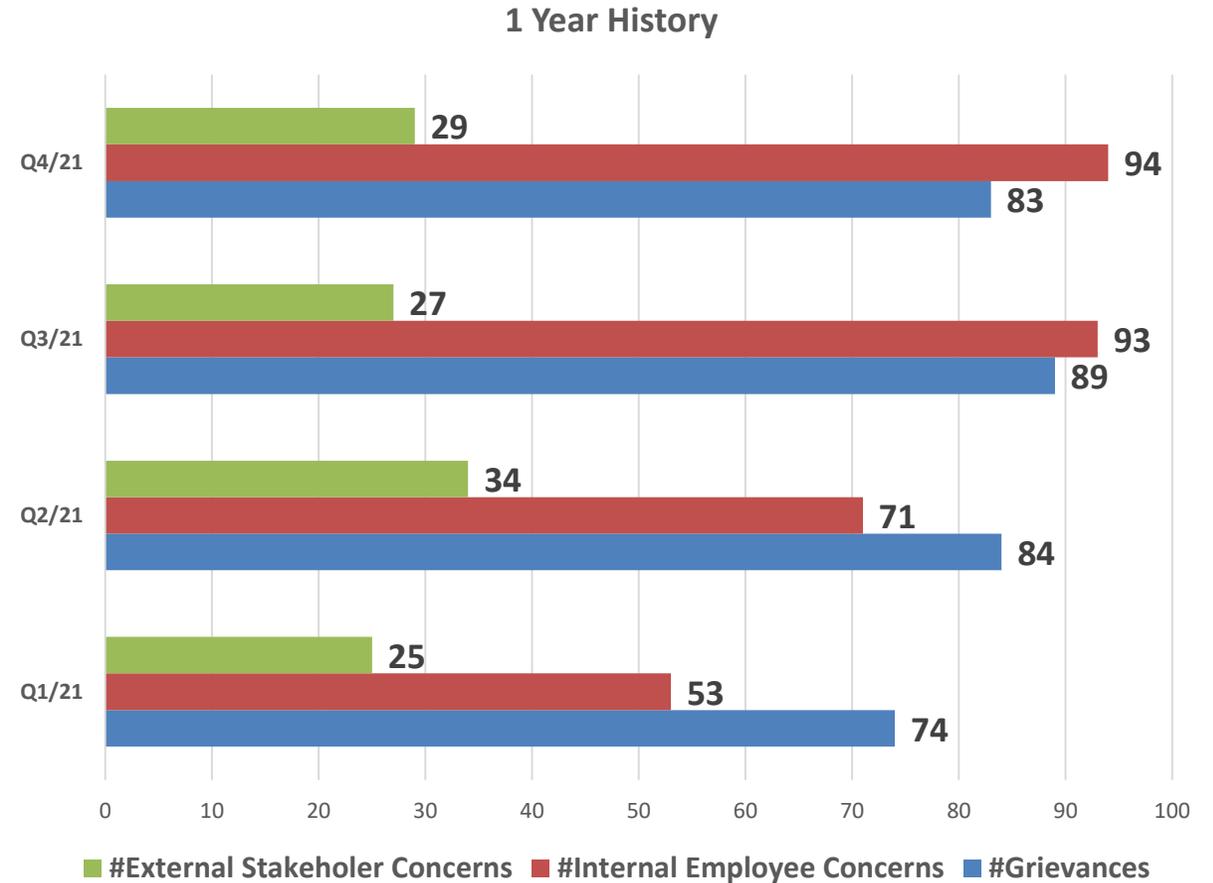
Internal Stakeholder Concern:

An Alliance staff member's expression of dissatisfaction about any matter related to service provision or Alliance functions.

Complaints and Grievances Overview

Q4 FY21 yielded 210 entries

- 83 (40%) Grievances – Members/legal guardians
- 94 (44%) Internal Employee Concerns – Alliance staff
- 29 (14%) External Stakeholder Concerns – Outside entities
- 4 (2%) Compliments

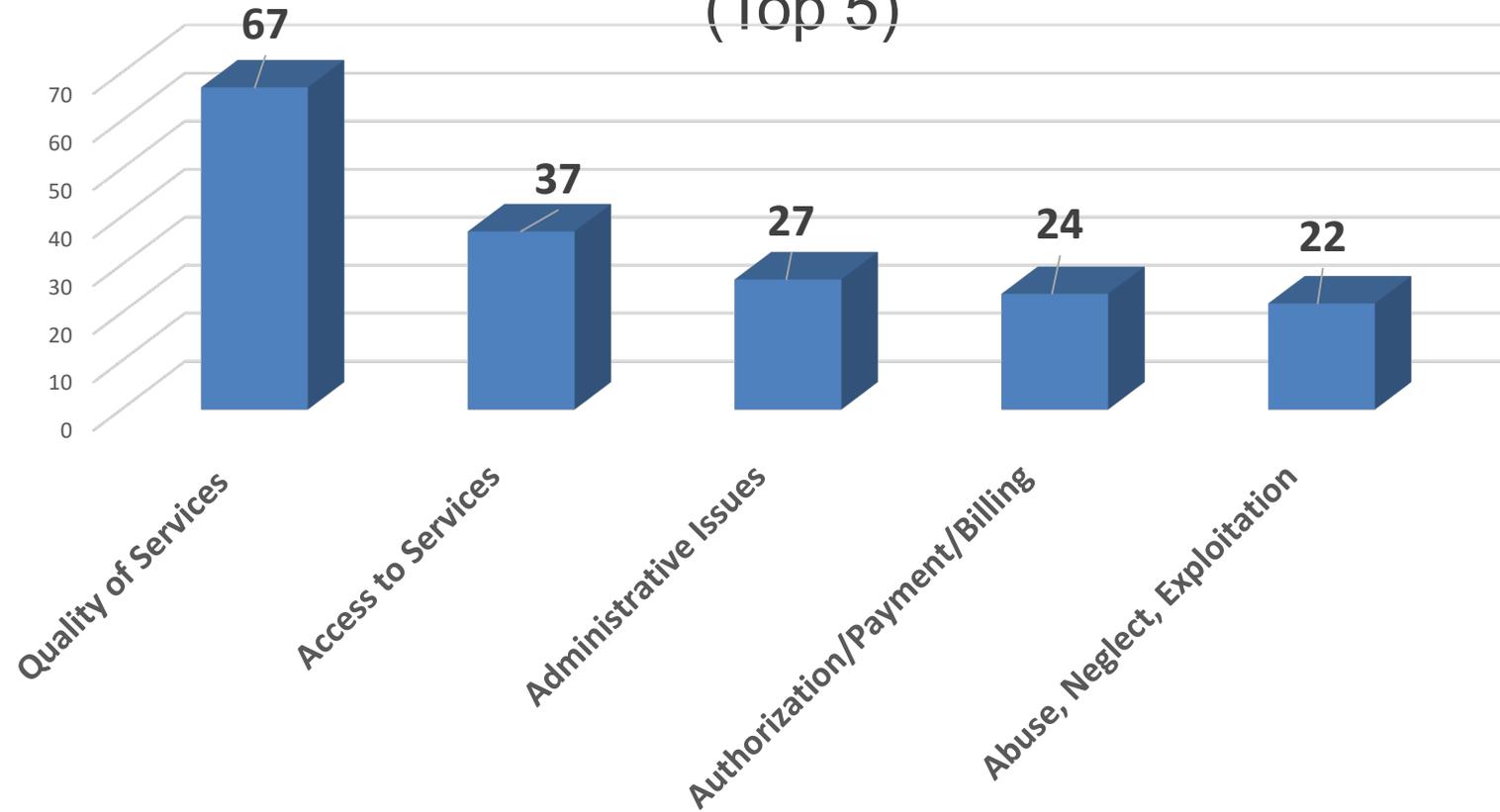


Nature of Issue Definitions

Reporting Category	Definition
Abuse, Neglect and Exploitation	Any allegation regarding the abuse, neglect and/or exploitation of a child or adult as defined in APSM 95-2 (Client Rights Rules in Community Mental Health)
Access to Services	Access to Services as any complaint where an individual is reporting that he/she has not been able to obtain services
Administrative Issues	any complaint regarding a Provider's managerial or organizational issues, deadlines, payroll, staffing, facilities, etc.
Authorization/Payment Issues/Billing PROVIDER ONLY	Any complaint regarding the payment/financial arrangement, insurance, and/or billing practices regarding providers
Basic Needs	Any complaint regarding the ability to obtain food, shelter, support, SSI, medication, transportation, etc.
Clients Rights	Any allegation regarding the violation of the rights of any consumer of mental health/developmental disabilities/substance abuse services. Clients Rights include the rights and privileges as defined in General Statutes 122C and APSM 95 -2 (Client Rights Rules in Community Mental Health)
Confidentiality/HIPAA	Any breach of a consumer's confidentiality and/or HIPAA regulations.
LME/MCO Functions	Any complaint regarding LME functions such as Governance/ Administration, Care Coordination, Utilization Management, Customer Services, etc.
LME/MCO Authorization/ Payment/Billing	Any complaint regarding the payment/financial arrangement, insurance, and/or billing practices of the LME/MCO
Provider Choice	Complaint that a consumer or legally responsible person was not given information regarding available service providers.
Quality of Care – PROVIDER ONLY	Any complaint regarding inappropriate and/or inadequate provision of services, customer services and services including medication issues regarding the administration or prescribing of medication, including the wrong time, side effects, overmedication, refills, etc.
Service Coordination between Providers	Any complaint regarding the ability of providers to coordinate services in the best interest of the consumer.
Other	Any complaint that does not fit the above areas.

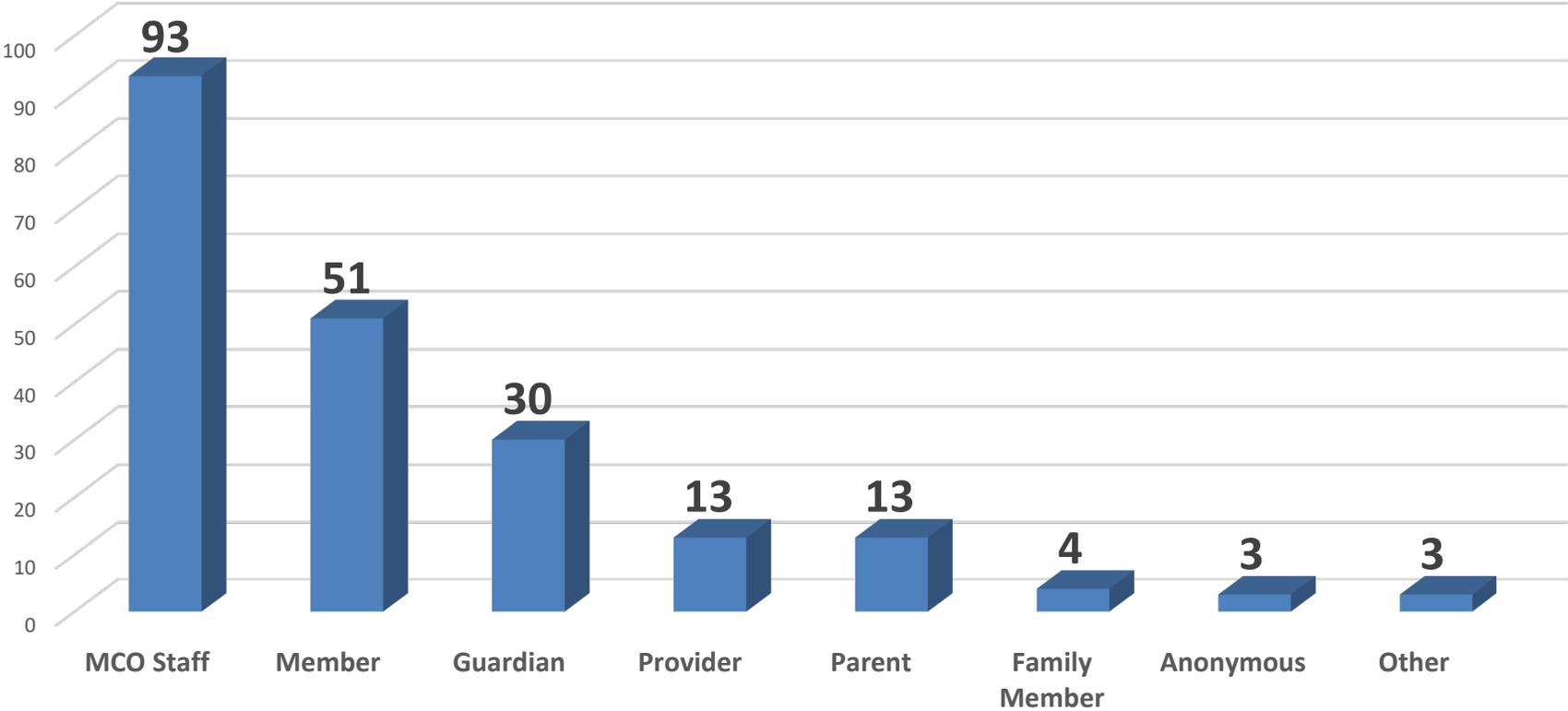
Nature of Issue/Type

(Top 5)



- **Quality of Services - 32% of all Complaints/Grievances**
- **Access to Services - 17% of all Complaints/Grievances**

Source: *Who submitted concerns?*



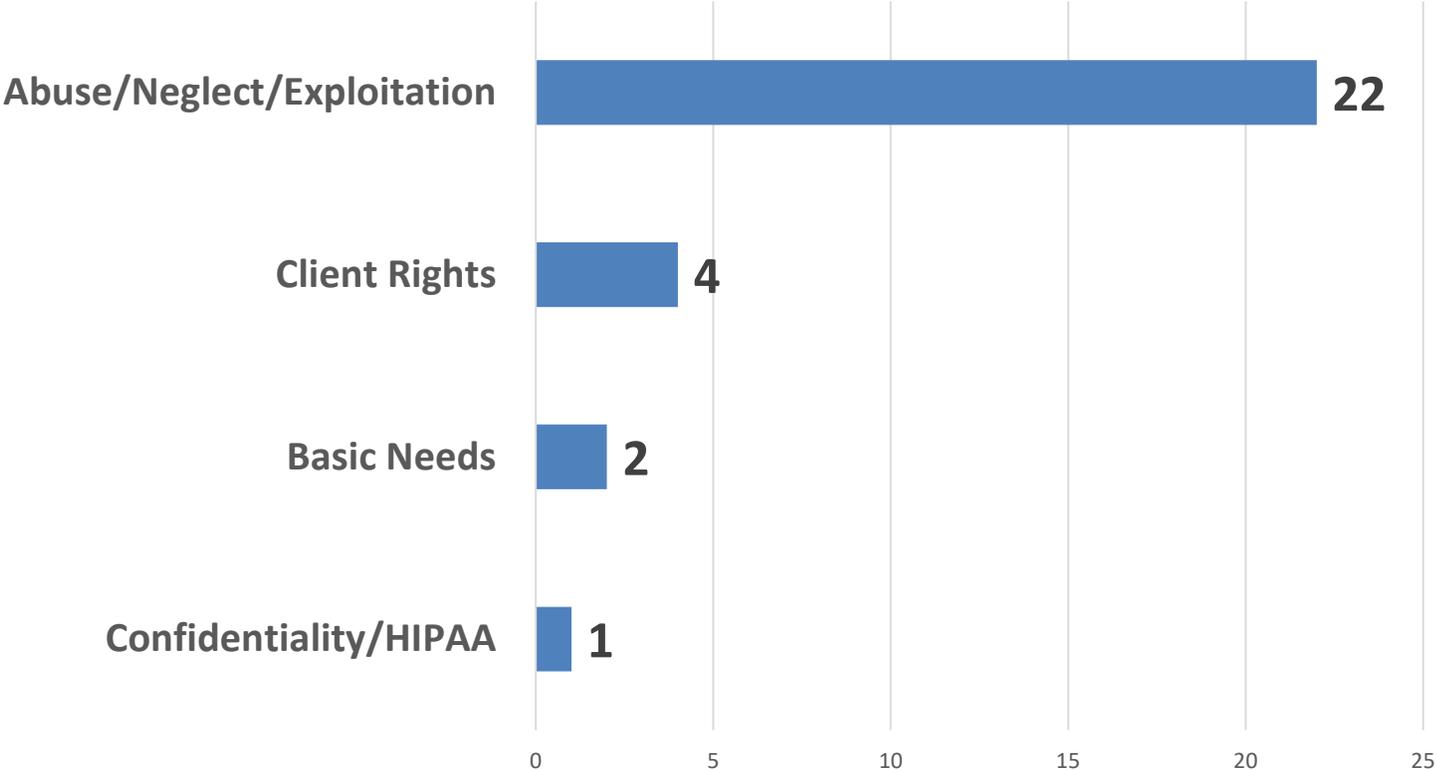
- **93 (44%) Submitted by MCO staff**
- **81 (39%) Submitted by Members or Legal Guardian (Grievances)**

Complaints Against Alliance

13 Complaints Against Alliance

	Nature of Issue	Description
18	LME/MCO Functions	<ul style="list-style-type: none">• Primarily complaints against Alliance staff
5	Authorization/Payment/Billing – LME/MCO Only	<ul style="list-style-type: none">• Reimbursement issues• Billing/Payment flexibilities during COVID

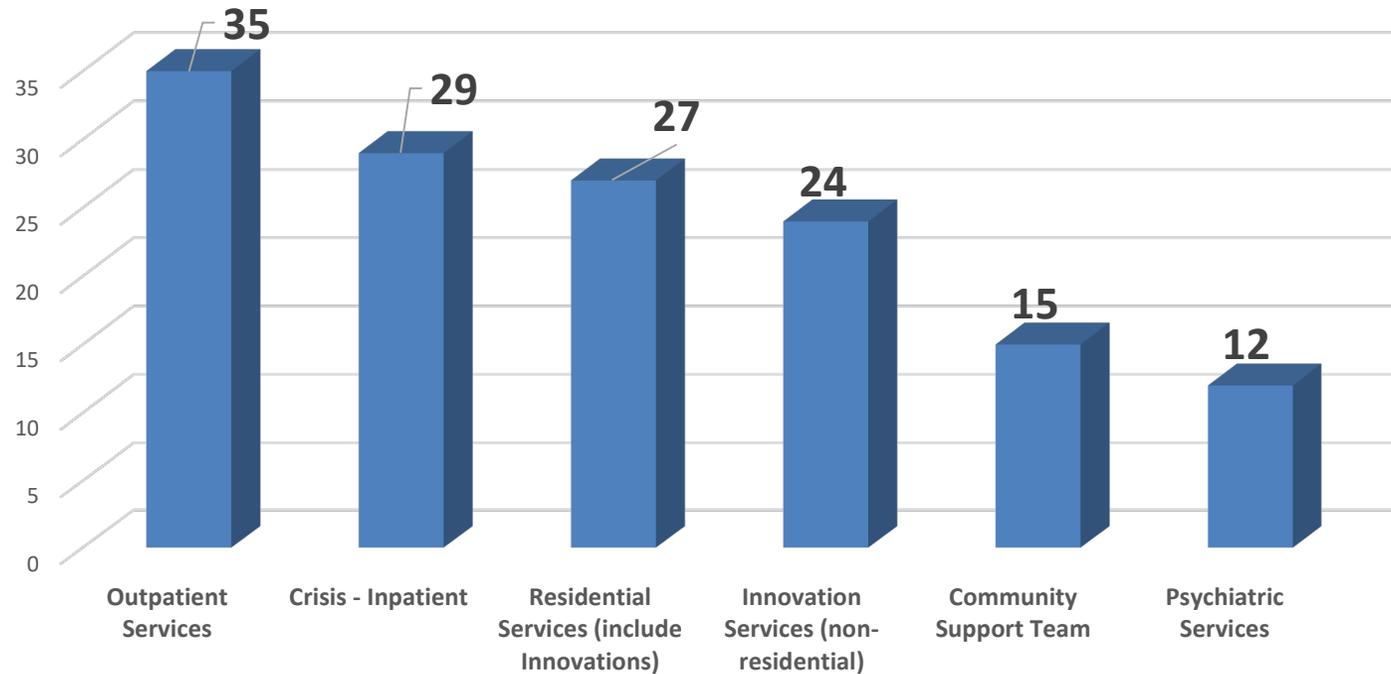
Human Rights Issue



SERVICE BREAKDOWN

Top 4 Services Overall

(10+ filings)



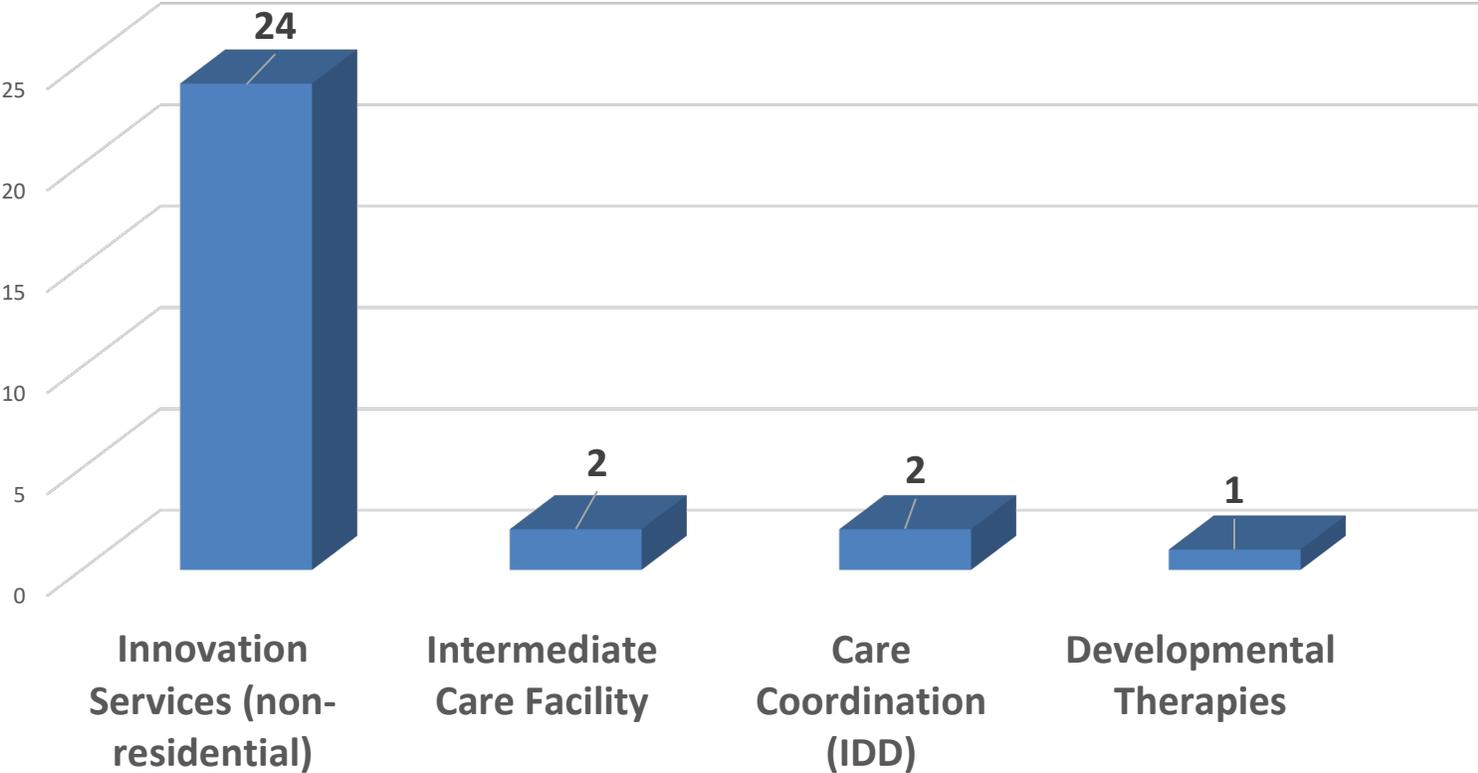
- 17% Outpatient Services

- 14% Crisis - Inpatient Services

- 13% Residential Services

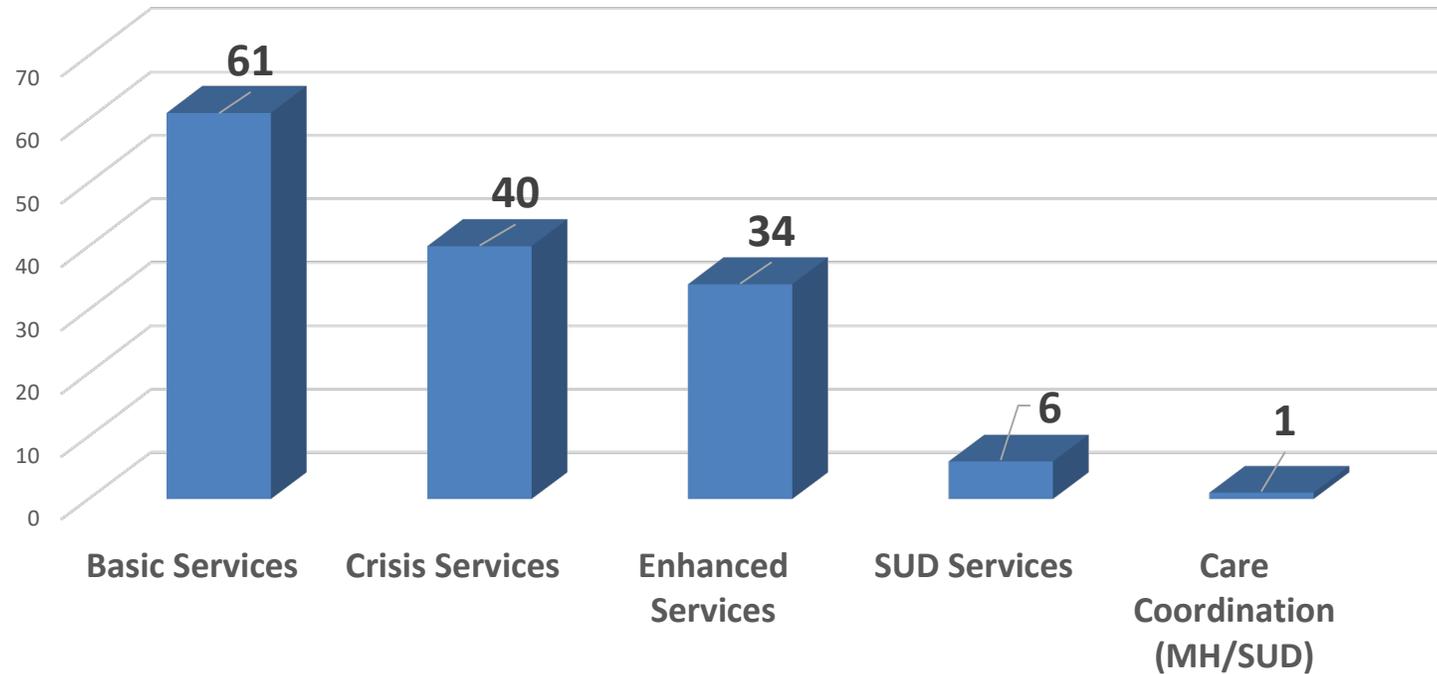
- 11% Innovations Services

IDD Services (29)



- **14% of all complaints and grievances were from IDD services**
- **83% of IDD services were Non-Residential Innovations Services**

MH/SUD (142)



- **68% of all complaints and grievances were from MH/SUD services**
- **43% of all complaints and grievances were from Basic Services**



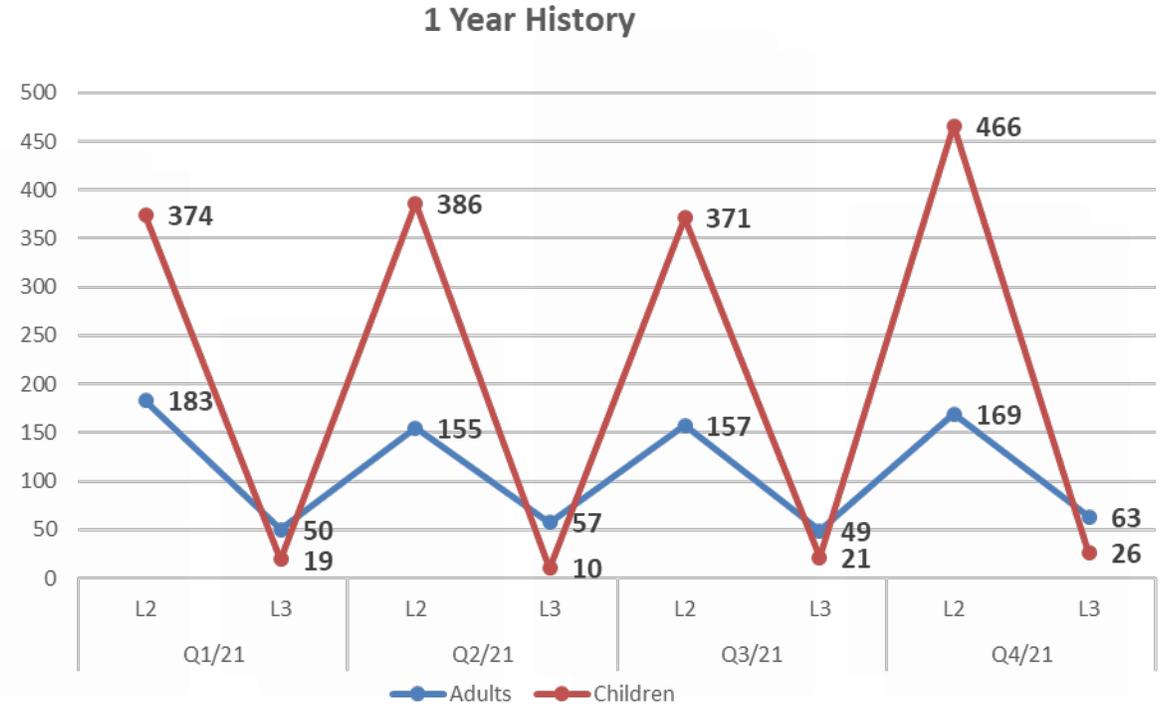
Incident Trends Report
Q4 FY21

Incident Report Breakdown

- 724 Reports were entered in to NC-IRIS for 505 members
- 492 children
- 232 adults

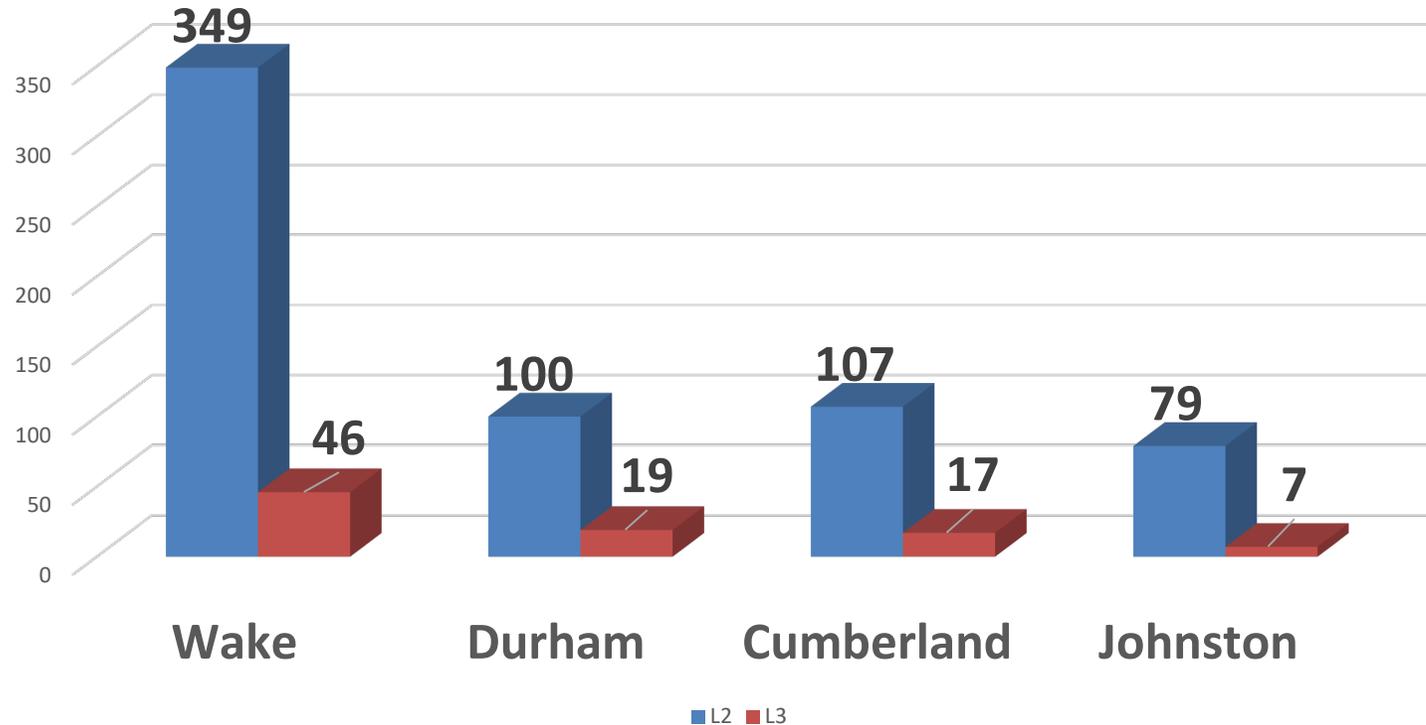
LEVELS

- 635 Level 2 reports
- 89 Level 3



Incident Levels by County

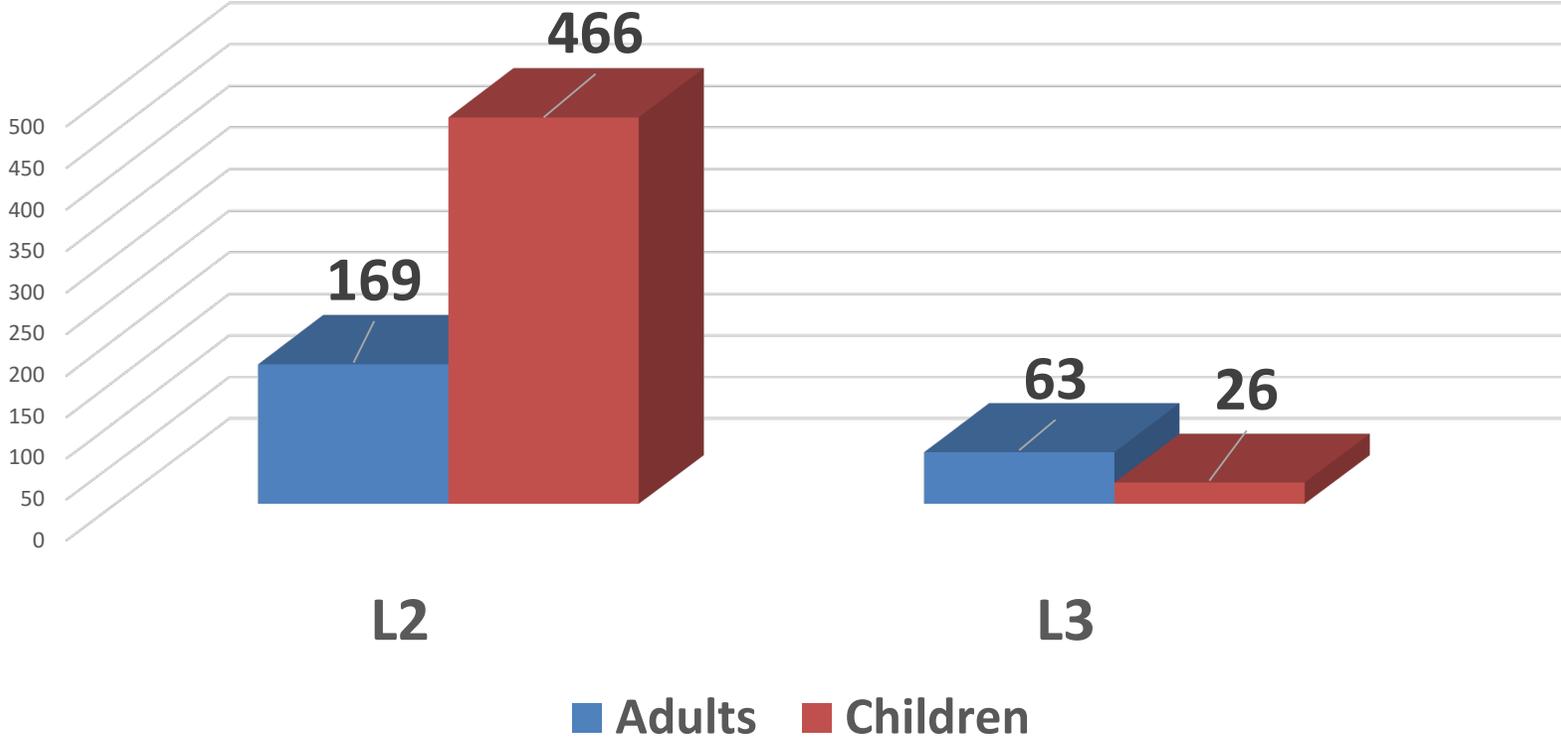
Level 2s and Level 3s



Wake County submitted the largest number of Level 2 and Level 3 reports in the 4th quarter of FY2021

