



Thursday, March 03, 2022

AREA BOARD REGULAR MEETING

5200 W. Paramount Parkway, Morrisville, NC 27560
4:00-6:00 p.m.

MEMBERS PRESENT: Glenn Adams, Cumberland County Commissioner, JD; Leigh Altman, Mecklenburg County Commissioner, JD (via Zoom); Heidi Carter, Durham County Commissioner, MPH, MS (via Zoom); Maria Cervania, Wake County Commissioner, MPH (via Zoom); Carol Council, MSPH (via Zoom); David Curro, BS (via Zoom); Vicki Evans (via Zoom); Amy Fowler, Orange County Commissioner, MD (via Zoom); Lodies Gloston, Vice-Chair, MA (via Zoom); Ted Godwin, Johnston County Commissioner (via Zoom); David Hancock, MBA, MPAff; D. Lee Jackson, BA (via Zoom); John Lesica, MD (via Zoom); Donald McDonald, MSW (via Zoom); Lynne Nelson, Chair, BS; Gino Pazzaglini, MSW LFACHE; Pam Silberman, JD, DrPH (via Zoom); Anthony Trotman, MS (via Zoom); and McKinley Wooten, Jr., JD

APPOINTED MEMBERS ABSENT: Dena Diorio, MPA; and Samruddhi Thaker, PhD

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

ALLIANCE STAFF PRESENT: Brandon Alexander, Communications and Marketing Specialist II; Joey Dorsett, Senior Vice-President/Chief Information Officer; Diane Fening, Executive Assistant I; Cheala Garland-Downey, Executive Vice-President/Chief Human Resources Officer; Ashley Holmes, Integrated Health Care Consultant II (via Zoom); Veronica Ingram, Executive Assistant II/Clerk to the Board (via Zoom); Mya Lewis, Waiver Contract Manager; Shawn Mazyck, Senior Vice-President/Provider Network (via Zoom); Mehul Mankad, Chief Medical Officer; Ann Oshel, Senior Vice-President/Community Health and Well-Being (via Zoom); Sara Pacholke, Senior Vice-President/Financial Operations (via Zoom); Brian Perkins, Senior Vice-President/Strategy and Government Relations; Monica Portugal, Executive Vice-President/Chief Risk and Compliance Officer (via Zoom); Robert Robinson, CEO; Paige Rosemond, Director of Foster Care Support (via Zoom); Matthew Ruppel, Senior Director of Program Integrity (via Zoom); Sean Schreiber, Executive Vice-President/Chief Operating Officer; LaTanya Sobczak, Clinical Director IDD/TBI (via Zoom); Tammy Thomas, Senior Vice-President/Business Evolution; Sara Wilson, Chief of Staff; Carol Wolff, General Counsel; and Doug Wright, Director of Community and Member Engagement; and Ginger Yarbrough, interim Quality Management Director (via Zoom)

1. CALL TO ORDER: Board Chair Lynne Nelson called the meeting to order at 4:03 p.m.

| AGENDA ITEMS: | DISCUSSION: |
|-----------------------|--|
| 2. Agenda Adjustments | There were no adjustments to the agenda. |
| 3. Public Comment | There were no public comments. |
| 4. Chair's Report | <p>Chair Nelson shared the following:</p> <ul style="list-style-type: none">She expressed gratitude to outgoing board members: McKinley Wooten and Donald McDonald, whose terms end March 31, 2022. She presented a commemorative plaque to each on behalf of the board and staff.She reminded board members that annual compliance attestations are due by March 31, 2022. Questions may be addressed to Monica Portugal, Chief Risk and Compliance Officer. Veronica Ingram, Clerk to the Board, will follow-up with board members who have not completed the attestation.Annual Board Budget Retreat: this is part of the agency's budget process and is scheduled for Monday, March 21, 2022. This will be a hybrid meeting with options for presenters and board members to attend at the Morrisville office; all guests and other staff may attend online. |

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AREA BOARD REGULAR MEETING

5200 W. Paramount Parkway, Morrisville, NC 27560
4:00-6:00 p.m.

| AGENDA ITEMS: | DISCUSSION: |
|----------------------|--|
| | <ul style="list-style-type: none">Update on Board Member's Terms and Seat Attrition: As an update from last month's meeting, Carol Wolff, General Counsel, reviewed the current seats on Alliance's board, the reallocation of seats, and the attrition plan that was approved at the December 2, 2021, board meeting (when the by-laws were updated). The presentation is saved as part of the board's files.Board Member Matrix: As discussed at the November 2022 meeting, the board decided to review its current membership to best determine the background and experience needed to fill future vacancies. Part of this work included a survey of current members (at that time) and specific measures requested by the board. Robert Robinson, CEO, reviewed the survey results and recommendations based on the board's requested metrics. The presentation is saved as part of the board's files. |
| 5. CEO's Report | <p>Mr. Robinson expressed gratitude to Doug Wright, Director of Community and Member Engagement, for his service to the community and Alliance; he congratulated Mr. Wright on his upcoming retirement.</p> <p>Mr. Robinson also introduced the following new staff: Mya Lewis, Medicaid Contact Manager; LaTanya Sobczak, Clinical Director IDD/TBI (Intellectual, Developmental Disability/Traumatic Brain Injury); Tammy Guess, Director of Child and Adult Services; and Paige Rosemond, Director of Foster Care Support.</p> |
| 6. Consent Agenda | <p>A. Draft Minutes from February 3, 2022, Board Meeting – page 6</p> <p>B. Audit and Compliance Committee Report – page 11</p> <p>C. Executive Committee Report – page 14</p> <p>D. Quality Management Committee Report – page 16</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 discussion about the consent agenda.</p> <p><u>BOARD ACTION</u></p> <p>A motion was made by Commissioner Adams to adopt the consent agenda; motion seconded by Mr. Wooten. Motion passed unanimously.</p> |
| 7. Committee Reports | <p>A. Consumer and Family Advisory Committee – page 21</p> <p>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 report included draft minutes and documents from the following meetings: Steering Committee on February 7, 2022; Durham on February 14, 2022; Wake on February 8, 2022; Johnston on February 15, 2022; and Cumberland on January 27, 2022.</p> <p>Doug Wright, Director of Community and Member Engagement, presented the report on behalf of Jason Phipps, CFAC Chair. Mr. Wright shared an update from Mecklenburg and Orange CFAC's initial meetings, including selecting chairpersons for each local CFAC. He also mentioned a revised relational agreement between CFAC, the Alliance board, and Alliance staff; the advocacy toolkit was redistributed to members, and preparation for Alliance's budget retreat. The CFAC report is attached to and made part of these minutes.</p> <p><u>BOARD ACTION</u></p> <p>The board received the report.</p> |

Thursday, March 03, 2022

AREA BOARD REGULAR MEETING

5200 W. Paramount Parkway, Morrisville, NC 27560
4:00-6:00 p.m.

| AGENDA ITEMS: | DISCUSSION: |
|---|---|
| | <p>B. Finance Committee – page 164</p> <p>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 recommendation to approve a contract.</p> <p>David Hancock, Committee Chair, presented the report. Mr. Hancock provided an overview of two items requiring the board's approval. Per the board's policy, contracts over a specified amount require board approval. The Finance Committee previews the contracts before they are brought to the board for review and approval. Joey Dorsett, Senior Vice-President/Chief Information Officer, provided background information on the proposed contract with Acero Health Technologies. The Finance Committee report is attached to and made part of these minutes.</p> <p><u>BOARD ACTION</u></p> <p>A motion was made by Mr. Hancock to authorize the CEO to enter into a contract with Acero Health Technologies for IT consulting application development and quality assurance related to the BH/IDD (behavioral health/intellectual, developmental disabilities) Tailored Plan contract requirements for an amount not to exceed \$1,000,000; motion seconded by Mr. Wooten. Motion passed unanimously.</p> <p>Mr. Hancock reviewed the second item for board approval, which is an exemption from an RFP (request for approval), not a contract.</p> <p><u>BOARD ACTION</u></p> <p>A motion was made by Mr. Hancock to approve the resolution to exempt the Mecklenburg office electrical plans from the provisions of G.S. 143-64.31 requiring an evaluation of firms to perform architectural, engineering, and surveying work; motion seconded by Vice-Chair Gloston. Motion passed unanimously.</p> <p>The resolution is attached to and made part of these minutes.</p> |
| 8. Closed Session(s) | <p><u>BOARD ACTION</u></p> <p>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 Commissioner Godwin. Motion passed unanimously.</p> |
| 9. Reconvene Open Session | <p>The board returned to open session.</p> |
| 10. Special Update/ Presentation: Members Accessing Services – page 175 | <p>Alliance has an interest in promoting a positive consumer experience for those members interested in access to behavioral healthcare. Per Chair Nelson, the presentation was postponed until the next meeting.</p> |
| 11. Adjournment | <p>All business was completed; the meeting adjourned at 6:00 p.m.</p> |

Thursday, March 03, 2022

AREA BOARD REGULAR MEETING

5200 W. Paramount Parkway, Morrisville, NC 27560
4:00-6:00 p.m.

Next Board Meeting
Thursday, April 07, 2022
4:00 – 6:00 pm

Minutes approved by board on April 7, 2022.



**RESOLUTION of the BOARD OF DIRECTORS
exempting Mecklenburg office electrical plans from G.S. 143-64.31**

THAT WHEREAS, G.S. 143-64.31 requires the initial solicitation and evaluation of firms to perform architectural, engineering, surveying, construction management-at-risk services, and design-build services (collectively “design-services”) to be based on qualifications and without regard to fee; and

WHEREAS, Alliance proposes to enter into one or more contracts for design services for work on Alliance’s Mecklenburg office workstation reconfiguration and installation; and

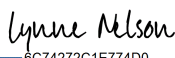
WHEREAS, G.S. 143-64.32 authorizes units of local government to exempt contracts for design services from the qualifications-based selection requirements of G.S. 143-64.31 if the estimated fee is less than \$50,000; and

WHEREAS, the estimated fee for design services for the above-described project is less than \$50,000.

NOW, THEREFORE, BE IT RESOLVED, by the Alliance Health Board of Directors that;

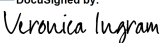
1. The above-described project is hereby made exempt from the provisions of G.S. 143-64.31.
2. This resolution shall be effective upon adoption.

Adopted this the 3 day of March, 2022.

DocuSigned by:

6C74272C1E774D0...
Lynne Nelson, Chair of the Board of Directors

CERTIFICATION

I, Executive Secretary to the Alliance Health Board of Directors, hereby certify this Resolution is a true and exact copy of a resolution adopted by the Board of Directors during a regular meeting on March 3, 2022.

DocuSigned by:

41BBDAADA1C345C...
Executive Secretary to the Board



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

ITEM: Draft Minutes from the February 3, 2022, Board Meeting

DATE OF BOARD MEETING: March 3, 2022

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 February 3, 2022, meeting.

CEO RECOMMENDATION: Approve the draft minutes from the February 3, 2022, meeting.

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

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Thursday, February 03, 2022

AREA BOARD REGULAR MEETING

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

MEMBERS PRESENT: Glenn Adams, Cumberland County Commissioner, JD; Leigh Altman, Mecklenburg County Commissioner, JD; Heidi Carter, Durham County Commissioner, MPH, MS; Maria Cervania, Wake County Commissioner, MPH; Carol Council, MSPH; David Curro, BS; Dena Diorio, MPA; Vicki Evans; Amy Fowler, Orange County Commissioner, MD; Lodies Gloston, Vice-Chair, MA; Ted Godwin, Johnston County Commissioner; D. Lee Jackson, BA; John Lesica, MD; Lynne Nelson, Chair, BS; Gino Pazzaglini, MSW LFACHE; Pam Silberman, JD, DrPH; Anthony Trotman, MS; and McKinley Wooten, Jr., JD

APPOINTED MEMBERS ABSENT: David Hancock, MBA, MPAff; Donald McDonald, MSW; and Samruddhi Thaker, PhD

GUEST(S) PRESENT: Jeff Barnhart, McGuireWoods Consulting LLC; 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); Paige Rosemond; and Pamela Wade

ALLIANCE STAFF PRESENT: Brandon Alexander, Communications and Marketing Specialist II; Joey Dorsett, Senior Vice-President/Chief Information Officer; Angel Felton-Edwards, Senior Vice-President/Population Health and Care Management; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Cheala Garland-Downey, Executive Vice-President/Chief Human Resources Officer; Ashley Holmes, Integrated Health Consultant II; Veronica Ingram, Executive Assistant II; Joshua Knight, Director of Internal Audit; Mya Lewis, Waiver Contract Manager; Mehul Mankad, Chief Medical Officer; Shawn Mazyck, Senior Vice-President/Provider Network; Beth Melcher, Senior Director of Clinical Innovation; Ann Oshel, Senior Vice-President/Community Health and Well-Being; Sara Pacholke, Senior Vice-President/Financial Operations; Brian Perkins, Senior Vice-President/Strategy and Government Relations; Monica Portugal, Chief Risk and Compliance Officer; Robert Robinson, Chief Executive Officer; Matthew Ruppel, Senior Director of Program Integrity; Sean Schreiber, Executive Vice-President/Chief Operating Officer; Ashley Snyder, Director of Accounting and Finance; 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 4:02 p.m. She welcomed four new members: Commissioner Leigh Altman, Commissioner Amy Fowler, Dena Diorio and Anthony Trotman.

| AGENDA ITEMS: | DISCUSSION: |
|-----------------------|--|
| 2. Agenda Adjustments | There were no adjustments to the agenda. |
| 3. Public Comment | There were no public comments |
| 4. Chair's Report | Chair Nelson reported the following: <ul style="list-style-type: none">Per Alliance <i>Policy G-1: Board of Directors Conflict of Interest</i>, annual disclosures are needed for all Board members by March 31. Members may contact Monica Portugal, Chief Risk and Compliance Officer, with questions about the form or policies.The annual Board budget retreat is part of the agency's budget process and is scheduled for Monday, March 21. It will be a hybrid event with lunch at 12:30 and presentations from 1:00 to 3:00. Kelly Goodfellow, Chief Financial Officer, will provide additional information including how to RSVP. |
| 5. CEO's Report | Mr. Robinson reported the following: <ul style="list-style-type: none">Starting February 7 staff will begin a phased approach to returning to the office; the last phase is expected to finish in May 2022.As requested by Board members, Mehul Mankad, Chief Medical Officer, provided an overview of 2019 and 2020 data on suicides. Dr. Mankad also reviewed the agency's efforts to combat suicide, emphasizing access to care. The presentation is saved as part of the Board's files. |

Thursday, February 03, 2022

AREA BOARD REGULAR MEETING

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

| AGENDA ITEMS: | DISCUSSION: |
|----------------------|---|
| 6. Consent Agenda | <p>A. Draft Minutes from December 2, 2021, Board Meeting – page 4 B. Client Rights/Human Rights Committee Report – page 9 C. Quality Management Committee Report – page 51</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 discussion about the consent agenda.</p> <p><u>BOARD ACTION</u> A motion was made by Dr. Silberman to adopt the consent agenda; motion seconded by Dr. Lesica. Motion passed unanimously.</p> |
| 7. Committee Reports | <p>A. Consumer and Family Advisory Committee – page 56 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 draft minutes and documents from the following January meetings: Steering, Durham, Wake, and Johnston.</p> <p>Doug Wright, Director of Community and Member Engagement, presented the report on behalf of CFAC Chair, Jason Phipps. Mr. Wright shared that CFAC's revised by-laws will be presented for approval and thanked the Board for the continued recognition of the importance of including CFAC in Board meetings. He also shared about interest meetings in Orange and Mecklenburg counties to establish local CFACs in those areas. Once voted in by the CFAC steering committee, these new local CFACs will meet and develop their own charters. Mr. Wright also shared about training on the Ombudsman, concerns about the Innovations waitlist, and allocation of new Innovations waiver slots approved in the North Carolina budget. 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 – page 111 The Executive Committee sets the agenda for Board meetings and acts in lieu of the Board between meetings. The Executive Committee's actions are reported to the Board at the next scheduled meeting. This month's report included draft minutes from the previous meeting and a reappointment recommendation. Chair Nelson reviewed the recommendation.</p> <p><u>BOARD ACTION</u> A motion was made by Mr. Pazzaglini to recommend to the Durham Board of County Commissioners the reappointment of Carol Council to Alliance's Board; motion seconded by Mr. Curro. Motion passed unanimously.</p> <p>Chair Nelson also shared that the Executive Committee met with the four recent appointees to the Board. She reviewed the typical appointment process which includes the Executive Committee interviewing applicants and forwarding recommendations to this Board for review, then the Board forwards recommendations to the respective Board of County Commissioners for final approval. Considering the unique appointment, Chair Nelson recommended that the Board accept the recent appointments.</p> |

Thursday, February 03, 2022

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 Vice-Chair Gloston to accept the appointments from Orange and Mecklenburg Counties (Commissioner Amy Fowler, Commissioner Leigh Altman, Dena Diorio, and Anthony Trotman); motion seconded by Mr. Pazzaglini. Motion passed unanimously.</p> <p>C. Finance Committee Report – page 114 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 month's report included documents and draft minutes from the previous meeting and a request to approve a budget amendment, which requires super-majority approval.</p> <p>Gino Pazzaglini presented the report on behalf of David Hancock, Finance Committee Chair. The Finance Committee met directly before the Board meeting. Sara Pacholke, Senior Vice-President/Financial Operations, reviewed the budget amendment, which she and Mr. Pazzaglini shared are common occurrences. Ms. Pacholke reviewed potential reasons for budget amendments per NC General Statute 159-08; this budget amendment relates to additional funding with Orange and Mecklenburg counties' realignment with Alliance in December. The Finance Committee report is attached to and made part of these minutes.</p> <p><u>BOARD ACTION</u> A motion was made by Mr. Wooten to approve the FY22 budget amendment 1 to increase the budget by \$349,500,867.00 bringing the total FY22 budget to \$923,449,490.00; motion seconded by Vice-Chair Gloston. Motion passed unanimously.</p> <p>Kelly Goodfellow, Executive Vice-President/Chief Financial Officer, provided an overview of the March 21, 2022, budget retreat, which will be held virtually and in-person. She shared that it will focus primarily on Medicaid funding and not state funding.</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 Commissioner Fowler. Motion passed unanimously.</p> |
| 9. Reconvene Open Session | <p>The Board returned to open session.</p> |

Thursday, February 03, 2022

AREA BOARD REGULAR MEETING

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

| AGENDA ITEMS: | DISCUSSION: |
|---|--|
| 10. Special Update/Presentation: Supporting Youth with Complex Needs – page 127 | <p>Beth Melcher, Ph.D., Senior Director of Clinical Innovation, provided an update on Alliance initiatives to respond to the needs of youth who have multiple and complex needs and who interface with DSS and other systems. She provided background including partnerships with Wake and Cumberland DSS (Departments of Social Services) to address complexity needs for specific youth.</p> <p>She reviewed a comprehensive plan to address gaps in service continuum and reduce the number of youths needing out of home placement or reduce the duration of that placement. Additionally, part of Alliance's efforts include a regional child facility-based crisis, designated beds in Mecklenburg, creation of group home crisis beds, and expanding the capacity of rapid response and transitional therapeutic foster care bed as well as developing a mobile outreach engagement stabilization. She reviewed early intervention strategies and recent legislation, Senate Bill 693 to support youth, and potential next steps. The presentation is saved as part of the board's files.</p> <p><u>BOARD ACTION</u> The Board received the training/presentation.</p> |
| 11. Adjournment | All business was completed; the meeting adjourned at 6:02 p.m. |

Next Board Meeting
Thursday, March 03, 2022
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: March 3, 2022

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 notes 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 Curro, Committee Chair; Monica Portugal, Chief Compliance Officer

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Wednesday, February 16, 2022

BOARD AUDIT AND COMPLIANCE COMMITTEE - REGULAR MEETING

(virtual meeting via videoconference) NOTES
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: None

GUEST(S) PRESENT: None

STAFF PRESENT: Monica Portugal, EVP, Chief Risk & Compliance Officer; Josh Knight, Director of Internal Audit; Jamie Preslar, Administrative Assistant III

- 1. WELCOME AND INTRODUCTIONS** – At 4:11 pm, Chair David Curro determined that there was no quorum. The two members chose to receive a few updates from staff present and notes were kept.
- 2. REVIEW OF THE MINUTES** – The minutes from the August 25, 2021, and October 20, 2021, meetings will be reviewed at the next regular meeting of the Audit and Compliance Committee.

| AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME: |
|---|---|-------------|-------------|
| 3. Records Retention and Destruction Schedule | Not reviewed; to be moved to next regular meeting. | N/A | N/A |
| 4. OCR Report 2021 | Not reviewed; to be moved to next regular meeting. | N/A | N/A |
| 5. Delegation Oversight Program | Portugal presented an overview of the updated Delegation Oversight Program, which includes pre-delegation audits, ongoing performance monitoring, and annual delegation audits, and a Delegation and Accreditation Oversight Committee that reviews results and make determinations. Alliance will have seven delegated vendors perform various functions for the Tailored Plan. Evans asked questions regarding implied delegation and non-emergency medical transportation. Portugal and Knight responded. Curro shared that the full Board could benefit from hearing this presentation. | N/A | N/A |
| 6. Audits A. Single Audit CAP B. Internal Audits C. Privacy Audits D. Compliance Audits E. Delegation Audits | Not reviewed; to be moved to next regular meeting. | 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; minutes approved on [Click or tap to enter a date..](#)

Wednesday, February 16, 2022

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

| AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME: |
|---|---|-------------|-------------|
| 7. Work Plan/Audit Plan Dashboard | Portugal briefly reviewed the work plan and audit plan dashboards. Only one work plan item is at risk of not being completed before the end of the fiscal year. Two audits were not started due to staffing, seven are complete and nine in process. | N/A | N/A |
| 8. Compliance Dashboard | Portugal reviewed the Compliance Dashboard and quarterly reports, summarizing not met items and providing explanatory detail for the Committee. Touched on categories including employee training, provider actions, compliance reports, security awareness, and HIPAA incidents. Curro asked questions/presented suggestion. Portugal responded. | N/A | N/A |
| 9. 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 |

10. **ADJOURNMENT:** The meeting adjourned at 4:52 pm; the next meeting will be April 20, 2022, from 4:00 p.m. to 5:00 p.m.

*Items shared during the 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..](#)



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

ITEM: Executive Committee Report

DATE OF BOARD MEETING: March 3, 2022

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 Committee's 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

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Monday, February 21, 2022

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); Lodies Gloston, MA (Network Development and Services Committee Chair/Board Vice-Chair)-entered at 4:23 p.m.; 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): Alex Yarijanian

STAFF PRESENT: Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Veronica Ingram, Executive Assistant II/Clerk to the Board; Brian Perkins, Senior Vice-President/Strategy and Government Relations; Robert Robinson, CEO; Sara Wilson, Chief of Staff; and Carol Wolff, General Counsel

- 1. WELCOME AND INTRODUCTIONS** – the meeting was called to order at 4:02 p.m.
- 2. REVIEW OF THE MINUTES** – The Committee reviewed minutes from the January 10, 2022, meeting; a motion was made by Dr. Silberman and seconded by Mr. Pazzaglini to approve the minutes. Motion passed unanimously.

| AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME: |
|---|--|--|-------------|
| 3. Updates | <p>A. BUDGET RETREAT REMINDER: Kelly Goodfellow, Executive Vice-President/Chief Financial Officer, provided the update on the March 21, 2022, budget retreat, which will be hybrid. Onsite attendees are limited to board members and staff who are presenting. Lunch is at 12:30 and the presentations begin at 1:00 p.m.</p> <p>B. BOARD MATRIX: Mr. Robinson reviewed background, survey results and recommendations for filling future board vacancies; the recommendation are based on criteria previously specified by the board.</p> <p>C. BOARD SEAT, TERMS, AND ATTRITION: Carol Wolff, General Counsel, provided the update; she reviewed current terms and attrition.</p> <p>COMMITTEE ACTION: The committee received the updates.</p> | Updates may be shared with the Board at the March meeting. | 3/3/22 |
| 4. Recommendations for Chairing Hybrid Meetings | <p>Veronica Ingram, Clerk to the Board, reviewed recommendations, which were developed to facilitate effective meetings as board committees resume holding in-person meetings that may also include virtual attendees. The goal is to improve the meeting experience for virtual and in-person committee members. The document is saved as part of the board's files.</p> <p>COMMITTEE ACTION: The committee received the recommendation.</p> | N/A | N/A |
| 5. Agenda for March Board Meeting | Committee reviewed the draft agenda and provided input. Chair Nelson directed staff to include an update on the board matrix and terms/attrition during the chair's report. | Ms. Ingram will forward the agenda to staff. | 2/21/22 |

- 6. ADJOURNMENT:** the meeting adjourned at 4:38 p.m.; the next meeting will be March 21, 2022, at 4:00 p.m.

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



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

ITEM: Quality Management Committee Report

DATE OF BOARD MEETING: March 3, 2022

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; Mehul Mankad, MD, Chief Medical Officer

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Thursday, February 03, 2022

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); ☐ Maria Cervania, (Wake County Commissioner)

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: Mehul Mankad, Chief Medical Officer; Ginger Yarbrough, Acting Director Quality Management and NCQA Accreditation Manager; Diane Fening, Executive Assistant I; Doug Wright, Director of Community and Member Engagement; Tia Grant, Quality Improvement Manager

1. WELCOME AND INTRODUCTIONS – The meeting was called to order at 1:00 pm

2. REVIEW OF THE MINUTES –The minutes from the December 2, 2021 meeting were reviewed. Marie Dodson moved to approve the minutes; Lodies Gloston seconded. The motion passed.

| AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME: |
|---------------|--|--|-------------|
| OLD BUSINESS | <ul style="list-style-type: none">Wes Knepper has transitioned to a different position with another organization. Ginger Yarbrough is serving as acting director until a new SVP for QM has been hired. QM director is one of the key personnel for the TP transition. State wrote job description. Candidate must live in driving distance of one of our sites-HQ or Charlotte. We have launched a national search. <p>QIP Updates-Tia Grant</p> <ul style="list-style-type: none">Team doing a deeper dive to understand the effectiveness of the action items that are in place. Want to make sure we have the right area of focus. Also trying to touch base with some of our MCOs to see how they are performing and potentially gain access to some of their best practices.Tia reported on TCLI PCP visits slight downtick. We have a nurse on staff that is engaged in performing outreach to members who haven't had a confirmed PCP visit. She is also takes part in the transition meetings so she can ask questions about touchpoints, and if there are any roadblocks to getting a PCP visit, and to help members if they have any concerns with receiving a PCP visit. We hope to see uptick in results. | <p><i>QM – Quality Management</i></p> <p><i>QIP-Quality Improvement Plan</i></p> <p><i>TCLI or TCL-Transitions to Community Living</i></p> <p><i>PCP – Primary Care Provider</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, February 03, 2022

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">Pam reminded the group that we were going to look at reports on quarterly basis rather than a monthly basis. Also, three month rolling averages were asked for.Mehul said that we have tried a variety of approaches to improve 7-day outcome. Value-based contracting has had a measurable good outcome. We've had the best measurable outcome with Triangle Springs. We continue to work on getting hospitals to come on board.Showed the state scorecard that lists all LME/MCOs and end of last quarter. Broken down by types of discharges – under Medicaid benefit plan or under single stream state. Partners and Vaya have achieved outcomes that are double or triple over some of the other LMEs.Approach that we use right now is classic PDSA cycle. We are realizing that we need to marry quality improvement approach with real dollars. Mehul's agenda is to get concrete knowledge of what they are doing by the next meeting. Recommendation we received from some of our consultants is to switch from PDSA cycle to MCAP (medical cost action plan). We will be using this model for specific things for sizeable investment of funds. Will hear more about this next month. The other piece is a change in venue. We need to be more systematic in the way we identify funds and target projects. Kelly is going to create some structures and share that with you as they are developed. One of the first things we want to put through this process is 7-day.Tia said that we already have cross functional teams working on 7 day. | <i>PDSA – Plan-Do-Study-Act</i> | |
| 3. NEW BUSINESS | <p>Quality Impact of County Realignment – Ginger</p> <ul style="list-style-type: none">Ginger gave a broad overview of what we have noticed since county realignment. Some of projects may have hit resource constraints. Claims data is a bit delayed. Challenges getting providers enrolled in billing, but it's getting better. Some data delayed more than usual. We don't have access for pharmacy data yet for Orange and Mecklenburg. Some of our interventions for new counties will require more time. Grievances team-we saw slight | | |

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Thursday, February 03, 2022

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: |
|---------------|--|---|-----------------------------|
| | <p>increase in grievances and incidents. Numbers weren't out of line with what we expected.</p> <ul style="list-style-type: none">What are we doing to onboard former Cardinal staff to understand how Alliance does things? Before hiring push, HR revamped new employee orientation. Within Care Management. they have implemented new onboarding. Several additional days to learn our system, processes, shadow staff. <p>Performance Dashboard – Ginger</p> <ul style="list-style-type: none">We have four metrics that did not meet-three of which we have QIPs for. The fourth is related to our Innovations waiver. New beneficiaries being enrolled receiving services within 45 days of plan approval. There is a system wide shortage of direct support providers. There is state money coming to help recruit. The State is very interested in increasing hourly wage of direct support professionals. Pam would like an update next month on whether this has been implemented. <p>Tailored Plan Required QIPs – Ginger</p> <ul style="list-style-type: none">The State has determined how we are going to be doing our performance improvement plan (QIPs). Two must be clinical and one non-clinical. Also have to have two for TCL-one clinical and one non-clinical. We've been given two of the clinical QIPs that we are all are going to be doing: Comprehensive Diabetes Care HbA1c Poor Control and Follow Up Hospitalization for Mental Illness: 7 day and 30 day. Waiting on final approval. We have not identified our non-clinical or our TCL QIPs. Not due until July. We have a little more time to decide. <p>Implicit Bias Article – Mehul</p> <ul style="list-style-type: none">This article has been circulating and Mehul wanted to share it with the committee. Moving article. Summary- putting together a course on documentation for our employees. Legal is helping him build this training and | <p>Ginger will provide an update on implementation of the State's plan to increase the hourly wage of direct support professionals.</p> <p>Mehul will check to see if we have a HEDIS measure regarding substance abuse</p> | <p>3/3/22</p> <p>3/3/22</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, February 03, 2022

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: |
|---------------|---|---|-------------|
| | <p>Sherry Perkins as well. Another piece we are adding is a new quality subcommittee – health equity. This will have internal people and providers. Third thing we are doing is sharing this topic more widely. Dr. Mehul will be sharing this at the Provider Quality subcommittee monthly meeting as well as the all-provider meeting. The article states that if you are black, the chance is 2.5 times higher than for a white person that a negative term was used in your chart.</p> <ul style="list-style-type: none">• Dr. Mehul is talking this to the Cumberland CFAC next month so he will give us feedback from that.• Carol is interested data in how many of our substance abuse members are on medication assisted treatment in relation to outcomes. Mehul will look and see if this is a HEDIS measure. | <p>members on medication assisted treatment in relation to outcomes</p> <p>At the next meeting, we should be able to get HEDIS information separated out by race and ethnicity.</p> | 3/3/22 |

5. **ADJOURNMENT:** the meeting adjourned at 2:11 pm; the next meeting will be March 3, 2022, at 1:00.



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

ITEM: Consumer and Family Advisory Committee (CFAC) Report

DATE OF BOARD MEETING: March 3, 2022

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 and documents from the following meetings: Steering Committee on February 7, 2022; Durham on February 14, 2022; Wake on February 8, 2022; Johnston on February 15, 2022; and Cumberland on January 27, 2022.