Adults vs. Children

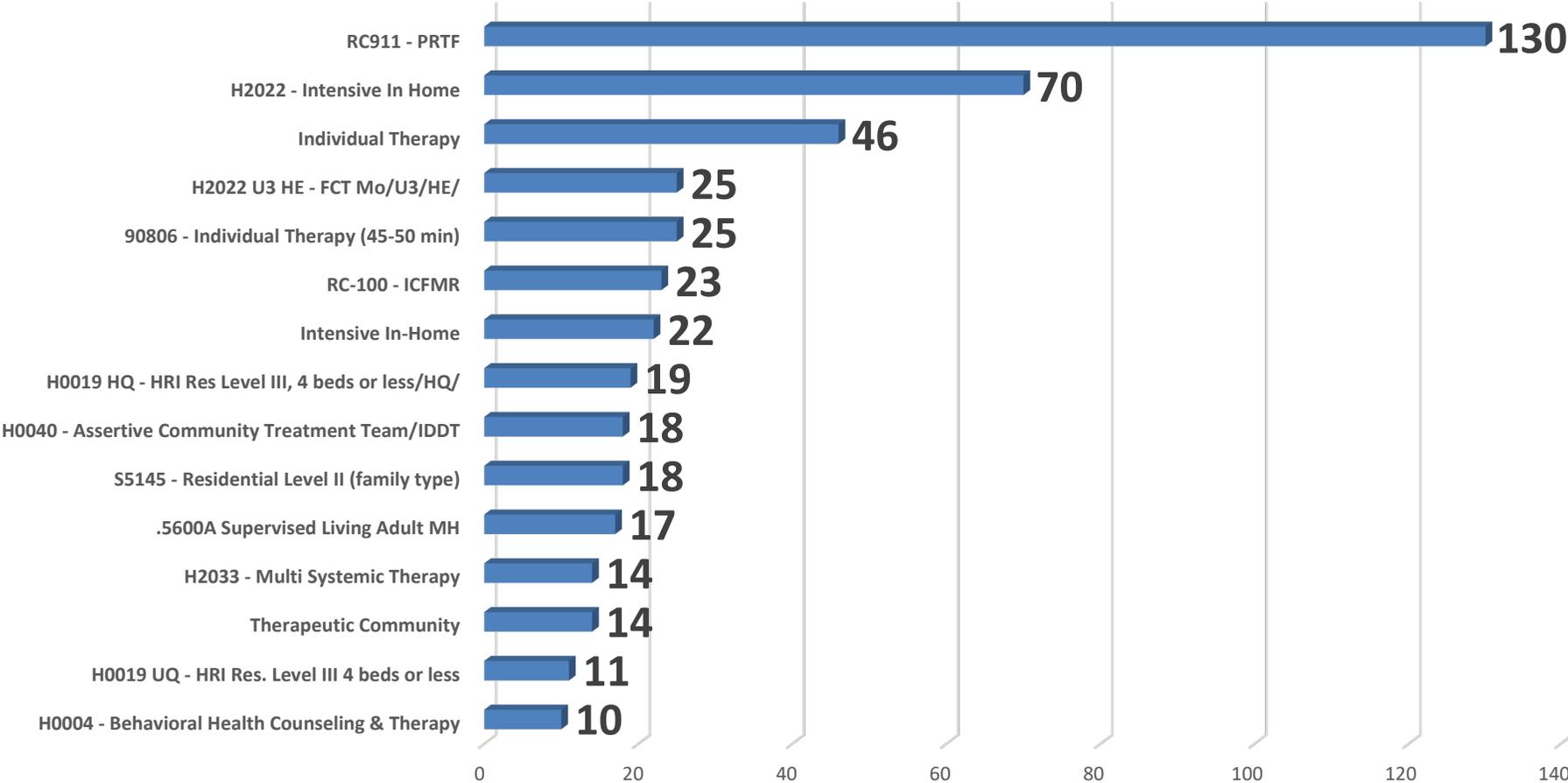
(By Level)



- A total of 492 Incidents were reported for children
- A total of 232 Incidents were reported for Adults

Service Breakdown

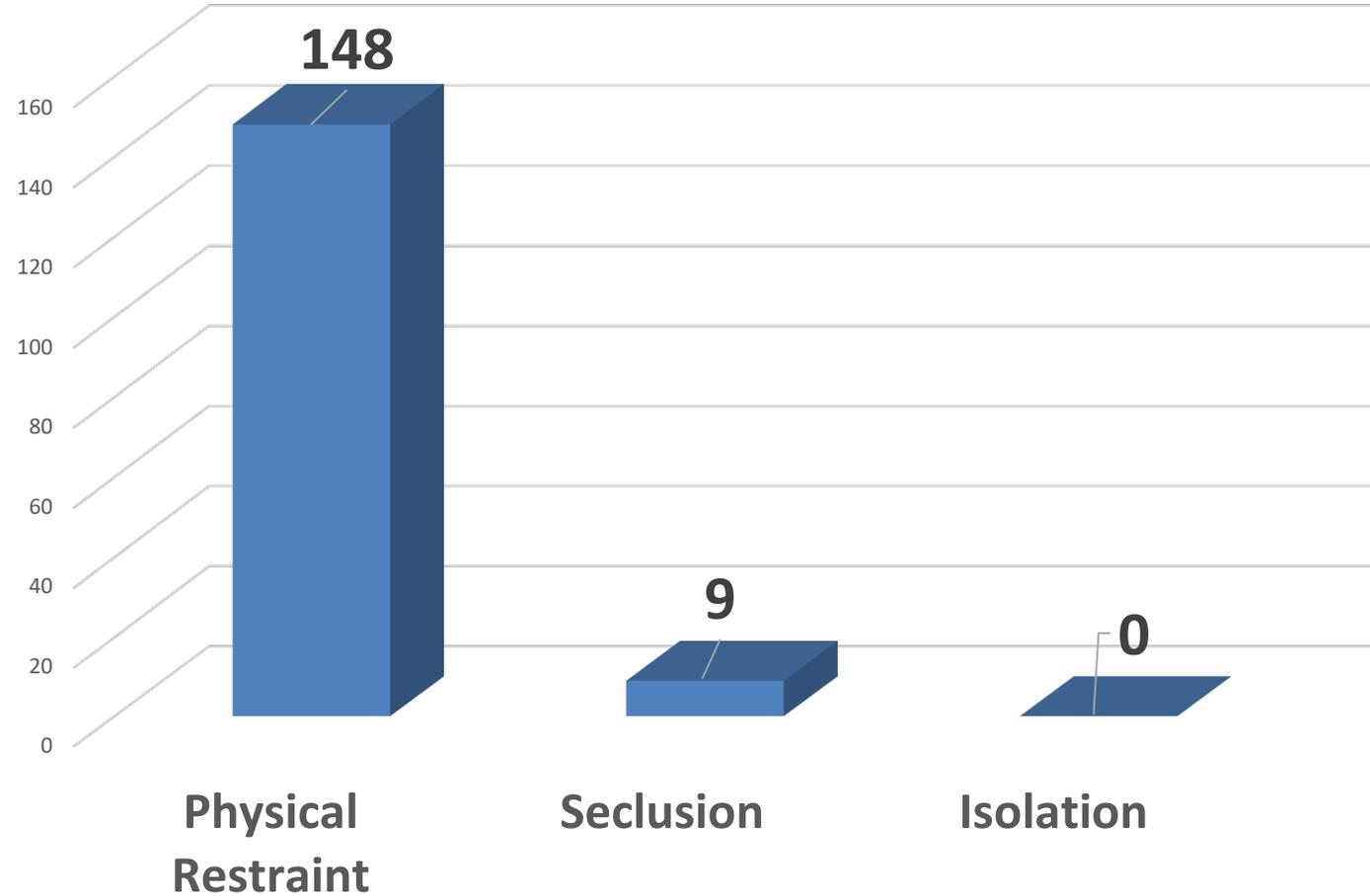
10+ Reports



• PRTF - 18% of all reports

REPORTS BY INCIDENT CATEGORY (Primarily Human Rights Related)

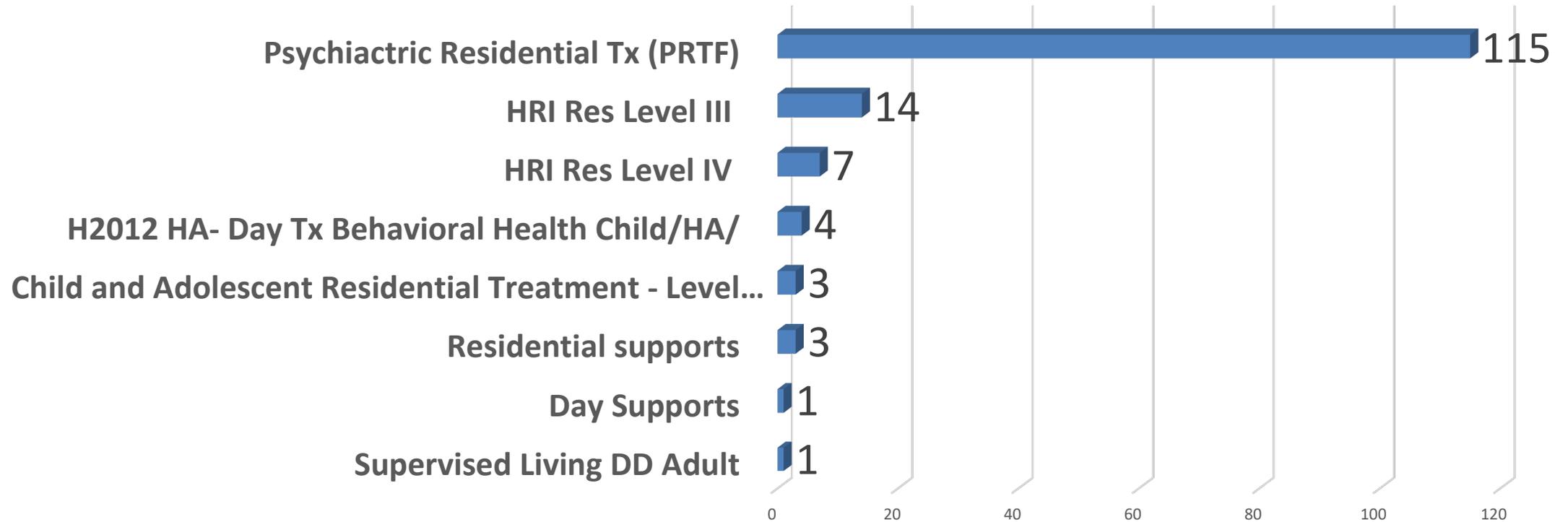
Restrictive Interventions



- **157 Restrictive Interventions reported (*75% of all Incident Reports*)**
- **73% of Restrictive Interventions were Physical Restraints**

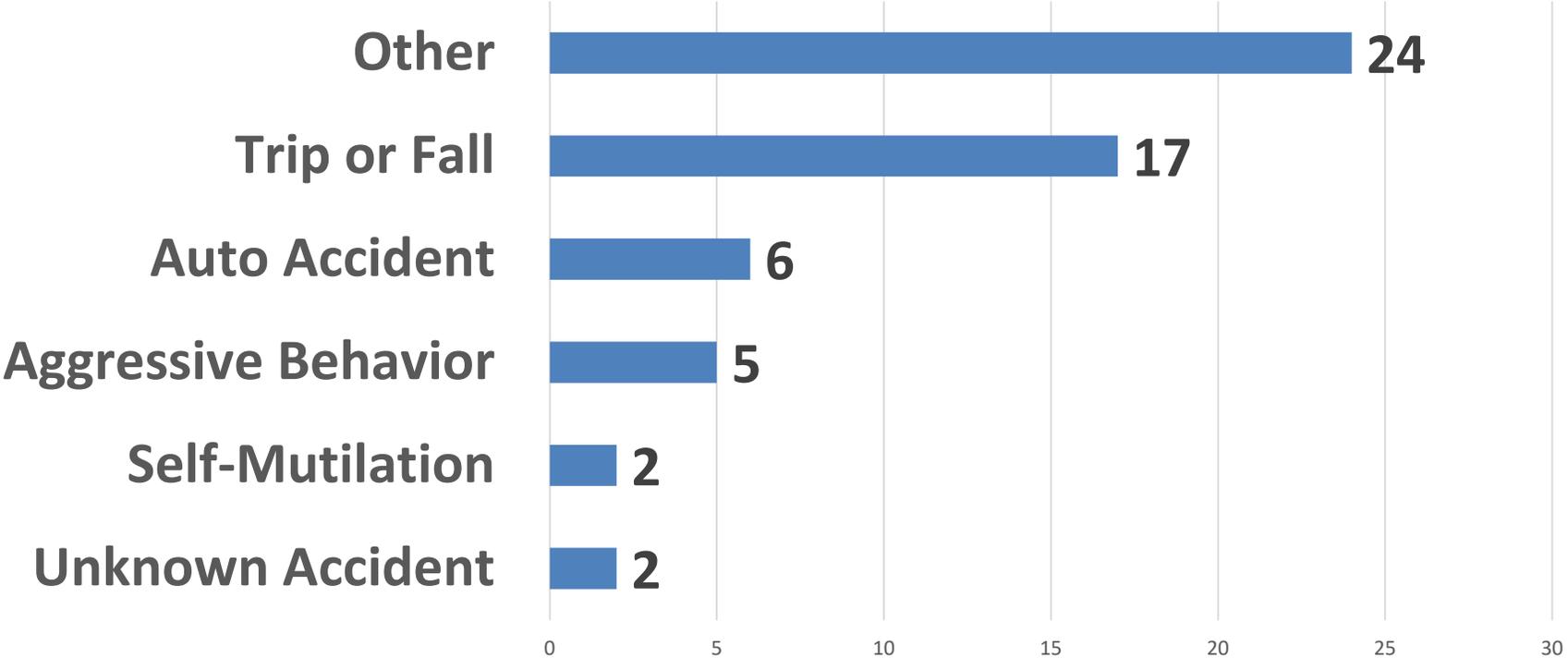
Physical Restraint

(Service Breakdown)



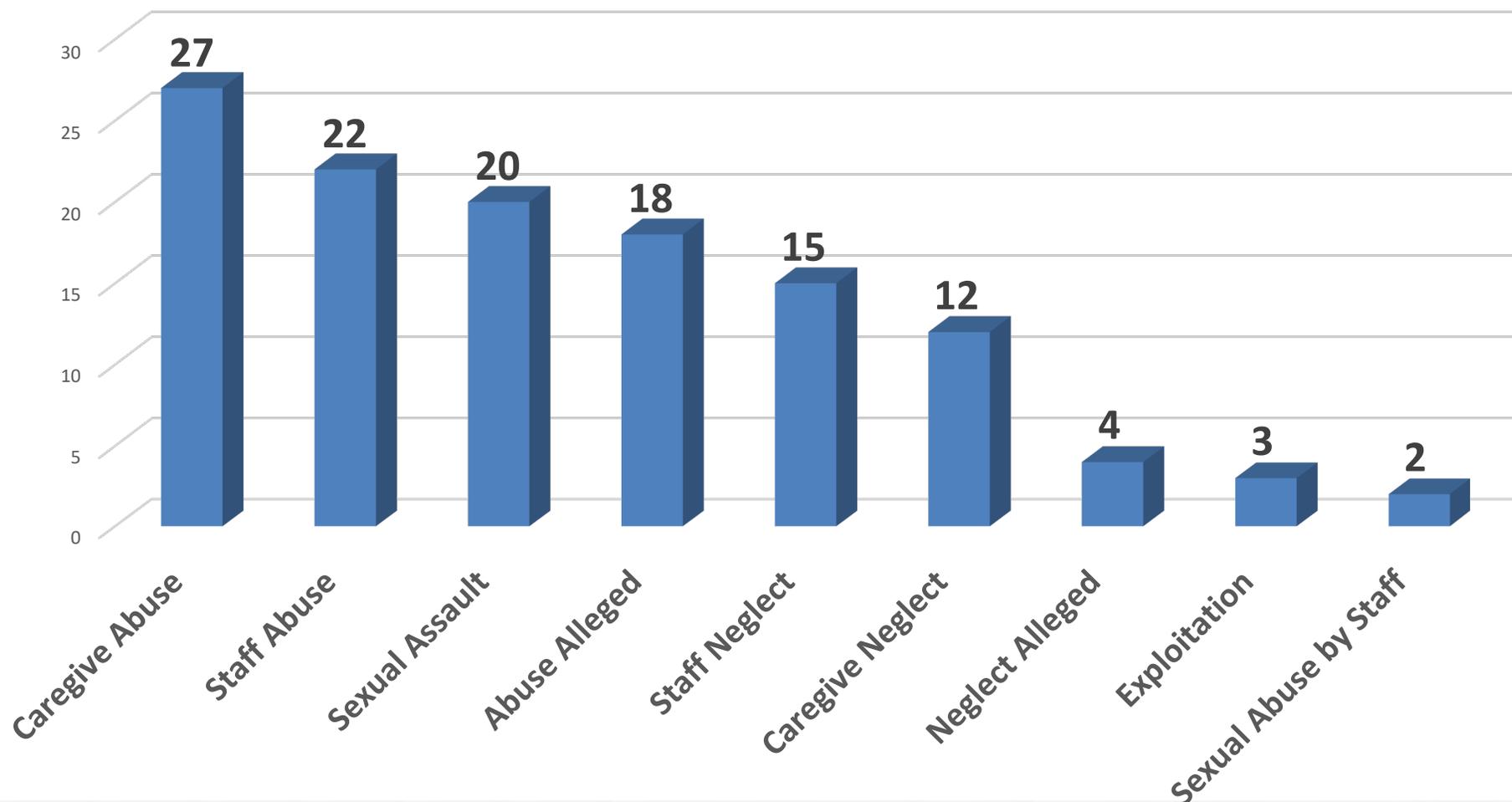
• 73% of Restrictive Interventions were from PRTF Programs

Injury Categories



- **56 Total**
- **43% - “Other” Category**
- **30% - Trip or Fall Category**

Abuse/Neglect/Exploitation



- **123 reported in this category (59% of all Incidents)**

- **13 Substantiated**

2 - Caregiver Abuse

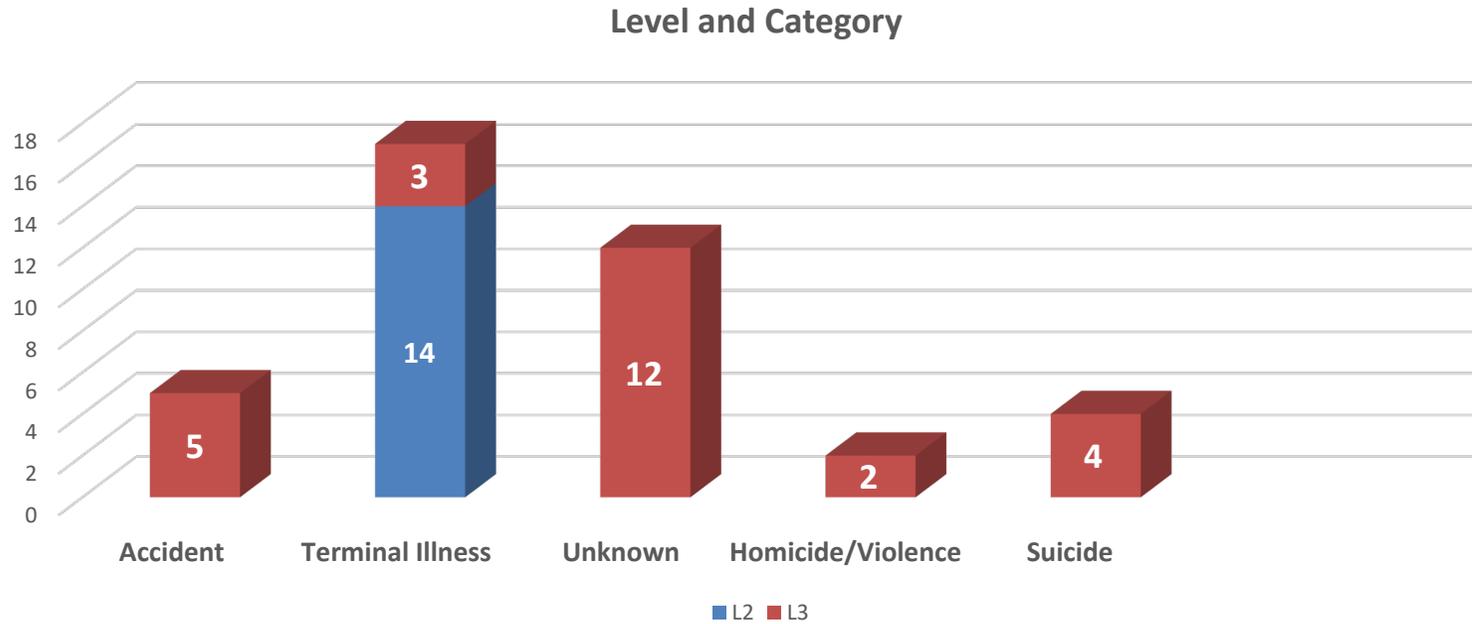
1 - Sexual Assault

1- Sexual Abuse by Staff

3 - Staff Abuse

6 - Staff Neglect

Member Deaths



- A total of 40 deaths were reported during the 4th quarter
- All L2 deaths -Terminal Illness (35% of all Deaths)
- 26 Confirmed L3 deaths

7 OCME Reports Reviewed by Med Team

1 confirmed L3 - Suicide
6 confirmed L2 - Accidents

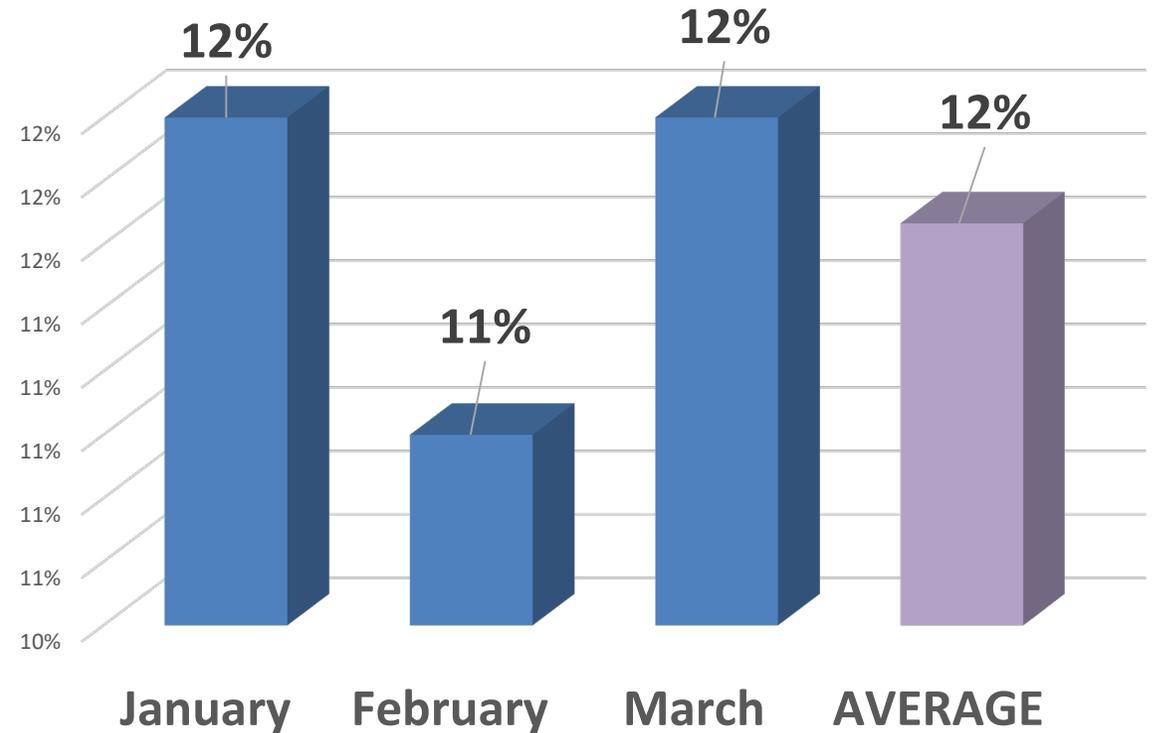
FY/Quarter	No. Reviewed	Confirmed Cause of Death
2020/Q1	1	Accident
2020/Q2	1	Accident
2020/Q3	1	Accident
2021/Q2	1	Accident
2021/Q3	1	Accident
2021/Q4	2	Accident, Suicide

Incident Report Compliance

Incident Report Compliance (Q4 FY2021)

- **Four (4) Plans of Correction issued during 3rd Quarter**
- **11 Late Incident emails sent for 1 late report submitted**

Late Incident Report Submission



- **Same average as 3rd Quarter**



**Alliance Health
BOARD OF DIRECTORS
Agenda Action Form**

ITEM: Executive Committee Report

DATE OF BOARD MEETING: November 4, 2021

BACKGROUND: The Executive Committee sets the agenda for Board meetings and acts in lieu of the Board between meetings. The Executive Committee may act on matters that are time-sensitive between regularly scheduled Board meetings and fulfill other duties as set forth in the by-laws or as otherwise directed by the Board of Directors. The Executive Committees' actions are reported to the Board at the next scheduled meeting. This report includes draft minutes from the previous meeting.

SPECIFIC INFORMATION FOR BOARD REVIEW (if applicable/available): N/A

REQUEST FOR AREA BOARD ACTION: Receive the report.

CEO RECOMMENDATION: Receive the report.

RESOURCE PERSON(S): Lynne Nelson, Board Chair; Robert Robinson, CEO

[\(Back to agenda\)](#)



Monday, October 18, 2021

BOARD EXECUTIVE COMMITTEE - REGULAR MEETING

(virtual meeting via videoconference)
4:00-6:00 p.m.

APPOINTED MEMBERS PRESENT: David Curro, BS (Audit and Compliance Committee Chair) – entered at 4:13 pm; Lodies Gloston, MA (Network Development and Services Committee Chair/Board Vice-Chair); David Hancock, MBA, PFAff (Finance Committee Chair); Lynne Nelson, BS (Board Chair); Gino Pazzaglini, MSW LFACHE (previous Board Chair); and Pam Silberman, JD, DrPH (Quality Management Committee Chair)

APPOINTED MEMBERS ABSENT: Donald McDonald, MSW (Client Rights/Human Rights Committee Chair)

BOARD MEMBERS PRESENT: None

GUEST(S): None

STAFF PRESENT: Veronica Ingram, Executive Assistant II; Brian Perkins, Senior Vice-President/Strategy and Government Relations; Robert Robinson, CEO; Jennifer Stoltz, Administrative Assistant II; Sara Wilson, Senior Director of Government Relations; and Carol Wolff, General Counsel

- 1. WELCOME AND INTRODUCTIONS** – the meeting was called to order at 4:00 pm
- 2. REVIEW OF THE MINUTES** – The Committee reviewed minutes from the September 20, 2021, meeting; a motion was made by Vice-Chair Gloston and seconded by Mr. Pazzaglini to approve the minutes as submitted. Motion passed unanimously.

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
3. Closed Session	COMMITTEE ACTION: A motion was by Dr. Silberman to enter closed session pursuant to North Carolina General Statute (NCGS) 143-318.11 (a) (1) and (a) (6) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1 and to consider the qualifications, competence, and performance of an employee. Motion seconded by Mr. Pazzaglini. Motion passed unanimously.	N/A	N/A
4. Reconvene Open Session	Committee returned to open session.	N/A	N/A
5. County Realignment Update	Brian Perkins, Senior Vice-President/Strategy and Government Relations, presented the update. He noted recent meetings with stakeholders (county staff, providers, residents, etc.) in Mecklenburg and Orange counties. He also reviewed upcoming meetings and additional communication to persons who will be served by Alliance.	None specified.	N/A
6. Agenda for November Board Meeting	Committee reviewed the draft agenda and provided input.	Ms. Ingram will forward the agenda to staff.	10/18/21

- 7. ADJOURNMENT:** the meeting adjourned at 4:35 pm; the next meeting will be November 15, 2021, at 4:00 p.m.

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on [Click or tap to enter a date..](#)



**Alliance Health
BOARD OF DIRECTORS
Agenda Action Form**

ITEM: Finance Committee Report

DATE OF BOARD MEETING: November 4, 2021

BACKGROUND: The Finance Committee's function is to review financial statements and recommend policies/practices on fiscal matters to the Board, including reviewing/recommending budgets, audit reports, and financial statements. This Committee also reviews and recommends policies and procedures for managing contracts and other purchase of service arrangements.

This month's report includes documents and draft minutes from the previous meeting.

SPECIFIC INFORMATION FOR BOARD REVIEW (if applicable/available): N/A

REQUEST FOR AREA BOARD ACTION: Approve the report.

CEO RECOMMENDATION: Approve the report.

RESOURCE PERSON(S): David Hancock, Committee Chair, Kelly Goodfellow, Executive Vice-President/Chief Financial Officer

[\(Back to agenda\)](#)



Finance Committee Meeting

Thursday, November 4, 2021

3:00-4:00 pm

AGENDA

- 1. Review of the Minutes – October 7, 2021**
- 2. Monthly Financial Reports as of September 30, 2021**
 - a. Summary of Net Position
 - b. Summary of Savings/(Loss) by Funding Source
 - c. Statement of Revenue and Expenses (Budget & Actual)
 - d. Senate Bill 208 Ratios
 - e. DHB Contractual Ratios
- 3. Year End Summary**
- 4. Contract(s)**
- 5. Adjournment**

Next Meeting: Thursday, December 2, 2021 from 2:30-4:00

Alliance Health

Held virtually via Zoom



Thursday, October 07, 2021

BOARD FINANCE COMMITTEE - REGULAR MEETING

5200 W. Paramount Parkway, Morrisville, NC 27560
 Virtual Meeting via videoconference - 3:00-4:00 p.m.

APPOINTED MEMBERS PRESENT: David Hancock, MBA, MPA (Committee Chair), D. Lee Jackson, Carol Council, Gino J. Pazzaglini, and Vicki Evans

BOARD MEMBERS PRESENT: n/a

GUEST(S) PRESENT: Mary Hutchings, Wake County; Denise Foreman, Wake County

STAFF PRESENT: Rob Robinson, CEO, Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Sara Pacholke, Senior Vice-President Financial Operations

1. **WELCOME AND INTRODUCTIONS** – the meeting was called to order at 3:00 PM
2. **REVIEW OF THE MINUTES** – The minutes from the September 2, 2021, meeting were reviewed; a motion was made by Ms. Evans and seconded by Mr. Pazzaglini to approve the minutes. Motion passed unanimously.

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
3. Monthly Financial Report	<p>The monthly financial reports were discussed which includes Summary of Savings/(Loss) by Funding Source, the Statement of Revenue and Expenses, Senate Bill 208 Required Ratios, and DHB Contract Ratios as of August 31, 2021.</p> <p>Ms. Pacholke discussed the following:</p> <ul style="list-style-type: none"> • Through 8/31/21, we have savings of \$3.1M. • We are meeting all SB208 ratios • We are meeting all DHB contractual ratios <p>A question was asked regarding rate request for providers. Ms. Goodfellow discussed how COVID rate increases have been extended through 12/31/21. Alliance needs time and more information related to the county realignment to perform an analysis of all rates post COVID. Alliance is recommending the State continues a COVID PMPM add on for some time after COVID ends to all provider operations to stabilize.</p>		
4. 6/30/2021 Update and Approval of Committed Funds and Reinvestment Plan	<p>Ms. Pacholke gave an update on the 6/30/2021 close. The current audit is in process. We are working towards the 10/31 deadline to issue the financial statements, however based on timing and the having new auditors the statements might be issued after 10/31. There is a grace period through December and we are confident we will issue the financials by then.</p> <p>Ms. Pacholke discussed the \$140,769,874 6/30/21 net position pending any audit adjustments and the \$44,636,221 one year reinvestment plan. Net position as of 6/30/21:</p> <ul style="list-style-type: none"> • Investment in capital assets - \$5,089,165 investment in capital assets • Restricted - \$75,620,287 		

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on [Click or tap to enter a date..](#)

Thursday, October 07, 2021

BOARD FINANCE COMMITTEE - REGULAR MEETING
5200 W. Paramount Parkway, Morrisville, NC 27560
Virtual Meeting via videoconference - 3:00-4:00 p.m.

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
	<ul style="list-style-type: none"><li data-bbox="520 321 1388 375">• Unrestricted - \$60,060,022 which includes \$47,630,674 of funds to be committed <p data-bbox="470 380 1451 467">A motion was made by Mr. Pazzaglini and seconded by Ms. Council to recommend the Board approve the one year reinvestment plan of \$44,636,221 and commit \$47,630,674 as of 6/30/21. Motion passed unanimously.</p>		

5. **ADJOURNMENT:** the meeting adjourned at 3:28 PM; the next meeting will be November 4, 2021, from 3:00 p.m. to 4:00 p.m.