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, February 07, 2022

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, ☑ Jason Phipps, ☑ Brianna Harris, ☑ Sharon Harris, ☑ Shirley Francis, ☑ Brenda Solomon, ☑ Dave Curro, ☑ Annette Smith, ☑ Charlitta Burrus, ☑ Regina Mays, ☑ Felishia McPherson, ☑ Michael Maguire, ☑ Faye Griffin

BOARD MEMBERS PRESENT: None

GUEST(S): ShaValia Ingram, NCDHHS; Sandy McMillian

STAFF PRESENT: Doug Wright, Director of Community and Member Engagement; Ramona Branch, Member Inclusion and Outreach Manager; Noah Swabe, Member Inclusion Specialist; Erica Asbury, Member Inclusion Specialist; LaKeisha McCormick, Member Inclusion and Outreach Manager; Douglass McDonnell, Member Inclusion Specialist; Eileen Bennett, Member Inclusion Specialist

1. **WELCOME AND INTRODUCTIONS** – the meeting was called to order at 5:35 pm
2. **REVIEW OF THE MINUTES** – The minutes from the January 3, 2022 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 | D. Wright announced that Wake County Subcommittee member Gregory Schwiezer passed and to please keep both his husband and family in our thoughts and prayers. Moments were taken to honor his memory. | Ongoing | N/A |
| 4. State Updates | ShaValia Ingram, NCDHHS was in attendance and went over the State updates February CEE: <ul style="list-style-type: none">➤ Heart Health Month and recipes and ideas to jumpstart your fitness are linked. Black History Month as well.➤ Joint DMHDDSAS & DHB Update call: Providers 2/3/22 from 3 pm - 4 pm➤ Joint DMHDDSAS & DHB Update call: Consumers & Family Members Monday, 2/28/2022 from 2 pm - 3 pm➤ Regional CFAC Meetings have NOT been scheduled at this time➤ State to Local Collaboration Meeting<ul style="list-style-type: none">○ Next Call: 2/23/22 6-7:30pm➤ A new pilot program is being developed related to TBI. The next Brain Advisory Council meeting will be on 3/9/3033 9am-1pm please send and email to request for meeting access.➤ Advanced Medical Home Plus has completed desk reviews. Information about it may be found in the Tailored Care Management Updates 1/28/22. | 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, February 07, 2022

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">➤ NCTIDE Behavioral Health Conference will be 4/25-4/27/2022 in Wilmington NC.➤ The NC Medicaid Hot Topic Series is every 3rd Thursday and the next one will be on 2/17/22 at 5:30 pm➤ The Resource Guide for Veterans may be viewed electronically but hard copies may be requested through CEE team➤ Community Inclusion and Recovery:How Community Inclusion Helped Me will be on 2/22/22 at 2pm and will support peer specialists➤ The 2022 CIT Conference will be in Raleigh 2/24/22 9-4:30.➤ One Community in Recovery will be April 27th-29th at the GTCC Colfax, NC it will be offered both in person and virtual➤ The Women's Recovery Conference will be 5/4-5/6/2022➤ The Legislative Breakfast registration ends 2/26/2022➤ The State of the Child Conference is May 11,2022 | | |
| 5. LME-MCO Updates | <p>D. Wright went over the new names of the CFAC members for both Orange and Mecklenburg Counties.</p> <p>Mecklenberg:John Corrigan,Jocie Cremisi,Randy Sperling,Ruth Reynolds,Michael Flood, Jim Sonda, Melida, Linda Hamilton, Shagun Gaur, Ronald Clark, Beverly Corpening. M. Macguire moved to accept the list and D. Curro second</p> <p>Orange: Dotty Foley, Allen Ditmer, Paula Harrington. M. Macguire motioned to accept the list as read and M. Dodson second. Motion passed unanimously.</p> <ul style="list-style-type: none">➤ D. Wright stated that the next step is to have contact with the members and the initial meeting will be set up for the last week of February. They are expected to develop a charter and J. Phipps and M. Macguire will be linked in. Orientation packets will go out as well. In response to a question, D. Wright stated that the maximum number is 14.➤ D. Wright emphasized that getting the information out and sharing it about the NC Olmstead plan is everyone's responsibility and challenged the attendees to go through the document and to spend time understanding it. | 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, February 07, 2022

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">➤ Members were asked to please read document in its entirety and submit any questions or concerns to Doug or their Member Inclusion Specialist for answers or clarification➤ A. Smith announced that the joint oversight committee IDD/ SA/MH has not been active for 10 years and there will be lobbying to have it reinstated. There are also many vacancies listed on the DHHHS website. D. Wright stated that legislatures could be invited to CFAC Steering committee or Subcommittee meetings He also promised that staff will send out the Advocacy Tool Kit that was developed last year to everyone again. | | |
| 6. By-Laws/ Charters | D. Wright reported that the local CFAC determine who will attend the Steering Committee meeting based on the determination that it would be the chairperson and one member. Those two people will be the only people that are entitled to the stipend. D. Curro asked if the past chairperson could attend. D. Wright stated yes. M. Macguire motioned to have the bylaws accepted with the suggested changes and M. Dodson second. Motion passed unanimously. | Ongoing | N/A |
| 7. Relational Agreement/ Human Rights | <p>D. Wright presented the Relational Agreement. D. Curro motioned to accept what was presented and M. Macguire second. Motion passed unanimously.</p> <p>The Human Rights reports were presented by D. Wright and he asked that members please take the time to review them and feel free to contact anyone on the staff to discuss or to ask questions.</p> | Ongoing | N/A |
| 8. Steering Committee Meeting | D Wright confirmed that the March meeting will also be virtual. | N/A | N/A |
| 9. Subcommittees <ul style="list-style-type: none">• Wake• Durham• Cumberland• Johnston• Area Board | J. Phipps stated that the minutes from the subcommittees would be accepted as written. | 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, February 07, 2022

CONSUMER AND FAMILY ADVISORY COMMITTEE - REGULAR MEETING
5200 W. Paramount Parkway, Morrisville, NC 27560
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| AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME: |
|---|--|-------------|-------------|
| <ul style="list-style-type: none">Human RightsQuality Management | | | |
| 10. Announcements | D. Wright announced that the board retreat will take place on 3/21/22. D. Wright announced that Ramona Branch is the new Member Inclusion Manager effective today. Wes Knepper has left and there will be a new Quality manager. | N/A | N/A |

11. ADJOURNMENT: **Motion was made by C. Burris and second by M. Dodson 7:06pm** The next meeting will be March 7, 2022, at 5:30 p.m.



COMMUNITY ENGAGEMENT & EMPOWERMENT TEAM

Community Updates | February, 2022

NCDHHS- DMH/DD/SUS

February 2022 Awareness Activities

February has several Awareness campaigns that different organizations and others bring to the forefront of the country's attention. As we all know February is the month of Love so what better time to bring the awareness of heart health up. The stress of the past two years may have increased your awareness of wanting to take better care of yourself, stress and anxiety can put undue stress on your heart as you watch any news cast or talk show they talk about the importance of heart health. Here are a few links to assist you in your quest for a healthier heart(make sure that you check with your medical doctor prior to any activities that you may not be use to.)

<https://tinyurl.com/yc7vp9hk>– National Heart, Lung and Blood Institute. 25 ways to celebrate Heart Month

<https://tinyurl.com/yz3ux5wr>—Heart healthy dish and copies of the recipe. NHLBI offers a variety of recipes on its website.

<https://tinyurl.com/bdhv3hbz> — Jump start your Heart Health with a walking program.

Black History Month

This year's theme for Black History Month, "**Black Health and Wellness**", takes a look at how American healthcare has often underserved the African-American community. As the COVID-19 pandemic has recently shown, a widespread disparity of access to quality healthcare negatively impacts outcomes for blacks and other minorities.

The North Carolina General Assembly created the African American Heritage Commission (AAHC) in 2008 to "assist the Secretary of Cultural Resources in the preservation, interpretation, and promotion of African American History, arts, and culture. Please visit their web page and find all the exciting activities that they have planned for February and throughout the year. [home-page | NC AAHC](#)

Check in your local areas for any upcoming celebrations for Black History month .

NC Integrated Care for Kids (InCK) Pilot Begins

NCDHHS recently launched the Integrated Care for Kids (InCK) pilot program in Alamance, Orange, Durham, Granville and Vance counties. Supported by grant funding from CMS, the NC InCK model is a collaboration between Duke University Health System, UNC Health System and NCDHHS.

The pilot will cover approximately 95,000 children across InCK's five counties. The NC InCK model aims to improve the quality of care and reduce expenditures for children under 21 years of age covered by Medicaid or CHIP (NC Health Choice) through prevention, early identification and treatment of behavioral and physical health needs. NC InCK also aims to bring together child-specific services from different agencies and providers to help meet the health, education and social needs of children and families. NC InCK also supports communities in coordinating services for children between health care and social services providers.

For more information, please see [NC Integrated Care for Kids \(InCK\) Pilot Begins](#).

Please join us Feb. 2, 2022, for a Community Partners Webinar: Updates on NC Medicaid Managed Care and Healthy Opportunities

NC Medicaid Managed Care is live with Standard Plans launching July 1, 2021. Make sure you have the latest information and resources to help you navigate managed care.

Join us **Wednesday, Feb. 2, from 2:30-3:30 p.m.**, to hear the latest updates on the state's launch of NC Medicaid Managed Care and an update on Healthy Opportunities pilots. There will also be an opportunity for questions and answers.

To register for the webinar, simply click on the link below. Feel free to share the webinar invitation and registration link with other community partners you think would be interested in attending.

Updates on NC Medicaid Managed Care and Healthy Opportunities

2:30-3:30 p.m., Wednesday, Feb. 2, 2022

[Click here to register](#)

For more information or questions contact us at Medicaid.NCEngagement@dhhs.nc.gov

Note: Registration will close at 2 p.m., Feb. 2, 2022.



Monthly Meetings

PROVIDER & CONSUMER CALLS

Joint DMHDDSAS & DHB Update call: Providers

During this call, panelists will present policy updates to Providers from DMHDDSAS and DHB representatives followed by an open Q&A session.

Thursday, February 3, 2022 3:00 p.m. — 4:00 p.m.

Register at: <http://tiny.cc/gaxnuz>

Closed Captioning: <https://tinyurl.com/bd8hsphy>

Joint DMHDDSAS & DHB Update call: Consumers & Family Members

During this call, panelists will present policy updates to Consumers & Family Members from DMHDDSAS and DHB representatives followed by an open Q&A session.

Monday, February 28, 2022 2:00 p.m. — 3:00 p.m.

Register at: <https://tinyurl.com/2p98uywj>

Closed Captioning: <https://tinyurl.com/5n7f8m3p>

After registering, you will receive a confirmation email containing information about joining the webinar.

Regional CFAC Meetings

Meetings have not been scheduled at this time, Stay tuned for date and time!!

In Person Training—CE&E Team

As we start to Prepare for 2022– Remember to get with your CE&E Team member to set up Trainings for your community events, committee's, and CFAC meetings.

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

Badia Henderson: Badia.Henderson@dhhs.nc.gov

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 website](#)

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

State CFAC

The State Consumer and Family Advisory Committee (SCFAC)

meeting is on the 2nd Wednesday of every month and is open to the public. January,

SCFAC meetings will be held as hybrid meetings – the in-person option at this time is only for committee members. A virtual platform and teleconference options are provided for additional attendees.

Visit the State CFAC page for more information

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

Next Meeting: **Wednesday, February 9, 2022 –Virtual only**

Time: **9:00 a.m. — 3:00 p.m.**

Join by web browser: <https://tinyurl.com/htra3ane>

Phone in option: 1-415-655-0003

Meeting Number: 24255343106



State to Local Collaboration Meeting

The State to Local Collaboration Call will resume the regular scheduled time 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: February 23, 2022 from 6:00 p.m. – 7:30 p.m.

To Join click here [-https://tinyurl.com/yc5crpv6](https://tinyurl.com/yc5crpv6)

1-415-655-0003 US Toll

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>

Tailored Care Management Updates

As part of the transition to NC Medicaid Managed Care, NC Medicaid has worked with stakeholders to design the Tailored Care Management model for the Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plan population. Tailored Care Management will launch in December of this year with the implementation of Behavioral Health I/DD Tailored Plans. NC Medicaid has the following updates related to Tailored Care Management.

AMH+/CMA Certification Round Two Desk Reviews Completed

The Department has completed desk reviews of the Round Two Advanced Medical Home Plus (AMH+) practices/Care Management Agencies (CMAs) provider certification applications and has advanced 32 providers to the site review stage of the certification process. For more information, please see Medicaid bulletin article [Tailored Care Management Updates – Jan. 28, 2022](#).

Continued on page 3

Tailored Care Management Updates

Updated Guidance

NC Medicaid has published updated guidance on Tailored Care Management, including updates to the [Tailored Care Management Provider Manual](#), the [use of Care Manager extenders](#), [Tailored CM 101 Frequently asked Questions](#) and [updated guidance on rates](#). For more information, please see Medicaid bulletin article [Tailored Care Management Update: AMH+/CMA Certification Round Two Desk Reviews Completed](#).

All updates can be found on the Tailored Care Management webpage at: <https://medicaid.ncdhhs.gov/transformation/tailored-care-management>

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 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, our 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>

NC TIDE 2022

Behavioral Health Conference

Monday, April 25, 2022-

Wednesday April 27, 2022

Wilmington, NC

[Registration link](#) [Session Information](#)

[Sponsorship Opportunities](#)

[Hotel Reservation](#)

Registration is Open click on above links. Register by 4/1/22 to take advantage of the early bird savings!!

Buy 4 and get the 5th one for free.



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](#)

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.

Traumatic Brain Injury

- A new pilot program is being developed as part of the TBI grant in collaboration with the Brain Injury Association of NC (BIANC) and a Domestic Violence pilot site to screen individuals for TBI.
- A new pilot program is being developed in collaboration with the Justice Innovations Section and the Brain Injury Association of NC (BIANC) to screen individuals for TBI and Mental Health at a Probation pilot site.
- The IDD/TBI Section is in the process of developing rules for a new state funded residential service for individuals with TBI. This will be posted for public comment in the near future.

The **next Brain Injury Advisory Council (BIAC) meeting will be held on Wednesday, March 9th from 9am to 1pm.** For meeting access information please send an email request with subject of "BIAC Meeting" to TBIContact@dhhs.nc.gov

The TBI Program is recruiting for membership on the TBI Grant Steering Committee. This steering committee plays an important role in oversight of grant activity, monitoring project progress, making recommendations, problem solving challenges and other critical functions. Interested individuals should contact Sandy Pendergraft at sandy.pendergraft@bianc.net or Michael Brown at michael.brown@dhhs.nc.gov. All are welcome and encouraged to join!

The Brain Injury Association of NC (BIANC) website offers a large variety of information, educational learning tools and maintains a comprehensive online resource guide. The website can be found at www.bianc.net

A diverse and growing library of free online TBI training modules can be found at www.biancteach.net

[Toolkit: Traumatic Brain Injury and Substance Use Disorders: Making the Connections.](#)

NC Medicaid Managed Care Hot Topics Webinar Series

Every 3rd Thursday of the month from 5:30 p.m.-6:30 p.m.
Medicaid Hot Topics Tailored Plan and Behavioral Health Feb 17, 2022 05:30 p.m.

[Register for 3rd Thursday webinars](#)

Veterans, Service Members & Families

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 Family and Children](#)

[Sesame Street for Military Families](#)

[Understanding Refugee Trauma: For School Personnel](#)

[After a Crisis: Helping Young Children Heal](#)



Educational Opportunities

NCDD Self-Advocate Discussion Series Session #5 Building and Maintaining Relationships with NC Legislators and Policymakers

This session is the last in the Self-Advocate Discussion Series. Policy experts will share best ways to build and maintain relationships with NC legislators and policymakers. Panel members NC Representative Zack Hawkins and Legislative Advocates Julia Adams-Scheurich (NC) and Charlie Miller (GA) will balance training, knowledge sharing, and attendee experience for relationship building with decision-makers. *The webinar will have ASL, CART captioning and Spanish translations.*

February 2 • 1 - 2 PM — [via Zoom](#) (click link to Register)

Tailored Care Management Learning Collaborative Live Webinar Series

Wednesday, February 2, 2022 [Emergency Services and Walk-in Crisis](#)

Wednesday, February 16, 2022 [Tailored Plan Billing and Coding](#)

Friday, February 25, 2022 10:15 AM: [TCM: Providing Whole-Person Care for Individuals with TBI and their Families](#)

[Click here to see all TCM Education Courses](#)

Community Inclusion and Recovery: How Community Inclusion Helped Me

Tuesday, February 22

200pm ET/1:00 pm MT/11:00 am PT

[Click Here to Register](#)

Learning Objectives:

- State the definition of Community Inclusion.
- Describe how Community Inclusion benefits everyone, including community members with disabilities.
- List at least 3 obstacles to Community Inclusion and 3 ways peer specialists can navigate those obstacles.

Conferences for 2022



February 24, 2022 9:00 AM - 4:30 PM

[Register](#)



The National Council For Mental Wellbeing invites you to Join thousands of professionals representing the very best of our field as they convene at NatCon22, the largest conference in mental health and substance use treatment, from April 11-13, 2022, to be held at the Gaylord National Resort & Convention Center in the Washington, D.C., metropolitan area .

[Register Now](#)

Save the Date for Spring 2022 13th Annual NC "One Community in Recovery" Conference:

Healing Together After Being Apart
April 27-29, 2022

The Conference Center at GTCC, Colfax, NC Attend in person or via live webinar! To find out more

about this conference click

on the following link:

<https://tinyurl.com/y63cmame>



Save the date:
Healing Clients, Families, and Ourselves
May 4-6, 2022

Advocacy Opportunity

February 26,2022 from 7:30-12:00pm



Join local elected officials, mental health providers and community members in conversation about current events in mental health care: <https://tinyurl.com/yc48wprz>

Registration ends February 26th

Check-in starts at 7:30 AM

8:00-8:45 AM— Vendor Time and OJ reception

9:00-12:00 PM— Main Event

20th Annual State of the Child Conference

March 11,2022 8:50-12:50



[Webex Events \(classic\)](#)

Provider Appeal Rights Defined in the Standard Plan Contract Section V.D.5

Provider appeal rights defined in the Standard Plan Contract Section V.D.5 Provider Grievances and Appeals, and the appeal processes outlined in the Prompt Payment Fact Sheet, include deadlines to submit appeals which may vary by Standard Plans, from 30 days to 365 days after the decision, giving rise to the right to appeal. The Department shared concerns from providers about these deadlines with the Standard Plans. In response, Standard Plans will temporarily extend the following minimum appeal timeframes to support the transition to NC Medicaid Managed Care:

For more information, see [Extension to NC Medicaid Managed Care Appeals Deadlines](#)

| Appeal Submission Date | Minimum Appeal Timeframe |
|-------------------------------------|---|
| Through Jan. 31, 2022 | 90 calendar days from the decision giving rise to the |
| Feb. 1, 2022 through March 31, 2022 | 60 calendar days from the decision giving rise to the |
| April 1, 2022 and later | 30 calendar days from the decision giving rise to the right to appeal |

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>

Peer Support Job Board

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

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.