DRAFT

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on [Click or tap to enter a date..](#)



Alliance Health
Statement of Net Position
As of September 30, 2021

	Current Year September 30, 2021 <small>Actual</small>	Prior Year June 30, 2021 <small>Actual</small>	YTD Change September 30, 2021 <small>Change</small>	YTD % Change September 30, 2021 <small>% Change</small>
Assets				
Current Assets				
Cash and cash equivalents	31,478,868	9,182,030	22,296,837	242.8 %
Restricted cash	4,125,492	4,125,492	-	0.0 %
Short term investments	95,332,159	105,329,570	(9,997,410)	(9.5) %
Due from other governments	15,186,894	11,995,440	3,191,454	26.6 %
Accounts receivable, net of allowance	478,564	260,552	218,012	83.7 %
Sales tax refund receivable	173,739	108,644	65,095	59.9 %
Prepaid expenses	2,847,238	842,976	2,004,262	237.8 %
Total Current Assets	149,622,954	131,844,704	17,778,250	13.5 %
Noncurrent Assets				
Noncurrent Restricted cash	74,489,898	71,808,392	2,681,505	3.7 %
Other Assets	321,460	321,461	-	0.0 %
Capital Assets, Net of AD	4,897,795	5,031,937	(134,142)	(2.7) %
Deferred Outflows of Resources	10,588,273	10,588,273	-	0.0 %
Total Noncurrent Assets	90,297,426	87,750,063	2,547,363	2.9 %
Total Assets	239,920,380	219,594,767	20,325,613	9.3 %
Liabilities and Net Position				
Liabilities				
Current Liabilities				
AP and Other Current Liabilities	14,041,570	6,255,972	7,785,599	124.5 %
Claims and Other Service Liabilities	36,624,276	33,056,185	3,568,090	10.8 %
Unearned Revenue	17,675,334	17,309,099	366,235	2.1 %
Current Portion of Accrued Vacation	2,240,684	2,240,684	0	(0.0) %
Due to Other Entities	748,613	-	748,613	0.0 %
Total Current Liabilities	71,330,477	58,861,940	12,468,537	21.2 %
Noncurrent Liabilities				
Net Pension Liability	20,448,550	19,448,550	1,000,000	5.1 %
Accrued Vacation	888,802	888,801	0	0.0 %
Total Noncurrent Liabilities	21,337,352	20,337,351	1,000,000	4.9 %
Total Liabilities	92,667,829	79,199,291	13,468,537	17.0 %
Net Position				
Capital Assets at Beginning of Year	5,031,937	5,031,938	-	0.0 %
Restricted	75,620,287	75,620,287	-	0.0 %
Unrestricted	59,743,251	59,743,251	-	0.0 %
Current Year Change in Net Position	6,857,076	-	6,857,076	0.0 %
Total Net Position	147,252,551	140,395,476	6,857,076	4.9 %
Total Liabilities and Net Position	239,920,380	219,594,767	20,325,613	9.3 %



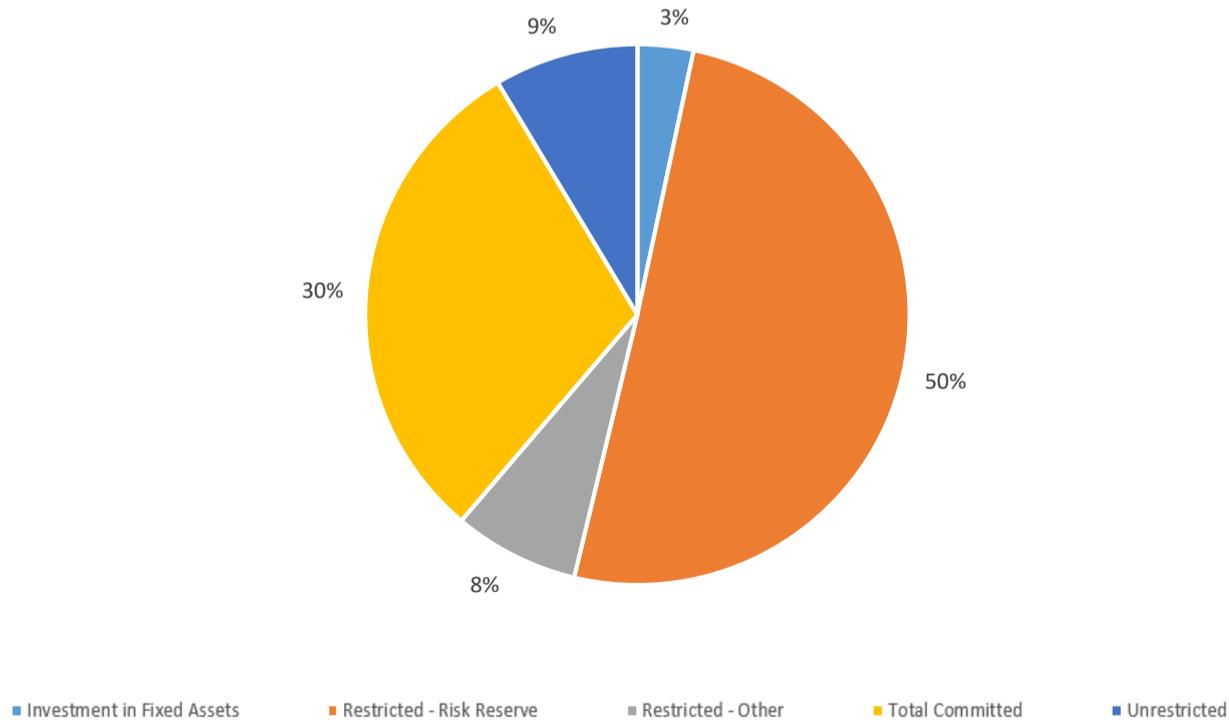
Summary of Savings/(Loss) by Funding Source as of September 30, 2021

	Revenue	Expense	Savings/(Loss)
Medicaid Waiver Services	\$ 117,435,903	\$ 111,387,080	\$ 6,048,823
Medicaid Waiver Risk Reserve	2,739,177	-	2,739,177
Federal Grants & State Funds	19,327,679	19,556,364	(228,685)
Local Funds	6,244,099	6,244,099	-
Administrative	17,996,265	19,698,505	(1,702,240)
Total	\$ 163,743,123	\$ 156,886,048	\$ 6,857,075

Fund Balance

	June 30, 2021	Change	September 30, 2021
Investment in Fixed Assets	5,031,938	(134,143)	4,897,795
Risk Reserve	71,494,795	2,739,177	74,233,972
Other	8,986,362	2,004,262	10,990,624
Total Restricted	80,481,157	4,743,439	85,224,596
Committed	47,630,674	(3,123,053)	44,507,621
Unrestricted	7,251,706	5,370,832	12,622,539
Total Unrestricted	54,882,380	2,247,779	57,130,160
Total Fund Balance	\$ 140,395,475	\$ 6,857,075	\$ 147,252,551

September 30, 2021 Actual



Reinvestment Detail

	Committed Funds FY22	Spent September 30, 2021	Balance to Spend
General Expenses	\$ 2,000,000	-	\$ 2,000,000
Child Facility Based Crisis Center	7,000,000	354,859	6,645,141
Total - Services	9,000,000	354,859	8,645,141
Administration			
Tailored Plan planning and implementation	35,636,221	2,019,581	33,616,640
Total - Administrative	35,636,221	2,019,581	33,616,640
Total Service and Administration	\$ 44,636,221	\$ 2,374,440	\$ 42,261,781

Fund Balance Detail

	June 30, 2021	Change	September 30, 2021
Investment in Fixed Assets	5,031,938	(134,143)	4,897,795
Restricted - Risk Reserve	71,494,795	2,739,177	74,233,972
Restricted - Other			
State Statutes	4,017,894	-	4,017,894
Prepays	842,976	2,004,262	2,847,238
State	351,452	-	351,452
Cumberland	3,002,823	-	3,002,823
Durham	771,217	-	771,217
Restricted - Other	8,986,362	2,004,262	10,990,624
Committed			
Intergovernmental Transfer	2,994,453	(748,613)	2,245,840
Reinvestments-Service	9,000,000	(354,859)	8,645,141
Reinvestments-Administrative	35,636,221	(2,019,581)	33,616,640
Total Committed	47,630,674	(3,123,053)	44,507,621
Unrestricted	7,251,706	5,370,832	12,622,539
Total Fund Balance	\$ 140,395,475	\$ 6,857,075	\$ 147,252,551
Restricted			4,609,296
Unrestricted			2,247,779
Total Fund Balance Change			\$ 6,857,075

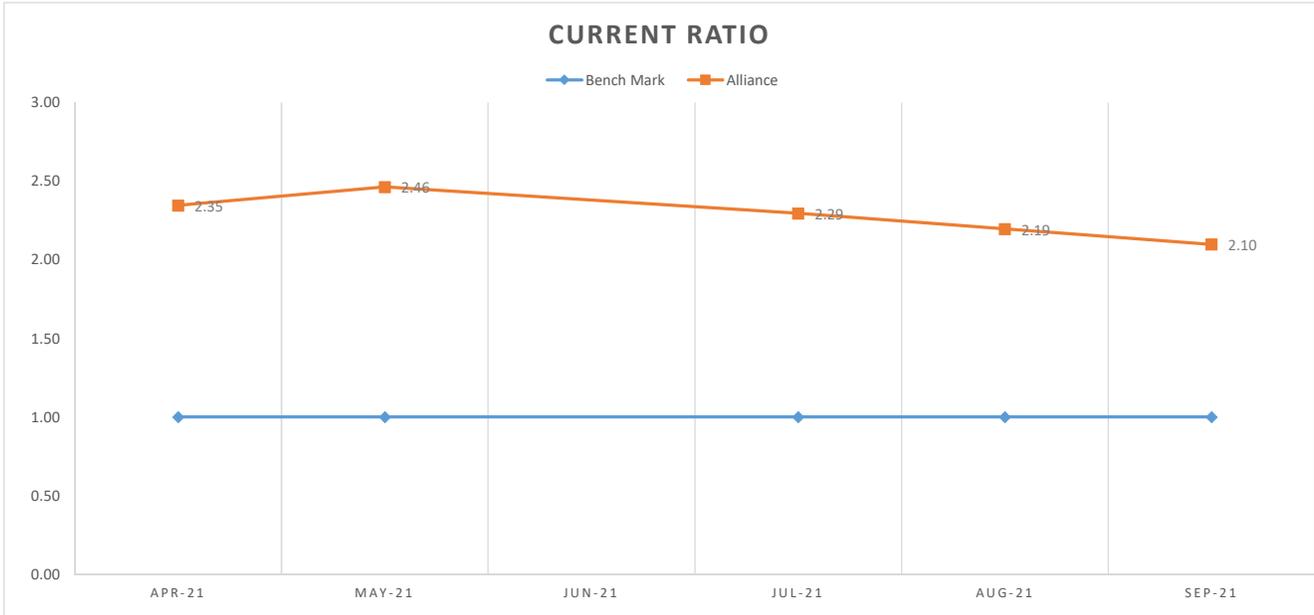


Alliance Health
Statement of Revenue and Expenses
As of September 30, 2021

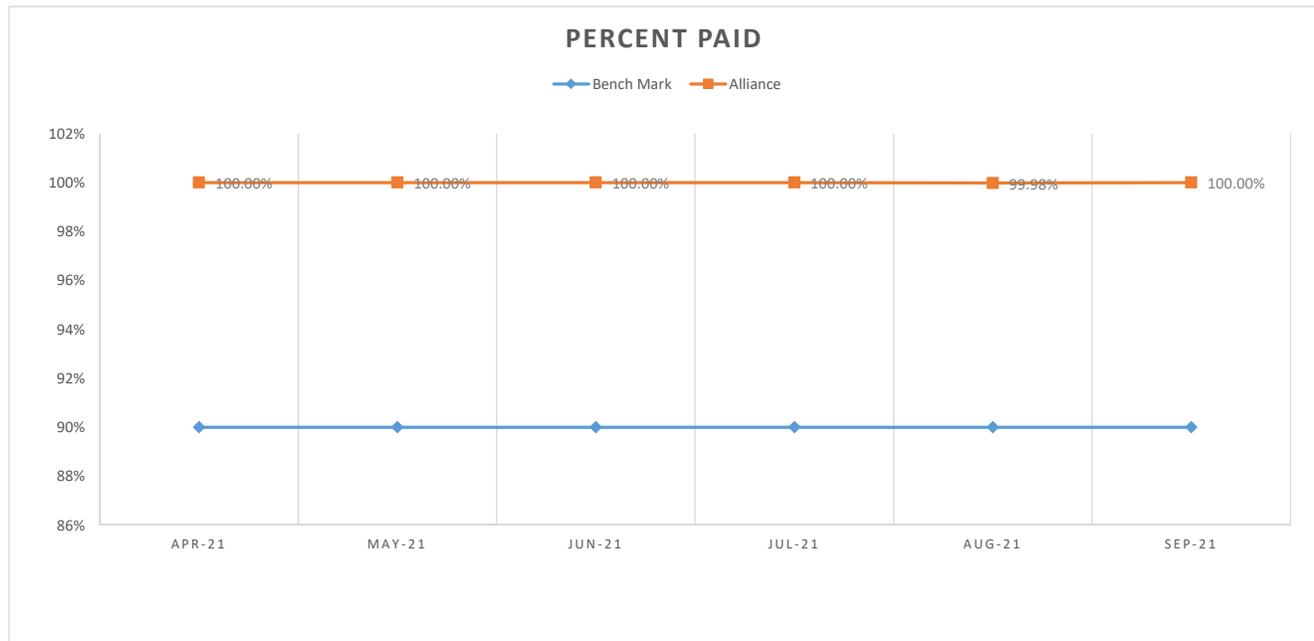
	Current Month Actual September 30, 2021	Year to Date Actual September 30, 2021	Current Year Budget June 30, 2022	Budget Remaining June 30, 2022
Revenue				
Service Revenue				
Medicaid Waiver Service	40,871,739	120,175,080	419,996,322	299,821,242
State and Federal Grants	8,189,174	19,327,679	52,437,919	30,208,497
Local Grants	1,459,907	6,244,099	39,083,864	32,839,765
Total Service Revenue	50,520,820	145,746,858	511,518,105	362,869,504
Administrative Revenue				
Medicaid Waiver	5,558,069	16,342,014	57,688,571	41,346,557
State and Federal	395,693	1,187,077	3,851,407	2,268,638
Local	32,545	97,635	390,540	260,360
Miscellaneous	123,143	369,539	500,000	9,175
Total Administrative Revenue	6,109,450	17,996,265	62,430,518	43,884,730
Total Revenue	56,630,270	163,743,123	573,948,623	406,754,234
Expenses				
Service Expense				
Medicaid Waiver Service	36,330,734	111,387,080	419,996,322	283,703,428
State and Federal Service	8,388,288	19,556,364	52,437,919	30,112,747
Local Service	1,459,907	6,244,099	39,083,864	35,796,574
Total Service Expense	46,178,929	137,187,543	511,518,105	349,612,749
Administrative Expense				
Salaries and Benefits	5,298,774	15,369,266	46,893,788	31,296,029
Professional Services	877,426	1,979,801	7,400,697	4,271,975
Operational Expenses	896,301	2,352,211	7,636,033	4,843,377
Miscellaneous Expense	514	(2,773)	500,000	502,773
Total Administrative Expense	7,073,015	19,698,505	62,430,518	40,914,154
Total Expenses	53,251,944	156,886,048	573,948,623	390,526,903
Current Year Change in Net Position	3,378,325	6,857,075	-	16,324,708



Senate Bill 208 Ratios - As of September 30, 2021



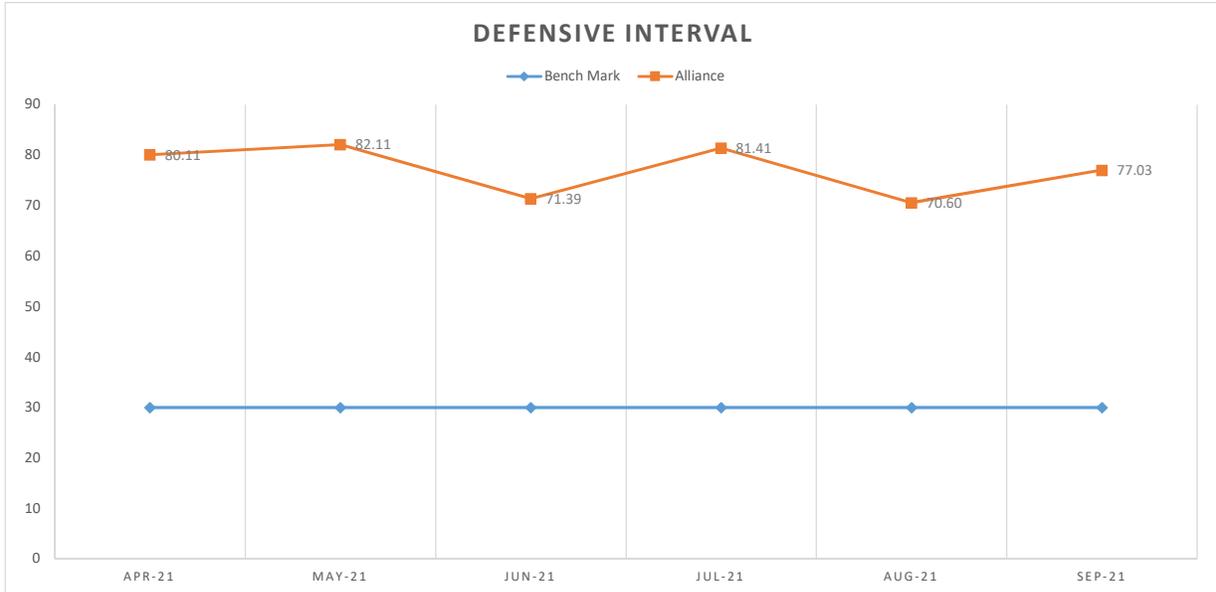
Current Ratio = Compares current assets to current liabilities. Liquidity ratio that measures an organization's ability to pay short term obligations. The requirement is 1.0 or greater.



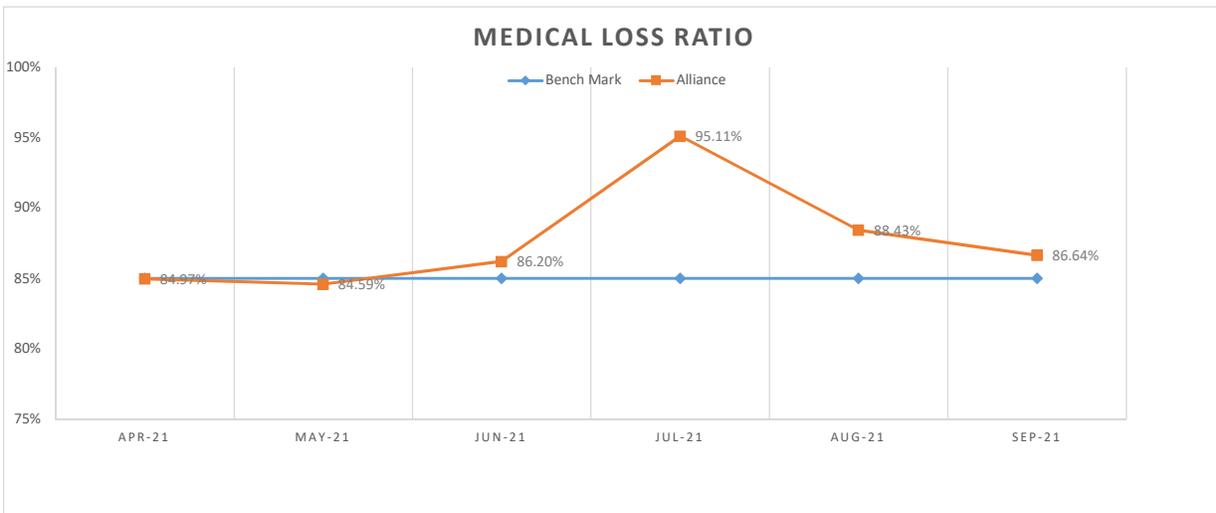
Percent Paid = Percent of clean claims paid within 30 days of receiving. The requirement is 90% or greater.



Division of Health Benefits Ratios - As of September 30, 2021



Defensive Interval = Cash + Current Investments divided by average daily operating expenses. This ratio shows how many days the organization can continue to pay expenses if no additional cash comes in. The requirement is 30 days or greater.



Medical Loss Ratio (MLR) = Total Services Expenses plus Administrative Expenses that go towards directly improving health outcomes divided by Total Medicaid Revenue. The requirement is 85% or greater cumulative for the rating period (7/1/20-6/30/21).



**Alliance Health
BOARD OF DIRECTORS
Agenda Action Form**

ITEM: Quality Management Committee Report

DATE OF BOARD MEETING: November 4, 2021

BACKGROUND: The Quality Management (QM) Committee serves as the Board's monitoring and evaluation committee charged with the review of statistical data and provider monitoring reports. The goal of the committee is to ensure quality and effectiveness of services and to identify and address opportunities to improve LME/MCO operations and local service system with input from consumers, providers, family members, and other stakeholders.

This report includes draft minutes from the previous meeting.

SPECIFIC INFORMATION FOR BOARD REVIEW (if applicable/available): N/A

REQUEST FOR AREA BOARD ACTION: Receive the report.

CEO RECOMMENDATION: Receive the report.

RESOURCE PERSON(S): Pam Silberman, Committee Chair; Wes Knepper, Senior Vice-President/Quality Management

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Thursday, October 07, 2021

BOARD QUALITY MANAGEMENT COMMITTEE - REGULAR MEETING
 5200 W. Paramount Parkway, Morrisville, NC 27560
 1:00-2:30 p.m.

This meeting was held virtually, via Zoom

APPOINTED MEMBERS PRESENT: David Curro, BS (Board member); Marie Dodson (CFAC), Pam Silberman, JD, DrPH (Board member; Committee Chair)
 Israel Pattison (CFAC); Carol Council (Board Member); Lodies Gloston (Board Member)

APPOINTED, NON-VOTING MEMBERS PRESENT: Diane Murphy, (Provider, IDD) Dava Muserallo, (Provider MH/SUD)

BOARD MEMBERS PRESENT:

GUEST(S) PRESENT: Mary Hutchings; Yvonne French (LME Liaison); Pamela Wade

STAFF PRESENT: Wes Knepper, SVP Quality Management; Diane Fening, Executive Assistant I; Doug Wright, Director of Community and Member Engagement; Tia Grant, Quality Improvement Manager; Damali Alston, Director of Network Evaluation; Mehul Mankad, Chief Medical Officer; Laini Jarrett, Quality Review Coordinator II; Sean Schreiber, Chief Operating Officer; Carlyle Johnson, Director of Provider Network Strategic Initiatives; Gracia Shembo, QI Specialist II

- 1. WELCOME AND INTRODUCTIONS** – The meeting was called to order at 1:00 pm
- 2. REVIEW OF THE MINUTES** –The minutes from the September 2, 2021 meeting were reviewed. Carol Council made a motion to approve the minutes and Lodies Gloston seconded. The motion passed.

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
OLD BUSINESS	<p>QIP Updates</p> <ul style="list-style-type: none"> Wes went over the 6 active QIPs and one that has been closed. All of the open ones are HEDIS. HEDIS SSD-Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications is trending up for adults only. Some of our providers are using Point of Care testing. Members are getting what they need. Doing deep analysis of this. We hope that as more people are receiving care in person, it will pick up. The 7 day follow up measures- Medicaid SUD. This hovers around 40% on average. When we add Mecklenburg, based on data that we have, it will probably go down to 30%. The state funded SUD measure is at 41%. We think that this is largely due to our outreach efforts, we are hoping that the same value-based incentives will be going to drive performance. The state mental health measure is trending up but is not at 40% yet. QIP post closure review – Adverse letters (improve the quality of UM decision documentation of adverse letters sent to members). This project was closed 9/3/20. We check a year later to make sure it still is above benchmark and it was. 	<p><i>QIP-Quality Improvement Plan</i></p> <p><i>HEDIS - Healthcare Effectiveness Data and Information Set</i></p> <p><i>SUD-Substance Use Disorder</i></p> <p><i>UM – Utilization Management</i></p>	

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on [Click or tap to enter a date..](#)

Thursday, October 07, 2021

BOARD QUALITY MANAGEMENT COMMITTEE - REGULAR MEETING
 5200 W. Paramount Parkway, Morrisville, NC 27560
 1:00-2:30 p.m.

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
	<ul style="list-style-type: none"> Another QIP that we are still gathering baseline data for is the TCLI QIP. This one is about connecting people that have been identified as able to transition to living independently to a primary care provider either for that transition or afterward to make sure their physical health needs are addressed. <p>Performance Dashboard</p> <ul style="list-style-type: none"> The three that were not met were the 7 day follow up measures. The uninsured SUD was not met as well as the quarterly Innovations (receiving services within 45 days of approval of an ISP and then timely submission of level 2 and 3 incidents). There are direct support worker shortages. And the last was the incident reporting timeframe. There were a few providers that were issued corrections about this. <p>Super Measures & Watch Measures</p> <ul style="list-style-type: none"> We went over the uninsured and Medicaid population SUD and mental health watch measures. We track those seen within between 1-7 days, and 1-30 days. Many more people getting seen between 1-30 days than 1-7 days. Retro Medicaid impacts the 45 days window for Innovations services. To receive the Innovations services you have to have Medicaid and also receive a special IN indicator turned on for Medicaid to receive C-waiver services. You cannot get that indicator turned on by local DSS offices until your ISP (individual service plan) has been created. The ISP has to be done, sent to the DSS office and then DSS will turn it on. It's a bit of a guessing game by our care managers as to when to do that. We get a global eligibility file from DSS every day. 	<p><i>TCLI-Transitions to Community Living</i></p> <p><i>ISP – Individual Service Plan</i></p>	
<p>3. NEW BUSINESS</p>	<p>Current and Future Opioid Work (Carlyle Johnson)</p> <ul style="list-style-type: none"> Carlyle presented a PowerPoint on current and future plans to address the opioid crisis. He gave a brief review of epidemic, its impact on NC and Alliance, the NC Opioid Action Plan, Alliance's actions to address the opioid epidemic, implications for Tailored Plan preparation and future opportunities and challenges. Carlyle's PowerPoint presentation is attached. 		

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on [Click or tap to enter a date..](#)

Thursday, October 07, 2021

BOARD QUALITY MANAGEMENT COMMITTEE - REGULAR MEETING
5200 W. Paramount Parkway, Morrisville, NC 27560
1:00-2:30 p.m.

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
	Next Topics November – performance dashboard, oversight of over/under-utilization of services, QIP updates.		

5. **ADJOURNMENT:** the meeting adjourned at 2:22 pm; the next meeting will be November 4, 2021, at 1:00.

DRAFT

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on [Click or tap to enter a date..](#)



**Alliance Health
BOARD OF DIRECTORS
Agenda Action Form**

ITEM: Consumer and Family Advisory Committee (CFAC) Report

DATE OF BOARD MEETING: November 4, 2021

BACKGROUND: The Alliance Consumer and Family Advisory Committee, or CFAC, is made up of consumers and/or family members that live in Cumberland, Durham, Johnston, or Wake counties who receive mental health, intellectual/developmental disabilities and substance use/addiction services. CFAC is a self-governing committee that serves as an advisor to Alliance administration and Board of Directors. The Alliance CFAC meets at 5:30pm on the first Monday in the months of February, April, June, August, October and December at the Alliance Corporate Office, 5200 West Paramount Parkway, in Morrisville. Sub-committee meetings are held in individual counties; the schedules for those meetings are available on our website.

This report includes draft minutes documents from the following meetings: Steering Committee on October 4, 2021; Durham on October 11, 2021; Wake on October 10, 2021; and Johnston on October 19, 2021; Cumberland CFAC had not met in time for distribution of materials.

SPECIFIC INFORMATION FOR BOARD REVIEW (if applicable/available): N/A

REQUEST FOR AREA BOARD ACTION: Receive the report.

CEO RECOMMENDATION: Receive the report.

RESOURCE PERSON(S): Jason Phipps, CFAC Chair; Doug Wright, Director of Community and Member Engagement

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Monday, October 04, 2021

CONSUMER AND FAMILY ADVISORY COMMITTEE - REGULAR MEETING
5200 W. Paramount Parkway, Morrisville, NC 27560
Held Via Video Conference

MEMBERS PRESENT: ☑ Pinkey Dunston, ☑ Trula Miles, ☑ Marie Dodson, ☑ Jerry Dodson, ☑ Tracey Glenn Thomas, ☑ Brianna Harris, ☑ Sharon Harris
☑ Shirley Francis, ☑ Brenda Solomon, ☑ Dave Curro, ☑ Annette Smith, ☑ Vicky Bass, ☑ Renee Lloyd, ☑ Tekkyon Lloyd, ☑ Michael Maguire, ☑ Faye Griffin

BOARD MEMBERS PRESENT: None

GUEST(S): Stacey Harward, NCDHHS

STAFF PRESENT: Doug Wright, Director of Community and Member Engagement, Starlett Davis, Member Engagement Specialist, Ramona Branch, Member Engagement Specialist, Noah Swabe, Member Engagement Specialist, Erica Asbury, Member Engagement Specialist

- WELCOME AND INTRODUCTIONS** – the meeting was called to order at 5:35 pm
- REVIEW OF THE MINUTES** – The minutes from the September 7, 2021 meeting were reviewed; a motion was made by Marie Dodson and seconded by Dave Curro to approve the minutes. Motion passed unanimously.

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
3. Public Comment Individual/Family Challenges and Solutions	No comments.	Ongoing	N/A
4. State Updates	Stacey Harward, NCDHHS was in attendance and went over the State updates October CEE: <ul style="list-style-type: none"> ➤ Long Term Care Planning Month ➤ MIAW 2021- Mental Illness Awareness Week runs from October 3-9 and coincides with additional related events: <ul style="list-style-type: none"> ○ Tuesday Oct 5: National Day of Prayer or Mental Illness Recovery and Understanding ○ Thursday Oct 7: National Depression Screening Day ○ Saturday Oct 9: NAMIWALKS United Day of Hope ○ Sunday Oct 10: World Mental Health Day ➤ Joint DMHDDSAS & DHB Update call: Providers Thursday, October 7th from 3 pm - 4 pm ➤ Joint DMHDDSAS & DHB Update call: Consumers & Family Members Monday, October 25th from 2 pm - 3 pm ➤ Regional CFAC Meetings: <ul style="list-style-type: none"> ○ Alliance, Eastpointe, Sandhills and Trillium October 18, 2021, from 6 pm—7 pm ○ Cardinal, Partners and Vaya October 26, 2021, from 6 pm—7 pm 	Ongoing	N/A

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on [Click or tap to enter a date..](#)

Monday, October 04, 2021

CONSUMER AND FAMILY ADVISORY COMMITTEE - REGULAR MEETING
 5200 W. Paramount Parkway, Morrisville, NC 27560
 Held Via Video Conference

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
	<ul style="list-style-type: none"> ➤ State to Local Collaboration Meeting <ul style="list-style-type: none"> ○ Next Call: October 27, 2021 from 6:00 – 7:30 pm ➤ NC Medicaid Managed Care Hot Topics Webinar Series <ul style="list-style-type: none"> ○ Every 3rd Thursday of the month from 5-30-6:30 PM ○ Next webinar: October 21, 2021 ➤ Pinehurst Conference will be held both virtual and in person this year from December 8-10 		
<p>5. LME-MCO Updates</p>	<p>Local Community Collaboration and Engagement Strategy</p> <p>Doug went over the main highlights of this 15-page document that everyone received an electronic copy of in their email.</p> <ul style="list-style-type: none"> ➤ This document addresses in detail how Alliance will work to reduce potential local barriers to health such as program eligibility, enrollment continuity, member and recipient engagement, unmet resource needs and local continuums of care. It also describes our approach to build partnerships at the local level to increase the availability of natural, community and recovery supports for the people we serve ➤ Members were given a chance to ask questions and give feedback on the document ➤ Members were asked to please read document in its entirety and submit any questions or concerns to Doug or their Member Engagement Specialist for answers or clarification 	<p>Ongoing</p>	<p>N/A</p>
<p>6. By-Laws/ Charters</p>	<ul style="list-style-type: none"> ➤ Process – Have put meeting on hold due to delay in the meet and greet; Israel Pattison is willing to support this effort as well, he was a significant contributor to the current by-laws ➤ The following members will serve on the subcommittee for the By Laws and Charters <ul style="list-style-type: none"> ○ Marie Dodson- Johnston County ○ Dave Curro- Durham County ○ Charlitta Burruss- Durham County ○ Annette Smith- Wake County 	<p>Ongoing</p>	<p>N/A</p>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on [Click or tap to enter a date..](#)

Monday, October 04, 2021

CONSUMER AND FAMILY ADVISORY COMMITTEE - REGULAR MEETING
 5200 W. Paramount Parkway, Morrisville, NC 27560
 Held Via Video Conference

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
7. Realignments	<ul style="list-style-type: none"> ○ Michael Maguire-Cumberland County ➤ Meet and greet scheduled for 13th of October <p>Doug has been planning a meet and greet to welcome the CFAC members from Mecklenburg and Orange counties from Cardinal. There are currently (3) members from Mecklenburg and (4) from Orange. Cardinal had regional CFAC subcommittees instead of individual county CFAC. The members will be invited to join the November Steering Committee meeting</p>	Ongoing	N/A
8. Steering Committee Meeting	<p>Long term – should it be a virtual meeting considering the addition of Mecklenburg and Orange Counties?</p> <p>The group unanimously voted to have the Steering Committee Meeting virtual for the long term.</p>	N/A	N/A
9. Subcommittees <ul style="list-style-type: none"> • Wake • Durham • Cumberland • Johnston • Area Board • Human Rights • Quality Management 	<p>Vicky Bass- Alliance Permanent Supportive Housing Training</p> <p>Charlitta Burruss- Alliance Permanent Supportive Housing Training; Advocacy focus points for upcoming year</p> <p>Felisha McPherson- Alliance Permanent Supportive Housing Training</p> <p>Marie Dodson- Alliance Permanent Supportive Hosing Training; Guardianship Video</p> <p>Dave Curro- Governance, Realignment, and Board Seats</p> <p>Doug Wright- N/A</p> <p>Israel Pattison/Marie Dodson/Dave Curro- 7-day challenge</p>	Ongoing	N/A
10. Announcements	Assistive Technology Expo: October 7, 2021 held virtually- Erica will send out link to participate to all members on list serve	N/A	N/A

11. ADJOURNMENT: **7:05pm** The next meeting will be November 1, 2021, at 5:30 p.m.

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on [Click or tap to enter a date..](#)

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D. Collaboration with Community Partners

1. Embedded Liaisons
2. DSS
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- A. Training and Community Events
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- A. Social Drivers of Health (NCCARE360/ Network of Care)
- B. Community Inclusion Planning Meetings - Fidelity
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- A. HealthCrowd
- B. Housing and Community Living
- C. County Dashboards
- D. Provider Collaboratives
- E. NCCARE360

Introduction to Alliance’s Community Collaboration and Engagement Approach

This document will address in detail how Alliance will work to reduce potential local barriers to health such as program eligibility, enrollment continuity, member and recipient engagement, unmet resource needs and local continuums of care. It also describes our approach to build partnerships at the local level to increase the availability of natural, community and recovery supports for the people we serve.

A. System of Care Philosophical Framework

System of Care is an overarching framework and the way we do business. Alliance’s System of Care (SOC) embraces and promotes the concept that individuals and families should receive the services and supports they need in their homes, at work, in school, and in the community. These services and supports should be Evidence-Based or grounded in Best Practice, strength-based, person-centered, family-focused, and provided within environments of greatest independence that are appropriate and safe.