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

- 3897 Certified Peer Support Specialists as of January 21, 2021
- 1618 Certified Peers are employed as PSS
- 802 PSS are seeking employment

Full & up-to-date statistics can be found by visiting:

<https://pss.unc.edu/data>

Your feedback is appreciated

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/community-empowerment-and-engagement>



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

North Carolina's Olmstead Plan

December 20, 2021

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Abbreviations Used in this Document

| | |
|--|---|
| ACH – Adult care home | I/DD – Intellectual and other Developmental Disabilities |
| ADA – Americans with Disabilities Act | IDM – Informed Decision Making |
| ADATC – Alcohol and Drug Addiction Treatment Center | IPS/SE – Individual Placement Support - Supported Employment |
| ADVP – Adult Developmental Vocational Program | LME/MCO – Local Management Entity/Managed Care Organization |
| CAP/C – Community Alternatives Program for Children | MFP – Money Follows the Person |
| CAP/DA – Community Alternatives Program for Disabled Adults | MORES – Mobile Outreach Response Engagement Stabilization |
| CARES Act – Coronavirus Aid, Relief and Economic Security Act | NCCDD – North Carolina Council on Developmental Disabilities |
| CIE – Competitive Integrated Employment | NC CORE – North Carolina Collaborative for Ongoing Recovery through Employment |
| CMS – Centers for Medicare and Medicaid Services | NC FIT – North Carolina Formerly Incarcerated Transitions Program |
| DAAS – Division of Aging and Adult Services | NCI – National Core Indicators® |
| DHB – Division of Health Benefits | NC PAL – North Carolina Psychiatry Access Line |
| DHHS – Department of Health and Human Services | NC START – North Carolina Systemic, Therapeutic, Assessment, Resources and Treatment |
| DMH/DD/SAS – Division of Mental Health, Developmental Disabilities and Substance Abuse Services | OPSA – Olmstead Plan Stakeholder Advisory |
| DPI – Department of Public Instruction | Pre-ETS – Pre-Employment Transition Services |
| DSB – Division of Services for the Blind | PROMS – Patient-Reported Outcomes Measures |
| DSOHF – Division of State Operated Healthcare Facilities | PRTF – Psychiatric Residential Treatment Facility |
| DSP – Direct Support Professional | RSVP – Referral, Screening, and Verification Process |
| DSS – Division of Social Services or local Department of Social Services | SAMHSA – U.S. Substance Abuse and Mental Health Services Administration |
| DVRS – Division of Vocational Rehabilitation Services | SED – Serious Emotional Disturbance |
| EMS – Emergency Medical Services | SMI – Serious Mental Illness |
| EPSDT – Early and Periodic Screening, Diagnostic and Treatment | SPMI – Severe and Persistent Mental Illness |
| FMAP – Federal Medical Assistance Percentage(s) | START – Sobriety Treatment and Recovery Teams |
| HCBS – Home and Community Based Services | SUD – Substance Use Disorder |
| HUD – U.S. Department of Housing and Urban Development | TBI – Traumatic Brain Injury |
| ICF/IID – Intermediate Care Facility for Individuals with Intellectual Disabilities | TCL – Transitions to Community Living |
| | WIOA – Workforce Investment Opportunity Act |



Introduction

In its landmark ruling, *Olmstead v. L.C.*, the United States Supreme Court made “the case for community” on behalf of two people with disabilities, Lois Curtis (L.C.) and Elaine Wilson (E.W.) – and millions of Americans who would follow. The case rested on the foundational “integration mandate” of the Americans with Disabilities Act (ADA) and opened the door for people with disabilities to live the everyday lives that each of us so cherish. Under *Olmstead*, people with disabilities who reside or work in publicly funded, congregate settings – or who are at serious risk of entering such settings – must be given the opportunity to live side-by-side with everyone else, to the fullest extent possible. In this spirit, our state’s Olmstead Plan renews and strengthens our shared commitment to offer North Carolinians the opportunity to receive services and supports in places and in ways that are person-centered and integrated into day-to-day life.

The Olmstead Plan is a cross-population blueprint, addressing the health and well-being of children and families, youth, adults, and elders with disabilities. It reflects the contributions of many and incorporates much of the work we have already done as a state to advance independence, integration, inclusion, and self-determination for those with disabilities. Going forward, this strategic plan, and the work plans that flow from it, will shape policy, practices, and funding decisions.

Realizing the promise of *Olmstead* is not something we can do from the top down, or even from the bottom up. This effort requires all of us. We must coalesce around a common purpose, one that engages people with lived experience and families; advocacy groups; organizations, agencies and associations; regional management entities; and service providers. We are grateful to those already leading the way, including the many people who participated directly in this Plan’s development. Governor Cooper and I are committed, with your continued help, to making the promise of *Olmstead* a reality. Together, we will build partnerships that reach across the Administration, garnering support from the housing community; employers; schools; colleges and universities; transportation systems; the General Assembly; and the general public.

The Olmstead Plan is a living, breathing document. It will guide a changing system of services and supports. Its first phase covers 2022 to 2023; but we will not stop there. We continue the journey, advised each step of the way by those with lived experience, their families, and diverse stakeholders. Today, we celebrate the vision adopted by the Plan’s Stakeholder Advisory: North Carolina champions the right of all people with disabilities to choose to live life fully included in our communities. Tomorrow, I ask that you join us in the work that lies ahead.

Kody H. Kinsley

Secretary of the North Carolina Department of Health and Human Services

Acknowledgments

The development of this initial Olmstead Plan – a plan that applies, across the lifespan, to all people with a disability or behavioral health disorder who are in or at risk of entering publicly-funded, congregate settings – would not have been possible without the contributions of the following people: members of the Olmstead Plan Stakeholder Advisory (OPSA) and its Community Co-Chairs; the staff of the Office of the Senior Advisor on the Americans with Disabilities Act, Office of the Secretary, North Carolina Department of Health and Human Services (DHHS); the leadership and staff of many other DHHS divisions and offices, including the OPSA Departmental Co-Chair; the national experts who graciously volunteered their time and expertise to present during the OPSA's meetings, including Allan Bergman, Amy Hewitt, Leigh Ann Kingsbury, Marti Knisley, Joe Macbeth, Jonathan Martinis, Estelle Richman, Mark Salzer, and Ann Turnbull; members of the eight OPSA committees and their chairs, inclusive of representatives of the North Carolina General Assembly; stakeholders from across North Carolina, among them Local Management Entities/Managed Care Organizations; Area Agencies on Aging; legal professionals; Area Health Education Centers; provider agencies; professional associations; advocacy groups; family members of individuals with lived experience; and, most importantly, people whose lives are at the center of this Plan.

Going forward, we will continue to rely on the ongoing participation and commitment of these individuals, and those who will follow, to assist North Carolina in realizing the vision of *Olmstead* and its capacity for strengthening the vibrancy, health, and well-being of this state's communities and its people.



Olmstead v. L. C.

Within the disability community, the *Olmstead v. L. C.* Supreme Court case¹ is often compared to *Brown v. Board of Education*, and with good reason. Like *Brown*, *Olmstead* is a transformative driver of cultural and systemic change. The *Olmstead* decision, which derives from the Americans with Disabilities Act (ADA), provided our country with a sweeping interpretation of the ADA's "integration mandate." Writing for the court, Justice Ruth Bader Ginsburg stated that "unjustified segregation" of people with disabilities in institutional settings was unlawful discrimination under the ADA. The ruling established that public entities, such as the North Carolina Department of Health and Human Services, must provide community-based services to people with disabilities when: (1) such services are appropriate; (2) the affected person doesn't oppose treatment that takes place in the community; and (3) providing such services can be "reasonably accommodated, taking into account the resources available...and the needs of others who are receiving disability services..."² Since the ruling, implementation of the *Olmstead* decision has brought thousands of people with disabilities into the mainstream of American life.

¹ *Olmstead vs. L.C.*, 1999, 527 U.S. at 600-01. Retrieved October 10, 2021 from <https://supreme.justia.com/cases/federal/us/527/581/>

² *Olmstead vs. L.C.*, 1999, 527 U.S. at 600-01. Retrieved October 10, 2021 from <https://supreme.justia.com/cases/federal/us/527/581/>

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The Development of North Carolina's Olmstead Plan

In January 2020, the North Carolina Department of Health and Human Services (DHHS) engaged the Technical Assistance Collaborative (TAC), in partnership with the Human Services Research Institute, to assist in the development and implementation of a comprehensive, effectively working plan to support the state's residents with disabilities in the most integrated settings appropriate to their needs, as required under *Olmstead*. Following 15 listening sessions and extensive qualitative and quantitative data review, TAC issued a report that included both an assessment and an analysis of how the systems, funding, services, and housing options of the DHHS and other state agencies function to serve people with disabilities in integrated settings.³ The findings of this report, summarized below, were among many sources of information used in the development of the state's Olmstead Plan. The report also offered information germane to subsequent phases of the initiative, specifically, technical assistance for implementation activities, as deemed necessary, and development and implementation of a system for performance evaluation and outcome measurement.

In the early summer of 2020, the DHHS Secretary announced appointments to the Olmstead Plan Stakeholder Advisory (OPSA), a group of diverse stakeholders from the disability advocacy community, including individuals with lived experience and their families; service providers; managers of provider networks (e.g., the Local Management Entities/Managed Care Organizations or LME/MCOs); professional associations; policymaking leaders within the DHHS; and state legislators from both sides of the aisle. The 2021 OPSA was co-chaired by the recent past chairs of The Coalition and the North Carolina Coalition on Aging. These Community Co-Chairs were joined by a Departmental Co-Chair, the Deputy Secretary for the Division of Health Benefits (NC Medicaid). Please see [Appendix B](#) for the 2021 list of OPSA members and their affiliations.

Shortly after the OPSA's first meeting, the DHHS adopted the following mission statement for the Olmstead initiative:

In collaboration with our partners, the NC DHHS provides essential services to assist people with disabilities to reside in and experience the full benefit of inclusive communities.

³ Technical Assistance Collaborative, Inc. and Human Services Research Institute (2021). [An assessment of the North Carolina Department of Health and Human Services' system of services and supports for individuals with disabilities](https://bit.ly/3uZFBPB) [PDF], Raleigh, NC: North Carolina Department of Health and Human Services, <https://bit.ly/3uZFBPB>

After discussion with its membership, the OPSA also adopted this vision statement:

North Carolina champions the right of all people with disabilities to choose to live life fully included in the community.

The DHHS recognized that while the OPSA would play a key role in advising the Department during plan development, the focused work for development and implementation would require staff and individuals involved in carrying out the day-to-day work. The DHHS subsequently complemented the Advisory with a team of subject matter and data experts from across the Department, along with representatives from LME/MCOs and their provider networks. This OPSA Staff Work Group is led by the Office of the Senior Advisor on the Americans with Disabilities Act (ADA) and the Office of the General Counsel. The DHHS next formed committees from the OPSA's membership, composed of external stakeholders, DHHS leadership, and other DHHS staff members, to develop recommendations and action steps to address plan priorities. The 2021 committees were:

| | |
|-------------------------------|---------------------------------------|
| Housing | Employment |
| Community Capacity Building | Transitions to Community |
| Children, Youth, and Families | Workforce Development |
| Older Adults | Quality Assurance and Quality of Life |

The Department selected eight OPSA members to chair the committees, and each committee was assigned staff to guide and inform its work. Please see [Appendix B](#) for a list of OPSA committees and membership.

To date, the OPSA has convened six quarterly meetings which have spotlighted key policy innovations; featured presentations from national experts;⁴ provided committee updates; and reviewed progress and provided feedback on Olmstead Plan development. The subcommittees have met regularly, providing meeting minutes and summaries to the Assistant Director for Olmstead Plan Development in the Office of the Senior Advisor on the ADA; these were forwarded to TAC for review.

⁴ In 2020, the OPSA heard from TAC Executive Director Kevin Martone on Olmstead Plan development; Burton Blatt Institute Senior Director for Law and Policy Jonathan Martinis on supported decision-making; and Executive Director of the National Alliance for Direct Support Professionals (NADSP) Joe Macbeth and Director of the Institute for Community Integration (ICI) Amy Hewitt, Ph.D. on workforce development. In 2021, the OPSA hosted expert presentations from the Lewin Group's Leigh Ann Kingsbury on person-centered systems and aging with disabilities; High Impact's Allan I. Bergman on competitive integrated employment; former Secretary of the Pennsylvania Department of Public Welfare and former Senior Advisor to the Secretary of Housing and Urban Development Estelle Richman on effective system change strategies; Mathematica's Jessica Ross and Carey Appold on quality measurement; TAC's Jim Yates on the Center for Medicare and Medicaid's (CMS) Final Home and Community Based Services (HCBS) Settings Rule; and TCL Independent Reviewer Marti Knisley on supported housing. TAC Senior Consultant Sherry Lerch attended all quarterly meetings.

The draft Olmstead Plan was released for public comment from October 12 through November 8, 2021. Comments were submitted by 91 individuals and organizations. The DHHS reviewed and considered all public comments received, contributing to an initial Olmstead Plan that is both comprehensive and achievable.

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North Carolina's System to Support Individuals with Disabilities

Systems Overview

State Structure

The North Carolina Department of Health and Human Services (DHHS) has 34 divisions and offices covering six broad service areas: Health; Opportunity and Well-Being; Medicaid; Operational Excellence; Policy and Communications; and Health Equity. The DHHS also oversees 14 facilities: developmental centers; neuro-medical treatment centers; psychiatric hospitals; alcohol and substance use disorder treatment centers; and two residential programs for children. These divisions and offices are responsible for the oversight of state and federal funding; program development; establishing and informing statewide policy; providing advocacy and protection for recipients; providing technical assistance on evidence-based and promising practices; and overseeing quality improvement.

The Role of Local Management Entities/Managed Care Organizations, Tailored Plans, and Standard Plans

Since July 1, 2013, Local Management Entities/Managed Care Organizations (LME/MCOs) have been responsible for statewide management and oversight of the public system of mental health, developmental disabilities, and substance use disorder services at the community level. Their role is to coordinate both behavioral health and intellectual and other developmental disabilities (I/DD) services, and payments for those services. This coordination is accomplished through a network of local community service providers which contract with and are monitored by the LME/MCOs. The LME/MCOs receive a monthly payment from the DHHS' Division of Health Benefits (NC Medicaid) based on the number of Medicaid beneficiaries residing in each LME/MCO's catchment area. Medicaid beneficiaries receive mental health, substance use disorder, and I/DD services through the LME/MCO's authorization for services within their network. LME/MCOs are also charged by General Statute to serve people who are uninsured, with funding supplied through U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) block grants that require matching state funds as a "Maintenance of Effort." The state portion of non-Medicaid funding is appropriated by the General Assembly and referred to as "single stream funding."

Prior to July 1, 2021, Medicaid beneficiaries were enrolled in NC Medicaid Direct, administered by the DHHS, for physical health and pharmacy benefits. Effective on that date, most Medicaid beneficiaries were required to enroll in a Medicaid managed care plan run by an insurance

company, referred to as a “Standard Plan.” Standard Plans provide integrated physical health, behavioral health, pharmacy benefits, and long-term services and supports to most Medicaid beneficiaries, as well as programs and services that address unmet health-related resource needs.

Beginning on December 1, 2022, selected LME/MCOs will operate Behavioral Health I/DD Tailored Plans to provide specialized services for individuals with significant behavioral health conditions, I/DD, or traumatic brain injury (TBI). Tailored Plans will include integrated physical health care, pharmacy benefits, and long-term services and supports, as well as programs and services to address unmet health-related resource needs.

NC Medicaid’s [“Tailored Plan Information for Providers”](#) [PDF] resource provides more information.

System Strengths, Gaps, and Challenges in Supporting Individuals with Disabilities

Strengths of the System

North Carolina has been engaged for many years in transforming its services and systems to support individuals with disabilities as fully included members of their communities.