The needs of the individual and family should dictate the type and mix of services and supports provided. Individuals and families should be full participants in all aspects of the planning and delivery of their services and supports, and this should be guided by one comprehensive, integrated, and individualized plan. Agencies and programs should be sensitive and responsive to cultural differences and unique needs. In addition, agencies, programs, services, and supports should promote a common mechanism for planning, developing, and coordinating services while maintaining a professional standard of confidentiality for every individual and family. Communities should determine local service needs and how these services should be delivered.

Alliance has a long and proud history of engaging our community partners in this highly collaborative approach- an approach we believe will be highly suitable for an integrated care management model.

B. Addressing Equity/Health Disparities

A core principle of public health is that every person should be able to reach his or her full health potential. Most health disparities affect groups marginalized because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location, or some combination of these. People in such groups not only experience worse health but also tend to have less access to the social determinants or conditions (e.g., healthy food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination) that support health.

In designing our population health efforts as well as ensuring our members social determinants needs are met we will first consider our historically marginalized communities in our outreach and education efforts. NCCARE360 will be a resource used to try and connect people to the resources they need to live healthy and to track that effort. We will work with our Quality Management Department to identify disparities, develop interventions, and measure our effectiveness in overcoming these disparities.

C. Applying the Collective Impact Approach

At Alliance we realize we are but one piece of the puzzle in each of the communities we serve. To attain long lasting and significant change and results we must work with all of our stakeholders in a more impactful way. For those challenges that are particularly complex and cross multiple systems we practice the collective impact approach whose basic tenets include:

- Establishing a common agenda and vision amongst diverse stakeholders.
- Establishing shared measurements that tracks progress.
- Fostering mutually reinforcing activities so our efforts are coordinated and not duplicative.
- Continuous communication that builds trust and goodwill.

Approach to Understand the Unique Needs of the Counties and Communities the BH I/DD Tailored Plan Serves

We strongly believe that local communities solve local problems drawing upon their unique talents, assets and culture. As a local partner we not only participate in finding solutions but we provide the necessary key local data and transparency to ensure we are addressing the right challenges and can track progress.

A. Provider Network Adequacy Report

A significant component of understanding the unique needs of areas we serve and access to care barriers is our annual Provider Network Adequacy report.

The analysis will include a comprehensive review of the characteristics and demographics of the individuals and communities within the Alliance area, review of provider network capacity and access, and qualitative input from members, families, County Agencies, stakeholders, providers, and Alliance staff. This includes a data informed process of identification and prioritization of community and service needs and gaps in which we will focus to bring about change. As part of our community engagement we have highly specialized positions who bring expertise to a variety of areas such as criminal justice, homelessness and crisis supports. The primary purpose of these specialist roles is to cultivate mutually reinforcing partnerships, reduce barriers to care and improve coordination amongst multiple systems.

B. Director Meetings

In Durham we have staffed the Durham Directors, a group of local governmental leaders representing the City and County governments, housing authority, first responders, DJJ, DPS, Durham Tech, Criminal Justice Resource Center, public health, DSS, District Court Judge, District Attorney and the Youth Detention Center for over 20 years. This group inspired the creation of the Wake Directors several years ago with a similar make up as Durham Directors with the addition of WakeMed and UNC to include issues such as Emergency Department diversion. The purpose of these groups is to promote SOC as a “way of doing business” by enhancing collaboration, decreasing fragmentation and duplication of systems, addressing policy barriers and generating shared solutions to community problems. Our goal is to develop similar collaborative groups in each of the counties we serve.

C. County Commissioner Advisory Committee

Our Board of Directors includes a County Commissioner Advisory Board. The County Commissioner Advisory Board is critical to informing the larger board of the local impact of Alliance. The County Commissioner Advisory Board helps prioritize local budgetary requests and needs, raises particular community challenges and shares any feedback from county constituents.

D. County Dashboards

The objective of the County Analytics Dashboard is to provide an insight into some of the key performance indicators of our organization, focusing on the ability to compare them between counties in our catchment area. The dashboard does a deep dive into patients, disabilities, penetration rates, services provided, providers, and location details. We use this information to understand our population and our ability to meet service needs. This also gives us quick information to share with our county partners so they have a better understanding of our efforts in their communities.

E. SDOH Data and Population Health Data – Community Health Needs Assessment

The Community Health Needs Assessment (CHNA) is a vital assessment for our partnerships as it identifies health concerns and outcomes for both individual groups and the community as a whole. Alliance staff are active participants in the process of developing this assessment and addressing priority issues identified in the assessment.

In addition, using risk stratification scoring Alliance has identified the most vulnerable groups in which we serve. Often these overlay with the Community Health Needs Assessment and census tract Social Vulnerability Index- using this holistic approach to understanding the areas of opportunity in our communities we will do targeted outreach, education and engagement.

Methods of Collaborative Outreach and Engagement with County Agencies, CBOs, and other Community Partners

A. Collaboration with Members, Their Families and Caregivers, and Local Communities

1. Consumer and Family Advisory Committee (CFAC)

The Alliance Consumer and Family Advisory Committee (CFAC) is comprised of members, recipients, and family members in each of our counties with an overarching steering committee made up of leadership from those local committees. They are autonomous in nature and Alliance supports them to fulfill their statutory requirements. Staff with lived experience are assigned to each group to ensure they receive information and have the opportunity to communicate with Alliance management and our Board of Directors. A CFAC member also sits on the Board and gives guidance and direction into clinical and financial operations.

The chair of the CFAC Steering Committee presents at each Board meeting about activities, concerns, and suggestions. CFAC also advises Alliance on the adequacy of our network and services annually through participation in a survey and providing feedback to our Provider Network staff. The Alliance CFAC averages 48-60 meetings per year. We will continue to present information to CFAC monthly on Medicaid Transformation, including development of the Tailored Plan, and solicit their input. Feedback and suggestions will be included in CFAC meeting minutes and reported monthly to the Board of Directors and Alliance management. Our CFACs are already engaged with this process, having reviewed and commented on recent policy papers developed by the Department, and will continue to advise Alliance.

2. Community Collaboratives

Community Collaborative

Drawing upon the collective impact approach, a framework that builds consensus with multiple and diverse stakeholders creating a shared vision for change and cross system strategies Alliance facilitates Community Collaboratives in each of our counties. Community Collaboratives are groups of community members and organizations who come together to implement a System of Care approach by creating neighborhood and community environments that empower and support children and their families. We convene a Community Collaborative in each of our counties and strive to improve family and youth participation that reflects the populations we serve.

Crisis Collaborative

Crisis Collaboratives are a group of behavioral health providers, hospitals, facility-based crisis units, health departments, mobile crisis, first responders, and other community stakeholders whose goal is to improve the health of individuals with mental health, substance use, and intellectual and developmental disability issues by providing crisis care in a timely manner and in the most appropriate setting. The mission of the Crisis Collaborative is to enhance countywide resources and improve mental health, substance use, and intellectual and developmental disability system processes to ensure that the care provided to individuals in crisis is provided by a coordinated and collaborative system of public and private providers.

Juvenile Justice Behavioral Health Partnerships

The North Carolina Juvenile Justice Behavioral Health Partnerships are local teams across NC working together to deliver effective, family-centered services and supports for juvenile justice involved youth with substance use, mental health challenges or facing issues in both areas. These partnerships require an organized person-centered system that operates under System of Care principles.

At a minimum, the partnerships address the completion of substance abuse and mental health comprehensive clinical assessments, provide evidence-based treatment options to youths, and support the Child and Family Team Process.

The goal of this partnership is to help facilitate and support this process in each of our communities with our Crisis and Justice Support teams, ensuring our members' needs are met and the trajectory of their lives is a positive one.

3. Community Based Education and Events

Our education and engagement efforts are applicable to both urban and rural settings. Our Community Education and Outreach team provides trainings on a variety of topics aimed at improving overall health and quality of life. We will continue to provide health and wellness education virtually, telephonically, and in-person.

Our training menu covers a broad range of topics from disease management, access to care, recovery principles, and Mental Health First Aid (MHFA). Recognizing that law enforcement is integral in mental health responses we train first responders and community members in Adult MHFA and in Youth MHFA. As we move into Tailored Plan implementation, our education and outreach efforts will include partnerships with Departments of Social Services (DSS), the enrollment broker and ombudsman offices to ensure our members and recipients understand eligibility for various health plans and other key considerations to address continuity of care and wellness. Future education topics will also include a broader focus to better address physical health needs including preventive care, smoking cessation, impact of nutrition, diabetes, and others.

Annually we participate in multiple community-based outreach events such as resource fairs, education events, stand down events for veterans, as well as cross agency training events. Our community relationships continue to ensure we have a seat at the table in almost all community events where our members and the community as a whole could benefit from information and resources.

B. Collaboration with Local Community Stakeholders

1. Collaboration with Local Government

Alliance has a long history of maintaining and enhancing relationships with local county leadership. Besides the Directors Groups described above we participate on the local COC's, CIT Steering Committees, Gang Reduction Committees, Early Childhood Collaboratives, School Safety Committee, DSS Permanency Improvement Project and a variety of local coalitions, committees and ad hoc groups.

2. Collaboration with Enrollment Brokers and the Ombudsman Program

Alliance values and understands the importance of collaborative outreach and engagement with key Medicaid partners including the Enrollment Broker and the Member Ombudsman Program. Alliance will continue to host local community forums across our counties served with the purpose of educating Medicaid beneficiaries and the community about the transition to Managed Care. Alliance will invite Enrollment Broker(s) and a representative from the Ombudsman Program to directly present information about their roles and services provided. We will continue working with the Enrollment Broker and Ombudsman Program to provide community education and ensure that information about both programs is included in our educational materials and community presentations. We welcome participation from the Enrollment Broker and Ombudsman Program in Alliance's Member-facing workgroups such as Consumer and Family Advisory Committee (CFAC) and other stakeholder groups as appropriate, per approval from the Department. We will ensure that Department approved materials are available in hard copy and electronic format for distribution to local Department of Social Services (DSS) offices and to members who may utilize the Ombudsman Program

for assistance. Alliance will engage in joint community-based education events and activities with the staff of the Enrollment Broker and Ombudsman Program and other key Department partners as requested by the Department, including but not limited to health education and promotion fairs, forums, town halls and other community events.

3. Community Advisory Groups

a. Long Term Services and Supports (LTSS) Member Advisory Committee

Alliance is committed to meeting the needs of members utilizing LTSS, including care provided in the home, in community-based settings or in facilities. This Committee will meet on at least a quarterly basis to gather stakeholder input and advice and will reflect LTSS covered populations including:

1. Members accessing LTSS
2. Representatives of LTSS members (e.g., authorized representatives);
3. LTSS providers
4. Care managers from AMH+ practices and CMAs serving members with LTSS needs, and
5. Alliance staff involved in the authorization of LTSS and/or care management of LTSS members.

b. Innovations Waiver Stakeholder Group

Alliance will develop a stakeholder group consisting of Innovations waiver members, families, advocates, and providers to provide recommendations regarding implementation and operation of Innovations waiver services and policies. Alliance will meet with this stakeholder group on at least a quarterly basis.

c. Traumatic Brain Injury (TBI) Waiver Stakeholder Group

Alliance will develop a stakeholder group consisting of TBI waiver members, families, advocates, and providers to provide recommendations regarding implementation of TBI waiver services and policies. Alliance will meet with this stakeholder group on at least a quarterly basis.

C. Collaboration with Community Based Organizations to Address Unmet Social Needs

1. Collaborating with Community Based Organizations – Early Engagement

Alliance has a strong reputation for collaborating with Community Based Organizations (CBO's) and other human service agencies. Through NCCARE360 and our Network of Care efforts we have a comprehensive understanding of the community resources, zip codes where there are food deserts or other scarcities and high opportunity census tracts. To not only foster further collaboration but to identify areas for possible investments to bolster CBO capacity, Alliance will hire Community Engagement Specialists who work throughout our region to forge partnerships, understand the unique needs and offerings of CBO's and ensure there is seamless access to resources and resolution of referrals for the people we serve.

2. Collaborating with Community Based Organizations – Advancing Our Partnership

As mentioned above, Alliance is hiring dedicated staff to partner with CBO's throughout our region. In addition, we are convening Community Roundtables with our CBO's that will allow

the opportunity to share information and resources, increase understanding of the Medicaid system, review data from NCCARE360, address inequities and disparities and ensure we have an up to date resource directory that is linked to NCCARE 360. As part of our SDOH strategy Alliance is interested in continuing to make investments to increase capacity of CBO's or address a unique health condition of our population. In addition to the substantial housing investments we have made, last year we made donations to food and diaper banks, homeless shelters and food insecurity programs related to school aged children.

3. Community Based Organizations with Which Alliance Will Partner

Alliance has, and will continue, to partner with the full range of CBO's outlined in the RFA as well as those specific to the four social needs domains through Healthy Opportunities.

D. Collaboration with Community Partners

Healthy communities evolve when key partners work together to address the barriers and inequities that exist in every community. Our efforts to work with our communities will be grounded in our system of care principles, utilizing the collective impact model when appropriate, and always working to eliminate the inequities that prevent marginalized sectors from receiving the supports they need. Below are some of the ways we can help this ongoing process.

1. Embedded Liaisons

Upon request from public partners, we explore the value of having embedded positions to assist with system navigation.

2. DSS

Alliance values and understands the importance of collaborative outreach and engagement with key partners, including our local Departments of Social Services, to address complex social issues such as crisis services and diversion, homelessness and children in foster care. Alliance currently has three co-located positions within our local DSS agencies.

In addition, System of Care Coordinators serve as liaisons with our county DSS's and meet regularly with leadership and front-line staff to identify and resolve system barriers and provide technical assistance for individual cases. DSS representatives attend all of our local Community Collaboratives. As a partner who serves many Alliance members and recipients, DSS is vital to this conversation and will remain a primary partner around the table.

3. Public Health

Our Public Health Departments are key partners as we expand our management of care to include the physical and pharmacy needs of our members. We will work to include our PHDs in our local collaboratives and help to build the connections needed to do meaningful work in our communities. We plan to work with them on our education and outreach areas, utilizing their expertise to help us better support our members with population health strategies. Our goal will be to ensure our members receive that integrated care so important in helping them meet their health care goals.

4. Public Schools

Alliance partners with public schools throughout our catchment area to support a System of Care approach to improve educational outcomes for the young people we serve. Local representatives from public schools participate regularly within our Community Collaboratives across all our counties. With guidance from the School Based Mental Health Policy effective in November 2020, Alliance is in process of developing or updating MOU's with all schools in our catchment area updating to better support our members. The School Based Mental Health policy and MOU require Alliance and schools to work together to support the behavioral health needs of shared members. Another tool to advance our partnership is the adoption of the universal release of information which helps coordinate care and timely communication amongst multiple providers supporting the child and family.

As an example of a highly specialized partnership with funding from Wake County, Alliance and Wake County Public Schools have formalized a partnership to implement a comprehensive School Based Mental Health Team (SBT.) The SBT connects students to treatment and support transitions of care from crisis programs and other out of home placements, including PRTF's. This team also includes other specialized programs such as assisting families with system navigation, and partnering with local Resource Officers to help divert youth who commit non-violent offenses at school from incurring legal charges in the criminal justice system. This team also has future plans to expand embedded liaisons within WakeMed to collaborate with treatment teams for members presenting to the ED/Hospital. Alliance is willing to develop similar specialized school-based programs throughout our catchment area.

5. Children's Developmental Services Agencies

Alliance recognizes the value of early intervention in providing a vital opportunity to identify and impact how a child with special needs develops and learns. We therefore look forward to the opportunity to develop and strengthen our partnerships with our local CDSAs.

System of Care Coordinators have already extended an invitation to local CDSA's to join the Community Collaborative in their respective county and will work to actively engage them in this group. The Collaboratives, drawing upon the collective impact approach, a framework that builds consensus with multiple and diverse stakeholders creating a shared vision for change and cross system strategies, will develop yearly action plans that strive to improve cross-system coordination and function. As a partner CDSA's will be an important part of the discussion to ensure that the needs of children birth thru 5 are part of our system development.

6. Criminal Justice

Community Health & Well-Being (CHWB) has a Crisis and Justice Team with many years of experience working in both the criminal justice system and the behavioral health system. The team is responsible for planning and coordinating Crisis Intervention Team training (CIT) and Juvenile Justice Behavioral Health partnerships (JJBH). The team also provides technical assistance on how to navigate services and supports for members and recipients involved in the criminal justice and behavioral health systems. Some of our work in the community includes CIT: Crisis Intervention Team training, Veteran CIT (VCIT) for officers who have received CIT training and are a veteran of one of our military branches, Mental Health First Aid

(MHFA). Criminal Justice Specialists have a working relationship with our local jails, prison/reentry Councils, MH Probation, and Court Liaisons.

Alliance staff has been part of several initiatives along the sequential intercept continuum, from the 0 intercept through intercept 5/community supports. We have and will continue to be involved in diversion programs, behavioral health urgent care, ILI/rental assistance, alternative responses to 911, gang reduction, community para-medicine, and various other county by county projects.

7. Housing Authorities/Developers

Working with public housing authorities, DSS and COC agencies we provide financial assistance for rapid re-housing and eviction prevention for our members that includes both an internal Supportive Housing team and a Housing Assistance team to help partner agencies navigate the often-complex behavioral health system.

8. Physical Health Providers

As with our behavioral health providers, good partnerships and communication are essential. We will work to develop the relationships needed to include our physical health providers in our efforts to ensure members whole person care is being addressed. We hope to be able to take advantage of their expertise, knowledge and education efforts to assist us in supporting our members. We will offer any technical assistance and training that is relevant and needed.

9. CMA (Case Management Agencies), AMH (Advanced Medical Homes)

As with our physical health providers, good partnerships and communication are essential. Community Health and Well-being can impact member outcomes most effectively through our Community Inclusion Planning Meetings. We will offer technical assistance, support, and staff to help our provider care management partners utilize this approach to support their most significant cases for both children and families and adult members.

Measures of Successful Engagement and Collaboration

A. Training and Community Events

There are three education and outreach strategies to achieve our goals. Each strategy has a purpose and expected outcomes listed. The effectiveness of each strategy will be evaluated no less than quarterly, and the strategies will be adjusted or modified as needed to ensure that expected outcomes are achieved. These strategies are tied to the work plans of the individuals primarily responsible for its implementation and the Alliance Strategic Plan. Future plans will be driven by the measurable expected outcome data and the Alliance Strategic Plan. Our training and community events will be opportunities to improve the health literacy of our members.

1. Community Presentations and Trainings

Purpose: To provide opportunities for stakeholders to receive presentations on how to navigate, access, and use the public healthcare system in the Alliance catchment area, i.e. how do we access care if we need it. To reduce the impact of myths and stigmas on

penetration rates for health issues, i.e. increase the number of stakeholders willing to ask for help. To increase stakeholders' level of balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions for their healthcare needs.

Outcomes: Individuals will increase their level of knowledge as measured by the comparison of test answers before and after receiving the presentation or training. Individuals will give the presentation or training an average score of a four (good) on the Alliance Evaluation Survey using the five-point (Likert) scale. Each Alliance Education Specialist will provide an average of four presentations and one training per month as measured by the Community Relations monthly report. We will expand Mental Health First Aid training to educate our system and members to promote wellness and prevention to reach the goal of advancing person-directed health.

2. Behavioral Health Awareness Weeks/Months Toolkits

Purpose: To increase the awareness and reduce stigma with stakeholders and general public around disabilities, physical and behavioral health issues.

Outcomes: Individuals will increase their level of knowledge as measured by the comparison of test answers before and after receiving the screening/training. Record the number of individuals attending or the collective impact of the event. Individuals will give the event an average score of a four (good) on the Alliance Evaluation Survey using the five-point (Likert) scale.

3. Outreach - Community Events

Purpose: To provide opportunities for stakeholders to receive information on how to navigate, access, and use the public healthcare system in the Alliance catchment area, i.e., How do we access care if we need it? To reduce the impact of myths and stigmas that effect penetration rates for healthcare, i.e., increase the number of stakeholders willing to ask for help. To increase stakeholders' level of knowledge to assist them in understanding the challenges, barriers, opportunities and/or solutions for their healthcare.

Outcomes: Participate an average of at least one community event or fair per month as measured by the Community Relations Monthly report. Participate in the established conference sponsorship/vendor: NC NAMI Annual Conference, NC CIT conference, etc. At a minimum, ensure an Alliance representative attends the local NAMI affiliate monthly educational meeting. Coordinate run/walk teams at Alliance with the goal of increasing participation from the previous year, as measured by fund raising amounts, number of contributors, and the number of participants in the run/walk.

B. Community Level SDOH Data

Alliance is in the process of developing a comprehensive SDOH strategy that includes a strong emphasis on data and analytics. In addition to dashboard data from NCCARE360 that will allow us to identify gaps in CBO capacity we will also be assessing social needs from health risk assessments, community health needs assessments, claims data and census tract data overlaid with Social Vulnerability Index data and member addresses in that census tract. By incorporating multiple sources of community level data, we will be able to specifically target education and

outreach efforts in our high opportunity areas, determine additional Value Added Benefits as well as address social needs gaps.

C. Community Collaborative

Drawing upon the collective impact approach, a framework that builds consensus with multiple and diverse stakeholders creating a shared vision for change and cross system strategies Alliance facilitates Community Collaboratives in each of our counties. Community Collaboratives are groups of community members and organizations who come together to implement a System of Care approach by creating neighborhood and community environments that empower and support children and their families. They collaborate to build an array of services, supports and linkages among public and private human service agencies, families, neighborhoods and communities.

These services also cater to the responsiveness of children, helping them reach their full potential as responsible, productive and caring individuals. Collaboratives are open and welcome everyone in the community to come and participate. Members can participate on impact teams that concentrate their efforts on specific issues. Developing a strategic plan, working to implement interventions, then measuring and reporting out on our successes is a key part of our approach.

Measures to Foster Community Inclusion Supporting BH I/DD Tailored Plan Members and Recipients

A. Social Drivers of Health (NCCARE360/ Network of Care)

While all four counties in our service area are now actively interacting with NCCARE360, in Wake and Durham counties we also administer a Network of Care (NOC) model through local funding. NOC is a resource platform and educational repository to connect the general public to a full range of community supports. With a combined 3200 resources in each directory we employ two full time NOC Administrators who work closely with our community-based organizations to ensure new resources are added and existing resources are accurate and up to date. Our Wake County NOC Administrator spends half of his time co-located at the homeless day services center to help persons navigate systems and get connected to appropriate resources.

B. Community Inclusion Planning Meetings – Fidelity

Community Inclusion Planning Meetings adhere to System of Care Values and Principles: meetings are strength-based and led by the member whenever possible, participants selected to provide knowledge and expertise in each meeting are selected based on his or her ability to contribute to the member's personal goals and needs while also taking responsibility for success-based outcomes. Each participant is also responsible for collaboration and creating a comfortable space for the meeting to occur.

The following fidelity tools are in place to ensure Community Inclusion Planning Meetings adhere to Continued Quality Improvement (CQI) and provide a standard framework for members, community participants and the facilitator are:

1. CIPM Standard Operating Procedures (SOP) and Process
2. CIPM Action Plan Form

3. CIPM Etiquette Sheet
4. CIPM Fidelity Observation Tool (adapted from Wraparound Fidelity Assessment System: Team Observation Measure 10/2017).
5. CIPM Survey identifies measurement areas in the following: System of Care Values, System of Care Principles, 11 Core Principles of Wraparound and adhering to the CIPM Process (#1)

C. Child/Family Teams- Fidelity

Child and Family Teams are an important tool in supporting our youth and families. They provide a collaborative structure where family members and their community support can come together to develop a comprehensive, supportive plan based on the needs and preferences of the youth and family.

To achieve this, Alliance works within the System of Care model to:

- Offer and facilitate CFT trainings (intro to advanced) to providers and community partners
- Ensure fidelity to CFT model thru:
 - Training effectiveness measures
 - CFT meeting fidelity monitoring
 - Technical assistance to providers and partners
 - Youth/family CFT satisfaction surveys

We expect to increase fidelity to CFT model, increase provider, partner and youth/family satisfaction with CFT process, increase the number of providers/partners trained in CFT01 and CFT02, and increase youth/family perception of community membership and inclusion.

Reporting of Outcomes to County Agencies, CFACs, CBOs, and Other Community Partners

A. HealthCrowd

We have increased efforts to provide education and outreach to our members as they make decisions about their health and well-being. We will continue our contract with Healthcrowd, an enhanced digital platform to expand communications through text messages. Some of our previous outreach campaigns included targeted messages about tobacco cessation resources, medication adherence, and HOPE4NC resources to assist individuals impacted by the COVID-19 pandemic.

Text messages also focus on the importance of following up with primary care about recommended healthcare screenings and preventive care. When indicated, members who opt-in may receive targeted text reminders about the importance of routine follow-up with their doctor for monitoring and other routine lab work, such as a blood glucose (sugar) test when recommended. The messages encourage members to call their doctor with any questions. All text messaging content has been approved by DHHS.

Our Healthcrowd vendor sends us routine reports across all campaigns. Our QM team uses data reports from Healthcrowd to help monitor the effectiveness of these interventions, such as HEDIS

gap closure rates for members included in targeted HEDIS educational outreach campaigns. Reporting about opt-in rates, members reached, and outcomes of targeted campaigns will be shared with community stakeholders as needed.

B. Housing and Community Living

Housing is an important social driver of health and argumentatively the leverage point for all other whole person interventions. Alliance has been a statewide leader in the development of a robust supportive housing program. Practicing a Housing First philosophy we operate a full array of community living options targeted towards not only the TCL population but other high-risk populations served through the Tailored Plan. As we expand into other counties we will replicate effective programs as well as build out our Recovery Oriented System of Care and our community living redesign which offers alternatives to congregate care.

C. County Dashboards

The objective of the County Analytics Dashboard is to provide insight into some of the key performance indicators of our organization, focusing in the ability to compare them between counties in our catchment area. The home page shows average patients served, dollars paid, dollars per patient, penetration rate and active providers in comparative formats and for individual counties for both state and Medicaid funded recipients. The dashboard does a deep dive into patients, disabilities, penetration rates, services provided, providers, and location details. We use this information to understand our population, the services needed and provided and our ability to meet those needs. This also gives us quick information to share with our county partners so they have a better understanding of our efforts in their communities.

D. Provider Collaboratives

Alliance also facilitates 11 unique provider learning collaboratives comprised of Providers, stakeholders, and other community partners that focus on quality measures and removing barriers to achieving those quality standards. Providers who participate in service specific provider collaboratives receive outcome measures quarterly. Using our analytics capabilities, Alliance uses data to help guide technical assistance topics provided through these learning collaboratives.

E. NCCARE360

NCCARE360 is a statewide coordinated network that unites health care and human service organizations to address member social determinants of health (SDOH) needs using a shared technology platform. This system allows social service providers to connect those with identified needs to community resources. Users can complete referrals, communicate with treatment team members, and track an individual's progress to having their needs met. NCCARE360 will be one of the tools Alliance uses to address SDOH needs for our members. We will utilize the reporting structure on the platform to track success as well as report back to our community partners. Our Quality Management Department has already begun to take the data learned, analyze it, and report out to our SDOH CQI Committee for action.



COMMUNITY ENGAGEMENT & EMPOWERMENT TEAM

Community Updates | October 2021

NCDHHS- DMH/DD/SUS

Long Term Care Planning Month

Long-Term Care Planning Month encourages seniors and their loved ones to take a look at what their needs are and where they may need to add in some assistance. We can't predict the future, so we need to explore Long Term Care Planning whether that is in the home or in a facility .

Remember long-term care is not just medical it is whole person care. Medical is apart of it but so is personal care, grocery shopping, housing keeping, shopping and the list goes on. Medical Insurance does not generally cover these services so one must plan. Advance planning offers seniors more choices and decision-making opportunities. When seniors plan ahead, they have more time to save for long-term care, too.

HOW TO OBSERVER

Visit with family and make a plan. Explore options and discover what is available to you.

Resources:

<https://www.ncdhhs.gov/media/13369/open>

<https://www.ncdhhs.gov/assistance/adult-services/home-care-independence>

<https://www.ncdhhs.gov/assistance/disability-services/community-alternative-programs-disabled-adults>

National Disability Employment Awareness

“NDEAM is held each October to commemorate the many and varied contributions of people with disabilities to America’s Workplaces and economy “

“The theme for NDEAM 2021, “America’s Recovery: Powered by Inclusion,” reflects the importance of ensuring that people with disabilities have full access to employment and community involvement during the national recovery from the COVID-19 pandemic”

To download the poster click this link:

<https://tinyurl.com/267tbp65>

The Disability Employment Initiative (DEI) aims to improve education, training and employment opportunities and outcomes for youth and adults with disabilities who are unemployed, underemployed and/or receiving Social Security disability benefits. ODEP jointly funds and administers the DEI with DOL's Employment and Training Administration (ETA).

<https://tinyurl.com/7aw9hjjs>

[Americans with Disabilities Act | U.S. Department of Labor \(dol.gov\)](https://www.dol.gov)



Mental Illness Awareness Week

MIAW 2021- Mental Illness Awareness Week runs from October 3-9 and coincides with additional related events:

- Tuesday Oct 5: National Day of Prayer or Mental Illness Recovery and Understanding
- Thursday Oct 7: National Depression Screening Day
- Saturday Oct 9: NAMIWALKS United Day of Hope
- **Sunday Oct 10: World Mental Health Day**

Mental health conditions are important to discuss year round, highlighting them during MIAW provides a dedicated time for Mental health advocates across the country to come together as one unified voice.

MIAW’s awareness campaign for 2021 is “Together for Mental Health” focus on the importance of advocating for better care for people with serious mental illness (SMI)

<https://youtu.be/BMp0KFBBCT4>

DYSLEXIA AWARENESS MONTH

5-10% of the world’s population suffers with dyslexia, making their lives more difficult each and every day. **Dyslexia Awareness Month** is the perfect time to think about how much harder dyslexic people’s lives are than those without and take time to try to be more understanding of their situation. People who suffer with dyslexia find it more difficult to read and write, Imagine staring at a page and the letters start to jump around, you have difficulty seeing the difference between a b and a d sometimes entire lines move and these are just a few of the every day issues occur. Stigma ,Embarrassment runs hand in hand with the above issues of having dyslexia.

Free Resources:

<https://www.twinkl.com/resource/cfe-s-79-cfe-first-level-dyslexia-week-awareness-resource-pack>

Activities

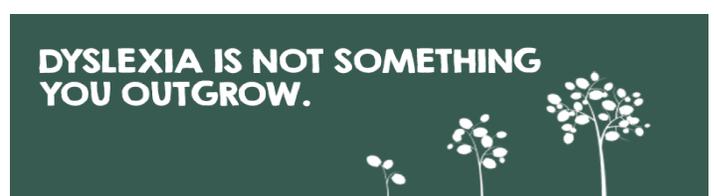
[Understanding and empathy:](#) what it's like to be affected by dyslexia

[Trespassers will be prosecuted:](#) activity to promote discussion

[Hare and turtle:](#) activity to promote discussion

[Dyslexia is a gift:](#) successful people with dyslexia

Download this article to [raise awareness of dyslexia in your school](#)



Monthly Meetings

PROVIDER & CONSUMER CALLS

Joint DMHDDSAS & DHB Update call: Providers

Thursday, October 7th from 3 pm - 4 pm

Joint DMHDDSAS & DHB Update call: Consumers & Family Members

Monday, October 25th from 2 pm - 3 pm

Links are distributed to listserv members closer to the date of the call. If you would like to be on our list serve please email the CE&E Team at:

CEandE.staff@dhhs.nc.gov

Regional CFAC Meetings

Alliance, Eastpointe, Sandhills and Trillium

October 18, 2021, from 6 pm—7 pm

Microsoft Teams meeting :

[Click here to join the meeting](#)

call in (audio only)

+1 984-204-1487,,666533989#

Phone Conference ID: 666 533 989#

Cardinal, Partners and Vaya

October 26, 2021, from 6 pm—7 pm

Microsoft Teams Meeting

Join on your computer or mobile app

[Click here to join the meeting](#)

call in (audio only)

+1 984-204-1487,,211081322#

State to Local Collaboration Meeting

The State to Local Collaboration Call will resume the regular schedule of every **4th Wednesday** of the month. CFAC members can use the same Phone Number and Conference ID for each meeting. Links to participate by web will be sent out before each meeting.

The call-in number and conference ID will not change.

Next Call: October 27, 2021 from 6:00 – 7:30 pm

<https://tinyurl.com/S2L-CollaborationCall>

+1-415-655-0003

Conference ID: 171 710 7705

NC Medicaid Managed Care Launched

Beneficiaries have several resources to [help answer questions](#) about their transition to NC Medicaid Managed Care. Those who want a reminder of which health plan they are enrolled in should call the [Enrollment Broker](#) at 833-870-5500 (TTY: 833-870-5588). Questions about benefits and coverage can be answered by calling their health plan at the number listed in the welcome packet or on the [What Beneficiaries Need to Know on Day One fact sheet](#). For other questions, beneficiaries can call the NC Medicaid Contact Center at 888-245-0179 or visit the “Beneficiaries” section of the [Medicaid web-site](#)

Learn More : <https://tinyurl.com/bpx5w7br>

State CFAC

The State Consumer and Family Advisory Committee (SCFAC)

Nothing About Us, Without Us.

meeting is on 2nd

Wednesday of every

month and is open to

the public. October, SCFAC meeting will be held as hybrid meeting – the in person at this time is only for committee members , virtual platform, or by teleconference is for all others.

Visit the State CFAC page for more information

www.ncdhhs.gov/divisions/mhddsas/councils-commissions/state-consumer-and-family-advisory-committee.

Next Meeting: **Wednesday, October 13, 2021**

Time: **9 am to 3 pm**

Join by web browser:

<https://tinyurl.com/StateCFACMeeting>

Call-in: +1-415-655-0003

Local CFAC Updates

Many local CFACs continue to meet virtually, some have started to have blended meetings . Make sure that you check with your LME/MCO to get the full calendar of events and meeting details, including how to connect with virtual meetings and or in person meetings.

Click on the directory link to find your LME/MCO: <https://www.ncdhhs.gov/providers/lme-mco-directory>

Information from the September State to Local Collaborative call

The following information is from the State to Local Collaborative call from September 2021

This link is to the recording of the to the state to Local meeting recording: <https://tinyurl.com/yu5kreu3>

Password: vUh7hyu4

The below links are for the NC collaborative for Children, Youth and Family :

<https://nccollaborative.org/>

This link provides you with a map that shows you where your community collaborative are located and broken up into each individual LME/MCO :

<https://nccollaborative.org/community-collaboratives/>
<https://nccollaborative.org/what-is-system-of-care/>

This is a link to the last meeting of the State Collaborative Policy Institute with keynote speaker Dr. Wong. – The link takes you to a video of the meeting and provides you with some additional opportunities to attend Meetings and or Trainings that will be provided by the State Collaborative Policy institute.

<https://zoom.us/rec/share/p1X6iLD1TBTikHclvCL48hPjn7uQVVZGE3MTZhMsBS-FUVS-6pKebwCPiVz-YPBm.8IcOnq0hs2fAYJK>

Have a question about anything— send it to us!!

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services is working to centralize questions coming in so that we can ensure that questions are answered in a timely manner by the appropriate subject matter experts. In order to do this we have two portals for incoming questions which are an email Bhidd.helpcenter@dhhs.nc.gov or web portal

<https://tinyurl.com/386hpk6h> Please help us better our response time by using these avenues for submitting questions.

Where you can find more information

Medicaid Transformation

Here are some additional sites that you may go to find more information on Medicaid Transformation:

<https://medicaid.ncdhhs.gov/transformation>
<https://medicaid.ncdhhs.gov/transformation/more-information>

NC Olmstead

Learn more about NC Olmstead

<https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/nc-olmstead>
<https://www.ncdhhs.gov/events>

Grant Opportunities

<https://tinyurl.com/DMHDDSAS-Grants>

IDD Supported Living Levels 2/3 Workgroup News

Supported Living Levels 2 and 3 Workgroup Quarterly Meetings:

The NC Innovations Waiver has a Service called Supported Living which provides services and supports to individuals on the Innovations Waiver who choose to live in their own home or apartment. If you are an Innovations waiver recipient and you would like more information on Supported Living please ask your Innovations Care Coordinator.

Anyone utilizing Innovations Supported Living Levels 2 or 3; providers or families/natural supports are invited to participate in quarterly meetings held regarding Innovations Supported Living. To receive more information on the meetings and be added to our listserv, please contact Christina Trovato at christina.a.trovato@dhhs.nc.gov and ask to be added to the SL 2/3 listserv.

DHHS I/DD Stakeholder Workgroup Meetings

The workgroup is responsible for researching, recommending, and providing support/guidance for future implementation of best or promising practices to meet the needs of Individuals with Intellectual/Developmental Disabilities.

The workgroup will work collaboratively with a shared vision and planning. It is the last item on this link.

Dates for the next workgroup :

November 18th—3-5 PM

<https://tinyurl.com/4thc69tk>

NC Medicaid Beneficiary Portal

Medicaid serves low-income parents, children, seniors, and people with disabilities. The Beneficiary Portal offers information on applying for Medicaid and more.

[Go to the Beneficiary Portal](#)

Learning Opportunities & Webinars



ONLINE REGISTRATION — [CLICK HERE](#)

CONFERENCE BROCHURE [HERE](#)

Program at a Glance [HERE](#)

Tailored Care Management will be the predominant care management model for the Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plan population, which includes individuals with significant behavioral health conditions (including serious mental illness, serious emotional disturbances and severe substance use disorders), I/DD and traumatic brain injury (TBI). Tailored Plan members will obtain care management through one of three approaches: through an Advanced Medical Home Plus (AMH+) practice, Care Management Agency (CMA), or a care manager based at a Tailored Plan.

The Tailored Care Management 101 webinar series was designed to help develop a shared understanding of the model across the North Carolina provider community (including advanced medical homes and behavioral health, I/DD, and TBI providers) and anyone interested.

The webinar series will run from October through mid-December, on Fridays from 12 to 1 p.m., and cover

<https://tinyurl.com/s8mpvexn>

10-1-21	Introduction to Tailored Care Management
10-8-21	Becoming an AMH+/CMA
10-15-21	Health Information Technology (IT) Requirements and Data Sharing
10-22-21	Partnering with a Clinically Integrated Network and Other Partners
10-29-21	Delivery of Tailored Care Management
11-5-21	Transitional Care Management and Community Inclusion Activities
11-19-21	Conflict-Free Care Management and Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver
12-3-21	Billing
12-10-21	Oversight and Quality Measurement/Improvement

Educational Opportunities

NC Medicaid Managed Care Hot Topics Webinar Series

Every 3rd Thursday of the month from 5-30-6:30 PM
October 21, 2021 | Medicaid Hot Topics Tailored Plan and Behavioral Health [Register for 3rd Thursday webinars](#)

Educational Tool Kit—English & Spanish

Over the past 2 years many youth and Teens have not been able to feel safe or stable due to the uncertainty of the times that we are living in. Covid –19 has caused many to have trauma in the way that it has disrupted “normal “ life. MHA’s 2021 Back to School Toolkit—Facing Fears, Supporting Students aims to help students, parents and school personal recognize how feeling unsafe can impact Mental Health and School Performance and what can be done to help young people who maybe struggling with mental health

Due to popular demand, we have also created Spanish-language fact sheets and worksheets that can be downloaded separately [here](#).

North Carolina AHEC - Course Events and catalog
[AHEC Course Catalog \(ncahec.net\)](#)



are pleased to announce

Introduction and Overview of Customized Employment

Why You Thought You Were Doing CE, But NOT!

10-11/12– 2021

FREE

5 hour training / delivered over zoom for a 2 day period

<https://tinyurl.com/35n2yj7p>



Emergency Rental Assistance Program

The HOPE Program serves 88 counties in North Carolina and the remaining 12 counties are served by local Emergency Rental Assistance Programs.

For helpful information on how to find housing and utility help, click on the following links: [Mortgage Assistance for Homeowners](#), [Rent Assistance for Landlords](#), [Rent/Utility Assistance for Tenants](#).

The Housing Opportunities and Prevention of Evictions Program (HOPE) provides rent and utility assistance to low-income renters that are experiencing financial hardship due to the economic impacts of COVID-19. If you have questions or need help applying, program representatives are available 8 a.m. – 5 p.m. Monday through Friday: HOPE Call Center: [\(888\)927-5467](tel:8889275467)

Traumatic Brain Injury

- The DMHDDAS TBI Program will be meeting with the Brain Injury Association of NC (BIANC) in early October to discuss implementation activity for year one of the TBI grant awarded by the Administration for Community Living (ACL).
- The Brain Injury Advisory Council (BIAC) has formed a workgroup that will discuss the ACL requirements of Council membership composition and develop recommendations for meeting those requirements which will be submitted to DHHS leadership for consideration.

For information and training opportunities related to brain injury please visit www.bianc.net

Veterans, Servicemembers & Families

NC Women MilVets Summit

Emerging and Lighting The Way Forward

October 21,2021

Virtual Event Register Now at

www.wmvse.org



Our Next GWG Meeting will be held on Thursday, October 28, 2021 from 2-4pm. Topic for Agenda will be: the **Social Determinants of Veteran Suicide; Part II –The Role of Trauma**

Please sign up on the newsletter link as this will be a virtual meeting.

<https://ncgwg.org/>

Resource Guide for Veterans can be viewed electronically at <https://helpncvets.org/resources/>

If you would like a hard copy of the Veterans Resource Guide or would like to partner with us to get these guides out into the community, please notify your CEE Team member.

Resource Link for Veterans and Military Members:

<https://www.va.gov/VE/pressreleases/2021081801.asp>

[Guidelines for Helping Your Family after Combat Injury](#)

[Impact of Invisible Injuries: Helping your F](#)



In Person Training—CE&E Team

The CE&E Team has started our Community Training's in-person! Reach out to your CE&E Team members to set up any of our trainings or from our Technical Assistance Program (TTAP) Our team will continue to follow all guidelines that are suggested by the State, the CDC or your organization/facility. Training opportunities include

The CE&E Team is here to help— contact us to begin planning for your next event!

Please reach out to our team at :

CEandE.staff@dhhs.nc.gov

Stacey Harward, BSW: Stacey.Harward@dhhs.nc.gov

ShaValia Ingram MS, MSW, LCSWA:

Shavalia.Ingram@dhhs.nc.gov

Wes Rider, BS: Wes.Rider@dhhs.nc.gov

Kate Barrow, BA: Katherine.Barrow@dhhs.nc.gov

Press Releases from the State

To find out the newest information from the State please check our web site at:

<https://www.ncdhhs.gov/press-releases>

2021 Innovator of the Year

"Bazelon Center for Mental Health Law in Washington D.C. names NC Leader as the 2021 Innovator of the year! The Bazelon Center is well known for playing a key role in the passage of the Americans with Disabilities Act (ADA) (1990) and the Olmstead Settlement (1999) in which the Supreme Court ruled that people with mental health diagnoses cannot be segregated in institutions. The Bazelon Center has protected human rights and advanced civil rights of people with mental illness and developmental disabilities. We would like to congratulate Cherene Caraco's for her commitment to mental health recovery. Cherene Caraco's is the founder CEO of the Charlotte-based non-profit organization Promise Resource Network!

PEER SUPPORT CERTIFICATION RENEWAL REMINDERS

Attention Peer Support Specialists!

Peer Support Certification Renewal reminders are sent 60 days before your certification expires. Please visit the Peer Support Program [website](#) for details on how to renew your certification.

Peer Support Job Board

Click [here](#) for up-to-date available peer support jobs across the state.

Upcoming PSS Trainings

- [New PSS 40-Hour Trainings](#)
- [20-Hour Additional Trainings](#)

Reporting Complaints or Ethical Violations

Allegations or observation of unethical and/or illegal behavior of a CPSS may be reported at <https://pss.unc.edu/contact-us> or by calling 919-843-3018.

PSS Employment Information

- 3784 Certified Peer Support Specialists as of Sept 24, 2021
- 1593 Certified Peers are employed as PSS
- 824 PSS are seeking employment

Full & up-to-date statistics can be found by visiting: <https://pss.unc.edu/data>

Latest NC Certified Peer Support Specialist News

NEW! Peer Support Certification applications, including payment, can be submitted online on the NC CPSS program website. Visit <https://pss.unc.edu/certification> to get started, or call 919-843-3018 if you have any questions. As a reminder, please take a moment to read the Peer Support Certification & Re-certification policies, especially if your certification is about to lapse, by clicking this link: <https://pss.unc.edu/new-policies-effective-july-1st-2020>.

Your feedback on this page is much appreciated!

Please feel free to email us at

CEandE.Staff@dhhs.nc.gov with any tips.

Community Engagement & Empowerment Team

The Division of MH/DD/SAS, Community Engagement and Empowerment team provides education, training, and technical assistance to internal and external organizations and groups to facilitate community inclusion and meaningful engagement of persons with lived MH/DD/SUD experience across HHS policy making, program development, and service delivery systems. Learn more at: <https://www.ncdhhs.gov/assistance/mental-health-substance-abuse/>

RESEARCH FINDINGS AND POLICY SOLUTIONS TO ADDRESS THE NORTH CAROLINA REGISTRY OF UNMET NEEDS



September 30, 2021

FUNDED BY THE NORTH CAROLINA COUNCIL ON
DEVELOPMENTAL DISABILITIES



NCCDD
North Carolina Council on
Developmental Disabilities

Mailing Address: 5000 Centregreen Way, Suite 500, Cary, NC 27513

Office Phone: (919) 395-5239

www.ccrconsultants.com

Research Findings and Policy Solutions to Address the North Carolina Registry of Unmet Needs

Executive Summary

Medicaid program Home- and Community-Based Services (HCBS) Waivers fund long-term services in community versus institutional settings and one means for States to achieve compliance with the 1999 U.S. Supreme Court *Olmstead v. L.C.* decision. The waivers have been shown to increase quality of life and address unmet needs for people with intellectual and/or developmental disabilities (IDD). In North Carolina, Innovations Waiver services include: assistive technology; community living and support services; community navigator services; community networking; community transition; crisis services; Day Supports; respite services; financial support services; home modifications; individual goods and services; natural supports education; residential supports; specialized consultation services; supported living; supported employment; and vehicle modifications. Unfortunately, in North Carolina only 22% of Medicaid beneficiaries with intellectual disabilities or autism are enrolled in the Innovations Waiver. It can take an individual as many as 12 years to receive a slot after being placed on the waiting list, which is called the Registry of Unmet Needs (RUN). This report summarizes research interviews from eight States including North Carolina, NC LME/MCO interviews, and NC stakeholder focus groups. We found variability in Waiver-eligible populations, administrative oversight, and waiting lists across States and among NC regions. However, most states have a waiting list for the valuable home- and community-based services covered by the Innovations Waiver. Recommended strategies and long-term solutions include increasing the number of Waiver slots with sustainable federal and State match funding; outreach and education to potentially eligible individuals and their families; streamlining and centralizing the application process; enhancing supported employment; and increasing Direct Support Professional wages to ensure access to services for individuals enrolled in the Waiver. Without increased Waiver capacity, a large segment of the IDD population and their families will remain unsupported or only partially supported and Medicaid beneficiaries with IDD will be at risk for unnecessary institutionalization.

Authors: Christina Dupuch, MSW, CCR; Sarah Pfau, JD, MPH, CCR; Shreyas Hallur, Duke University; and Michelle S. Franklin, PhD, RN, FNP-BC, PMHNP-BC, CNS, Duke-Margolis Center for Health Policy.

This initiative is supported at 100% by the North Carolina Council on Developmental Disabilities and the funds it receives through P.L. 106-402, the Developmental Disabilities Bill of Rights and Assistance Act of 2000.

Methodology

We used a multiprong strategy to generate the findings identified in this report. Under a one-year contract with the North Carolina Council on Developmental Disabilities, CCR worked with Duke University researchers to design a survey instrument, conduct interviews with a national sample, and evaluate states' historical and current practices, gaps, and solutions to ensuring access to Medicaid Home- and Community-Based Services (HCBS) Waivers for individuals with intellectual and developmental disabilities.

We interviewed 10 Developmental Disabilities Council Directors and Department of Health and Human Services (DHHS) leaders representing eight states: Georgia (GA), Louisiana (LA), Maryland (MD), North Carolina (NC), Tennessee (TN), Texas (TX), Washington (WA), and Wisconsin (WI). CCR and Duke University researchers met with both DHHS and NCCDD representatives to seek approval of the best list of States that appeared to have similarities to North Carolina in terms of population size or geography or political party composition in the State's legislative body. The researchers also considered whether States of interest had made recent changes to address their waiting lists or had unique policy experience to share regarding HCBS IDD waivers. The semi-structured interview guide is provided in **Appendix A**.

Via email, telephone calls, and virtual face-to-face meetings we also surveyed the seven North Carolina Local Management Entity / Managed Care Organizations (LME/MCOs) that administer IDD, behavioral health (BH), and substance use disorder (SUD) services under Medicaid managed care for all 100 North Carolina counties. The survey questions are provided in **Appendix B**. We also met with eight stakeholder groups to present information about the project and gather feedback. Stakeholders included: NC Council on Developmental Disabilities members; the Developmental Disabilities Consortium; the *Olmstead* Community Capacity Committee; the Cardinal Innovations Healthcare LME/MCO IDD Stakeholder Group; Money Follows the Person beneficiaries; the IDD committee of a statewide provider association for IDD, BH, and SUD services (the North Carolina Providers Council); the NC Waiver Action Team; and the State Consumer and Family Advisory Committee.

Key Findings

State Interviews

We gathered qualitative data during live interviews that lasted an average of 68.5 minutes each (range 53 – 92 minutes). While North Carolina has one IDD waiver serving 13,138 people and has 15,187 people on the RUN (note that these are point-in-time statistics that change monthly), states on average have 3.6 waivers serving almost 20,000 people. Other states' waiting lists have an average of 27,000 people who wait for about 9.1 years for a slot. One exception, WI, has eliminated its waiting list. Conversely, TX has 159,000 people on the waiting list and a wait time of 12-15 years.

Some states construct waivers to cover services throughout an individual's lifespan, while other states use separate child and adult waivers or some combination. Numerous states (including NC) follow a first come, first served approval process for available slots, while some open needs-based slots. One state, TN, prioritizes individuals who are seeking employment, are transition age youth, and are in crisis status [e.g., therefore eligible for reserve slots]. For individuals who are waiting and not enrolled in Medicaid, there are few options for supportive services. However, States do have mechanisms for informing individuals about those services. Nonetheless, there may be insufficient outreach and education, care management or funding for those services.

To be eligible for the North Carolina Innovations Waiver, an individual must:

- Meet the requirements for Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) level of care
- Live in an ICF-IID or be at risk of being placed in an ICF-IID
- Be able to stay safe, healthy and well in the community while using NC Innovations Waiver Services
- Need and use NC Innovations Waiver services listed in their person-centered plan at least once a month
- Want to use NC Innovations Waiver services instead of living in an ICF-IID

Interviewees in States that implement a first come, first served approach to Waiver placement acknowledged that inequities to access can arise when the most well-informed, well-resourced, or most proactive families sign up first or find ways to access open slots first. Each of the state interviewees expressed concerns about inequities in waiver distribution; however, they have not formally studied the issue. Every interviewee also stated that it is not easy for families to understand information published by State Medicaid agencies or to sign up for the waiver. Most states refer to their waiting list by an alternate name because federal law technically prohibits the existence of a waiting list. Interviewees reflected that Medicaid agencies do not publish their waiting list data.

“It is very confusing to families. . . we get calls all the time. . . a parent said to me once – it’ll always stick with me – ‘It’s like going into a room of curtains and if one is pulled back all you see is the next curtain.’”

Most interviewees reported additional unmet service needs such as supported employment (available via Vocational Rehabilitation and (b)(3) in NC), low direct support professional wages, and lack of self-determination and choice. Specific underserved subpopulations include rural populations, historically marginalized populations, LGBTQ+, children, transition age youth, aging individuals, and dual-diagnosed individuals.

States have employed different strategies to address their waiting lists and the unmet service needs of the individuals on the waiting lists. Strategies have included a tiered waiver system (tiered funding corresponding with tiered categories of service needs) and advocacy through cross-sector partnerships. Most interviewees reported being dependent on legislative action to increase the number of Waiver slots and corresponding State match funding. That is the case in North Carolina. Future strategies suggested to improve Waiver access include increasing the number of slots with sustainable funding; educating potentially eligible individuals and families and streamlining the application process; enhancing supported employment; and increasing direct support professional (DSP) wages.

Table 1 summarizes key interview findings by State.

Table 1: Summary of State Findings

State Interviewed	Waiver program characteristics	Waiting list status	Strategies for reducing or eliminating the waiting list	Policy recommendations
<p>GA Waiver Programs Georgia Medicaid</p>	<p>Implemented in the late 1980s and up for CMS renewal/at end of five-year cycle, but concerns about proposed changes (e.g., self-directed supported employment at risk)</p> <p>Two Waiver categories, each one with expenditure caps: 1) supports waiver for HCBS/limited supports; and 2) comprehensive waiver for residential and other intensive supports.</p> <p>There is a separate, independent care waiver for individuals with ASD or TBI but services are “a mishmash” and there isn’t a waiver</p>	<p>Currently serve 13,464 individuals with a \$719 annual budget</p> <p>There are approximately 7,000 individuals on the planning list; average wait time is 10 years;</p> <p>Six regional offices of the State Department of Behavioral Health and Developmental Disabilities manage Waiver funding and slot allocation; the process is not standardized, although the Department is working on a set of standardized criteria</p>	<p>Produced a film titled, “6,000 Waiting” that highlights stories from Waiver-enrolled and waiting list individuals in each Senatorial district</p> <p>Relies on other resources & payors such as the education system, GA Pediatric Program, Autism State Benefit Plan, or Division of Family and Children’s Services can cover services.</p> <p>Initial (within 14 days) and annual assessments completed for pre-eligible individuals to ensure that circumstances and prioritization remain current on the planning list; also calls to individuals on the planning</p>	<p>Ensure access to adequate provider networks and services in both urban and rural areas</p> <p>Don’t just survey providers about system gaps and service needs; include enrollees and families</p> <p>Need models that address waiting lists with needs-based prioritization versus models that allocate Waiver slots to the “squeaky wheels” or the most connected or influential families</p> <p>Need a streamlined application process that is not difficult for families to access or complete</p> <p>Need outreach and education for eligible individuals / their families regarding the Waiver and the application process (GA estimates 10,000 additional individuals eligible to apply)</p> <p>Need to address needs outside of IDD services such as affordable housing and crisis intervention for dually diagnosed individuals</p> <p>Need adequate Medicaid reimbursement rates for Waiver providers</p> <p>Need adequate hourly wages for DSPs</p> <p>Encourage self-directed plans and mobilize community resources and coordinators for</p>

	<p>focused on children</p> <p>Consideration for individuals most in need facilitates the prioritization of the planning lists. Evaluation includes priorities related to health and safety and caregiver support systems.</p> <p>Needs assessments tools are Determination of Need – Revised and Behavioral Health and Medical Needs assessments. Scores allow those with the greatest unmet need to move to services more quickly.</p> <p>Operating under a DOJ Settlement Agreement and still have institutional beds to eliminate</p>		<p>list quarterly to update them on their status</p> <p>Although not the goal for the GA Council on DD, rather than appropriating more money for the Waiver, the GA legislature wants to cut services for existing Waiver enrollees or give fewer slots to minors as a means of saving money and creating more slots</p> <p>The GA Council on DD advocates for recurring appropriations via a 20 year-old “waiting list campaign;” see approximately 125 new Waiver slots added annually</p> <p>GA has a bill (not enacted) to require elimination of the waiting list within five years</p>	<p>community integration for individuals with IDD</p> <p>End sub-minimum wage and Day Programs and foster supported employment; use provider reimbursement rates that incentivize supported employment</p>
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Research Findings and Policy Solutions to Address the North Carolina Registry of Unmet Needs

<p>LA Medicaid Waiver Services Louisiana Department of Health</p>	<p>Four diverse HCBS waivers targeting different age groups and service needs; BUT applying soon to CMS for one, 4-tiered waiver</p> <p>LA does not consider the tiered waiver to be <i>needs-based</i> since an assigned tier may not be dependent on the severity of an IDD. Could be dependent on emergent circumstances such as caregiver availability, risk for incarceration, losing [aging out of] EPSDT, etc.</p> <p>No Group Homes; only ICF-IIDs with 4-6 beds</p>	<p>Reduced a 2015 waiting list of approximately 40,000 with a wait time of 10-14 years</p> <p>Current waiting list has 13,200 individuals</p>	<p>Worked with the legislature to invest State funding and add 600 slots per year</p> <p>LA has statutorily dedicated funding (12% of General Fund surplus) for the Waiver</p> <p>Also consider, where feasible, earmarking a percentage of “sin taxes” and lottery or sports wagering State profits as statutorily dedicated funding to sustain Waiver slots</p>	<p>Don’t rely solely on the SIS; use diverse screening tools</p> <p>Need more person-centered planning such as Charting the Life Course</p> <p>Consider a tiered waiver and assess individuals for both “urgent” and “emergent” service needs</p> <p>Need more supported employment services</p> <p>Educate beneficiaries and case managers and make the application process transparent and accessible</p> <p>Increase direct care wages via legislation and facilitate workforce opportunities with community colleges, nursing schools</p>
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Research Findings and Policy Solutions to Address the North Carolina Registry of Unmet Needs

<p>MD DDA Medicaid Waiver Programs Maryland Department of Health</p>	<p>Established in the 1980s</p> <p>One Community Supports Waiver and one Family Supports Waiver, each serving 300 individuals. Previously capped at \$25K and \$15K respectively, but no longer capped under the recent renewal.</p> <p>One Comprehensive Waiver serving 16K individuals, and 600 individuals on the waiting list receive case management</p> <p>Minimum eligibility age for Waiver services in a residential setting is 21 years</p> <p>One ASD Waiver with 1400 slots through Dept. of Education for individuals under 21</p>	<p>4,000 individuals on a needs-based waiting list (SIS included among screening tools) but an estimated 24,000 – including children in the state – are potentially eligible.</p> <p>Four regional DDA offices collect and track waiting list data</p>	<p>State Cabinet agencies collaborate to help transitioning youth with disabilities (funding for the fiscal year in which they turn 21)</p> <p>The legislature meets annually with stakeholder groups (the Arc, DD Council, providers groups) to conduct a fiscal analysis of Waiver funding and service utilization</p> <p>Advocates work with the legislature to protect/sustain existing State match funding, but it has been difficult to increase funding for the past 12 years</p> <p>No specific initiatives to address the waiting list, but the legislature sets aside annual funding to assist 48 waiting list individuals with crisis resolution and 168</p>	<p>Need meaningful ways to advance supported employment in this employment first state</p> <p>Need a family friendly application process; “Make it easier to get on the list and make it easier to get the services.”</p> <p>Need to evaluate and potentially broaden the Waiver service definitions</p> <p>Need to increase the long-stagnant provider reimbursement rates to improve and ensure access to covered services</p> <p>Need statewide outreach and education to capture diverse populations who may be eligible / to eliminate disparities</p>
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Research Findings and Policy Solutions to Address the North Carolina Registry of Unmet Needs

			<p>individuals with crisis prevention</p> <p>Implementing an initiative to reach underserved minorities by training and funding Cultural Brokers</p>	
<p>NC NC Innovations Waiver NC Medicaid</p>	<p>Established in the 1980s but demand grew primarily in the 1990s; most recent CMS renewal was in 2020</p> <p>Same eligibility criteria for ICF-IID and HCBS waiver services is problematic</p> <p>RUN shift to a Waiver slot is 'first come, first served' versus needs-based or tiered</p> <p>Operating under a DOJ Settlement Agreement</p>	<p>13,138 approved and funded slots in NC (\$135K annual budget per enrollee)</p> <p>Approximately 15,000 on the RUN; wait up to 12 years</p> <p>Seven Local Management Entity Managed Care Organizations manage regional RUNs and funding for available slots</p>	<p>Advocacy for General Assembly appropriations of additional State-funded services for individuals on the RUN</p> <p>Enrolling RUN and non-RUN individuals with IDD into Medicaid managed care to improve access to non-Waiver services</p>	<p>Some people may be accessing more services than they can use</p> <p>Need to evaluate the system and ensure person-centered planning</p> <p>Need parity in wages for DSPs in both institutional and HCBS settings; today institutional wages (in State institutions in particular) are higher</p> <p>Fund Supported Employment and post-secondary education</p> <p>It isn't advisable to continue to run parallel public and private ICF-IID facilities</p> <p>Need centralized and periodic collection of beneficiary/family/guardian survey data re: service needs for RUN individuals</p> <p>Need to evaluate racial, ethnic, and socioeconomic disparities among RUN individuals with IDD and individuals with IDD within the general population</p>

Research Findings and Policy Solutions to Address the North Carolina Registry of Unmet Needs

<p>TN 1915(c) HCBS Waivers Division of TennCare</p>	<p>Has one Employment and Community First Choices waiver for individuals with IDD; includes 7,000 individuals from legacy “high need, high cost” developmental center programs</p> <p>TN also launched a Katie Beckett program in 2019 for children who don’t qualify for Medicaid</p> <p>Has a centralized referral list enrollment Web page that categorizes needs-based versus first come, first served based eligibility criteria (needs based can include aging caregiver or multiple complex needs while first come, first served can include employed individuals in</p>	<p>Approximately 10,000 enrolled in the Waiver and approximately 5,000 on the referral list</p> <p>Communication and management across four different agencies</p>	<p>Tennessee’s newly passed TennCare III program (branded as a “block grant” by some) is poised to overhaul funding and create a windfall of new federal funding that the state has suggested, but not committed, will go to eliminating the waiting list.*</p> <p>The legislature appropriates funding for approximately 200 new slots some years, but not consistently; has been annual since 2016</p> <p>15 year-old TN Disability Pathfinder Service via Vanderbilt University with a toll-free information line & searchable database of more than 3,000 services; working to modernize with an app and more</p> <p>Two years ago the Governor</p>	<p>Need providers training to provide respite care for minor children, particularly in the age of COVID</p> <p>Need adequate support and hourly wages for DSPs; training isn’t enough</p> <p>Person-centered planning and supported employment are important and employment needs to be meaningful, age-appropriate, and integrated in the community; not separate workshops.</p> <p>Need outreach and education for eligible individuals and families regarding the referral list Need clear language in materials and videos.</p> <p>Need an assessment process that leads to <i>meaningful</i> person-centered planning</p> <p>Need better case management to help people on the referral list access services; there are local funding stipends up to \$4K in TN for e.g., respite and vehicle modifications</p>
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Research Findings and Policy Solutions to Address the North Carolina Registry of Unmet Needs

	<p>need of support and youth of transition age); the State reserves some slots in the first come, first served category for adult individuals who have a planned transition from home (e.g., due to aging caregivers) or who want to sustain a family living arrangement with supports.</p>		<p>was committed to cutting the referral list in half by supporting legislated funding, but that never went through when COVID hit</p>	
<p>TX Intellectual or Developmental Disabilities (IDD) - Long-term Care Texas Health and Human Services</p>	<p>Have 10 HCBS waivers so it's challenging to educate families about the nuances of each waiver so they can choose</p>	<p>Approximately 160,000 on the interest list; wait 12-15 years</p>	<p>Numerous, diverse waivers and a strong voice for individuals with IDD</p> <p>Important to have a legislative champion</p>	<p>Need eligibility screening and consistent administrative oversight of the waiting list</p> <p>Consider a reduction in individual allocations to serve more people</p> <p>Find a means of addressing gaps and providing timely access to services for individuals on the waiting list</p>

Research Findings and Policy Solutions to Address the North Carolina Registry of Unmet Needs

<p>WA Home and Community Based Waivers (HCBS) Developmental Disabilities Administration</p>	<p>5 waiver programs including a Core Waiver (highest support level) and an Individual and Family Support Waiver and one for intensive supports for children</p> <p>“silver tsunami” concern as individuals on the waiting list are 40-50 years old, live with aging/elderly caregivers – what will happen to the individuals if they don’t get a Waiver slot?</p> <p>Non-eligible populations include ASD individuals</p> <p>First come, first served in terms of getting on the waiting list, but essentially becomes needs-based</p>	<p>150,000 people with DD in the state; approximately 50,000 have Waiver or State service supports</p> <p>Approximately 15K who are eligible but waiting to receive services</p> <p>Approximately 500 individuals living in institutions and Labor Union is opposed to closing</p>	<p>No State income tax so it is difficult to adequately fund systems and services and expand the number of Waiver slots</p> <p>Legislative advocacy is the means to expanding funding and the number of slots, but there aren’t any current initiatives in place. Have pushed for “case load forecasting” for the IDD population but the legislature has not agreed to it</p> <p>Ongoing work with the Protection and Advocacy agency and other associations to monitor and oppose bills that could be detrimental to the IDD population’s access to services</p> <p>Expand to statewide the successful ‘transition from</p>	<p>Capped waivers for individuals who don’t have the highest level of service needs can help share existing resources among more people; at least gets them into the system with a case manager.</p> <p>Need equitable means of applying for and accessing slots (including LEP educational materials) instead of most educated, non-minority, or most persistent families</p> <p>Need to educate all families about the Waiver consistently at time of birth if IDD known</p> <p>Need to educate consumers about Medicaid entitlement services and Aging and Long Term Supports Administration services available during the wait for a Waiver slot</p> <p>Need to cover dual services such as community inclusion and supported employment; don’t exclude services if Waiver enrollees get employment</p> <p>Need an <i>Olmstead</i> commission in WA</p>
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Research Findings and Policy Solutions to Address the North Carolina Registry of Unmet Needs

	once an individual is on the waiting list		school to work' programs. Employed individuals with IDD may be more likely to get a Waiver slot.	
<p>WI Children's Long-Term Support Program Wisconsin Department of Health Services</p>	Statewide managed care with four statewide plans with robust benefits	No Waiting List as of February 2021	<p>When WI went to Medicaid managed care, grassroots programs held out for a State commitment to ending the waiting list – Waiver slot must be treated as an entitlement. But it took years.</p> <p>Today, the waiver is an entitlement for all Medicaid-eligible individuals; no one will wait for a slot.</p> <p>WI has a <i>Survival Coalition</i> comprised of >20 statewide disability organizations that focus on policy, services, and voting.</p>	<p>Public rate bands that managed care plans can charge for enrollee services</p> <p>Need fewer Day Programs and more integrated employment</p> <p>Focus on the intersection of disabilities and racial disparities. Consider the incidence and prevalence of disabilities versus only racial composition of the population.</p> <p>Don't just use satisfaction surveys; assess service needs. There's a challenge to discuss what a person wants and needs versus what the system (and providers) are offering.</p>

* Note: As of 9/30/2021, this TN program approved under the Trump Administration is posted for public notice and comment under the Biden Administration and CMS approval is at risk for being retracted.

LME/MCO Surveys

The total number of individuals reported on the RUN in January 2021 across all seven LME/MCOs was 15,187. That’s a 6% increase from the 14,295 reported on the RUN across all seven LME/MCOs in a December 2019 *Administrative Functions Monitoring* report to DHHS. The average number of individuals on the RUN per region was 2,169 with the smallest waiting list in the Eastpointe catchment (597) and the largest waiting list in the Alliance Behavioral Health catchment (3,996).

The waiting time on the RUN ranges from five to 15 years. The wait time varies by slot type and by county within any given LME/MCO catchment area. LME/MCOs reported assigning Waiver slots on a first come, first served basis and then on a per capita basis within catchment area counties. The CMS-approved Innovations Waiver requires North Carolina to maintain “reserve capacity” – literally a reserved portion of the total Innovations Waiver slots available – for the following categories of eligible Medicaid beneficiaries:

- Community Alternatives Program for Children (CAP/C): To transition individuals when they age out of the CAP/C waiver.
- Military Transfers: participants who were on a comparable 1915(c) waiver in another state whose family was transferred to North Carolina for military service or who were receiving Innovations waiver services prior to their family transferring to another state and have now returned to North Carolina.
- Emergency needs in which an individual is at risk of imminent, significant harm.
- Money Follows the Person (MFP): To transition individuals out of institutional settings using the Money Follows the Person (MFP) federal grant.

Although all Medicaid beneficiary demographic data are available at the State level in the NCTracks Medicaid Management Information System, some LME/MCOs reported not having the ability to generate reports regarding sociodemographic or other trends within their RUN lists. Because individuals do not have to be Medicaid-eligible to qualify for the RUN and because RUN lists are managed at the LME/MCO level, NCTracks demographic data may not include all non-Medicaid individuals on the RUN. Four of the seven LME/MCOs reported monitoring RUN enrollees’ age, race, ethnicity, and county of residence. One LME/MCO collects the demographic information on applications but does not analyze or report it. Three LME/MCOs analyze the race and ethnicity of their RUN population. One LME/MCO, Vaya Health, provided its RUN race and ethnicity data with the survey responses. However, researchers did not request the data, so this report does not include a comparison across all seven LME/MCOs. The actual survey question as shown in **Appendix B** was, “Do you know the racial breakdown of the RUN list?” Please see **Table 2** for the Vaya Health data and a comparison column with race and ethnicity statistics from the 2020 U.S. Census general population report for North Carolina.

Table 2: Comparison of NC Population and Vaya Health LME/MCO RUN Population by Race and Ethnicity

Race and Ethnicity	NC General Population [2020 U.S. Census]	LME/MCO RUN Population
American Indian/Alaska Native	1.6%	12 (0.9%)
Asian	3.2%	11 (0.82%)
Black or African American	22.2%	87 (6.49%)
Native Hawaiian and other Pacific Islander	0.1%	3 (0.22%)
Two or more races	2.3%	4 (0.3%)
Unknown		47 (3.51%)
White	70.6%	1,176 (87.76%)

Sources: [U.S. Census Bureau QuickFacts: United States](#); Vaya Health LME/MCO



The researchers recommend statewide collection and analysis of these data under the new, multi-year grant project to ensure that systemic biases are not posing barriers to access for any race or ethnicity within any LME/MCO (future Tailored Plan) region. A Duke-Margolis Center for Health Policy literature review regarding racial and ethnic disparities and IDD diagnoses yielded findings that statistics relate historically marginalized racial and ethnic groups and disability to poverty, and poverty to disability. Furthermore, preterm birth and low birth weight are associated with both IDD and Black parental race. According to a February 2020 *National Health Statistics Reports* publication included on the **Resources** page, from the years 2015 through 2018 the prevalence of any developmental disability among children aged 3–17 years was 17.8%, but the prevalence was 19.8% among children living in rural areas as compared with 17.4% among children living in urban areas. Another study reviewed by Duke-Margolis Center for Health Policy researchers concluded, “Compared to non-Hispanic White students, non-Hispanic Black students were overrepresented in the ID classification and underrepresented in the ASD classification across urban and rural areas. Indicators of low resource availability were also associated with higher probabilities of ID versus ASD classification.”