The Transitions to Community Living (TCL) effort has resulted in positive outcomes and improved delivery of services for many adults with serious mental illness (SMI) in North Carolina and may act as a framework for serving people with other disabilities. North Carolina leverages numerous federal resources to support individuals with disabilities, including Medicaid Home and Community Based Services (HCBS) waivers, Money Follows the Person (MFP), the Children’s System of Care model, and the development of affordable housing. North Carolina has made progress in providing opportunities for competitive integrated employment for individuals with disabilities and Governor Cooper signed Executive Order No. 92, declaring North Carolina an Employment First state. The DHHS promotes evidence-based practices that support children, adults, and older adults with behavioral health disorders; individuals with I/DD; and individuals involved with the criminal justice system. North Carolina’s universities have created model programs and provide training and consultation in evidence-based practices. LME/MCOs provide community-based services and supports in addition, or as alternatives to, Medicaid state plan services. Finally, the DHHS has entered into a contract with the Cherokee Indian Hospital Authority to support the Eastern Band of Cherokee Indians in addressing the health needs of American Indian/Alaska Native Medicaid beneficiaries, the first Indian managed care entity of its kind in the nation.⁵

⁵ North Carolina Department of Health and Human Services (2021, October 3). [Eastern Band of Cherokee Indians \(EBCI\) tribal option overview](#), Retrieved October 10, 2021 from <https://bit.ly/3iQTlrb>

Challenges within the System

While progress has been made towards achieving the vision of *Olmstead*, there is more work to do. Not enough community-based service providers have developed the skills necessary to serve individuals with complex needs or challenging behaviors, leaving state-operated facilities and costly, out-of-state psychiatric residential treatment facilities (PRTFs) as the only options for services for these individuals. Gaps in services impede community integration; additional community-based service options and capacity are needed for children, adults, and older adults with disabilities to reduce reliance on institutional and congregate care settings. Yet the growth of service capacity is challenged by the staffing crisis faced by North Carolina and every state across the country. There are not enough staff, including, but not limited to, Direct Support Professionals, to serve individuals with disabilities. Finally, the supply of affordable, accessible housing is limited in locations where services and transportation are readily available for individuals with disabilities.

A number of barriers inhibit both access to the services and supports that do exist and to the development of additional services to support individuals with disabilities as integrated members of their communities. Individuals and families must wait for services and funding. The Registry of Unmet Need ("waiting list") exceeds 15,000 individuals with I/DD, more than the number of Innovations waiver participants. More than one in ten North Carolinians lacks access to health care coverage and must rely on limited and shrinking state funding for community-based services, leading them to turn instead to crisis, emergency department, and state-operated health care services. Finally, the overuse of full guardianship has been identified as a consistent barrier to community inclusion, affecting individuals with all disabilities and of all ages.

No Olmstead Plan can remedy every need and challenge a state faces in serving and supporting its residents with disabilities. This Plan, set forth by the DHHS, is intended to highlight how the Department's current work, future implementation efforts, and use of resources can be viewed through an *Olmstead* lens to achieve the state's vision of community inclusion for individuals with disabilities in North Carolina's publicly funded system of services and supports.

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North Carolina's Olmstead Plan Priorities

North Carolina's Olmstead Plan envisions all people with disabilities exercising their right to choose a life that is fully included in the community. This Plan is a *strategic plan*; it provides a framework for the system and identifies actions and the allocation of resources to help achieve this vision. Detailed work plans will be developed, as needed, to carry out the strategies within each Goal Area. The Department of Health and Human Services (DHHS) does not have the staffing capacity or the financial resources to address immediately every system gap or challenge; nor can the Department resolve all systemic barriers alone. This Plan sets forth priorities and strategies to continue strengthening the community-based system that we know today. For each priority, initial target measures are identified to assess progress in implementing strategies. We envision that the system will continue to evolve over the next few years; measures will be revised and refined, and new measures developed, as the DHHS enhances its ability to track data and establish baselines. This initial Plan will guide the Department's efforts as follows:

Year One: January 1, 2022 – December 31, 2022

Year Two: January 1, 2023 – December 31, 2023

As noted in the conclusion, the Plan is intended to be a living document that is subject to regular change, based on any number of circumstances, such as: meeting targets earlier than expected; failing to meet targets; receiving funding from the General Assembly or the federal government; or changing the trajectory of goals based on public input, learned experience, or circumstances that are unaccounted for or unforeseen.

Priority Area 1: Strengthen Individuals' and Families' Choice for Community Inclusion through Increased Access to Home and Community Based Services and Supports

What Priority Area 1 Means

Home and Community Based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their homes or in a community-integrated setting rather than in institutions or other isolating settings.

Why Priority Area 1 is Important

North Carolina has four Medicaid waivers that provide federal matching funds for HCBS: the Innovations waiver for individuals with intellectual and other developmental disabilities (I/DD); the Traumatic Brain Injury (TBI) waiver; and, for children and adults who are medically fragile or medically complex, the Community Alternatives Program for Children (CAP/C) waiver and the Community Alternatives Program for Disabled Adults (CAP/DA) waiver, respectively. The Centers for Medicare and Medicaid Services (CMS) issued a Final Rule on the requirements for settings in which residential and employment/day services are provided to HCBS recipients. North Carolina must be fully compliant with the Final Rule by March 23, 2023 or risk losing federal revenue.

There are currently waiting lists for two of North Carolina's four HCBS waivers. Approximately 2,100 people are on the CAP/DA waiver waiting list, and approximately 15,000 people are on the Innovations waiver waiting list (the Registry of Unmet Need).⁶ Although the CAP/C waiver does not have a waiting list, the maximum participant count of 4,000 is reaching its limit. The demand for CAP/DA waiver services will likely increase; over the last ten years, while the North Carolina population saw a 10 percent increase, there was a 41.9 percent increase in the population over 65 years old.⁷ Finally, while the TBI waiver is a "pilot" and does not have a waiting list, eligibility for this waiver is limited to a few counties within the state.

Section 9817 of the American Rescue Plan Act temporarily increases Federal Medical Assistance Percentage (FMAP) rates by 10 percentage points for certain Medicaid HCBS expenditures. This federal funding boost can help states increase community-based options for people with disabilities. The policy of promoting community inclusion comports with Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12131–12134, as interpreted by the Supreme Court in *Olmstead v. L.C.*, 527 U.S. 581 (1999). The ruling requires public entities to administer services to individuals with disabilities in the most integrated setting appropriate to their needs.

North Carolina's Priority Area 1 Efforts to Date

HCBS Transition Plan

- ✓ As of July 8, 2021, the DHHS had validated that 70.29 percent of the 6,000 residential, supported employment, and day supports sites providing HCBS to waiver recipients were in compliance with the Final Settings Rule.⁸
- ✓ The Department of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) is also revising I/DD and TBI state-funded service definitions to include HCBS principles, making these services comparable for recipients.

⁶ Per conversation with North Carolina Division of Health Benefits staff.

⁷ 2019 Population estimates, U.S. Census Bureau.

⁸ Per conversation with North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services staff.

Expanded Opportunities for Community Inclusion and HCBS

- ✓ On July 12, 2021, the DHHS submitted to CMS a proposal and estimated expenditures for a number of initiatives to strengthen HCBS in North Carolina in support of this Olmstead Plan (see strategies below). The DHHS has received a partial approval of the HCBS Transition Plan and, at the request of CMS, is in the process of providing clarification.
- ✓ The North Carolina General Assembly approved funding for additional participants in the Innovations waiver by 1,000 in 2022. The North Carolina legislature also funded 114 additional participants in the CAP/DA waiver.

Please see [Appendix A](#) for additional North Carolina efforts to date.

Proposed Priority Area 1 Strategies

- The DHHS will ensure that all remaining sites providing HCBS that are identified within the transition period are validated and in compliance with the Final HCBS Settings Rule by no later than March 2023.
- The DHHS will continue efforts to promote serving individuals in community-integrated settings and will assess annual expenditures for institutional and community-based services with the intent of further rebalancing state and federal resources to support more individuals with disabilities in the community.
- The Division of Health Benefits (DHB) will add Innovations, CAP/DA, and CAP/C waiver slots using enhanced FMAP, pending CMS approval, and newly appropriated state funds.
- The DHHS will expand eligibility for the TBI waiver by adding counties of residence, reducing the age of eligibility to 18 years old, and increasing the income limit to 300 percent of the federal poverty level.
- The DHB will develop an integrated, state waiting list database of people with I/DD and people with TBI for state-operated and state-funded services, along with Medicaid waiver-funded services. This will provide beneficial information about the demographics of people who require services and who may shift between programs. This database will not replace the Registry of Unmet Need, which will continue to be maintained by the Local Management Entities/Managed Care Organizations (LME/MCOs) and, eventually, the Tailored Plans.
- The DHB will inform families of children on the Registry of Unmet Need that their children may be eligible and should be assessed for services through the CAP/C waiver or Personal Care Services, as covered under the State Plan.
- The DHB is actively developing a Remote Supports service definition, initially for the TBI waiver renewal, followed by the Innovations waiver and, pending CMS approval, will use enhanced FMAP to add remote technology support to the CAP/C and CAP/DA waivers.
- The DHB will expand Home Health services to include persons who are transitioning from institutions to the community and who have three or more chronic conditions of any type. The DHB will also expand Specialized Therapies for the first year for people transferring to the community from institutions.

- The DHB is revising North Carolina's regulations that set the cap on eligibility for 1915(c) waiver benefits for individuals transitioning from institutional care, to reduce/eliminate the deductible for community-based services, thereby increasing access to HCBS for these individuals.

Baseline Data/Targeted Measures for Priority Area 1

Baseline Data for Priority Area 1⁹

As of May 1, 2021, there were 13,138 individuals with I/DD supported by the Innovations waiver, and more than 15,000 individuals on the Registry of Unmet Need.

In Fiscal Year 2019, there were 11,534 adults with physical disabilities supported by the CAP/DA waiver and 2,650 children with complex medical conditions supported by the CAP/C waiver.

The TBI waiver, which is not yet statewide, currently supports 41 individuals but has a capacity of 107 slots.

Targeted Measures for Priority Area 1

- By March 2023, 100 percent of HCBS settings will comply with the Final HCBS Settings Rule.

As noted in Table 1 below, the DHHS will provide more than 2,300 additional participants with access to HCBS waivers by December 31, 2023.

Table 1: Planned Increases to HCBS Waiver Participation in North Carolina

| Waiver Type | Calendar Year 2022 | Calendar Year 2023 |
|-------------|--------------------|--------------------|
| Innovations | Increase by 1,000 | Increase by 1,000 |
| CAP/DA | Increase by 114 | Increase by 200 |
| CAP/C | Expand to 5,000 | Increase if needed |

Resource Requirements for Priority Area 1

HCBS Transition Plan

The DMH/DD/SAS will cover the cost to apply the Final HCBS Settings Rule requirements to state-funded HCBS services within the existing state appropriation.

⁹ Except where otherwise noted, baseline data for all Priority Areas was provided to TAC by DHHS staff.

Expanded HCBS Opportunities

The cost of additional waiver slots will be covered through federal Medicaid revenues and increased state appropriations as approved by the North Carolina General Assembly.

The estimated state share of the cost of HCBS policy proposals will be covered through State Fiscal Year 2023 using a portion of the enhanced FMAP for HCBS.

Priority Area 2: Address the Direct Support Professional Crisis

What Priority Area 2 Means

Direct Support Professionals (DSPs) are individuals who are employed to “provide a wide range of supportive services to individuals...on a day-to-day basis, including habilitation, health needs, personal care and hygiene, employment, transportation, recreation, housekeeping and other supports, so that these individuals can live, work and participate in their communities” and “lead self-directed, community and social lives.”¹⁰ DSPs support activities of daily living to the extent needed and provide support and advocacy for individuals to be fully included in their communities. DSPs may work in community-based facilities or provide services to a Medicaid waiver participant in the person’s workplace or in their own home or that of the family.

Why Priority Area 2 is Important

The quality of support provided by DSPs to individuals with physical disabilities, I/DD, mental health needs, and substance use disorders has a profound influence on their satisfaction with services and supports paid for by the State of North Carolina. Specific factors that can have a significant impact on the quality of life for these individuals include the competence, stability, and satisfaction of DSPs, as well as turnover rates and vacancies.

The success of HCBS and other community-based services depends on having a workforce, inclusive of professional caregivers and, in some cases, family members who can meet the needs of individuals with disabilities living in the community. This is not only a matter of hiring enough qualified individuals, but of retaining them as well. While raising the hourly rate they receive is viewed as the priority solution to increase hiring of DSPs, requiring competency-based training is essential to improving the quality of services provided.

¹⁰ Congressional Record, November 4, 2003, p. H10301 as cited in Report to the President 2017, *America’s direct support workforce crisis: Effects on people with intellectual disabilities, families, communities and the U.S. economy*, President’s Committee for People with Intellectual Disabilities. The term “Direct Support Professionals” is increasingly used for the frontline workforce within other populations of people with disabilities.

North Carolina has more than 123,000 direct service workers,¹¹ including DSPs for the Olmstead population, and the need for these workers is projected to increase by at least 20,000 jobs by 2028.¹² However, the direct service workforce has high rates of turnover and lower rates of employee retention; 53 percent of the state's direct service workforce live at or near poverty level.¹³ Adequate rates of pay must be established, and competency-based training made available.

Currently, there is a gap between the HCBS services authorized and the services delivered by providers, attributed in large part to the lack of DSPs and in-home nurses. This gap will only widen as the DHHS is proposing to increase the number of participants for the Innovations, CAP/C, CAP/DA, and TBI waivers. Adding waiver slots without also addressing the shortage of DSPs may create an environment where people have more difficulty accessing services.

Raising DSP wages will go a long way in stabilizing the workforce, however additional efforts will also be necessary to maximize the available workforce. The expanded use of assistive technology is emerging as a strategy to relieve the overwhelming demand for DSPs. For example, "smart homes" support individuals with I/DD, TBI, and physical disabilities to live independently. The technology and supports are designed to anticipate challenges and threats to safety and resolve them before they happen, allowing staff to intervene only when needed rather than being present 24/7. While not the solution for everyone, technology can empower individuals with disabilities with greater independence and expand access to HCBS support.¹⁴

North Carolina's Priority Area 2 Efforts to Date

- ✓ In November 2021, the General Assembly approved budget included a rate increase for direct service workers employed by Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) and HCBS providers.
- ✓ The approved budget also included a rate increase for private duty nurses.
- ✓ The DHB developed and implemented a pilot program to expend \$1.6 million by June 30, 2021 to provide communication access services for deaf, deaf-blind and hard-of-hearing Medicaid beneficiaries.
- ✓ By December 2021 the Division of Aging and Adult Services (DAAS), in collaboration with the NC Assistive Technology Project, will have accessed funds awarded via a COVID Aging and Disability Resource Center grant. These funds will support the initiation of specific services to

¹¹ Goldsmith, T. (2018, November 29). [Demand for NC direct care workers, mount, but wages decline, North Carolina Health News](https://bit.ly/2YFDsMT), <https://bit.ly/2YFDsMT>

¹² Goldsmith, T. (2021, February 17). [As the long-term care industry shifts, COVID-19 shortchanges NC's frontline workers](https://bit.ly/3mHiCp1), North Carolina Health News, <https://bit.ly/3mHiCp1>

¹³ Robins, A. (2020, October 6). [Essential jobs, essential care: A conversation with North Carolina](https://bit.ly/3mIGrN5), PHI National, <https://bit.ly/3mIGrN5>

¹⁴ LADD, Inc. (n.d.) [Smart living](https://laddinc.org/program/smart-living/), Retrieved October 10, 2021 from <https://laddinc.org/program/smart-living/>

assist seniors with disabilities to learn about and use assistive technology for communication and safety.

- ✓ Self-direction is an option under the Innovations, CAP/DA, and CAP/C waivers.

Please see [Appendix A](#) for additional North Carolina efforts to date.

Proposed Strategies for Priority Area 2

- The DHB will allocate enhanced FMAP funds to increase DSP wages, to be sustained on an ongoing basis as a result of additional funds appropriated by the General Assembly.
- Beginning in March 2022, the DHB will conduct an annual survey of direct care workers/ Direct Support Professionals who serve Innovations waiver recipients, to assess whether the wages of licensed direct care workers, non-licensed direct care workers, or both need to be increased. If the DHB determines that there is a need for an increase in wages, the DHB will develop a plan, or update to a previously submitted plan as applicable, to implement the increase.
- The DHB will, pending CMS approval, allocate enhanced FMAP for the recruitment and training of DSPs.
 - The DHHS will consult with qualified individuals to determine the competency-based curricula for training DSPs across sectors.
- The DHHS will establish a certification process for DSPs that recognizes lived experience.
- The DHHS will establish a DSP credential that is portable among geographic regions of the state and will identify a credentialing association/board/entity to develop and manage the credentialing process; advocate for the credential; and manage grievances.
- The DHB will assess the impact of the rate increase for private duty nurses, approved by the General Assembly, on the ability of families to receive authorized services for their medically complex children, given the shortage of in-home nurses.
- The DHHS Individual Placement and Support Statewide Steering Committee meetings will include, as a recurring agenda item, review of challenges impacting the ability to hire new staff, in order to assist in the removal of barriers to obtaining and retaining quality trained staff.
- The Division of Services for the Blind (DSB) will provide virtual instruction to enable 50 individuals with visual impairment to successfully utilize assistive technology and adaptive devices to enhance their independent functioning in the home, family, community, and employment.
- The DMH/DD/SAS will work with the Standard Plans and LME/MCO Tailored Plans to increase the use of “smart home” technologies that support independent living.