For the LME/MCOs that collect and analyze the data about their RUN enrollees, the data inform the following:

- In lieu of Medicaid service needs and definitions to assist beneficiaries while they are on the RUN
- State-funded service needs and definitions to assist beneficiaries while they are on the RUN
- In-reach efforts
- Children with complex needs service needs
- Behavioral health and substance use disorder service needs
- Provider contracting and quality management activities
- (b)(3) services offerings

Survey responses revealed that LME/MCOs neither manage their RUN lists nor communicate with RUN enrollees in a standardized manner. For example, some LME/MCOs accept RUN self-referrals via both telephone lines and online portals, while some offer telephone access only. One LME/MCO has a toll-free line dedicated to RUN inquiries but most LME/MCOs process RUN self-referrals through their general access lines. In general, beneficiaries or their authorized representatives must call a designated telephone number and participate in an intake interview and an assessment and provide supporting documentation. LME/MCOs then work with care coordinators (some have care coordinators dedicated to RUN enrollees) and community-based resources including North Carolina System, Therapeutic, Assessment, Resources, and Treatment (NC START) to connect individuals on the RUN with services that are available. One LME/MCO proactively reassesses the service needs of individuals on the RUN quarterly, while some LME/MCOs assess the service needs of individuals annually. Four LME/MCOs reported updating individuals' information when contacted by the individual or their authorized representative. Three LME/MCOs reported proactively seeking updated information from RUN enrollees only as the enrollees approached receiving a slot.

The number of days for the application process before an appealable RUN eligibility decision is made can range from three to six months. However, many LME/MCOs use the date of the initial Web-based or telephone inquiry as the date for placement on the 'first come, first served' RUN. There is currently a dearth of information about the Waiver application process on the NC DHHS Website. It says, “How to Apply - If you are eligible, your LME-MCO can help you get services. There are only a certain number of NC Innovations Waiver slots. If the slots are full, your name will be added to the Registry of Unmet Need.” This information does not contain a direct link to the Department's LME/MCO Directory, so there is no point of contact with which to begin. At a minimum, a directory of LME/MCO Innovations Waiver enrollment telephone numbers [“access lines”] and online portals, where applicable, could be posted on this NC DHHS Web page to facilitate access to information. Ultimately, a statewide, centralized toll-free enrollment help line may best serve the individuals who need Innovations Waiver services.

Regarding community outreach and education to increase awareness of the Innovations Waiver and the application process among potentially eligible individuals, the LME/MCOs have diverse approaches. Some only post information on their websites, while others maintain online information but also distribute fliers at community events such as health fairs. Some LME/MCOs are more proactive and have Member Services or Care Coordination staff who work with local pediatric offices, schools, Child Development Service Agencies, Consumer and Family Advisory Committees, and local Department of Social Services offices.

For both Medicaid-eligible individuals and non-Medicaid individuals who qualify for the RUN, there are some services available during the wait for an Innovations Waiver slot. Those services are State-funded only and “(b)(3)” funded. Section 1915(b)(3) of the federal Social Security Act authorizes State Medicaid programs to use cost savings within a Medicaid managed care delivery system to provide non-Medicaid services. In North Carolina, the General Assembly authorizes and appropriates all State-only funding that LME/MCOs may receive within a budget year (the North Carolina budget year is July 1 through June 30). Both State-only funding and (b)(3) funding are available to provide IDD, behavioral health, and substance use disorder services administered by the LME/MCOs. Therefore, there is often not enough funding to provide all services to all individuals who need or request services. However, LME/MCOs did report covering State-funded and (b)(3) funded services to individuals on their RUN lists. Examples of State-funded services that LME/MCOs reported covering for individuals on the RUN include Developmental Day Programs, Respite, Personal Assistance, and Supported Employment. Examples of (b)(3) services that LME/MCOs reported covering for individuals on the RUN include Respite, Community Navigator, Supported Employment, and Applied Behavior Analysis Therapy. The LME/MCO survey questions in **Appendix B** did not yield a means of documenting a) how many individuals on the RUN, by LME/MCO, request State-funded or (b)(3) services; b) how many individuals on the RUN, by LME/MCO, access or use the services available; or c) whether any LME/MCOs do not have enough State or (b)(3) funding to provide all of the services requested by individuals on the RUN. The researchers recommend statewide collection and analysis of these data across all LME/MCOs under the new multi-year grant project.

Stakeholder Input

The stakeholder groups that advocate for NC Registry of Unmet Needs Waiver slots work toward a common goal despite their diverse perspectives and approaches. The nine stakeholder groups shared meaningful feedback regarding their concerns *and* their suggested solutions.

Table 3: Stakeholder Considerations, Concerns, and Solution Strategies for the NC RUN

Considerations and Concerns	Corresponding Solution Strategies
Awareness of the Waiver and the application process among potentially eligible individuals	Personalized outreach and education – a request to not simply direct individuals to a website
Individuals who <i>are</i> aware of the Waiver have low motivation to sign up for the RUN because they are aware of the long waiting time	Consider implementing multiple Waivers for different groups and funding allocations per person or a tiered Waiver
Individuals with IDD see the NCGA and the State making investments in select programs, but not the RUN	Advocate for annual, recurring funding to add a predictable number of Waiver slots each year and to fund the system and workforce capacity to serve individuals enrolled in the Waiver
Individuals on the RUN experience high frustration and a lack of hope while on the RUN	Individuals with IDD are aware that people are <i>talking about</i> the inherent challenges of the RUN, but what are people <i>doing</i> about the RUN? Need to reduce the waiting list
Individuals on the RUN do not receive regular updates about their status	Invite members of the RUN to share their perspectives and to help improve the system
Schools and providers need more education about how to make a referral to the RUN	Invite members of the RUN to be present at relevant State and local Board and Commission meetings in addition to CFAC meetings
Individuals on the RUN feel unseen among the State’s residents	Need “one voice” of a statewide advocacy group and need to use media outlets (all forms, including social media) to raise awareness with individuals’ vignettes

Policy Recommendations

The research project findings prompt policy recommendations to shorten Waiver waiting lists and address waiver awareness and accessibility inequities. Investment in a centralized database to maintain accurate eligibility and demographic data would inform next steps and has already helped some states shorten their waiting lists.

North Carolina State officials have discussed but not yet implemented a centralized, State-administered “unified RUN.” We understand that the forthcoming American Rescue Plan Act (ARPA) funding associated with the 10% Federal Medical Assistance Percentage for HCBS will facilitate this effort. Additional States interviewed are also relying on an influx of ARPA funding to facilitate legislatures’ actions to reduce Waiver waiting lists. With the most complex multi-payor Medicaid managed care system that North Carolina has implemented to date, a unified RUN at NC DHHS will be critical. In 2022 there will be six LME/MCOs, four statewide commercial plans, a Tribal Option Plan, and one regional, provider-led plan. Furthermore, the possibility of “churn” of beneficiaries across delivery systems (fee-for-service Medicaid Direct) and Plans (Tailored Plans, Standard Plans, the Tribal Option, and a future state Foster Care Plan) will also make it important to centralize the RUN. Otherwise, this could be one more component of the Medicaid program where beneficiary data are at risk for not being transferred or updated timely. Beneficiaries could be at risk for not receiving updates and notifications about their status on the RUN. Individual Plans could be at risk for inadvertently incorrectly recording individuals’ chronological placement on the first come, first served list.

We learned from the survey of LME/MCOs that RUN management differs across Plans. A unified RUN can be populated with standardized and real-time reporting from each Plan, but NC DHHS can oversee the data quality and accuracy and beneficiary updates. NC DHHS can also communicate directly with RUN enrollees on a more frequent basis (e.g., we recommend quarterly versus annual updates; most LME/MCOs conduct only annual updates). Some States interviewed also implement at least annual reassessments of all individuals on the waiting list to ensure continued eligibility for the waiting list and also to ensure that emergency needs or other service needs are documented and addressed.

Additional Waiver administration solutions may include a streamlined application and more widespread efforts to educate and refer the public to the Waiver. There is a consensus among State interviewees that potentially eligible individuals and their families need information about the Waiver *and* helpful guidance for the application process. Education and referrals could be coordinated with applicable hospital departments, pediatricians, local Departments of Social Services and Health Departments, primary care providers, schools conducting transition planning for children with Individualized Education Programs (IEPs), specialized therapy therapists and other specialists, psychologists and social workers, and NC’s Area Health Education Centers. Individuals and families not only need to know how to apply for the Innovations Waiver and the Registry of Unmet Needs, if applicable; they need to understand what services the Waiver will cover, and what non-Waiver services they may be eligible for while they wait on the RUN. Furthermore, State Developmental Disabilities Council representatives recommend educational materials that are both in writing and available via videos, in simple language that is not bureaucratic, and translated for individuals with Limited English Proficiency.

Perhaps most importantly, sustainable State and federal appropriations are needed to increase the number of Waiver slots and to support the workforce infrastructure to meet the need. The North Carolina General Assembly’s 2021 proposed State budget includes provisions to increase the number of Innovations Waiver slots by 1,000, to increase Group Home funding, and to increase IDD provider agency reimbursement rates and Direct Support Professional hourly wages. Without increased Waiver capacity, a large segment of the IDD population and their families will remain unsupported, and people with IDD will be at risk for unnecessary institutionalization. Adequate State funding to the LME/MCOs (future Tailored Plans) is also needed to allow LME/MCOs to cover the aforementioned State-funded services for the thousands of individuals on the North Carolina Registry of Unmet Needs. We acknowledge that increasing the number of Waiver slots without an adequate provider network and DSP workforce would be problematic. We work with LME/MCOs, provider agencies, and advocates across the State, and we know that lobbyists have met regularly with DHHS officials and NC General Assembly Members to address the direct support professional workforce crisis for both existing and new Innovations Waiver slots. The North

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Carolina General Assembly 2021 proposed State budget provisions include a newly established Home- and Community-Based Services Fund (using federal American Rescue Plan Act funding) to increase provider agency reimbursement rates and bring the hourly wage for Home- and Community-Based Direct Support Professionals to \$15. At the time of the publication of this report, there is no enacted State budget for fiscal year 2022. However, we should soon know how much funding the General Assembly appropriates to address the current workforce crisis and any future needs for staffing capacity to serve existing and new Innovations Waiver slots.

Finally, when advocating in any State for additional Waiver slots and corresponding appropriations, it is advisable to involve Waiver waiting list members in the legislative process to literally give a “face” to the issue. Legislators should not hear from only the Executive branch agencies administering Waiver services or the providers who render the services. Legislators need to hear all stakeholder perspectives, including those of waiting list members and their advocates.

LME/MCO Policy Recommendations:

- 1) Greater regulation of the RUN process either within the Waiver (which has the force and effect of administrative rule pursuant to NC Statutes) or within the LME-DHHS contracts;
- 2) DHHS-led, regular LME/MCO Executive Leadership meetings to facilitate standardized RUN oversight and management;
- 3) NCGA appropriations for additional Innovations Waiver slots;
- 4) NCGA appropriations for greater State supports for children with developmental disabilities whose families do not qualify for Medicaid, but for whom private insurance co-payment or private payment for supports is a financial hardship;
- 5) NCGA and CMS authorization and appropriations for broader Medicaid supports, including medical and non-medical drivers of health, and in-lieu-of services for individuals on the RUN;
- 6) A Statewide, DHHS-operated RUN database to increase administrative efficiency and accuracy and to centralize the oversight of slots, including eligibility determination and slot allocation;
- 7) Authorization to fill vacant slots in real time versus at the beginning of a new waiver budget year when a slot is vacated for a permanent reason such as death, a move out of state, a permanent move to a medical facility, or voluntary termination;
- 8) Consumer and family education about the RUN and the Innovations Waiver and assistance with referrals to other community support services available;
- 9) More staff designated to work with RUN applicants and to evaluate applicants for the Social Determinants of Health;
- 10) A meaningful feedback loop between each LME/MCO (or the State, if operations become centralized) and each individual on the RUN to include annual, but preferably quarterly, communication regarding RUN status; and
- 11) Standardization around individuals moving from one RUN to another LME/MCO RUN if the individual has moved out the catchment area.

Conclusion

Policy Recommendations for The North Carolina Innovations Waiver:

- Increase the number of Waiver slots so more individuals with IDD will be fully included, respected, valued, and supported in their communities.
- Increase direct support workforce capacity and wages to ensure adequate support for existing and new Waiver slots.
- Centralize the Registry of Unmet Needs database within NC DHHS to ensure accurate data and timely and periodic (quarterly) notifications to beneficiaries on the RUN.
- Offer an online portal via NC DHHS (or consider amending the Enrollment Broker contract) for beneficiaries to read about, self-refer, and apply for the RUN.
- Institute and centralize a RUN enrollment telephone line.
- Collaborate with the North Carolina Institute of Medicine (NCIOM) on a year-long Task Force and report that would yield recommendations to the North Carolina General Assembly. The task force could include representatives from the LME/MCOs (future Tailored Plans), the State Medicaid agency, consumers and their families, Disability Rights North Carolina, care management agencies, and State vendors.
- Develop educational content for potentially eligible individuals - including new North Carolina residents - and consider Limited English Proficiency needs and outreach strategies for Historically Marginalized Populations within all communities. Include education about what services individuals can expect to receive on the Waiver and what non-Waiver services may be available during time on the RUN.
- Coordinate with community-based stakeholders such as clinical practices, local DSS offices, and local schools to disseminate written education and outreach materials about the Innovations Waiver.
- Work with stakeholders who can lobby the North Carolina General Assembly to support new slots *annually* with recurring funding and adequate State funding for non-Medicaid services.
- Institute annual reassessments of individuals on the RUN to ensure that their service needs are accurately documented and to facilitate any care management that may help them access non-Waiver services.
- Expand the scope of data collected from RUN applicants to track the number of individuals on the RUN who are using one or more other services each month, and the service lines that they are using.
- Consider moving North Carolina away from a first come, first served RUN model and shifting to a needs-based placement with tiered enrollment and annual Innovations Waiver slot budget levels like those proposed in the 2021 Session Senate Budget bill.
- Consider standardized LME/MCO (future Tailored Plan) tracking of the numbers of individuals on the RUN who are receiving one or more *other* services per month and track those services by State-only versus Medicaid (b)(3) funding [Note: in 2022, NC DHHS anticipates replacing (b)(3) services with a new NC Medicaid 1915(i) Waiver]. Those service utilization data and initial and periodic assessment data could inform the strategic management of the RUN.

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In August of 2021 the North Carolina Department of Health and Human Services, in collaboration with the Technical Assistance Collaborative, circulated an online Strategic Housing Plan survey for review and feedback about housing experiences regarding affordability and supportive housing from individuals with disabilities, their family members, and providers. The Housing Plan will inform NC DHHS policies and resource allocation for creating and maximizing community-based housing opportunities for people with disabilities who are experiencing homelessness, living in an institution, or at risk of institutionalization over in the next five years. In addition to the online survey, DHHS will engage stakeholders in focus groups, individual housing surveys, and in-person planning sessions.

In August of 2021 the Division of Health Benefits in the North Carolina Department of Health and Human Services sent Joint Communication Bulletin #400 to the LME/MCOs to “Reiterate Olmstead Obligations and Address Department’s Current Initiatives and Planning.” The Bulletin stated, “North Carolina has an obligation under *Olmstead*, the Americans with Disabilities Act, and the North Carolina Persons with Disabilities Protection Act to provide appropriate opportunities for people with disabilities to become fully integrated into the community if they choose to do so. This is more than a legal obligation—it is a moral imperative.”

In September of 2021, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services in the North Carolina Department of Health and Human Services posted a structured list of resources for accessing Intellectual and Developmental Disabilities (including Autism) and Traumatic Brain Injury services in NC. The resource list includes information about the Innovations Waiver Registry of Unmet Needs and other Waivers of interest (e.g., CAP-C and CAP-DA); how individuals can access services even if they are not Medicaid beneficiaries; and how individuals can access services while they are on the Registry of Unmet Needs.

We sincerely hope that the research findings and policy recommendations included in this report will inform and contribute to the success of the NC DHHS *Olmstead* plan in North Carolina and future policy and programming strategies to address the “15,000 Waiting” in North Carolina.

Appendix A: State Interview Questions

Part 1: Questions about History and Process of State's HCBS IDD Waiver Program

1. We would like to begin by learning more about the history of your State's Home and Community-Based Services (HCBS) IDD waiver program.
 - a. When was the first waiver cycle approved by CMS and how was it shaped over time?
 - b. When was it last amended and in what ways?
2. How well do you believe your state's HCBS IDD Waiver is meeting the needs (e.g., habilitative services, housing, supportive employment, respite, etc.) of the IDD population in your state?

Additional Prompts:

- a. What are strengths of the current HCBS program?
- b. What are areas for improvement?
- c. Do you survey waiver enrollees or their parents or guardians regarding unmet needs?
If yes: When? (e.g., annually, when Person-Centered Plan is updated, other)
- d. Do you review State Waiver data annually to assess waiver funding, service utilization, etc.?
3. When individuals are approved for a HCBS IDD waiver, is this done on 1) a first-come, first-serve basis, 2) a needs-based strategy, or 3) a different or hybrid approach?
 - a. How many waiver slots does your state have?
 - b. How many potentially eligible individuals does your State Medicaid Program estimate your state has? [particularly adults / who is on the radar]?
4. Can you describe how easy or difficult it is for families to sign up for the HCBS IDD waiver?
 - a. What barriers are present that make it harder to sign up for the IDD Waiver?
 - b. What components of the process are in place to make it easier for someone to sign up for the IDD Waiver?"

Part 2: Questions about Waiting List

5. Does your state currently have a waiting list for the IDD waiver?
 - If yes:
 - a. Are you aware of how many are on the waitlist? Is this current information publicly available?
 - b. What is the average length of time on the waiting list (months or years)?
 - c. Is data tracked regarding the composition of the waiver wait list (e.g., age, race/ethnicity, gender, geography)
 - If so, who tracks this data?
 - Are there any disparities noted (e.g., among those who are receiving, on waiting list, in placement priorities)?
 - d. Are there other service definitions or programs that are available to individuals on the waitlist through the in lieu of service definition or other mechanisms that you have found helpful for individuals with I/DD on the HCBS waiver waitlist in your state?

Appendix A: State Interview Questions (cont'd.)

- If no:
 - a. Can you share more about what you think that means? Does that mean everyone that needs it has some access to services?

 - b. Is data tracked regarding the composition of the waiver recipient list (e.g., age, race/ethnicity, gender, geography)?
 - Are there any disparities noted (among those who are receiving, on waiting list, in placement priorities)?
- 6. If your state wanted to increase the number of waiver slots, would that be done through legislative action or is there another mechanism?
- 7. What has your state done to lower or intervene on the waiting list for the IDD population?

Part 3: Questions about Other Unmet Needs and Ideas to Improve HCBS IDD Waiver

8. As a DD Council, are you currently implementing or considering implementing strategies to help address unmet needs for the IDD population? If so, are any of these strategies, specifically related to reducing or controlling the waiting list?
 - a. Are you collaborating with Protection and Advocacy agencies?
 - b. Are you collaborating with Medical-Legal partnerships?
9. Will you describe any subpopulations and their needs that your DD Council is currently focused on?
10. Within your state, do children stay on the same waiver or do you have a waiver for children and a waiver for adults?
11. Next, will you share about any efforts targeted on the transition from adolescent to adulthood period at this time.
12. What ideas do you have on ways to improve the allocation and quality of HCBS IDD waivers?
13. Is there anything else you would like to share that we have not yet discussed?
14. Lastly, are there any other DD Council Directors in other states you think we should ensure we speak to?

Appendix B: North Carolina LME/MCO Survey Questions

1. How many individuals are currently on the RUN?
2. What is the average length of time for being on the RUN?
3. What is the process for being placed on the RUN?
4. Do you know the racial breakdown of the RUN list?
5. How often do you confirm the individual information?
6. Have you developed marketing strategies to educate the public about the RUN?
7. How are you utilizing the data from the RUN within the LME/MCO?
8. Do you share the RUN information with the BOD, CFAC, IDD Stakeholders, Provider Network, etc.?
9. What services and/or supports do you offer individuals on the RUN? (State-funded, Medicaid, B3, etc.)
10. Do you have a plan, or have you implemented strategies to improve supports for individuals on the RUN?
11. Please describe your process in awarding innovation slots to individuals on the RUN.
12. Do you have families who would share their stories from being on the RUN?
13. Based on your knowledge of managing the RUN, please provide recommendations that you would like to share with the NCCDD.

Resources

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LME Alternative Service Request for Use of DMHDDSAS State Funds

For Proposed MH/DD/SAS Service Not Included in Approved Statewide IPRS Service Array

Note: Submit completed request form electronically to Wanda Mitchell, Budget and Finance Team, at Wanda.Mitchell@ncmail.net, and to Spencer Clark, Chief's Office, Community Policy Management Section, at Spencer.Clark@ncmail.net. Questions about completing and submitting this form may be addressed to Brenda G. Davis, CPM Chief's Office, at Brenda.G.Davis@ncmail.net or (919) 733-4670, or to Spencer Clark at Spencer.Clark@ncmail.net or (919) 733-4670.

a. Name of LME Wake County Human Services Local Management Entity		b. Date Submitted 10/17/2008
c. Name of Proposed LME Alternative Service Assertive Engagement – YA341 (A Statewide Alt-Service Definition as of Jan 2011)		
d. Type of Funds and Effective Date(s): <i>(Check All that Apply)</i> <input type="checkbox"/> State Funds: Effective 7-01-07 to 6-30-08 <input checked="" type="checkbox"/> State Funds: Effective 7-01-08 to 6-30-09		
e. Submitted by LME Staff (Name & Title) Tamara Strickland, WCHS LME Care Coordination Program Manager or DeDe Severino, WCHS LME ASA Program Manager, Provider & Community Development	f. E-Mail tstrickland@co.wake.nc.us dede.severino@co.wake.nc.us	g. Phone No. 919-212-8356 919-250-1534
<u>Background and Instructions:</u> This form has been developed to permit LMEs to request the establishment in IPRS of Alternative Services to be used to track state funds through a fee-for-service tracking mechanism. An LME that receives state single stream or other state non-UCR funding shall use such funding to purchase or start up services included in the Integrated Payment and Reporting System (IPRS) service array and directed towards the approved IPRS target population(s). If the LME wishes to propose the use of state funds for the provision of an Alternative Service that is not included in the IPRS service array, the LME shall submit an <i>LME Alternative Service Request for Use of DMHDDSAS State Funds.</i> This form shall be completed to fully describe the proposed Alternative Service for which Division approval is requested in order to develop an IPRS reporting code and an appropriate rate for the Alternative Service. Please use the following template to describe the LME's proposed Alternative Service definition and address all related issues using the standard format and content categories that have been adopted for new MH/DD/SA Services. Please note that: <ul style="list-style-type: none"> • an individual LME Alternative Service Request form is required to be completed for <u>each</u> proposed Alternative Service; • a separate Request for Waiver is required to be submitted to the Division for the LME to be authorized by the Secretary to <u>directly</u> provide an approved Alternative Service; and • the current form is <u>not</u> intended to be utilized in SFY 07-08 for the reporting on the use of county funds by an LME. The Division continues to work with the County Funds Workgroup to establish a mechanism to track 		

and report on the use of county funds through IPRS reporting effective July 1, 2008.

Requirements for Proposed LME Alternative Service

(Items in italics are provided below as examples of the types of information to be considered in responding to questions while following the regular Enhanced Benefit Service definition format. Rows may be expanded as necessary to fully respond to questions.)

Complete items 1 through 28, as appropriate, for all requests.

<p>1</p>	<p>Alternative Service Name, Service Definition and Required Components</p> <p>Assertive Engagement</p> <p>Assertive Engagement is a way of working with adults and/or children who have severe or serious mental illness and/or addictive disorder and who do not effectively engage with treatment services. Assertive engagement is a critical element of the rehabilitation and recovery model as it allows flexibility to meet the consumers' particular needs in their own environment or current location (i.e., hospitals, jail, shelters, streets, etc.). It is designed as a short-term engagement service targeted to populations or specific consumer circumstances that prevent the individual from fully participating in needed care for mental health or addiction issues.</p>
<p>2</p>	<p>Rationale for proposed adoption of LME Alternative Service to address issues that cannot be adequately addressed within the current IPRS Service Array</p> <p>The Wake LME experiences a high volume of referrals from inpatient providers, many of whom are difficult to engage in traditional services post-discharge. This situation is also common to higher intensity outpatient treatment services, whereas consumers meet medical necessity criteria for that level of care, but do not follow-through with treatment recommendations. There is currently no service in the IPRS service array that permits billing and payment for providers who must work to build relationships in a variety of settings, including jails, inpatient facilities, facility based crisis and in the community. The most comparable service, Assertive Outreach, is intended for homeless individuals only, and is an attempt to engage individuals until the case is formally opened. The Wake LME finds a need to fund providers to work with difficult cases to promote treatment engagement and retention as a way of reducing the need for crisis services and stopping the cycle of readmission to higher levels of care.</p>
<p>3</p>	<p>Description of service need(s) to be addressed exclusively through State funds for which Medicaid funding cannot be appropriately accessed through a current Medicaid approved service definition</p> <p>Assertive Engagement is a method of working with adults and/or children who have a severe or serious mental illness and/or addictive disorder and have difficulty engaging in traditional services. Additionally, these adults and/or children also have a history of erratic or non-engagement in treatment, have a history of erratic or non-compliance with medication resulting in symptom manifestation and/or relapse or have a history of frequent hospitalizations, jail/detention days or involvement with law enforcement or utilization of crisis services. Currently, Medicaid does not allow billable services in hospitals or jail settings. Due to high recidivism, it is necessary for providers to remain involved while their consumers are in these facilities, as well as participate in treatment/discharge planning for potential consumers.</p>
<p>4</p>	<p>Please indicate the LME's Consumer and Family Advisory Committee (CFAC) review and recommendation of the proposed LME Alternative Service: <i>(Check one)</i></p> <p style="text-align: center;"> <input checked="" type="checkbox"/> Recommends <input type="checkbox"/> Does Not Recommend <input type="checkbox"/> Neutral (No CFAC Opinion) </p>

	<p>Assertive Engagement services must be delivered by practitioners employed by mental health or substance abuse provider organizations that:</p> <ul style="list-style-type: none"> • meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA); • meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and • fulfill the requirements of 10A NCAC 27G.
12	<p>Staffing Requirements by Age/Disability</p> <p>This service can be provided by licensed clinicians, QP, AP or Paraprofessional staff</p>
13	<p>Program and Staff Supervision Requirements</p> <p>AP or Paraprofessional staff must be supervised by a QP</p>
14	<p>Requisite Staff Training</p> <p>Staff providing this service must have knowledge of motivational enhancement techniques or complete such training prior to delivering this service.</p>
15	<p>Service Type/Setting</p> <p>Assertive Engagement is intended to be flexible in its approach to meet the needs of adults and/or children in their own setting or current location. This service can be delivered as part of the discharge planning process from state operated facilities and correctional facilities as well as in association with specific best and evidence based practices identified by the LME.</p>
16	<p>Program Requirements</p> <p>Assertive Engagement is designed to be an individual service requiring frequent contact to build/re-establish a trusting, meaningful relationship to engage or re-engage the individual into services and/or assess for needs. The service is designed to:</p> <ul style="list-style-type: none"> • Assess for and provide linkage to the appropriate level of care • Identify methods for helping consumers become engaged and involved in their care • Reduce hospitalization frequency and duration • Reduce utilization of crisis services • Reduce criminal/juvenile justice involvement and days incarcerated or in detention • Provide continuity of care regardless of life circumstances or recovery environment • Improve compliance with medication • Increase social networks and improve family relationships • Prevent relapse
17	<p>Entrance Criteria</p> <p>Consumers with a documented severe or serious mental illness and/or addictive disorder who have history of erratic or non-engagement in treatment are eligible for this service. They must be identified as in need of active engagement, have experienced a significant therapeutic disconnect with the service provider or have an instance of/situation resulting in hospitalizations, jail days, or involvement with law enforcement.</p>
18	<p>Entrance Process</p> <p>Selected providers offering high intensity or best practice services may be able to utilize the service as one strategy to engage and retain consumers, prevent the repeated use of hospital or</p>

	<p>other crisis services, and reduce jail/detention utilization. Elements of the assertive engagement process include building trust with the consumer; assisting consumers with meeting basic needs for shelter, food and safety; providing education regarding services and making collateral contacts with family and others working with the consumer. Wake LME has developed a methodology for identifying those consumers with a high level of non-compliance and numerous hospitalizations, and these consumers will be prioritized for this service. Wake LME will develop a benefit plan outlining the amount and intensity of the service, which may be provided, based on individual consumer need and available funding.</p>
19	<p>Continued Stay Criteria</p> <p>Not applicable; this is a short-term engagement service and not designed as a long-term method of service delivery.</p>
20	<p>Discharge Criteria</p> <p>Consumer is fully engaged in services; OR Consumer has refused recommended services after reasonable attempts have been made to engage him/her in treatment and no safety issues or concerns are present.</p>
21	<p>Evaluation of Consumer Outcomes and Perception of Care</p> <ul style="list-style-type: none"> • Describe how outcomes for this service will be evaluated and reported including planned utilization of and findings from NC-TOPPS, the MH/SA Consumer (Satisfaction) Surveys, the National Core Indicators Surveys, and/or other LME outcomes and perception of care tools for evaluation of the Alternative Service • Relate emphasis on functional outcomes in the recipient's Person Centered Plan <p>Since this is a very short-term service, standard outcome measurement instruments such as NC TOPPS, MH/SA Consumer Satisfaction or NCI surveys are not applicable.</p> <p>Consumer outcomes:</p> <ul style="list-style-type: none"> • Consumers will re-engage with a provider agency or engage with a new provider agency • Consumers' utilization of community-based services will increase • Consumers' state hospital admissions will be reduced • Consumers' state hospital bed utilization will be reduced • Consumers' admissions to crisis evaluation and observation services will be reduced • Consumers' admissions to facility based crisis services will be reduced • Consumers' rate of incarceration will be reduced
22	<p>Service Documentation Requirements</p> <ul style="list-style-type: none"> • Is this a service that can be tracked on the basis of the individual consumer's receipt of services that are documented in an individual consumer record? <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "No", please explain.</p> <ul style="list-style-type: none"> • Minimum standard for frequency of note, i.e. per event, daily, weekly, monthly, etc. Minimum standard is a daily service note that includes the consumer's name, date of service, purpose of contact, duration of contact and the signature and credentials of the person providing the service.
23	<p>Service Exclusions</p> <p>None, various basic and enhanced services, as appropriate, are allowable. Examples might include medication management/evaluation, SAIOP, SACOT, ACT, etc.</p>

24	<p>Service Limitations</p> <p>Not to exceed 2 hours per day.</p>
25	<p>Evidence-Based Support and Cost Efficiency of Proposed Alternative Service</p> <p>Assertive Engagement is a central component in a comprehensive continuum of community-based services. Research has shown a</p> <ul style="list-style-type: none"> • 35% decrease in hospitalization • 62% reduction in number of days in hospital • Significant improvement in coping skills and quality of life • Fewer interactions with police <p>www.scmh.org.uk</p>
26	<p>LME Fidelity Monitoring and Quality Management Protocols for Review of Efficacy and Cost-Effectiveness of Alternative Service</p> <p>System Level (across consumer served through this proposed alternative service definition):</p> <ul style="list-style-type: none"> • State hospital admissions will be reduced • State hospital bed utilization will be reduced • Recidivism rates for crisis evaluation and observation services will be reduced • Recidivism rates for facility-based crisis services will be reduced • Incarceration rate will be reduced
27	<p>LME Additional Explanatory Detail (as needed)</p> <p>None</p>

LME Alternative Service Request for Use of DMHDDSAS State Funds

For Proposed MH/DD/SAS Service Not Included in Approved Statewide IPRS Service Array

Note: Submit completed request form electronically to Wanda Mitchell, Budget and Finance Team, at Wanda.Mitchell@ncmail.net, and to Spencer Clark, Chief's Office, Community Policy Management Section, at Spencer.Clark@ncmail.net. Questions about completing and submitting this form may be addressed to Brenda G. Davis, CPM Chief's Office, at Brenda.G.Davis@ncmail.net or (919) 733-4670, or to Spencer Clark at Spencer.Clark@ncmail.net or (919) 733-4670.

a. Name of LME Wake County Human Services Local Management Entity		b. Date Submitted 10/20/2010
c. Name of Proposed LME Alternative Service Comprehensive Screening and Community Connection		
d. Type of Funds and Effective Date(s): <i>(Check All that Apply)</i> <input type="checkbox"/> State Funds: Effective 7-01-07 to 6-30-08 <input checked="" type="checkbox"/> State Funds: Effective 7-01-10 to 6-30-11		
e. Submitted by LME Staff (Name & Title) Jeffrey Hildreth, WCHS LME Adult DD Program Manager, Network Development or Patti Beardsley, WCHS LME Child DD Program Manager, Network Development	f. E-Mail jhildreth@wakegov.com pbeardsley@wakegov.com	g. Phone No. 919-857-9108 919-857-9111
<p><u>Background and Instructions:</u></p> <p>This form has been developed to permit LMEs to request the establishment in IPRS of Alternative Services to be used to track state funds through a fee-for-service tracking mechanism. An LME that receives state single stream or other state non-UCR funding shall use such funding to purchase or start up services included in the Integrated Payment and Reporting System (IPRS) service array and directed towards the approved IPRS target population(s). If the LME wishes to propose the use of state funds for the provision of an Alternative Service that is not included in the IPRS service array, the LME shall submit an <i>LME Alternative Service Request for Use of DMHDDSAS State Funds.</i></p> <p>This form shall be completed to fully describe the proposed Alternative Service for which Division approval is requested in order to develop an IPRS reporting code and an appropriate rate for the Alternative Service.</p> <p>Please use the following template to describe the LME's proposed Alternative Service definition and address all related issues using the standard format and content categories that have been adopted for new MH/DD/SA Services.</p> <p>Please note that:</p> <ul style="list-style-type: none"> • an individual LME Alternative Service Request form is required to be completed for <u>each</u> proposed Alternative Service; • a separate Request for Waiver is required to be submitted to the Division for the LME to be authorized by the Secretary to <u>directly</u> provide an approved Alternative Service; and • the current form is <u>not</u> intended to be utilized in SFY 07-08 for the reporting on the use of county funds by an LME. The Division continues to work with the County Funds Workgroup to establish a mechanism to 		

track and report on the use of county funds through IPRS reporting effective July 1, 2008.

Requirements for Proposed LME Alternative Service

(Items in italics are provided below as examples of the types of information to be considered in responding to questions while following the regular Enhanced Benefit Service definition format. Rows may be expanded as necessary to fully respond to questions.)

Complete items 1 through 28, as appropriate, for all requests.