Baseline Data / Targeted Measures for Priority Area 2

Baseline Data for Priority Area 2

The average starting wage for a DSP in North Carolina is \$10.88/hour; the average wage paid ongoing is \$11.95/hour.¹⁵

In Fiscal Year 2019, the penetration rate for assistive technology among Innovations waiver recipients was 7.9 percent.¹⁶

In Fiscal Year 2020, the Division of Vocational Rehabilitation Services (DVRS) provided assistive technology services including assessments, provision of adaptive equipment, and training for 700+ consumers.

Between April 2020 and August 2021, the DAAS Assistive Technology Project served 6,404 individuals. Of those served, 2,147 have a disability and 1,299 are age 60 or older.

In Fiscal Year 2019, the penetration rate for the self-directed Community Navigator service among individuals on the Innovations waiver was 24.8 percent;¹⁷ self-direction was selected by 23 percent of CAP/DA participants and 38 percent of CAP/C participants.

Targeted Measures for Priority Area 2

- Effective the first quarter of 2022, DSPs will be eligible to receive a wage increase of up to \$15.00/hour.
- By December 31, 2023, an additional 100 individuals will receive assistive technology, including “smart homes” technology, through Standard Plans and LME/MCO Tailored Plans.
- By December 31, 2023, 20 percent more seniors will have increased access to assistive technology through the Aging and Disability Resource Center DAAS Assistive Technology Project.
- By December 31, 2023, an additional five percent of individuals on the CAP/DA, CAP/C, and Innovations waivers will choose to self-direct their services.

Resource Requirements for Priority Area 2

The DSP wage increase will be covered via enhanced FMAP and a budget increase approved by the General Assembly through State Fiscal Year 2023.

¹⁵ National Core Indicators (2020). [National Core Indicators 2019 staff stability survey report](https://bit.ly/3aoa1ld) [PDF]. <https://bit.ly/3aoa1ld>

¹⁶ Technical Assistance Collaborative, Inc. and Human Services Research Institute (2021), [An assessment of the North Carolina Department of Health and Human Services' system of services and supports for individuals with disabilities](https://bit.ly/3uZFBPB) [PDF]. Raleigh, NC: North Carolina Department of Health and Human Services, <https://bit.ly/3uZFBPB>

¹⁷ DHHS Medicaid Claims Data.

Priority Area 3: Divert and Transition Individuals from Unnecessary Institutional and Segregated Settings

What Priority Area 3 Means

Diversion services provide individuals with disabilities the supports needed to remain at home, alleviating the need for institutional or congregate living. Many individuals with disabilities want to remain in their homes, but they or their families lack the resources or assistance they need to do so safely. More individuals could be supported in community-based settings of their choice if they and their families could easily access information about services to support greater independence.

Transition services and supports assist people to integrate into the community after leaving institutions or settings that hindered community inclusion. Individuals with disabilities can languish in such settings if they do not have either the resources to cover transition costs, such as first-month's rent or move-in expenses, and the ongoing tenancy supports to successfully maintain their housing.

Why Priority Area 3 is Important

Children and youth are negatively impacted by out-of-home placements, through reduced contact with their families, homes, communities, pets, friends, possessions, routines, and school settings. These changes can be traumatic, having a detrimental effect on children's brain development and neurological function. Adults also experience negative impacts when removed from their homes, resulting in loss of independent living skills and social supports. The longer an individual with a disability is in a more restrictive setting, the more challenging it is for them to return to independent living.

In addition to the individual benefits of diversion and transition services, there are cost savings that can be invested into serving more people in the community. For example, Money Follows the Person (MFP) offers individuals the opportunity to transition to the community where they can receive home- and community-based services; on average, North Carolina saves \$2,600 per person per month in its MFP program compared to the cost of institutional care.

Finally, diverting and transitioning individuals with mental health disorders from state psychiatric hospitals, adult care homes (ACHs), and homelessness are requirements of the Transitions to Community Living (TCL) settlement agreement with the U.S. Department of Justice.¹⁸ Over the last two years, North Carolina has been hampered in its ability to move individuals from ACHs

¹⁸ North Carolina Department of Health and Human Services (n.d.). [Transitions to community living](https://bit.ly/3FxewU8), Retrieved October 10, 2021 from <https://bit.ly/3FxewU8>

as a result of the COVID-19 pandemic. The state fell just short of its benchmark to have 3,000 persons in housing by June of 2021. Per the TCL independent reviewer's 2020 report, North Carolina is not on track to transition 2,000 individuals from adult care homes to supported housing slots, which is one of the main sub-requirements in the settlement agreement and the issue at the heart of the alleged *Olmstead* violations leading to the agreement.

North Carolina's Priority Area 3 Efforts to Date

Diversion

- ✓ The DHHS created the Referral, Screening, and Verification Process (RSVP)¹⁹ to identify when a person with a serious and persistent mental illness (SPMI) is referred to an ACH. An "Independent Reviewer" then screens them for eligibility to TCL, to potentially divert the admission to an ACH.
- ✓ The LME/MCOs are currently conducting in-reach with 1,241 adults with serious mental illness (SMI) and SPMI in state psychiatric hospitals, and with 3,852 individuals residing in ACHs, to engage and inform them about community mental health services and supportive housing options.²⁰
- ✓ The DHHS is proposing to use a portion of the American Rescue Plan Act five-percent set-aside, as well as Duke Endowment funds, to expand the availability of mobile crisis services to children. Use of the Mobile Outreach Response Engagement Stabilization (MORES) model, including training staff in the provision of crisis services to children and a family peer support component, will divert inpatient admissions and out-of-home placements for treatment.
- ✓ Supported with Governor's Task Force funds, the Division of Mental Health, the DMH/DD/SAS, the Vaya Health LME/MCO, and Mission Hospital have piloted the Resource Intensive Comprehensive Case Management model. The model focuses on diverting adults with SMI from unnecessary hospital emergency department admissions, instead linking them to intensive community supports.
- ✓ The Promise Resource Network, a nationally recognized peer-run organization in Charlotte, and the Sunrise Community for Recovery and Wellness in Asheville, operate peer-run respite centers that offer an alternative to emergency department visits, inpatient mental health services, and involuntary commitments through a non-forced, voluntary, and unlocked healing alternative.

¹⁹ North Carolina Department of Health and Human Services (n.d.). [Transitions to Community Living - Referral Screening Verification Process \(RSVP\)](#) [PDF].

²⁰ North Carolina Department of Health and Human Services (n.d.). [Transitions to Community Living - Referral Screening Verification Process \(RSVP\)](#) [PDF].

Transitions

- ✓ Since 2009, North Carolina has used the MFP program to transition more than 1,400 individuals from institutional settings to community-based living.
- ✓ Since 2013, the TCL effort has transitioned more than 5,000 individuals with serious and persistent mental illness from state psychiatric hospitals and ACHs, with nearly 3,000 to date occupying their own permanent supported housing and only 28 readmissions to a state psychiatric hospital.²¹
- ✓ The DMH/DD/SAS is engaged in Children's Residential Redesign, an effort focusing on family support partners to increase families' voice and choice; active decision-making; and appropriate transitions from placement to services and supports within the community.
- ✓ In 2021, the Green Tree Peer Center opened a peer-run crisis respite program to transition individuals from emergency departments by continuing to offer crisis support and a quiet space for up to 24 hours.
- ✓ In August 2021, the DMH/DD/SAS submitted a budget amendment under the Emergency COVID Grant to help no fewer than 200 individuals from impacted counties transition from incarceration into a North Carolina Oxford House.
- ✓ NC FIT (Formerly Incarcerated Transitions) program – a partnership among UNC Family Medicine, the North Carolina Department of Public Safety, The North Carolina Community Health Center Association, Federally Qualified Health Centers, county departments of public health, community-based reentry organizations, and local reentry councils – established patient-centered primary care medical homes for inmates returning to the community who have chronic medical conditions, mental illness and/or substance use disorders. The FIT program provides vouchers to cover office visits and medication costs for uninsured patients. It utilizes specially trained community health workers with a personal history of incarceration to establish rapport and trust and to act as peer navigators in all aspects of reentry.

Please see [Appendix A](#) for additional North Carolina efforts to date.

Proposed Strategies for Priority Area 3

- The DHHS has embarked on Child Welfare redesign to identify children and families served by the Division of Social Services (DSS), the DHB, and the DMH/DD/SAS, and to establish shared outcomes to reduce out-of-home placements.
- The DHHS will build, going forward, on lessons learned from the Child Welfare Transformation Work Group to reduce involvement of youth with disabilities in the juvenile justice system.
- The DMH/DD/SAS will implement new mobile crisis services teams for children.

²¹ Represents fewer than 28 individuals; some had more than one state psychiatric hospital readmission.

- LME/MCOs will seek to initiate in-reach with their members within seven days of admission to a state psychiatric hospital or ACH and will continue to provide frequent education about transition services and supports to members. The DHHS commits to establishing a process that ensures that people seeking Intermediate Care Facility admission will have an opportunity to hear about the community options that are available to them so that they can make an informed decision about where they want to live, work, and receive services.
- The DHB will use a portion of the enhanced FMAP under the American Rescue Plan Act of 2021 to expand Healthy Options Care Needs screening to HCBS beneficiaries.²²
- Pending CMS approval, the DHB will use a portion of the enhanced FMAP for bridge funding to cover transition support for individuals moving from institutional and congregate care settings into independent living.
- The Division of State Operated Healthcare Facilities (DSOHF) will continue to articulate specific stabilization goals, timeframes, and expectations for an individual's transition back to the community via the State Developmental Centers' Memorandum of Agreement with the individual and their family or guardian.
- The DSOHF is seeking and will incorporate stakeholder input as an initial step to developing a new strategic plan, to be completed by December 31, 2022, for the State Developmental Centers.
- The State Developmental Centers will establish Centers of Excellence for testing service models and approaches to support individuals with I/DD in the community. These will provide training, technical assistance, and consultation for community providers to build their expertise in supporting individuals with challenging and complex needs, thereby reducing reliance on future admissions to the Centers.
- The DHHS will develop an on-demand, Informed Decision Making (IDM) webinar for the LME/MCO staff and local DSS guardians.
- The DHHS will expand and monitor the use of Consumer Engagement IDM tool beyond TCL.
- The DHHS will expand the Barriers Committee, which helps to resolve barriers to community living for the TCL population, to all *Olmstead* populations.
- The DAAS will expand to statewide the use of the Screening and Priority Services tool, or an alternative tool, for prioritization of services.
- The DHHS will collect data on ambulance transports to locations other than emergency departments to assist in quantifying the need for expanded peer-run respite services.
- The DHHS will develop steps in its Strategic Housing Plan to bridge transitions between institutional settings and permanent housing. Efforts will encompass individuals discharged

²² North Carolina Department of Health and Human Services, Division of Health Benefits (2021). [North Carolina spending plan for the implementation of the American Rescue Plan Act of 2021, Section 9817 10% FMAP increase for Home and Community-Based Services](https://medicaid.ncdhhs.gov/media/9910/open) [PDF]. <https://medicaid.ncdhhs.gov/media/9910/open>

from, or at risk of entering, institutional settings, including jails and prisons. Additional focus on access to housing and community-based supportive services will facilitate successful reentry to the community.

Baseline Data/Targeted Measures for Priority Area 3

Baseline Data for Priority Area 3

Since the program was launched in 2009, NC Medicaid's MFP program has transitioned 395 older adults, 442 people with physical disabilities (under the age of 65) and 636 individuals with I/DD from nursing facilities, hospitals, ICF/IIDs, and psychiatric residential treatment facilities (PRTFs).

In State Fiscal Year 2020, the number of individuals discharged from state psychiatric hospitals to TCL and supported housing increased by 28 percent from fiscal year 2019, and the number of individuals with SMI referred to ACHs decreased by 33 percent.²³

In State Fiscal Year 2020, specially trained emergency medical services (EMS) workers in five counties in North Carolina (Forsyth, Orange, Stokes, McDowell, and Onslow) responded to behavioral health emergencies, reporting 1,565 community behavioral health paramedicine encounters. Of those encounters, 380 were treated on the scene and required no transport to a higher level of emergency response; another 159 encounters resulted in the individuals being transported to alternative emergency response facilities (e.g., behavioral health urgent care centers or facility-based care centers) instead of to hospital emergency departments.

As of July 2021, ten providers in five of the sixteen Area Agencies on Aging reported using the Screening and Priority Services Tool. Four Area Agencies on Aging had offered training on use of the tool.²⁴

Peer-run crisis centers have diverted 380 individuals (24%) from inpatient admissions and transitioned 159 individuals (10%) from emergency department stays.

In State Fiscal Year 2021, 240 individuals in recovery from substance use disorders, including opioid use disorder, were mentored and transitioned from incarceration into a North Carolina Oxford House.

²³ North Carolina Department of Health and Human Services (2021). [2019-2020 annual report of the North Carolina Transitions to Community Living Initiative](https://www.ncdhhs.gov/media/10458/open) [PDF]. Report to the Joint Legislative Oversight Committee on Health and Human Services, <https://www.ncdhhs.gov/media/10458/open>

²⁴ North Carolina Department of Health and Human Services (2018, November 18). [NC Area Agencies on Aging locations](#) [PDF].

In calendar Year 2021, RSVP received 1,335 valid referrals for TCL's population 5 category²⁵; 827 individuals within population 5 were screened as TCL-eligible and did not go to an ACH.²⁶

In Fiscal Year 2021, 111 individuals with SMI, or co-occurring mental illness and substance use disorder, who were homeless or at risk of homelessness received Projects for Assistance in Transition from Homelessness (PATH) services.

Targeted Measures for Priority Area 3

- In each of Fiscal Years 2022 and 2023, MFP will support 68 transitions to the Innovations waiver and 3 transitions to the TBI waiver.
- By December 31, 2023, the DHHS will transition 750 individuals from ACHs.
- By December 31, 2023, 400 individuals will receive bridge funding to transition from institutional and congregate care settings to independent living.
- By June 30, 2023, at least eight Area Agencies on Aging and 30 providers will be using the Screening and Priority Services Tool.
- The North Carolina Council on Developmental Disabilities' reentry initiative will assist in the transitions of 100 individuals with I/DD in 2022 and 60 more in the first six months of 2023 from certain jails and prisons into the community, supporting these individuals to access necessary supports and services, thereby reducing recidivism.²⁷

Priority Area 3 Resource Requirements

The cost of these initiatives will be covered by enhanced FMAP under the American Rescue Plan Act of 2021, pending CMS approval, and by Mental Health Block Grant set-aside funds; other federal funds; LME/MCO and Tailored Plan contracts; and existing state funds. Additional state funds may be requested as needed from the North Carolina General Assembly.

²⁵ TCL's category 5 is comprised of individuals diverted from entry into adult care homes pursuant to the preadmission screening and diversion provisions of the settlement agreement.

²⁶ Individuals diverted from entry into an adult care home pursuant to the preadmission screening and diversion provisions established by the state.

²⁷ North Carolina Council on Developmental Disabilities (2020). [Justice: Release, reentry and reintegration](https://bit.ly/3oUAGy8) [PDF]. <https://bit.ly/3oUAGy8>

Priority Area 4: **Increase Opportunities for Supported Education and Pre-employment Transition Services for Youth with Disabilities, and Competitive Integrated Employment for Adults with Disabilities**

What Priority Area 4 Means

Supported education is a person-centered approach that provides students with I/DD and mental health disorders the opportunity to pursue post-secondary education options. Pre-employment transition services (Pre-ETS) are described in the Workforce Investment Opportunity Act (WIOA). The DVRS is required to provide these services to students with disabilities, 14 to 21 years of age, in collaboration with Local Education Agencies for all eligible and potentially eligible students with disabilities. The DVRS also continues to provide vocational rehabilitation services to youth and adults with disabilities, 14 years of age and older, to assist them in reaching their goal of competitive, integrated employment (CIE).