1

Alternative Service Name, Service Definition and Required Components

Comprehensive Screening and Community Connection

Comprehensive Screening and Community Connection is a method of working with adults and children who have Developmental Disabilities who are seeking services and who are waiting for DD services in Wake County. LMEs across the state are struggling with eligibility and it appears as though there is no standardized process in practice. This proposed definition is an attempt to provide a structure and standardized practice around the initial contacts and work with families and consumers seeking services.

Comprehensive Screening (which includes gathering of pertinent evaluations and medical records) is critical in assuring those requesting DD Services meet the state definition for services and are appropriately receiving or waiting for services. It is expected that this service will include a minimum of 1 home visit to assess an individual's current functioning and level of need plus at least 4 hours of review and compilation of pertinent documents in order to make clinical recommendations.

Community Connection is a critical element of the DD Service continuum for persons who are in the process of accessing or waiting for services. It is designed as a short-term engagement service to assist individuals in understanding the DD System of Care, connecting individuals with non state-funded community services, supporting the individual and family in understanding the waiting list and accessing entitlement benefits which would facilitate service access. It is expected that this service would provide a maximum of 10 contacts over a period of 90 days, preferably in the individual's home or community and would be provided in conjunction with the Comprehensive Screening. Community Connection is by no means intended to replace DDTCM or obviate the TCM service. Community Connection is intended to be a brief, interim service extension to initial eligibility determination and needs assessment to empower families and alleviate initial stressors to consumers who will likely have to wait for services. It is designed to optimize direct client/family services while eliminating "non-service" activities such as PCP development. The service is designed to further empower families to advocate and access services and benefits independent of paid system resources.

2

Rationale for proposed adoption of LME Alternative Service to address issues that cannot be adequately addressed within the current IPRS Service Array

There are no services in the available array that allow for the compilation and review of evaluation materials necessary for determination of eligibility for DD Services (Comprehensive Screening). The gathering of and review of critical psychological, adaptive behavior, academic achievement, ST/PT/OT, medical, psychiatric/behavioral, and other evaluative materials in order to determine eligibility can be labor intensive and requires qualified and competent professionals in the field. Additionally, many children and adults with DD do not have insurance coverage or the financial means to pay for such a service. Whereas Medicaid pays for professional evaluations, it does not pay for review and synthesis of multiple and sometimes disparate evaluations.

In addition, the Community Connection component is proposed to provide limited and short-term services to assist those who do not have entitlement benefits in accessing services to which they

	<p>may be eligible and assisting consumers in navigating the system until they are connected to a permanent service provider. The Community Connection component is considered an initial, short-term 'interim' service that does not include PCP development. It is projected to be a cost effective service which will enable the LME to provide 'some' service to a greater number of people which may obviate the need for more intensive and expensive service options.</p> <p>Currently (as of 10/15/10) Wake County has 1138 people waiting for at least one service and most waiting for more than one service. Many people who are waiting for services may wait for several years for adequate funding for state-funded services to meet their needs. Of the 1138, 731 are waiting for CAP MR/DD funding. If an individual has Medicaid they are immediately referred for Targeted Case Management (TCM) but Wake County has the lowest Medicaid-eligible population as compared to any other LME in the state. This impacts our ability to serve the large numbers of individuals in need of IPRS funding. Wake LME has an average of 30 new referrals for DD Services every month and even with the downturn of the economy, we continue to have a large number of people moving here from out of state due to our schools, proximity to nationally and internationally renowned programs, and broad array of services. Comprehensive Screenings will ensure that those individuals receiving or waiting to receive services are appropriately eligible. Providing short-term support and connection to natural supports and non state-funded community resources upon entry will enable consumers to begin receiving supports earlier and will alleviate some needs of those for whom resources are currently not available. Short-term support may alleviate the need for more expensive and long-term services such as TCM. At a minimum, consumers and their families will be educated on navigating services and systems and their personal responsibility in the process. In order to best support people in need of service, Wake LME believes both components are integral to access and effective service delivery.</p> <p>Wake County LME can? will modify its existing waiting list format in order to identify consumers who receive this service and match that initial service data to subsequent need and service enrollment. The thorough assessment and exploration/exhaustion of natural supports anticipated to be delivered by the vendor(s) ensures that as funding becomes available, the LME will be able to quickly identify and prioritize those with higher needs.</p>
3	<p>Description of service need(s) to be addressed exclusively through State funds for which Medicaid funding cannot be appropriately accessed through a current Medicaid approved service definition</p> <p>Comprehensive Screening and Community Connection is a method of working with adults and/or children with DD to assist them in accessing needed services through comprehensive screening, determination of initial service need, and connection to IPRS or community support services and/or appropriate placement on the DD waiting list for services. While there are similar diagnostic and assessment type service definitions in place to address the MH and SA populations, there is not an equivalent for the DD population. Currently the only approved Medicaid service definition is Targeted Case Management and CAP-funded services.</p>
4	<p>Please indicate the LME's Consumer and Family Advisory Committee (CFAC) review and recommendation of the proposed LME Alternative Service: (Check one)</p> <p style="text-align: center;"> <input checked="" type="checkbox"/> Recommends <input type="checkbox"/> Does Not Recommend <input type="checkbox"/> Neutral (No CFAC Opinion) </p>
5	<p>Projected Annual Number of Persons to be Served with State Funds by LME through this Alternative Service</p> <p>300-400</p>
6	<p>Estimated Annual Amount of State Funds to be Expended by LME for this Alternative Service</p> <p>We estimate potentially expending between \$200,000-\$250,000 per year. This funding is</p>

	chosen rate was derived from the average of these two reimbursement rates.
11	<p>Provider Organization Requirements</p> <p>Comprehensive Screening and Community Connection services must be delivered by practitioners employed by a provider organization that:</p> <ul style="list-style-type: none"> • meets the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA); • meets the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and • fulfills the requirements of 10A NCAC 27G.
12	<p>Staffing Requirements by Age/Disability</p> <p>This service will be provided by licensed clinicians with DD expertise and/or other QDDP staff with knowledge and experience in case management and in interpreting evaluations, IEP's and other contributing and pertinent information.</p>
13	<p>Program and Staff Supervision Requirements</p> <p>At a minimum, direct supervision will be provided by a professional who meets the requirements as both QDDP and QMHP with consultation available by an appropriately licensed professional/credentialed staff within the program's agency.</p>
14	<p>Requisite Staff Training</p> <p>Staff providing this service must have knowledge of various professional assessment reports and materials, the skills and competence to read, comprehend, and interpret the reports accurately, and make appropriate clinical decisions. Staff must be trained in Person-Centered thinking and planning plus have a good working knowledge of community resources. Staff must have at least 5 years experience in the field of Developmental Disabilities and the provider must assure a balance of child and adult expertise.</p>
15	<p>Service Type/Setting</p> <p>Comprehensive Screening and Community Connection is intended to be flexible in its approach to meet the needs of adults and/or children in their own setting or current location. Typically, the service will occur in the individual's home or place of their choice.</p>
16	<p>Program Requirements</p> <p>Comprehensive Screening and Community Connection is designed to be an individual service to assist in the determination of eligibility, assist in accessing benefits and entitlements, and initial determination of service need. The service assists clients and families to understand and navigate access to the service delivery system and the community. The service is designed to:</p> <ul style="list-style-type: none"> • Access, compile, and synthesize existing evaluations necessary for the determination of eligibility for services • Assist client/family in accessing appropriate resources/referrals if updated and new evaluations are needed • Assist client/family in accessing initial natural and/or community supports if available • Assist client/family in identifying potential benefits/entitlements • Assess for and provide linkage to the appropriate level of care and services if available
17	<p>Entrance Criteria</p>

	Any child or adult who is a new consumer seeking services through STR who presents with a need for DD services or any individual who was previously screened but for whom the LME requires a reevaluation of eligibility and updated assessment of need are eligible for this service.
18	<p>Entrance Process</p> <p>The service will serve as the entrance into DD services by providing a comprehensive assessment through the gathering, interpretation, and synthesis of evaluations and school records that support a diagnosis of developmental disability. Individuals seeking services will contact the LME Access Unit. The LME will inform the individual/guardian and provider of the referral and will authorize the service. The provider will initiate contact with the individual/guardian within three business days of receipt of the referral.</p>
19	<p>Continued Stay Criteria</p> <p>Not applicable; this is a short-term engagement service, limited to no more than 90 days and not designed as a long-term method of service delivery. Continued needs will be addressed through an alternate service, dependent upon information obtained from the assessment, clinical recommendations and available supports.</p>
20	<p>Discharge Criteria</p> <p>A comprehensive assessment will be completed and provided to the LME upon completion of the service, or sooner, if needed. Individual's immediate needs will be assessed and stabilized or referred for further support. Each individual will be referred (through the LME) to appropriate resources as available or placed on a waitlist, maintained by the LME, to receive such supports. Individuals will be educated on their status of eligibility, available resources and personal responsibility to notify the LME should their situation change. An update with the provider's involvement and recommendations, along with any appropriate determination materials, will be forwarded to the LME.</p>
21	<p>Evaluation of Consumer Outcomes and Perception of Care</p> <ul style="list-style-type: none"> • <i>Describe how outcomes for this service will be evaluated and reported including planned utilization of and findings from NC-TOPPS, the MH/SA Consumer (Satisfaction) Surveys, the National Core Indicators Surveys, and/or other LME outcomes and perception of care tools for evaluation of the Alternative Service</i> • <i>Relate emphasis on functional outcomes in the recipient's Person Centered Plan</i> <ul style="list-style-type: none"> • Consumer outcomes: Families are provided tools and information in order to better access services and work within the system. • Families will be educated about resources, availability of resources and accessing paid and natural supports in order to meet their family members' needs. • Families will have an identified contact person with the system who they can access for 'consultation.' • This service will result in a document that well defines an individual's needs and strengths essential to the development of a comprehensive Person- Centered Plan. • Complete and comprehensive assessments and Person-Centered Plan will aid in determining most appropriate services to meet consumers' needs. • Emergent/Urgent consumer situations will be screened, triaged and expedited. • Consumers will be linked to appropriate and available resources sooner, limiting time lapses in service delivery. More consumers who are not currently in the service delivery system will begin receiving services (improved penetration). • Timeliness of service delivery may reduce utilization of crisis services including evaluation, observation and admission to facility-based crisis services.
22	Service Documentation Requirements

	<ul style="list-style-type: none"> • Is this a service that can be tracked on the basis of the individual consumer's receipt of services that are documented in an individual consumer record? <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>If "No", please explain.</i></p> <ul style="list-style-type: none"> • Minimum standard for frequency of note, i.e. per event, daily, weekly, monthly, etc. Minimum standard is a service note completed daily per service being billed that includes the consumer's name, date of service, purpose of contact, duration of contact and the signature and credentials of the person providing the service.
23	<p>Service Exclusions No other DD services can be billed on the same day as Comprehensive Screening and Community Connection.</p>
24	<p>Service Limitations Comprehensive Screening and Community Connection services will be provided an average of 15 hours per individual over a maximum period of 90 days.</p>
25	<p>Evidence-Based Support and Cost Efficiency of Proposed Alternative Service Previously, Wake LME made significant reductions in the number of individuals on the waitlist for DD services by providing a targeted approach to individuals waiting for services. Many who would otherwise not be deemed a priority or those for whom resources were not yet available were provided short term involvement with a DD professional who assisted with navigating available community supports, accessing entitlement benefits, and stabilizing emergent needs. This approach was successful with meeting the needs of individuals. The current proposed service, which offers this same targeted support upon entry into DD services, is designed to promote natural supports and other non state-funded connections within the community, assist with accessing entitlement benefits, avert crisis and reduce the number of individuals being placed on the waitlist.</p>
26	<p>LME Fidelity Monitoring and Quality Management Protocols for Review of Efficacy and Cost-Effectiveness of Alternative Service System Level (across consumer served through this proposed alternative service definition):</p> <ul style="list-style-type: none"> • 100% eligibility determination within 45 days of client initiated contact with the LME. • Reduced rates for crisis evaluation and observation services. • Reduced rates for facility-based crisis services and Developmental Center admissions. • Increased and expedited access to services. • Minimum of 90% to 95% agreement between provider's eligibility recommendation and LME determination. • Periodic review of provider records to ensure compliance.
27	<p>LME Additional Explanatory Detail (as needed) None</p>
28	<p>DMH Comments Removed ADMRI as a requested covered pop-group. Not a valid DMH pop-group (02-29-11).</p>



Monday, October 11, 2021

Durham CFAC MEETING - REGULAR MEETING

Virtual meeting via videoconference

MEMBERS PRESENT: Steve Hill, Tammy Shaw, Latasha Jordan, Dave Curro,
 Brenda Solomon, Chris Dale, Pinkey Dunston, Regina Mays, Charlitta Burruss, Helen Castillo, Deborah Dolan

BOARD MEMBERS PRESENT: None

GUEST(S): Suzanne Thompson, DHHS ShaValia Ingram, DHHS

STAFF PRESENT: Doug Wright, Director of Community & Member Engagement, Ramona Branch, Member Engagement Specialist,

<https://alliancehealthplan.zoom.us/meeting/register/tJYsfu2pqT4uGNFVqnthPr1QiVWiAekkIsUN>

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the September 13, 2021, Consumer and Family Advisory Committee (CFAC) meeting were not reviewed; due to low attendance and no quorum.

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
3. Public Comments/ Covid -19 Check In	This meeting was informational session due to low attendance and no quorum. Members are still being affected by Covid-19 and group members continue to support each other.	N/A	N/A
4. State Updates	ShaVaila Ingram, NCDHHS was in attendance and went over the State updates October CEE: <ul style="list-style-type: none"> ➤ Long Term Care Planning Month ➤ MIAW 2021- Mental Illness Awareness Week runs from October 3-9 and coincides with additional related events: <ul style="list-style-type: none"> ○ Tuesday Oct 5: National Day of Prayer or Mental Illness Recovery and Understanding ○ Thursday Oct 7: National Depression Screening Day ○ Saturday Oct 9: NAMIWALKS United Day of Hope ○ Sunday Oct 10: World Mental Health Day ➤ Joint DMHDDSAS & DHB Update call: Providers Thursday, October 7th from 3 pm - 4 pm ➤ Joint DMHDDSAS & DHB Update call: Consumers & Family Members Monday, October 25th from 2 pm - 3 pm ➤ Regional CFAC Meetings: 	N/A	N/A

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
	<ul style="list-style-type: none"> ○ Alliance, Eastpointe, Sandhills and Trillium October 18, 2021, from 6 pm—7 pm ○ Cardinal, Partners and Vaya October 26, 2021, from 6 pm—7 pm ➤ State to Local Collaboration Meeting <ul style="list-style-type: none"> ○ Next Call: October 27, 2021 from 6:00 – 7:30 pm ➤ NC Medicaid Managed Care Hot Topics Webinar Series <ul style="list-style-type: none"> ○ Every 3rd Thursday of the month from 5-30-6:30 PM ○ Next webinar: October 21, 2021 ➤ Pinehurst Conference will be held both virtual and in person this year from December 8-10 		
<p>5. LME/MCO Updates</p>	<p>Doug went over several alternative services that are available to those that are utilizing state funded services. These services are available, but are limited.</p> <p>Hospital Discharge Transition Service-</p> <ul style="list-style-type: none"> • Discharge planning to help get the recipient set-up with a provider in their community <p>Recovery Support-</p> <ul style="list-style-type: none"> • Referral and linkage of resources, advocacy, and participation in treatment planning- available for those with substance use disorders <p>Assertive Engagement-</p> <ul style="list-style-type: none"> • Working with recipients in the community who have a SPMI/SUD (and/or) who do not engage and utilize techniques to get them into care <p>Comprehensive Screening and Community Connection-</p> <ul style="list-style-type: none"> • Working with adults and children to get them screened and assessed for services on the innovations waiver <p>Local Community Collaboration and Engagement Strategy Doug went over the main highlights of this 15-page document that everyone received an electronic copy of in their email.</p>	<p>N/A</p>	<p>N/A</p>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
	<ul style="list-style-type: none"> This document addresses in detail how Alliance will work to reduce potential local barriers to health such as program eligibility, enrollment continuity, member and recipient engagement, unmet resource needs and local continuums of care. It also describes our approach to build partnerships at the local level to increase the availability of natural, community and recovery supports for the people we serve Members were given a chance to ask questions and give feedback on the document <p>Members were asked to please read document in its entirety and submit any questions or concerns to Doug or Ramona.</p> <p>Intellectual/Developmental Disability Waiver Administration and Need Across States- The Duke Margolis Center for Health Policy completed a study on the IDD waiver and waitlist and created a poster of information and policy recommendations. Members were asked to please read document in its entirety and submit any questions or concerns to Doug or Ramona.</p>		
6. Focus Points	<p>Ramona had sent out an email about the main focus points for the group the past month and there were no responses from the group. This brought up the conversation of member engagement with the Durham CFAC subcommittee. This particular meeting was scarce in attendance and it was suggested that the group needed to come up with ways to engage the CFAC group.</p> <ul style="list-style-type: none"> Ramona will re-send the advocacy focal points suggestions; trainings suggestions; email again Ramona will call members the day prior to the meeting or the morning of the meeting to remind members of the meeting Ramona will also send out reminders via email and text 	Ongoing	N/A
7. Announcements	<p>Adam Shields is the new Member Outreach and Engagement Manager (Terrasine's position) and he came on at the end of the meeting and introduced himself.</p>	N/A	N/A

ADJOURNMENT: 6:36pm The next meeting will be November 8, 2021, at 5:30 p.m.

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.

Respectfully Submitted by:

Ramona Branch , Member Engagement Specialist

10.18.2021

DRAFT

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.

LME Alternative Service Request for Use of DMHDDSAS State Funds

**For Proposed MH/DD/SAS Service Not Included
in Approved Statewide IPRS Service Array**

starkun 7/7

Note: Submit completed request form electronically to Wanda Mitchell, Budget and Finance Team, at Wanda.Mitchell@ncmail.net, and to Spencer Clark, Chief's Office, Community Policy Management Section, at Spencer.Clark@ncmail.net. Questions about completing and submitting this form may be addressed to Brenda G. Davis, CPM Chief's Office, at Brenda.G.Davis@ncmail.net or (919) 733-4670, or to Spencer Clark at Spencer.Clark@ncmail.net or (919) 733-4670.

a. Name of LME The Durham Center		b. Date Submitted 06/13/08
c. Name of Proposed LME Alternative Service Recovery Support		
d. Type of Funds and Effective Date(s): <i>(Check All that Apply)</i> <input type="checkbox"/> State Funds: Effective 7-01-07 to 6-30-08 <input checked="" type="checkbox"/> State Funds: Effective 7-01-08 to 6-30-09		
e. Submitted by LME Staff (Name & Title) Sarah Grey, LCSW - Director of Service Management	f. E-Mail sgrey@co.durham.nc.us	g. Phone No. 919-560-7244
Background and Instructions: This form has been developed to permit LMEs to request the establishment in IPRS of Alternative Services to be used to track state funds through a fee-for-service tracking mechanism. An LME that receives state single stream or other state non-UCR funding shall use such funding to purchase or start up services included in the Integrated Payment and Reporting System (IPRS) service array and directed towards the approved IPRS target population(s). If the LME wishes to propose the use of state funds for the provision of an Alternative Service that is not included in the IPRS service array, the LME shall submit an LME Alternative Service Request for Use of DMHDDSAS State Funds . This form shall be completed to fully describe the proposed Alternative Service for which Division approval is requested in order to develop an IPRS reporting code and an appropriate rate for the Alternative Service. Please use the following template to describe the LME's proposed Alternative Service definition and address all related issues using the standard format and content categories that have been adopted for new MH/DD/SA Services. Please note that: <ul style="list-style-type: none"> • an individual LME Alternative Service Request form is required to be completed for <u>each</u> proposed Alternative Service; • a separate Request for Waiver is required to be submitted to the Division for the LME to be authorized by the Secretary to <u>directly</u> provide an approved Alternative Service; and • the current form is <u>not</u> intended to be utilized in SFY 07-08 for the reporting on the use of county funds by an LME. The Division continues to work with the County Funds Workgroup to establish a mechanism to track and report on the use of county funds through IPRS reporting effective July 1, 2008. 		

Requirements for Proposed LME Alternative Service

(Items in italics are provided below as examples of the types of information to be considered in responding to questions while following the regular Enhanced Benefit Service definition format. Rows may be expanded as necessary to fully respond to questions.)

Complete items 1 through 28, as appropriate, for all requests.

1

Alternative Service Name, Service Definition and Required Components

(Provide attachment as necessary)

Recovery Support

Recovery support is intended to promote recovery for adults with substance use disorders by informing, arranging, referring, and assisting consumers in meeting basic needs across life domains that have been impacted by the substance use disorder. The goal of the service is to promote stability and recovery, improve functioning, and gain independence through supportive and helping relationships between the provider and consumer. The expected outcome is more sustained recovery and retention within clinical treatment services.

Recovery support can be offered by qualified professionals or by associate professionals, paraprofessionals, or peer specialists under the supervision of a qualified professional.

Activities include but are not limited to:

Referral and linkage to services and resources

Consumer education about services and resources including natural and community supports

Advocacy on behalf of the consumer

Assisting the consumer to access benefits and services

Participation in treatment planning sessions

2

Rationale for proposed adoption of LME Alternative Service to address issues that cannot be adequately addressed within the current IPRS Service Array

- ***Consumer access issues to current service array***
- ***Consumer barrier(s) to receipt of services***
- ***Consumer special services need(s) outside of current service array***
- ***Configuration and costing of special services***
- ***Special service delivery issues***
- ***Qualified provider availability***
- ***Other provider specific issues***

The Durham Center continues to experience workforce issues in substance abuse and lacks sufficient provider expertise within the Community Support providers' network to adequately address the needs of consumers with substance use issues. This lack of professionals skilled in dealing with substance use leads to therapeutic services delivery in office settings to maximize time of available staff, and not community based services. Yet, consumers with substance use disorders typically experience barriers accessing basic life needs and are often homeless, without income or transportation, lacking medical attention, and have limited recovery-oriented social supports. This leads to difficulty with retention of consumers in outpatient office-based programs. Community Support for these consumers does not appear to be a viable option for providers based on the limited workforce, problematic caseload sizes, and necessity to provide first responder services. Over 60% of adults experiencing substance abuse issues that request services through The Durham Center do not have Medicaid or other financial resources to assist them in addressing these concerns. It is essential that the clinical treatment of substance use

	<p>conditions be supported with linkage to basic resources and services such as housing, employment, medical care, transportation to services, linkage with recovery self-help programs and other benefits and services through case management strategies and also promote independence and recovery. The Durham Center believes that this support is crucial to retention of consumers within the clinical treatment programs, and provides the best opportunity for long-term recovery.</p>
3	<p>Description of service need(s) to be addressed exclusively through State funds for which Medicaid funding cannot be appropriately accessed through a current Medicaid approved service definition As above, The Durham Center requests the inclusion of Recovery Support into the IPRS service array to address gaps in services for adult substance abuse consumers.</p>
4	<p>Please indicate the LME's Consumer and Family Advisory Committee (CFAC) review and recommendation of the proposed LME Alternative Service: (Check one)</p> <p><input type="checkbox"/> Recommends <input type="checkbox"/> Does Not Recommend <input type="checkbox"/> Neutral (No CFAC Opinion)</p> <p>At the time of submission, the proposed definition had not be passed through a formal CFAC process. It is planned for presentation at the next CFAC meeting in July 08.</p>
5	<p>Projected Annual Number of Persons to be Served with State Funds by LME through this Alternative Service 450</p>
6	<p>Estimated Annual Amount of State Funds to be Expended by LME for this Alternative Service</p> <p>We cannot predict the amount of state money that will be used. We are single stream so none of our claims pay with real dollars. In addition, the timing of claims processing in IPRS can dictate how much money is drawn down for a particular service. We have sufficient County money to contribute to this service, and plan to regulate costs through our benefit plan and service package design. Additionally, only selected providers of best practice or high intensity services will be selected to utilize the service.</p>
7	<p>Eligible IPRS Target Population(s) for Alternative Service: (Check all that apply)</p> <p><u>Assessment Only:</u> <input type="checkbox"/> All <input type="checkbox"/> CMAO <input type="checkbox"/> AMAO <input type="checkbox"/> CDAO <input type="checkbox"/> ADAO <input type="checkbox"/> CSAO <input type="checkbox"/> ASAO</p> <p><u>Crisis Services:</u> <input type="checkbox"/> All <input type="checkbox"/> CMCS <input type="checkbox"/> AMCS <input type="checkbox"/> CDCS <input type="checkbox"/> ADCS <input type="checkbox"/> CSCS <input type="checkbox"/> ASCS</p> <p><u>Child MH:</u> <input type="checkbox"/> All <input type="checkbox"/> CMSED <input type="checkbox"/> CMMED <input type="checkbox"/> CMDEF <input type="checkbox"/> CMPAT <input type="checkbox"/> CMECD</p> <p><u>Adult MH:</u> <input type="checkbox"/> All <input type="checkbox"/> AMSPM <input type="checkbox"/> AMSMI <input type="checkbox"/> AMDEF <input type="checkbox"/> AMPAT <input type="checkbox"/> AMSRE</p> <p><u>Child DD:</u> <input type="checkbox"/> CDSN</p> <p><u>Adult DD:</u> <input type="checkbox"/> All <input type="checkbox"/> ADSN <input type="checkbox"/> ADMRI</p> <p><u>Child SA:</u> <input type="checkbox"/> All <input type="checkbox"/> CSSAD <input type="checkbox"/> CSMAJ <input type="checkbox"/> CSWOM <input type="checkbox"/> CSCJO <input type="checkbox"/> CSDWI <input type="checkbox"/> CSIP <input type="checkbox"/> CSSP</p> <p><u>Adult SA:</u> <input checked="" type="checkbox"/> All <input type="checkbox"/> ASCDR <input type="checkbox"/> ASHMT <input type="checkbox"/> ASWOM <input type="checkbox"/> ASDSS <input type="checkbox"/> ASCJO <input type="checkbox"/> ASDWI <input type="checkbox"/> ASDHH <input type="checkbox"/> ASHOM <input type="checkbox"/> ASTER</p> <p><u>Comm. Enhance.:</u> <input type="checkbox"/> All <input type="checkbox"/> CMCEP <input type="checkbox"/> AMCEP <input type="checkbox"/> CDCEP <input type="checkbox"/> ADCEP <input type="checkbox"/> ASCEP <input type="checkbox"/> CSCEP</p> <p><u>Non-Client:</u> <input type="checkbox"/> CDF</p>
8	<p>Definition of Reimbursable Unit of Service: (Check one)</p> <p><input type="checkbox"/> Service Event <input checked="" type="checkbox"/> 15 Minutes <input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Monthly</p>

	<input type="checkbox"/> Other: Explain _____
9	<p>Proposed IPRS <u>Average</u> Unit Rate for LME Alternative Service</p> <p><i>Since this proposed unit rate is for Division funds, the LME can have different rates for the same service within different providers. What is the proposed <u>average</u> IPRS Unit Rate for which the LME proposes to reimburse the provider(s) for this service?</i></p> <p style="text-align: center;">\$ <input type="text"/> <input type="text"/> 14.00</p>
10	<p>Explanation of LME Methodology for Determination of Proposed IPRS <u>Average</u> Unit Rate for Service (Provide attachment as necessary)</p> <p>To determine to the rate, we used the per unit cost of community support and increased it by 15%. We feel that components of community support closely resemble this new proposed service with additional work needed with the SA community.</p>
11	<p>Provider Organization Requirements</p> <p>Recovery Support services must be delivered by practitioners employed by substance abuse provider organizations that</p> <ul style="list-style-type: none"> • meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA); • meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and • fulfill the requirements of 10A NCAC 27G.
12	<p>Staffing Requirements by Age/Disability (Type of required staff licensure, certification, QP, AP, or paraprofessional standard)</p> <p>Recovery support may be provided by qualified professionals, associate professionals or paraprofessionals who meet standards and who have appropriate documented experience with the population served. The service may also be provided by peer specialists in substance abuse.</p>
13	<p>Program and Staff Supervision Requirements</p> <p>AP, PP and peer specialist staff must be supervised by a substance abuse qualified professional.</p> <p>The service is intended to support a consumer who currently receives clinical treatment services in accessing additional services and non-treatment supports necessary to promote increased independent functioning and recovery.</p>
14	<p>Requisite Staff Training</p> <p>Staff must be appropriately trained in working with the population including training on motivational enhancement and recovery culture within 90 days of employment.</p>
15	<p>Service Type/Setting</p> <p>The service can be provided in any setting.</p>
16	<p>Program Requirements</p> <ul style="list-style-type: none"> • Individual or group service • Required client to staff ratio (if applicable) • Maximum consumer caseload size for FTE staff (if applicable) • Maximum group size (if applicable) • Required minimum frequency of contacts (if applicable) • Required minimum face-to-face contacts (if applicable)

	The service can be provided to individuals or groups. Group size should not exceed more than 8. Maximum caseload size for one FTE is 60 cases.
17	<p>Entrance Criteria</p> <ol style="list-style-type: none"> 1. There is an Axis I diagnosis of a substance use disorder <p>AND</p> <ol style="list-style-type: none"> 2. The person has needs in at least 2 life domain areas affected by substance use
18	<p>Entrance Process</p> <p>The recommendation for Recovery support must be identified by a qualified professional through a clinical assessment and treatment planning process. Goals and interventions for Recovery Support must be identified on a Person-Centered Treatment plan that was developed by a qualified professional.</p>
19	<p>Continued Stay Criteria</p> <p>Consumer needs continued assistance to achieve desired outcomes on the Person-Centered or treatment plan.</p> <p>New goals are identified on the Person-Centered or treatment plan.</p> <p>The consumer is making reasonable progress toward goals identified on the plan.</p>
20	<p>Discharge Criteria</p> <p>Consumer has achieved goals and is no longer eligible for the service</p> <p>Consumer is not making progress with the service and all reasonable options have been exhausted.</p> <p>Consumer no longer wants the service</p> <ul style="list-style-type: none"> • Anticipated length of stay in service (provide range in days and average in days) 1-180 days, average is expected to be 75-90 days. • Anticipated average number of service units to be received from entrance to discharge The Durham Center will develop benefit packages for this service which will address routine amounts of this service. The service will be available only to selected programs and providers. The average units per consumer is anticipated to be 72- 96 units of the service, however this is the first year of the service and it is difficult to anticipate the amounts of service which may be needed to achieve outcomes. Therefore, we will likely start out with defined amounts of service and analyze cost and usage periodically throughout the year. • Anticipated average cost per consumer for this service
21	<p>Evaluation of Consumer Outcomes and Perception of Care</p> <ul style="list-style-type: none"> • Describe how outcomes for this service will be evaluated and reported including planned utilization of and findings from NC-TOPPS, the MH/SA Consumer (Satisfaction) Surveys, the National Core Indicators Surveys, and/or other LME outcomes and perception of care tools for evaluation of the Alternative Service • Relate emphasis on functional outcomes in the recipient's Person Centered Plan <p>This service could accompany a primary SA service. Depending on the type of primary SA service, NC-TOPPS would be required. Submission of NC-TOPPS by the primary SA service provider will be expected as usual, and an analysis of outcomes for the individuals engaged in Recovery Support will be pursued.</p> <p>Some additional consumer outcomes:</p> <ul style="list-style-type: none"> • Consumers' state hospital admissions will be reduced • Consumers' state hospital bed utilization will be reduced • Consumers will have a lower rate of admission to crisis evaluation and observation

	<p>services.</p> <ul style="list-style-type: none"> • Consumers will have a lower rate of admission to facility based crisis services for at least 90 days • Active pursuit of housing, medical treatment, and other basic needs will be evident • Engagement in appropriate recovery self-help programs will be evident
22	<p>Service Documentation Requirements</p> <ul style="list-style-type: none"> • <i>Is this a service that can be tracked on the basis of the individual consumer's receipt of services that are documented in an individual consumer record?</i> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>If "No", please explain.</i></p> <ul style="list-style-type: none"> • <i>Minimum standard for frequency of note, i.e. per event, daily, weekly, monthly, etc.</i> Full service note per event that documents the purpose, intervention and consumer's response to the service.
23	<p>Service Exclusions</p> <ul style="list-style-type: none"> • <i>Identify other service(s) that are limited or cannot be provided on the same day or during the same authorization period as proposed Alternative Service</i> SAIOP or SACOT
24	<p>Service Limitations</p> <ul style="list-style-type: none"> • <i>Specify maximum number of service units that may be reimbursed within an established timeframe (day, week, month, quarter, year)</i> 8 hours per day maximum.
25	<p>Evidence-Based Support and Cost Efficiency of Proposed Alternative Service Recovery support incorporates many activities traditionally identified as case management which has a long service history within the state. The service is determined to be necessary by The Durham Center due to the severe socioeconomic impact on adults of substance use disorders, the multiple resource and recovery needs and the lack of professional capacity to provide substance abuse focused community support activities due to workforce issues.</p>
26	<p>LME Fidelity Monitoring and Quality Management Protocols for Review of Efficacy and Cost-Effectiveness of Alternative Service Across consumer served through this proposed alternative service definition:</p> <ul style="list-style-type: none"> • State hospital admissions will be reduced • State hospital bed utilization will be reduced • Recidivism rates for crisis evaluation and observation services will be reduced • Admission rates for facility-based crisis services will be reduced
27	<p>LME Additional Explanatory Detail (as needed) N/A</p>

LME Alternative Service Request for Use of DMHDDSAS State Funds

For Proposed MH/DD/SAS Service Not Included in Approved Statewide IPRS Service Array

Note: Submit completed request form electronically to Wanda Mitchell, Budget and Finance Team, at Wanda.Mitchell@ncmail.net, and to Spencer Clark, Chief's Office, Community Policy Management Section, at Spencer.Clark@ncmail.net. Questions about completing and submitting this form may be addressed to Brenda G. Davis, CPM Chief's Office, at Brenda.G.Davis@ncmail.net or (919) 733-4670, or to Spencer Clark at Spencer.Clark@ncmail.net or (919) 733-4670.

a. Name of LME Crossroads Behavioral Healthcare		b. Date Submitted 2-28-09
c. Name of Proposed LME Alternative Service Hospital Discharge Transition Service: A Statewide Alt Service Definition YA346		
d. Type of Funds and Effective Date(s): <i>(Check All that Apply)</i> <input type="checkbox"/> State Funds: Effective 7-01-07 to 6-30-08 <input type="checkbox"/> State Funds: Effective 7-01-08 to 6-30-09		
e. Submitted by LME Staff (Name & Title) Diane Morrison, Admin. Director, Clinical Services Gail Hinson, Clinical Director, Clinical Services	f. E-Mail dmorrison@crossroadsbhc.org ghinson@crossroadsbhc.org	g. Phone No. 336-835-1000
<u>Background and Instructions:</u> This form has been developed to permit LMEs to request the establishment in IPRS of Alternative Services to be used to track state funds through a fee-for-service tracking mechanism. An LME that receives state single stream or other state non-UCR funding shall use such funding to purchase or start up services included in the Integrated Payment and Reporting System (IPRS) service array and directed towards the approved IPRS target population(s). If the LME wishes to propose the use of state funds for the provision of an Alternative Service that is not included in the IPRS service array, the LME shall submit an <i>LME Alternative Service Request for Use of DMHDDSAS State Funds.</i> This form shall be completed to fully describe the proposed Alternative Service for which Division approval is requested in order to develop an IPRS reporting code and an appropriate rate for the Alternative Service. Please use the following template to describe the LME's proposed Alternative Service definition and address all related issues using the standard format and content categories that have been adopted for new MH/DD/SA Services. Please note that: <ul style="list-style-type: none"> • an individual LME Alternative Service Request form is required to be completed for <u>each</u> proposed Alternative Service; • a separate Request for Waiver is required to be submitted to the Division for the LME to be authorized by the Secretary to <u>directly</u> provide an approved Alternative Service; and • the current form is <u>not</u> intended to be utilized in SFY 07-08 for the reporting on the use of county funds by an LME. The Division continues to work with the County Funds Workgroup to establish a mechanism to track 		

and report on the use of county funds through IPRS reporting effective July 1, 2008.

Requirements for Proposed LME Alternative Service

(Items in italics are provided below as examples of the types of information to be considered in responding to questions while following the regular Enhanced Benefit Service definition format. Rows may be expanded as necessary to fully respond to questions.)

Complete items 1 through 28, as appropriate, for all requests.

1	<p>Alternative Service Name, Service Definition and Required Components</p> <p><u>Hospital Discharge Transition Service:</u> This service includes face-to-face attendance at state and community psychiatric hospitals, facility based crisis centers, detox centers and other 24-hour facilities for the purposes of discharge planning with assigned and unassigned consumers. Services are inclusive of face to face contacts with consumers and staff, attendance at treatment/discharge meetings, and contact/linkage with community resources identified in discharge plan. The objective is to facilitate discharge planning and when applicable, complete all documentation required to transfer consumers to another appropriate service with an LME contract provider. The Hospital Discharge Transition Service should be used briefly and only until consumers are attached to a provider for ongoing services. It should also be used to engage those consumers on outpatient commitment who are not attached to a provider until these consumers are attached to a provider for ongoing services.</p>
2	<p>Rationale for proposed adoption of LME Alternative Service to address issues that cannot be adequately addressed within the current IPRS Service Array</p> <p>With the initiation of Implementation Update #49 on 9/2/08, all individuals receiving Medicaid Benefits will have those benefits temporarily suspended upon admission to any state hospital. This creates a huge barrier to receiving services while in the hospital as well as upon release back to the community. There are no unmanaged Community Support hours and providers may not bill for CS while a consumer is in the state hospital. This makes it impossible for the LME to reimburse providers for transitioning the most at risk consumers back to the community at the time of discharge. Many high risk, high cost consumers access Crisis services on a regular basis. These consumers are often treatment resistant and without additional support and encouragement will fall through the cracks and continue to increase recidivism.</p>
3	<p>Description of service need(s) to be addressed exclusively through State funds for which Medicaid funding cannot be appropriately accessed through a current Medicaid approved service definition</p> <p>There is currently a very serious gap in the treatment continuum when a consumer enters an inpatient facility. Most service definitions do not permit billing while consumers are inpatient and therefore providers often discontinue needed services for lack of ability to bill. Provider activities to be addressed through state funding which cannot be appropriately accessed through an approved Medicaid service definition would include:</p> <p><u>PRE DISCHARGE SERVICES – STATE HOSPITAL, ADATC, OTHER 24 HOUR FACILITIES</u></p> <ul style="list-style-type: none">• Face to face contact with consumer within 24 hours of notification from LME .<ul style="list-style-type: none">- determine consumer treatment needs, preferences, and provider choice upon discharge- identify natural and community supports- identify how and where the consumer will return to community- identify housing needs• collaboration with inpatient facility treatment team and Crossroads’ Hospital Liaison to develop discharge plan

- Complete necessary paperwork to make consumer active with your agency.
- Complete Intro PCP and refer all consumers who qualify to the appropriate Enhanced Service

POST DISCHARGE SERVICES-STATE HOSPITAL, ADATC, OTHER 24 HOUR FACILITIES

- Face-to-face appointment with all consumers who do not qualify for Enhanced Services at their home the day of discharge or within 3 days.
- If consumer does not qualify for an Enhanced Service, transport consumer to the first appointment.
- If consumer is not able to attend first appointment provider will outreach consumer and schedule a second appt. within 4 days
- Provide all necessary support and services until consumer becomes active with a provider
- Schedule consumer with a minimum of one billed medication management appointment within 14 days post discharge.
- Begin working on (re)linking with Medicaid and/or disability benefits (if appropriate)

PRE-DISCHARGE SERVICES – LEVEL 3.7 & LEVEL 4 DETOX and FACILITY BASED CRISIS

- Face-to-face appointment with consumer within 3 days of admission
 - determine consumer treatment needs, preferences and provider choice upon discharge
 - identify natural and community supports
 - identify how and where the consumer will return to community
 - identify housing needs
- collaboration with inpatient facility treatment team and Crossroads’ Hospital Liaison to develop discharge plan
- Complete necessary paperwork to make consumer active with a provider.
- Schedule an appointment for the day of discharge

POST DISCHARGE – LEVEL 3.7 & LEVEL 4 DETOX and FACILITY BASED CRISIS

- Provide transportation from the facility to the first appointment or Urgent Walk In Center on the day of discharge
- Transfer post discharge services to Provider or Urgent Walk In Center at that time.

4 Please indicate the LME’s Consumer and Family Advisory Committee (CFAC) review and recommendation of the proposed LME Alternative Service: *(Check one)*

- Recommends Does Not Recommend Neutral (No CFAC Opinion)

5 Projected Annual Number of Persons to be Served with State Funds by LME through this Alternative Service 491

6 Estimated Annual Amount of State Funds to be Expended by LME for this Alternative Service \$172,341 per year.

7 Eligible IPRS Target Population(s) for Alternative Service: *(Check all that apply)*

Assessment Only: All CMAO AMAO CDAO ADAO CSAO ASAO

Crisis Services: All CMCS AMCS CDCS ADCS CSCS ASCS

Child MH: All CMSED CMMED CMDEF CMPAT CMECD

	<p>Adult MH: <input checked="" type="checkbox"/> All <input type="checkbox"/> AMSPM <input type="checkbox"/> AMSMI <input type="checkbox"/> AMDEF <input type="checkbox"/> AMPAT <input type="checkbox"/> AMSRE</p> <p>Child DD: <input checked="" type="checkbox"/> CDSN</p> <p>Adult DD: <input checked="" type="checkbox"/> All <input type="checkbox"/> ADSN <input type="checkbox"/> ADMRI</p> <p>Child SA: <input checked="" type="checkbox"/> All <input type="checkbox"/> CSSAD <input type="checkbox"/> CSMAJ <input type="checkbox"/> CSWOM <input type="checkbox"/> CSCJO <input type="checkbox"/> CSDWI <input type="checkbox"/> CSIP <input type="checkbox"/> CSSP</p> <p>Adult SA: <input checked="" type="checkbox"/> All <input type="checkbox"/> ASCDR <input type="checkbox"/> ASHMT <input type="checkbox"/> ASWOM <input type="checkbox"/> ASDSS <input type="checkbox"/> ASCJO <input type="checkbox"/> ASDWI <input type="checkbox"/> ASDHH <input type="checkbox"/> ASHOM <input type="checkbox"/> ASTER</p> <p>Comm. Enhance.: <input checked="" type="checkbox"/> All <input type="checkbox"/> CMCEP <input type="checkbox"/> AMCEP <input type="checkbox"/> CDCEP <input type="checkbox"/> ADCEP <input type="checkbox"/> ASCEP <input type="checkbox"/> CSCEP</p> <p>Non-Client: <input checked="" type="checkbox"/> CDF</p>
8	<p>Definition of Reimbursable Unit of Service: <i>(Check one)</i></p> <p><input type="checkbox"/> Service Event <input checked="" type="checkbox"/> 15 Minutes <input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Monthly</p> <p><input type="checkbox"/> Other: Explain _____</p>
9	<p>Proposed IPRS <u>Average</u> Unit Rate for LME Alternative Service</p> <p><i>Since this proposed unit rate is for Division funds, the LME can have different rates for the same service within different providers. What is the proposed <u>average</u> IPRS Unit Rate for which the LME proposes to reimburse the provider(s) for this service?</i></p> <p style="text-align: right;">\$ <input type="text"/> 18.25</p>
10	<p>Explanation of LME Methodology for Determination of Proposed IPRS <u>Average</u> Unit Rate for Service <i>(Provide attachment as necessary)</i></p> <p>Based on the current Community Support rate for an Un-Licensed Qualified Professional. The proposed average cost for each delivered service is \$351.</p>
11	<p>Provider Organization Requirements</p> <p>Any comprehensive treatment service provider who is contracted with Crossroads Behavioral Healthcare may use this code</p>
12	<p>Staffing Requirements by Age/Disability <i>(Type of required staff licensure, certification, QP, AP, or paraprofessional standard)</i></p> <p>QP at minimum</p>
13	<p>Program and Staff Supervision Requirements</p> <p>QP must be directly supervised by a licensed or Masters level clinician. The licensed or Masters level clinician must be supervised in accordance to their agency's supervision requirement.</p>
14	<p>Requisite Staff Training</p> <p>Staff providing this service must have the following training;</p> <ul style="list-style-type: none"> • Motivational Interviewing • Recovery Education

	<ul style="list-style-type: none"> • Person Centered Planning • Same as required for the Basis and Enhanced services that provider is contracted with the LME to provide.
15	<p>Service Type/Setting State Hospitals, Local Hospitals, Facility Based Crisis Centers, Detox facilities and other 24 hour inpatient facilities</p>
16	<p>Program Requirements</p> <ul style="list-style-type: none"> • This will be an individual service • Contacts as identified in #3
17	<p>Entrance Criteria</p> <ul style="list-style-type: none"> • Inpatient status at a State Psychiatric facility or ADATC or any other 24-hour facility
18	<p>Entrance Process</p> <ul style="list-style-type: none"> • Client is admitted to a 24 hour facility for MH/SA treatment • Liaison identifies whether or not consumer is active with a provider • If so...informs provider of admission • If not... Liaison and/or social workers have a consent for treatment signed by consumer • A referral will be made to the Hospital Transition Service.
19	<p>Continued Stay Criteria</p> <p>Consumer has not had an intake/face to face with the Urgent Walk In Center or an outpatient provider.</p>
20	<p>Discharge Criteria</p> <ul style="list-style-type: none"> • Consumer will be discharged when active with outpatient provider • Anticipated length of stay is less than one week • Anticipated number of service units received from admission to discharge is 20 • Anticipated average cost per consumer for this service is \$351
21	<p>Evaluation of Consumer Outcomes and Perception of Care</p> <ul style="list-style-type: none"> • Increased frequency of consumer follow through with outpatient care • Consumer does not return to hospital or Detox within 30 days of discharge • Findings from the NC TOPPS
22	<p>Service Documentation Requirements</p> <ul style="list-style-type: none"> • <i>Is this a service that can be tracked on the basis of the individual consumer's receipt of services that are documented in an individual consumer record?</i> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>If "No", please explain.</i></p> <ul style="list-style-type: none"> • <i>Minimum standard for frequency of note, i.e. per event, daily, weekly, monthly, etc.</i> • All contacts will be documented with standard service note and filed in consumer chart • An invoice, documenting units claimed, will be submitted to Crossroads LME for authorization and payment
23	<p>Service Exclusions</p>

	This code will not be authorized past first completed outpatient appointment
24	<p>Service Limitations</p> <ul style="list-style-type: none"> • Specify maximum number of service units that may be reimbursed within an established timeframe (day, week, month, quarter, year) 8 hours a week maximum
25	<p>Evidence-Based Support and Cost Efficiency of Proposed Alternative Service</p> <ul style="list-style-type: none"> • Provide other organizational examples or literature citations for support of evidence base for effectiveness of the proposed Alternative Service According to the Community Systems Progress Indicators, timely engagement is a best practice that “provides the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.” For Substance Abuse consumers: “Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.” (Long-Range Plan for Meeting Mental Health, Developmental Disabilities & Substance Abuse Services Needs for the State of North Carolina, December 12, 2006, Heart of the Matter, Inc. & Pareto Solutions, LLC)
26	<p>LME Fidelity Monitoring and Quality Management Protocols for Review of Efficacy and Cost-Effectiveness of Alternative Service</p> <ul style="list-style-type: none"> • UR/UM committee can identify recidivistic consumers and compare before and after the implementation of the alternative service definition • Compare follow through with outpatient services after implementation of the alternative service definition • Monitor to ensure that service is initiated within 24 hours of LME notification • Monitor to ensure that <u>60%</u> of service was provided face to face • Monitor to ensure that service was provided consistent basis to the point that consumer receives a clinical intake assessment with an outpatient provider
27	<p>LME Additional Explanatory Detail (as needed) N/A</p>



INTRODUCTION

- Medicaid Home- and Community-Based Services (HCBS) Waivers fund long-term services and supports in the community versus institutions in compliance with the 1999 *Olmstead v. L.C.* U.S. Supreme Court decision
- HCBS Waivers increase quality of life and address unmet needs of those with intellectual and/or developmental disabilities (I/DD)¹⁻³
- Centers for Medicare and Medicaid Services (CMS) approval of diverse Waiver designs among States complicates evaluating their effectiveness^{1,2,4}
- In North Carolina:
 - 12+ year waiting list (“Registry of Unmet Needs”)⁵
 - Only 22% of 53,531 Medicaid beneficiaries with I/DD or ASD on NC Medicaid are enrolled in the IDD waiver (NC Innovations)⁶
 - Inequities: Non-Hispanic Blacks and Hispanics are less likely to receive waiver than non-Hispanic Whites⁶; Youth (≤ 21 years old), females, and rural residents less likely to receive Waiver⁶



Purpose: Identify effective strategies for improving access to I/DD Waiver slots by examining how States have a) designed and adapted their I/DD Waiver systems; b) shortened their waiting lists; and c) addressed unmet needs and inequities

METHODS

- **Sample:** 8 states represented by 10 state Developmental Disabilities Council Directors & DHHS leaders
- **Semi-structured Interviews**
 - Duration: 68.5 min (range 53-92 min)



Figure 1: States Included (N = 8)

RESULTS

Waiver Duration Structure (n):

- Lifespan (3)
- Separate children & adult (2)
- Combination (3)

Approval Process (n):

- First-come, first-served (4)
- Need-based (3)
- Employment and crisis status first (1)

All states reported that it is **not easy** to sign up for the Waiver (Quote 1)

Exemplar Quotes

1. *“It’s like going into a room of curtains, and when one is pulled back, all you see is the next curtain.”*
2. *“Only the most informed, empowered, confident families who have navigational capital, time and expertise are going to be able to make it through.”*
3. *“We can scream and scream and scream about people on the waiting list. And that film just makes it a lot more human.”*

Unmet Needs:

- No existing process for surveying unmet needs
- Lack of service providers, particularly in rural areas
- Low direct support professional (DSP) wages
- Problems helping people with I/DD get employment
- Lack of “true self-determination and choice”
- Many invisible to the Waiver system (not on waiting list)
- **Underserved subpopulations:** Rural, Historically Marginalized Populations, LGBTQ+, children, transition age, aging individuals, dual-diagnosed

Strategies to Address Unmet Needs:

- Legislative advocacy
- Partnership with community organizations
- Partnership with universities or protection & advocacy groups
- Collaboration with other State and local government agencies

Table 1: Descriptive measures of I/DD Waivers (N=8)

Outcome	North Carolina	Sample mean (range)	# states analyzed
# I/DD waivers	1	3.6 (1-10)	8
# waiver slots	13,138	19,814 (10k-60k)	6
# on waiting list	~14,000	27,155 (0-159k)	8
Waiting list time (y)	~10	9.1 (0-15)	5

Waiting List:

- Alternate names for waiting lists
- Wide range in waiting list size, long wait times (Table 1)
- Some states administer waiting lists and Waivers on local level
- Personal political/social influence can shorten wait (Quote 2)
- Medicaid agencies do not publish waiting list data
- Limited options for people waiting and not on Medicaid

State Waiting List Reduction Strategies:

- Prioritize sub-populations
 - LA eliminated waiting list by assessing high need individuals
 - GA proposed redirecting high-need funds to low-need recipients
- Implemented tiered Waiver enrollment (incremental funds by need)
- Lobbying and grassroots advocacy (Film *6000 Waiting*, Quote 3)

Mechanisms for Increasing Slots:

- Dependent on legislative action for State match appropriations
- “Stretch” existing funds through tiered enrollment
- Legal action via *Olmstead* and ADA protections yields variable results

Strategies for Improvement:

- Broaden Waiver capacity
- Streamline the application process
 - Case manager explains process to families
 - Flow charts, social stories, videos explaining process
 - One-size-fits-all application system
- Greater emphasis on self-determination and rights
- Increase DSP wages
- Enhance Supported Employment
- Improve housing options and close institutions

DISCUSSION

- NC I/DD Waiver slots are allocated disproportionately by age, race, sex, and geography. Other states express concern about similar inequities but often not formally studied
 - Other states working to tackle underserved populations in five-year plans, but under-resourced
- Many individuals are eligible but remain unaware of the I/DD waiver thus are “invisible” to the system
- First-come, first-served can contribute to inequities
- The lack of State waiting list transparency is problematic
- Tiered waivers have eliminated high need waiting lists and reduced per slot expenses
- Cross sector partnerships are crucial for improved advocacy and Waiver slot allocation
- Low DSP wages are a concern for all states



POLICY RECOMMENDATIONS

- Invest in the administrative oversight of a centralized database to maintain accurate waiting list eligibility and demographic data
- Sustainable State and federal appropriations for funding to increase the number of Waiver slots
- Address inequities and barriers to Waiver enrollment to ensure that all eligible people learn about, apply for, and receive a slot

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1. Leslie DL, Iskandarani K, Dick AW, et al. The effects of Medicaid home and community-based services waivers on unmet needs among children with autism spectrum disorder. *Medical care*. 2017;55(1):57.
2. Leslie DL, Iskandarani K, Velott DL, et al. Medicaid waivers targeting children with autism spectrum disorder reduce the need for parents to stop working. *Health Affairs*. 2017;36(2):282-288.
3. Eskow K, Chasson G, Summers JA. A Cross-Sectional Cohort Study of a Large, Statewide Medicaid Home and Community-Based Services Autism Waiver Program. *J Autism Dev Disord*. 2015;45(3):626-635. doi:https://dx.doi-org.proxy.lib.duke.edu/10.1007%2Fs10803-014-2217-4
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NCDHHS's Established Vision for Children and Families: Children are healthy and thrive in safe, stable and nurturing families, schools and communities.

The Division of Child and Family Well-Being Basics:

What: The Division of Child and Family Well-Being will bring together complementary programs from within NCDHHS that primarily serve children and youth to improve outcomes for children and their families. These programs include the following:

- Nutrition programs for children, families, and seniors, including WIC, FNS/SNAP, CACFP, and special metabolic formula program
- Health-related programs and services for children that enable them to be healthy in their schools and communities, such as school health promotion, home visiting services, and children and youth with special health care needs programs
- School and community mental health services for children and youth, including supporting children with complex needs, coordination with schools, and systems of care work to meet needs of families who are involved in multiple child service agencies
- Early Intervention/Infant-Toddler Program, which provides supports and services to young children with developmental delays or established conditions

Why: Across NCDHHS, we aim to make a positive impact on the lives of the people we serve and to ensure that programs and services reach those who need them the most. We are proud of how we transformed how we work as a team to serve children and families during an unprecedented global crisis. The Division of Child and Family Well-Being will build upon these lessons learned to further prioritize and coordinate whole child and family well-being. We will realize our vision for children and families by:

- **Enhancing how children and families access programs that support their well-being:** Coordination across programs serving children and families allows more families to access programs across mental, social, and health services. An early area of work will be making it easier for families to enroll in the nutrition programs in the Division (e.g., WIC and FNS/SNAP).
- **Coordinating increased investments to improve child health and well-being:** The investments will be informed by data with a focus on closing equity gaps in child well-being. An early focus will be maximizing the impact of the federal American Rescue Plan funds to address inequities in child well-being.
- **Elevating the value of our teams supporting child and family well-being:** We are inspired by our team members who passionately work to improve the lives of children and families in North Carolina. Our commitment is to create a thriving culture where we celebrate our positive impact on child and family well-being.

When: We expect that the launch of the Division will be a process that will start in the winter of 2021. NCDHHS is working with Guidehouse, a change management consultant to facilitate this transition and launch. This change will take place in overlapping phases: Alignment (review of current programs and opportunities for alignment, June-September), Design (transition planning, late August-November), Implementation (begin process of launch and early implementation, November-December), and Improvement (review and refine, ongoing).

Who: We are currently in the process of hiring a Division Director for the Division of Child and Family Well-Being. Dr. Charlene Wong, in her new role as Assistant Secretary for Children and Families, will

work closely with Susan Gale Perry, Chief Deputy Secretary for Opportunity and Well-Being and other senior leaders across the Department to establish the new division.

MEMBERS PRESENT: Annette Smith, Rebekah Bailey, Trula James, Karen McKinnon, Benjamin Smith,
 Diane Morris, Connie King- Jerome, Vicky Bass, Jessica Larrison, Gregory Schweizer, Bradley Gavriluk, Faye Griffin, Carole Johnson, Israel Pattison, Christopher Smith,

BOARD MEMBERS PRESENT: None

GUEST(S): Suzanne Thompson, DHHS ShaValia Ingram

STAFF PRESENT: Doug Wright, Director of Community & Member Engagement,

Erica Asbury, Member Engagement Specialist, Adam Shields, Member Engagement Manager, Laini Jarrett, Quality Review Coordinator

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the September 14, 2021, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; no motion was made because that meeting was a Community Forum for Medicaid Transformation. I. Pattison motioned to accept the minutes and G. Schweizer second.

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
3. COVID -19 check in /Public Announcements	V. Bass updated that Club House continues to have staffing concerns. She reported that multiple positions are available and that they are staggering the attendance. She is asking that we all be patient as agencies and providers attempt to get qualified staff in to work.	N/A	N/A
4. State Updates-S. Ingram	S. Ingram announced that CEE training is up and running and people may register through the link. This is Disability Awareness month, Breast Cancer Awareness Month as well as Dyslexia Awareness Month. Please be reminded that the Regional Meeting will be on 10/18/21 from 6-7pm. The state and local collaborative meeting will be on 10/27/21 from 6-7pm The IDD stakeholders meeting 11/18/21 from 3-5 pm The Parents and Professionals development services will be on 9/21 12-1pm The Veteran’s Governors work group will take place 9/23/21 from 2-4 pm. Tailored Care Management 101 services every Friday 12-1	Ongoing	N/A
5. State Updates	S. Ingram hot topics ae every 3 rd Thursday 5:30-6:30 to discuss Medicaid Managed Care	Ongoing	N/A

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.



Tuesday, October 12, 2021

Wake CFAC MEETING - REGULAR MEETING

Virtual meeting via videoconference

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
S. Ingram	The No Worries Summit for Veterans is 10/21/21. The Governor's work group will be 10/28 2-4pm to discuss the social determinants of Veterans. The Hope Program is still available for emergency rental assistance.		
6. Steering Committee Update/ MCO LME update D. Wright	D Wright reports that Alliance is continuing to work through acquiring both Mecklenburg and Orange Counties and the expected final transition will be 12/15/2021. There will be a meeting on 10/13/21 with both of the counties. D. Wright reports that he will be attending the meeting. He went on to share that the job openings throughout Alliance have been posted and interviews are being planned. D. Wright expressed that current staff from both of the new counties have been encouraged to apply for positions within Alliance. D. Wright reports that the bylaws and relational agreement are going to be address during the meeting. Steering Committee has agreed to meet virtually permanently.		N/A
7. Additional Discussion	E. Asbury mentioned that there had been an Assitive Technology meeting and that she would be sharing a summary sheet with the CFAC team. There was a discussion with the members about refurbished equipment. T. Miles share that the scrap exchange does have equipment from time to time. E. Asbury shared information and stats about October being Domestic Violence month as well. E. Asbury shared phone number and contact information for places where people could get help if needed		N/A

ADJOURNMENT: the next meeting will be November 9, 2021, at 5:30 p.m.

Respectfully Submitted by:

Erica Asbury, Member Engagement Specialist

10.15.2021

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.



Tuesday, October 19, 2021

Johnston CFAC MEETING - REGULAR MEETING
Virtual Meeting via Zoom
5:30 – 7:00 p.m.

MEMBERS PRESENT: Marie Dodson, Cassandra Williams-Herbert, Jason Phipps, Jerry Dodson, Marilyn Lund, Albert Dixon
BOARD MEMBERS PRESENT: None
GUEST(S): Cindy Lopain-Johnston NAMI, ShaValia Ingram-NC DHHS
STAFF PRESENT: Laressa Witt, Supportive Housing Manager, Noah Swabe, Member Inclusion and Engagement Specialist
<https://alliancehealthplan.zoom.us/j/92670863998>

Meeting ID: 926 7086 3998
Passcode: 012115

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from September were reviewed, a motion was made by Albert, seconded by Jerry, Motion Passed.

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
3. Public Comment Individual/Family Challenges and Solutions	Albert shared some struggles he was experience surrounding his housing situation. Albert shared he felt that some of the supportive housing providers needed more training about how to support members living independently.	Albert and Noah will meet one on one to discuss the challenges and work to find a solution.	Ongoing
4. Supportive Housing Training	Laressa Witt, Supportive Housing Manager with Alliance Health gave a presentation on Alliances housing programs and some of our supportive housing options at Alliance. Members were given the opportunity to ask questions and were encouraged to email Noah or Laressa with follow up questions.	None	None
5. LME/MCO Updates	Several alternative services are available to those that are utilizing state funded services. These services are available, but are limited. Information on the following services were sent out to CFAC members. Due to time we did not review these services during the meeting. CFAC members were encouraged to review the documents and reach out to Noah or Doug with questions or concerns. Hospital Discharge Transition Service- • Discharge planning to help get the recipient set-up with a provider in their community Recovery Support- • Referral and linkage of resources, advocacy, and participation in treatment planning- available for those with substance use disorders Assertive Engagement-	Continue to provide updates to the CFAC as we move toward becoming a Tailored Plan and the acquisition of Orange and Mecklenburg Counties.	Ongoing

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
	<ul style="list-style-type: none"> Working with recipients in the community who have a SPMI/SUD (and/or) who do not engage and utilize techniques to get them into care Comprehensive Screening and Community Connection- Working with adults and children to get them screened and assessed for services on the innovations waiver <p>Local Community Collaboration and Engagement Strategy</p> <ul style="list-style-type: none"> This document addresses in detail how Alliance will work to reduce potential local barriers to health such as program eligibility, enrollment continuity, member and recipient engagement, unmet resource needs and local continuums of care. It also describes our approach to build partnerships at the local level to increase the availability of natural, community and recovery supports for the people we serve <p>Intellectual/Developmental Disability Waiver Administration and Need Across States- The Duke Margolis Center for Health Policy completed a study on the IDD waiver and waitlist and created a poster of information and policy recommendations.</p> <p>Marie shared some information she learned from reading this report. Particularly questions about the waitlist and how the waitlist works. Marie encouraged CFAC members to read the study and bring back questions and concerns.</p>		
5. State Updates	ShaVaila Ingram, NCDHHS was in attendance and went over the State updates October CEE: <ul style="list-style-type: none"> Long Term Care Planning Month Joint DMHDDSAS & DHB Update call: Consumers & Family Members Monday, October 25th from 2 pm - 3 pm State to Local Collaboration Meeting Next Call: October 27, 2021 from 6:00 – 7:30 pm NC Medicaid Managed Care Hot Topics Webinar Series Every 3rd Thursday of the month from 5-30-6:30 PM Next webinar: October 21, 2021 	None	None

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.



Tuesday, October 19, 2021

Johnston CFAC MEETING - REGULAR MEETING
Virtual Meeting via Zoom
5:30 – 7:00 p.m.

AGENDA ITEMS:	DISCUSSION:	NEXT STEPS:	TIME FRAME:
	<ul style="list-style-type: none"> Pinehurst Conference will be held both virtual and in person this year from December 8-10 		
6. Draft Olmstead Plan	CFAC members discussed their concerns with the plan and funding. Members discussed if an Ad Hoc Committee would be beneficial to respond with concerns. Due to the timeline and fast approaching feedback due date, it was decided not to assemble an Ad Hoc Committee and respond individually.	CFAC members will respond individually with feedback. CFAC members were encouraged to reach out to Doug or Noah for any support or questions.	Ongoing
7. Announcements	None	None	None

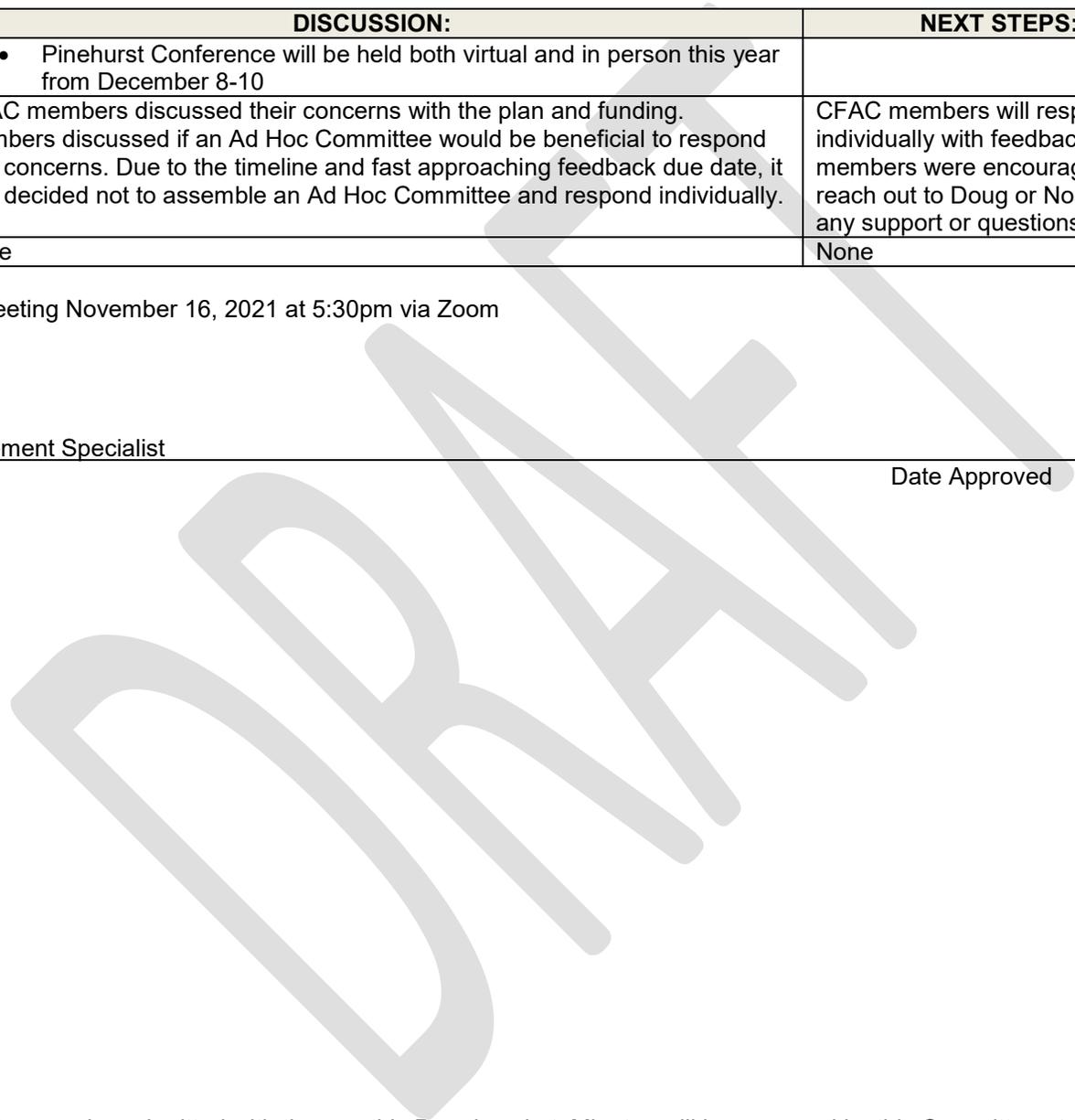
8. **ADJOURNMENT:** Next Meeting November 16, 2021 at 5:30pm via Zoom

Respectfully Submitted by:

Noah Swabe, Member Engagement Specialist

[Click here to enter text.](#)

Date Approved _____



Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.



**Alliance Health
BOARD OF DIRECTORS
Agenda Action Form**

ITEM: Lease of Suite 100A, at 201 Sage Road in Chapel Hill, NC

DATE OF BOARD MEETING: November 4, 2021

BACKGROUND: The Board is requested to accept the assignment of the lease of 201 Sage Road from Cardinal Innovations Healthcare. The property includes approximately 3000 square feet of space on the first floor in Suite 100A. The space includes a reception area, three offices and two conference rooms, fully furnished. Duke Primary Care occupies the remainder of the property, which is owned/managed by Sage Road, LLC. The term will commence on December 1, 2021, and expire on April 30, 2023. Rent will be \$5,957 per month through April 2022, increasing to \$6,090 per month through April 2023, plus operating expenses (prorated at 8.1% of the building expenses). Alliance will have the non-exclusive right to use up to 9 parking spaces in the parking lot. Cardinal will convey all of the furniture we would like to retain in the space, at no cost to Alliance. The space will be used for meeting space with members and families and Orange County assigned care managers and staff as needed.

The Board is requested to accept the assignment of the lease from Cardinal Innovations for Suite 100A, at 201 Sage Rd in Chapel Hill, NC. Per Alliance's by-laws, supermajority approval is required for this item.

SPECIFIC INFORMATION FOR BOARD REVIEW (if applicable/available): Accept the assignment of the lease from Cardinal Innovations for Suite 100A, at 201 Sage Rd in Chapel Hill, NC.

REQUEST FOR AREA BOARD ACTION: Accept the proposal.

CEO RECOMMENDATION: Accept the proposal.

RESOURCE PERSON(S): Carol Wolff, General Counsel; Robert Robinson, CEO

[\(Back to agenda\)](#)



**Alliance Health
BOARD OF DIRECTORS
Agenda Action Form**

ITEM: DEI Efforts as Hiring/Staffing Strategy

DATE OF BOARD MEETING: November 4, 2021

BACKGROUND: At the conclusion of the workforce demographic presentation at last month's meeting, the Board requested additional information regarding current DEI (diversity, equity, and inclusion) efforts and Alliance's hiring/staffing strategy.

SPECIFIC INFORMATION FOR BOARD REVIEW (if applicable/available): N/A

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Cheala Garland-Downey, Executive Vice-President/Chief Human Resources Officer

[\(Back to agenda\)](#)



**Alliance Health
BOARD OF DIRECTORS
Agenda Action Form**

ITEM: Medicaid Transformation Overview

DATE OF BOARD MEETING: November 4, 2021

BACKGROUND: This presentation will be a brief overview of Medicaid Transformation in NC, including a high level summary of the Tailored Plan features for board members, several of which have joined the Alliance Board of Directors since Medicaid Transformation began.

SPECIFIC INFORMATION FOR BOARD REVIEW (if applicable/available): N/A

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Sara Wilson, Chief of Staff

[\(Back to agenda\)](#)