Why Priority Area 4 is Important

Supported education assists individuals with mental health disorders in gaining access to the types of employment that meet their interests and abilities and increases their ability to be self-sufficient by earning above minimum wage, through post-secondary education. Pre-ETS provides students with job exploration counseling, work-based learning experience, counseling on employment options, workplace readiness training, and instruction in self-advocacy. CIE assists individuals with disabilities to increase their dignity, self-sufficiency, and quality of life, resulting in more positive outcomes than sheltered employment.

Participation in supported employment is a requirement in the U.S. Department of Justice TCL settlement agreement; 2,500 covered individuals are to be receiving supported employment services to meet the agreement's requirement of "substantial compliance" with respect to employment. However, according to the 2019 report of the Independent Reviewer designated by the Department of Justice to monitor North Carolina's compliance with the TCL settlement agreement, "the number of individuals in the TCL target population receiving Individual Placement and Support - Supported Employment (IPS/SE) remains low and IPS/SE teams struggle to improve their performance. Data supports that there are many more individuals in the TCL population who want the opportunity to go to work or back to work." In State Fiscal Year 2021, Access to Supported Employment had the lowest mean score of 22 Transitions to Community Living (TCL) performance indicators.

North Carolina's Priority Area 4 Efforts to Date

Supported Education/Pre-employment Transition Services for Youth

- ✓ The DVRS has 84 third-party cooperative agreements with school systems across the state in which the school systems contribute to the cost of dedicated vocational rehabilitation staff serving students with disabilities who express interest in CIE.
- ✓ The DMH/DD/SAS was awarded a U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) Healthy Transitions grant, targeted for transition-age youth and young adults²⁸; the grant focuses on screening, assessment, referral, and coordination of services, including access to employment and education services and supports.
- ✓ With the DVRS's active participation on the State Transition Team, joint trainings for Local Education Agencies and local vocational rehabilitation transition staff, developed in partnership with Department of Public Instruction, resulted in an analysis of local needs and goal-setting to address gaps in areas related to CIE.

Competitive, Integrated Employment

- ✓ In March 2019, the Cooper administration declared North Carolina an Employment First state under Executive Order No. 92, affirming that individuals with disabilities can and should be valued members of the competitive work force.²⁹
- ✓ The DHHS supports CIE for individuals with serious mental illness using the evidence-based practice of IPS/SE. This service is an entitlement for Medicaid beneficiaries and is available as funds allow for individuals supported with state funding.
- ✓ Supported employment is a covered service for participants in the Innovations waiver, TBI waiver, and available via (b)(3) services, as well as state-funded services.
- ✓ North Carolina's first episode psychosis program consists of three pilot sites³⁰; each site has a Supported Employment and Education specialist.
- ✓ In partnership with the North Carolina Business Committee on Education, the DVRS, North Carolina State University, and Wake Technical Community College, targeted community rehabilitation providers have developed Science, Technology, Engineering, and Math, including Computer Science (STEM/CS) internships for neuro-diverse individuals resulting in an 80-percent rate of hire.

²⁸ A student with a disability, age 14 to 22, is eligible for transition services as part of their Individualized Education Plan (IEP), so long as that student is enrolled in a public school, which includes charter schools.

²⁹ [North Carolina Executive Order No. 92: Employment First for North Carolinians with disabilities](#) (March 28, 2019).

³⁰ Mental Health Services - First Psychotic Symptom Treatment Session Law, 2018-5, Section 11L.1(x), [Report to the House Appropriations Committee on Health and Human Services And Senate Appropriations Committee on Health and Human Services And Fiscal Research Division](#) by North Carolina Department of Health and Human Services December 23, 2019. Retrieved 11/05/21 from <https://www.ncdhhs.gov/media/9295/download>

- ✓ Effective October 1, 2021, DVRS-funded work adjustment training must be provided in an integrated location, offer a choice of three, broad, occupational categories, and pay at least minimum wage for work performed.
- ✓ The DMH/DD/SAS directly provided or supports numerous trainings to increase referrals to IPS/SE:
 - An IPS/Employment and Recovery training provided to all six LME/MCOs gave LME/MCO staff responsible for In-reach, Utilization Management, Transition and Network Management a better understanding of the intersection of employment and recovery.
 - An 'In or At Risk' training, provided on 10/28/21, reviewed the In or At-Risk checklist data, and state expectations for improvement, along with recommendations, strategies, and plans for improvement.
 - The University of North Carolina Institute for Best Practices offers six IPS trainings quarterly.
- ✓ The Vaya, Trillium, and Alliance LME/MCOs have added an Employment Collaborative to include IPS/SE, Community Support Teams, Assertive Community Treatment (ACT), and Transition Management Services providers and service members to join forces, develop relationships, and learn about IPS/SE and how to refer eligible individuals to the service.

Please see [Appendix A](#) for additional North Carolina efforts to date.

Proposed Strategies for Priority Area 4

- The DHHS will work with the Department of Public Instruction to promote the inclusion of employment in every Individualized Education Plan (IEP).³¹
- The DHHS will strengthen efforts to coordinate employment services across agencies and systems to decrease reliance on segregated employment settings for youth, post-graduation.
- The DHHS is committed to expanding integrated, supported education and employment, including CIE and other meaningful day opportunities, for all individuals with disabilities, based upon each individual's informed choice and their unique circumstances and needs. The Department will continue its ongoing cross-division undertaking to improve supported employment opportunities for individuals with I/DD, including customized employment, and to align Medicaid- and state-funded supported employment services for these individuals with the Department's vision for integrated employment as part of Tailored Plan care management. The DHHS will expand a model in which services and supports will be provided to persons with I/DD to enable their employment in integrated community settings. These efforts will include helping individuals with I/DD prepare for and transition to CIE, following an individual's informed choice to explore and pursue CIE.

³¹ U.S. Department of Education (July 12, 2017). [Individuals with Disabilities Education Act: Sec. 300.320 Definition of individualized education program - Individuals with Disabilities Education Act](https://bit.ly/3ap1a2y), <https://bit.ly/3ap1a2y>

- The DSOHF will eliminate all State Developmental Center use of subminimum wage and will add programmatic offerings to allow for experiential, informed decision-making and better prepare individuals with skills to pursue CIE when they transition to a community setting.
- The DHHS will draw upon the experience of providers (e.g., Watauga Opportunities, Inc.) that have transitioned successfully from Adult Developmental Vocational Programs (ADVPs) to supported employment.
- The DHHS will solidify Medicaid coverage for supported employment through submission of a 1915(i) Medicaid State Plan Amendment and alignment of the supported employment service definition across funding streams.
- TCL program staff will monitor the LME/MCOs to improve their monitoring of and education for behavioral health service providers to increase IPS/SE referrals for TCL participants and other individuals with SMI/SPMI.
- The DHHS will provide trainings to DVRS, DMH/DD/SAS, and DHB employment provider agencies in evidence-based practices that support individuals to achieve CIE. Trainings will be conducted for two cohorts of 35 providers by the end of Fiscal Year 2022. The DHHS will provide two additional trainings, open to any service provider, outlining best practices in CIE (e.g., customized employment) for an additional 35 providers each. This statewide training effort will equip service providers to better assist all persons with disabilities in the pursuit of CIE at competitive wages, according to their informed choice.
- LME/MCO Tailored Plan staff will enhance assertive engagement in employment and education, along with strategies to address common barriers and obstacles, for members during In-Reach, transition planning, and after transitioning to supportive housing.
- The DMH/DD/SAS will continue transitioning reimbursement for IPS/SE for individuals with SMI/SPMI from fee-for-service to milestone payments. The DVRS anticipates establishing a milestone rate for work adjustment training in November 2022.
- The DAAS will continue to promote the Senior Community Service Employment Program (SCSEP), empowering low-income, older workers with disabilities to achieve economic independence while receiving training in community service activities that will assist them in gaining the marketable skills necessary to reenter the workforce.

Baseline Data/Targeted Measures for Priority Area 4

Baseline Data for Priority Area 4

In the 2018-19 In-Person Survey, National Core Indicators® (NCI)³² respondents in North Carolina were significantly below the NCI® national average in likelihood of having a paid

³² [National Core Indicators](#) (NCI) is a voluntary effort by public developmental disabilities agencies to measure and track their own performance. North Carolina participates in the NCI.

community job (12% vs. 19%), and significantly above the NCI® national average in not having a paid community job despite wanting one (58% vs. 44%).³³

In State Fiscal Year 2019, 4,817 individuals with a disability successfully exited the DVRS vocational rehabilitation program into CIE.

- ▶ 34 percent were transition-age youth.
- ▶ 34 percent were individuals with cognitive disabilities.
- ▶ 38 percent were individuals with a psychosocial disability.

In fiscal year 2019, 27.7 percent of individuals receiving state-funded developmental disability services authorized by the LME/MCOs received ADVP services, while only 1.1 percent received supported employment.

In federal Fiscal Year 2019, DSB vocational rehabilitation services were provided to 3,085 individuals with blindness or low vision.

From October 1, 2020 through August 30, 2021, the DVRS provided employment services to over 29,000 North Carolinians with disabilities and has provided pre-employment transition services in all 100 counties of the state, serving over 3,000 students with disabilities at a cost of \$8,678,871.

In Fiscal Year 2021, the DVRS purchased the following services for persons with disabilities in addition to directly provided services:

- | | |
|--|--|
| ▶ Job Placement and Supports for \$16.67M | ▶ Assessment for \$2.30M |
| ▶ Training for \$5.56M | ▶ Treatment for \$2.22M |
| ▶ Transportation and Maintenance for \$4.39M | ▶ Rehabilitation Technology for \$1.40M |
| ▶ Pre-Employment Transition Services for \$7.37M | ▶ Auxiliary and Other Services for \$1.61M |

In State Fiscal Year 2021, more than 3,150 individuals achieved goals for CIE after working with the DVRS.

In State Fiscal Year 2021, Employment First efforts by the DHHS and the Office of State Human Resources touched over 1,400 North Carolinians to further the goals of Governor's Executive Order 92.

³³ National Core Indicators – The National Association of State Directors of Developmental Disabilities Services and the Human Services Research Institute (2020). [In person survey \(IPS\) state report 2018-19, North Carolina report](https://bit.ly/2YHKNfh) [PDF]. <https://bit.ly/2YHKNfh>

North Carolina's Coordinated Specialty Care First Episode Psychosis programs reported that participants exceeded the national averages for "any time spent in work or school" and for "any time spent in work" by 12 months and 24 months, respectively.

The TCL rate for CIE is 39 percent.

Targeted Measures for Priority Area 4

- By December 31, 2022, the DVRS is committed to increasing by five percent the number of students with disabilities who are provided pre-employment transition services.
- By December 31, 2023, the DVRS will increase by five percent the number of vocational rehabilitation participants achieving CIE after having been provided supported employment or other on-the-job supports.
- North Carolina CSC FEP programs will report a two-percent increase above the national averages for "any time spent in work or school" by 12 months and 24 months, and for "any time spent in work" by 12 months and 24 months.
- By the end of Fiscal Year 2022, the DHHS will conduct training with two cohorts of 35 DVRS, DMH/DD/SAS, and DHB employment provider agencies on evidence-based practices that support individuals to achieve CIE. The DHHS will provide two additional trainings, open to any service provider, outlining best practices in CIE (e.g., customized employment) for an additional 35 providers each.
- By December 31, 2023, increase by five percent the number of individuals receiving state-funded and Medicaid funded supported employment services authorized by the LME/MCOs for individuals with an I/DD.
- By December 31, 2022, increase by three percent over the previous calendar year the number of participants who exit the DSB vocational rehabilitation program in unsubsidized CIE.
- The DVRS has committed to ensuring that at least 34 percent of career training program participants will receive a measurable skill gain to help them achieve their employment goal.
- By June 30, 2023, increase by 16 percent IPS/SE service (through IPS/SE or ACT) to TCL members and/or CIE rates.

Resource Requirements for Priority Area 4

The cost of these initiatives will be covered using federal vocational rehabilitation awards, educational funds, aging funds, LME/MCO Tailored Plan contracts, and existing state funds. Additional state funds may be requested as needed from the General Assembly. These goals are set by the DHHS and the listed divisions; funds will be expended as made available, according to funding guidelines.

Priority Area 5: Increase Opportunities for Inclusive Community Living

What Priority Area 5 Means

Inclusive community living requires access to safe, decent, and affordable housing and individualized services and supports. People with disabilities are able to live in homes, apartments, and communities of their choice – and contribute to the communities – when they have access to the services and supports they may need. Affordable, accessible housing paired with individualized services and supports helps to ensure individual well-being.

Why Priority Area 5 is Important

Housing is one of the most researched social determinants of health. Selected housing interventions have been found to improve health outcomes and decrease health care costs.³⁴ People who are chronically homeless face substantially higher morbidity associated with both physical and mental health conditions and increased mortality. People who are not chronically homeless, but face housing instability (in the form of moving frequently, falling behind on rent, or couch surfing), are more likely to experience poor health in comparison to their stably housed peers.³⁵ Residential instability is associated with health problems among youth, including increased risks of teen pregnancy, early drug use, and depression.³⁶

Conversely, research shows that providing safe, decent, and affordable housing with voluntary individualized services and supports is more cost-effective than institutional or congregate housing options; is better aligned with individual housing preferences; and demonstrates positive outcomes such as reduced hospitalizations and homelessness, increased housing stability, and improved behavioral and physical health.³⁷ Permanent supportive housing (PSH) combines lease-based, permanent affordable housing in the community with voluntary, flexible, and individualized services to support successful tenancies, and is an evidence-based practice for individuals with serious mental illness and/or substance use disorders and for individuals who are homeless or are at risk of becoming homeless. Supported living is the more commonly used term in the context of individuals with I/DD or a traumatic brain injury and is a covered service within the Innovations waiver.

Research has also established the correlation between environmental factors within homes, such as lead exposure, mold, pest infestation and over-crowded living conditions, and poor

³⁴ Taylor, L. (2018, June 7). [Housing and health: An overview of the literature](https://bit.ly/3Bzdidp), *Health Affairs*, <https://bit.ly/3Bzdidp>

³⁵ Taylor, L. (2018, June 7). [Housing and health: An overview of the literature](https://bit.ly/3Bzdidp), *Health Affairs*, <https://bit.ly/3Bzdidp>

³⁶ Taylor, L. (2018, June 7). [Housing and health: An overview of the literature](https://bit.ly/3Bzdidp), *Health Affairs*, <https://bit.ly/3Bzdidp>

³⁷ Taylor, L. (2018, June 7). [Housing and health: An overview of the literature](https://bit.ly/3Bzdidp), *Health Affairs*, <https://bit.ly/3Bzdidp>

health outcomes.³⁸ Many studies focusing on improving health have demonstrated positive results through improved housing quality and safety.³⁹

There is an affordable housing crisis in North Carolina (and nationally). While the cost of housing varies geographically, a person with a disability receiving Supplemental Security Income (SSI) in North Carolina would have to pay 99 percent of their monthly income to rent an efficiency unit and 102 percent of their monthly income for a one-bedroom unit, making independent living unaffordable without rental assistance. Key Rental Assistance is the only state-funded subsidy program that is “disability neutral,” that is, not targeted to any particular group of people with disabilities.

Housing is a requirement within the TCL settlement agreement with the U.S. Department of Justice.

North Carolina's Priority 5 Efforts to Date

Access to Safe, Decent, and Affordable Housing

- ✓ The DHHS has contracted for the development of a Strategic Housing Plan that will serve as a roadmap for the expansion of affordable housing capacity for North Carolinians with disabilities. A Housing Leadership Committee was established to assist with plan development and includes representatives from state and local housing partner agencies, housing and service providers, people with lived experience, family members, advocates, and others.
- ✓ Per North Carolina's Consolidated Plan, 200 Low Income Housing Tax Credit units are set aside each year for individuals with disabilities; 10 percent of the units must be accessible.⁴⁰
- ✓ In 2020, the North Carolina Housing Finance Agency applied for and was awarded \$7,000,000 for U.S. Department of Housing and Urban Development (HUD) Section 811⁴¹ Project Rental Assistance units with about 188 apartments targeted for individuals with disabilities transitioning from or at risk for institutionalization.
- ✓ North Carolina sought and received HUD approval for a remedial preference for individuals with SMI/SPMI who are living in an ACH or who are at risk of entry into an ACH. This preference enables individuals with SMI/SPMI who are being diverted or discharged from an ACH to have priority access to a number of newly created housing units.

³⁸ Taylor, L. (2018, June 7). [Housing and health: An overview of the literature](https://bit.ly/3Bzdldp), *Health Affairs*, <https://bit.ly/3Bzdldp>

³⁹ Taylor, L. (2018, June 7). [Housing and health: An overview of the literature](https://bit.ly/3Bzdldp), *Health Affairs*, <https://bit.ly/3Bzdldp>

⁴⁰ North Carolina Housing Finance Agency (n.d.). [Low-Income Housing Tax Credits](https://bit.ly/3ApwGrP), Retrieved October 10, 2021 from <https://bit.ly/3ApwGrP>

⁴¹ Schaak, G., and Sloane, L. (2015). [Section 811 Supportive Housing for Persons with Disabilities program](https://bit.ly/3mXL0n1) [PDF]. *Advocates' Guide 2015*. Washington, D.C.: National Low-Income Housing Coalition. <https://bit.ly/3mXL0n1>

Access to Housing-Related Services and Supports

- ✓ In 2016, the DHHS established a service definition for supported living.⁴² Supported living enables people with significant disabilities to live in their own homes. A person who experiences a disability partners with an organization, family, friends, and community resources to experience life in a way that results in:
 - A safe and decent home of one's own
 - Personalized assistance
 - Choice
 - Support from others who care about and respect the person
- ✓ The North Carolina Council on Developmental Disabilities (NCCDD), with support from the state's MFP program, funded a three-year grant to the Vaya Health LME/MCO to launch and expand supported living services across the state. The NCCDD also produced a resource web page on the topic.⁴³
- ✓ In 2020, the DHHS amended the Innovations waiver to allow individuals receiving Supported Living Level 3 to exceed the \$135,000 cap.
- ✓ 2,957 individuals are currently in supportive housing through TCL, and 4,573 have been housed over the life of the program.⁴⁴
- ✓ The DHHS embedded housing-related services and supports into Medicaid policy and the state-funded Community Support Team service definition to support and sustain reimbursement.
- ✓ A state-funded program unique to North Carolina, DVRS's Independent Living Rehabilitation Program (ILRP), helps individuals with disabilities integrate into the community. The ILRP prioritizes people in institutional settings; people who can be diverted from institutionalization; and individuals who need support to maintain community-based living.
- ✓ The General Assembly approved an increase to \$1,228 per month for state-county Special Assistance/In-Home program participants.

Please see [Appendix A](#) for additional North Carolina efforts to date.

⁴² North Carolina Council on Developmental Disabilities (2020). [Justice: Release, reentry and reintegration](https://bit.ly/3oUAGy8) [PDF]. <https://bit.ly/3oUAGy8>

⁴³ North Carolina Council on Developmental Disabilities (n.d.). [Supported living guidebook/resource manual](https://bit.ly/3AFXu7D). Retrieved October 10, 2021 from <https://bit.ly/3AFXu7D>

⁴⁴ North Carolina Department of Health and Human Services (2021). [2019-2020 annual report of the North Carolina Transitions to Community Living Initiative](https://www.ncdhhs.gov/media/10458/open) [PDF]. Report to the Joint Legislative Oversight Committee on Health and Human Services. <https://www.ncdhhs.gov/media/10458/open>

Proposed Strategies for Priority Area 5

Increase Access to Safe, Decent and Affordable Housing

- The DHHS will issue a Strategic Housing Plan for Individuals with Disabilities in the spring/summer of 2022. The Strategic Housing Plan will be based on the Olmstead Plan Stakeholder Advisory (OPSA) Housing Committee's Driver Diagram (See [Appendix C](#)).
- The DHHS will support HUD housing providers, for example The Arc of NC, in their efforts to gain more flexibility in the use of existing housing and vouchers.

Increase Access to Housing-Related Services and Supports

- The DHB will issue clarification about the criteria that allows individuals receiving Supported Living Level 3 to exceed the \$135,000 cap.
- The DHHS will encourage the LME/MCOs and subsequently their Tailored Plans to utilize "In Lieu Of" services to offer the individualized services and supports necessary to provide their members with community-based alternatives to institutional and congregate care settings.
- The DHHS will expand Community Inclusion pilots, beyond Eastpointe and Alliance LME/MCOs, to enhance promotion of successful tenancy and housing retention for the TCL population.
- The DSOHF State Developmental Centers will provide opportunities for individuals receiving services at the State Centers to learn about supported living and to meet with individuals with I/DD who are living in the community with supported living services and supports.
- The DHHS and system partners will promote the NCCDD's Supported Living Guidebook/Resource Manual for Individuals with I/DD.⁴⁵
- The DHB will include performance measurements related to housing stability in Tailored Plans, with incentives for high performance.
- The DVRS will expand efforts towards a comprehensive array of services and service delivery, and access to assistive technology, mobility, and transportation to support individuals in independent living.

Baseline Data/Targeted Measures for Priority Area 5

Baseline Data for Priority Area 5

In 2019, the DSB served 1,109 eligible individuals (365 through Independent Living Rehabilitation and 744 through Independent Living Older Blind). The DSB also held 33 daily living skills classes, attended by 380 eligible individuals.

⁴⁵ North Carolina Council on Developmental Disabilities (n.d.). [Supported living guidebook/resource manual](#). Retrieved October 10, 2021 from <https://bit.ly/3AFXu7D>

As of December 2020, 114 individuals supported by the Innovations waiver resided in Supported Living Level 1; 126 individuals resided in Supported Living Level 2; and 85 individuals resided in Supported Living Level 3 – for a total of 325.

Targeted Measures for Priority Area 5

- Measures for increasing access to safe, decent affordable housing are deferred, pending release of the Strategic Housing Plan in 2022.
- By June 30, 2022, the DHHS will house 750 additional TCL participants, including 450 from ACHs.
- By December 31, 2023, the DHHS will attain a 12 percent increase in the number of Innovations beneficiaries with I/DD utilizing Supported Living levels 2 and 3 to assist with living in their own home in the community.
- By December 31, 2023, the DHHS in partnership with the LME/MCOs will increase by five percent the number of individuals with TBI receiving Supported Living services to support greater independence in the community.
- By December 31, 2023 all LME/MCO Tailored Plans will implement Community Inclusion pilots.
- By December 31, 2023, 80 percent or more of ILRP participants will achieve their goal of living independently in their homes and communities.

Additional measures are deferred pending release of the NC Strategic Housing Plan in late spring 2022.

Resource Requirements for Priority Area 5

Upon release of the Strategic Housing Plan, the DHHS will work with the North Carolina Housing Finance Agency and other partners to maximize the use of federal, state, local, and private resources to develop accessible housing and to make housing affordable for individuals with disabilities. The LME/MCOs, and subsequently the Tailored Plans, are expected to fund Supported Living and “In Lieu Of” services.

Priority Area 6: Address Gaps in Services

What Priority Area 6 Means

Gaps in services occur when a service doesn't exist in the array, or when there is insufficient service capacity to meet the needs of individuals assessed as needing the service.

Why Priority Area 6 is Important

The lack of adequate community-based services and insufficient access to existing services are primary factors contributing to the admission to, and extended stay in, institutional settings for

individuals with disabilities. There is considerable variability in service penetration rates among disability populations across the different LME/MCOs.⁴⁶

Children

While overall numbers for psychiatric residential treatment facility utilization have been trending slightly downward, the proportion of children going out of state is increasing.⁴⁷ This is often due to lack of bed availability and lack of in-state provider specialization/training in the populations needing services. As a result of the COVID-19 pandemic, by December 2020, the rate of hospital emergency department discharges for pediatric patients with a behavioral health condition had increased by 70 percent over the prior year, according to the North Carolina Healthcare Association's patient data system.⁴⁸ Emergency department visits are also often the result of an inadequate array of community-based services or of inadequate access to the services that exist.

Adults

The DHHS has made progress in reaching milestones established for the TCL settlement agreement with the Department of Justice but continues to be challenged with supporting individuals outside of segregated settings. In June 2021, 63 of the nearly 3,000 TCL members who were housed did not remain stably housed in the community. Several of these TCL members expressed their desire to return to the congregate ACH setting as a result of isolation and feelings of loneliness that were amplified by the COVID-19 pandemic.

Older Adults

One in three North Carolina residents who is age 65 or older has at least one disability.⁴⁹ The presence of a disability often contributes to social isolation and increases the likelihood of depression, substance use disorders, and poor health care outcomes. A nationwide survey conducted by Cigna Healthcare reported that three in five adults now struggle with feelings of loneliness.⁵⁰ This figure has increased by 13 percent since 2018.

North Carolina's Priority 6 Efforts to Date

- ✓ The DHHS established the Division of Child and Family Welfare, which will focus on supporting whole child and family health for North Carolinians, including all child nutrition programs (the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC], the Supplemental Nutrition Assistance Program [SNAP], and the Child and Adult

⁴⁶ The service penetration rate is based on the number of unduplicated eligible individuals and consumers who have received at least one billable service during the fiscal year.

⁴⁷ Per conversation with DMH/DD/SAS staff.

⁴⁸ Strickland, S. (2021, June 14). [Letter: Behavioral health crisis across North Carolina has reached a state of emergency](https://bit.ly/3ByL2b0). North Carolina Healthcare Association. <https://bit.ly/3ByL2b0>

⁴⁹ U.S. Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities (n.d.). [Disability impacts North Carolina](https://bit.ly/3oWLpZv) [PDF], <https://bit.ly/3oWLpZv>

⁵⁰ Cigna Newsroom (n.d.). [Loneliness is at epidemic levels in America](https://bit.ly/3j8SLW7). Retrieved September 10, 2021 from <https://bit.ly/3j8SLW7>

Care Food Program [CACFP]); the full range of prevention services for children beginning at birth; children's mental health services; and early intervention programs.

- ✓ All LME/MCOs support high fidelity wraparound as an "In Lieu Of" service. The DHHS is piloting the use of youth peers, embedded in high fidelity wraparound teams with a case manager and a family partner.
- ✓ The Rapid Response Team for Crisis Care Management was created in December 2020 to address the immediate needs of DSS-involved children in emergency departments, local Departments of Social Services, or other inappropriate settings. The team meets regularly to respond to referrals from local DSS or LME/MCOs when crises exist, and takes swift action to address the immediate need.
- ✓ The DHHS was awarded a SAMHSA grant to support crisis system redesign.
- ✓ The DHHS' TBI waiver renewal application will expand the waiver and supported living services to an additional catchment area, allowing more individuals with TBI to live at home with supports.
- ✓ The DSOHF has implemented outpatient programs at the Alcohol and Drug Abuse Treatment Centers (ADATCs) to enhance the array of services available to support individuals with substance use disorders and co-occurring mental health disorders.
- ✓ The General Assembly approved an extension of Medicaid coverage for 12 months postpartum for pregnant women with incomes equal to or less than 196 percent of the federal poverty level.

Proposed Strategies for Priority Area 6

North Carolina will fill gaps in services by identifying and applying population-specific, evidence-based, best and promising practices to support individuals with disabilities.

Strategies for Children

- The DHHS will seek approval from CMS to allow a parent to retain Medicaid eligibility when the child is being served temporarily by the foster care system, regardless of the type of out-of-home placement, and the parent is making reasonable efforts to comply with a court-ordered plan of reunification.
- The DHHS will expedite efforts to enhance the array of high-quality, community-based services and supports to address the needs of children and families, thereby reducing the number of children and youth admitted to in-state and out-of-state PRTFs:
 - Expand the availability of mobile crisis services to children using the MORES model, including training staff in the provision of crisis services to children and a family peer support component, to divert inpatient admissions and out-of-home placements for treatment.

- Implement Sobriety Treatment and Recovery Teams (START), a specialized child welfare service delivery model that has been shown, when implemented with fidelity, to improve outcomes for children and families affected by parental substance use and child maltreatment.
- Promote use of the North Carolina Psychiatry Access Line (NC PAL), telephone consultation to connect pediatricians and primary care physicians with child psychiatrists to improve diagnoses and to reduce polypharmacy for children.
- Scale the reach of high-fidelity wraparound services from 33 counties to availability statewide.
- Implement facility-based and in-home respite service pilots for foster parents, birth parents, and adoptive families caring for children with behavioral health needs.
- Per Session Law 2021-132 (Senate Bill 693), “develop a plan to increase the supply of appropriate treatment and residential settings for minors in need of behavioral and mental health services.”
- Refine the Rapid Response Team process to improve timeliness of response and outcomes.
- Expedite licensure for time-sensitive services/programs to allow children prompt access to services in the community.
- The DHHS will enhance access to children’s mental health services by expanding mental health services in primary care, schools, and specialty care.
- The DHB will work with Standard Plans and LME/MCO Tailored Plans to continue to promote children’s access to personal care services via Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and its coverage of Health Check.
- LME/MCOs, and eventually Tailored Plans, will increase the availability of high-fidelity wraparound services, care coordination, and therapeutic foster care families.
- The DHHS, in partnership with the LME/MCOS, will increase the supply of outpatient therapists trained to treat children with co-occurring mental health disorders and I/DD.

Strategies for Adults

- The DHHS will continue advocating for Medicaid expansion, which would provide an estimated 600,000 North Carolinians with health care coverage for chronic conditions, reducing opioid-related complications and improving mental health.⁵¹
- The DHB will submit a 1915(i) state plan amendment to transition Medicaid coverage for selected (b)(3) services for children and adults.

⁵¹ Per communication with DHHS staff.

- The DMH/DD/SAS will enhance crisis response services and increase access to them using American Rescue Plan Act funds.
- The DMH/DD/SAS will work with peer-run organizations to quantify existing, peer-run services and to determine meaningful targets for future DHHS support of peer-run services.
- The DHHS will expand research-based, behavioral health treatment services for adults with autism.
- The DHHS will expand core, community-based services for individuals with TBI, including cognitive rehabilitation, life skills training, and neuro-behavioral programming.

Strategies for Older Adults

- The DAAS, in partnership with Centers for Independent Living and others, will organize a cross-departmental effort to address senior social isolation.
- Issue one-time payments focused on social drivers of health to strengthen services to this vulnerable population incident to the heightened challenges caused by COVID-19.
- Make Senior Centers more welcoming to individuals with I/DD, TBI, and SMI.

Baseline Data/Targeted Measures for Priority Area 6

Baseline Data for Priority Area 6

Among all individuals with SMI or Serious Emotional Disturbance (SED) served in community mental health programs in North Carolina, only 2.5 percent are ages 0-12 compared to 29.3 percent in this age group nationally.⁵²

As of March 31, 2021, 410 North Carolina children with Medicaid were placed in an in-state PRTF.

As of March 31, 2021, 248 North Carolina children with Medicaid were placed in an out-of-state PRTF.⁵³

In federal Fiscal Year 2018, 22 counties in North Carolina had no child psychiatric providers, and six counties had only one provider per 10,000 Medicaid-enrolled youth; eight counties did not have any pediatric provider.⁵⁴

In 2019, two Children's Mobile Crisis Teams were implemented.

⁵² U.S. Substance Abuse and Mental Health Services Administration (2020). [North Carolina 2019 Mental Health National Outcome Measures \(NOMS\): SAMHSA Uniform Reporting System \(URS\)](https://bit.ly/3Byvgww) [PDF]. Page 5. <https://bit.ly/3Byvgww>

⁵³ An out-of-state facility may be the closest facility to the child's home depending on where the child lives.

⁵⁴ NC-PAL (n.d.). [North Carolina – Psychiatry Access Line](https://ncpal.org/node/3). Retrieved August 24, 2021 from <https://ncpal.org/node/3>

In North Carolina's 2019 report to SAMHSA, community mental health services utilization per 1,000 people was 9.16 percent, well below the national average of 23.88 percent.⁵⁵

63 of nearly 3,000 individuals housed by TCL did not remain stably housed due to the lack of social connectedness.

As of August 2021, there were 3,945 individuals receiving Special Assistance/In-Home. This includes 1,017 individuals served through TCL.

In Fiscal Year 2018, of the 36,068 individuals with TBI who received one or more behavioral health services, 6,450 received crisis services; 1,280 lived in a skilled nursing facility; and 910 lived in a congregate care setting other than a skilled nursing facility.

Targeted Measures for Priority Area 6

- Children at risk of out-of-home placement will receive the evidence-based practice of high fidelity wraparound services when appropriate to divert such placements.
- By December 31, 2023, the DHHS will reduce by 10 percent the number of children placed in North Carolina-based PRTFs.
- By December 31, 2023, the DHHS will reduce by 50 percent the number of children placed in out-of-state PRTFs.
- By July 2022, five additional Children's Mobile Crisis Teams will be operational.
- By December 31, 2022, fifty adults over age 21 with Autism Spectrum Disorder will receive research-based, behavioral health treatment.
- The DMH/DD/SAS will provide a minimum of five, TBI-specific trainings to community-based providers, statewide, through in-person, webinar, or online training module formats.
- The state-county Special Assistance/In-Home standard monthly payment will increase for adult participants.

Resource Requirements for Priority Area 6

The DHHS will access Coronavirus Aid, Relief, and Economic Security (CARES) Act funding; American Rescue Plan Act funding, including enhanced FMAP; federal Medicaid revenue ongoing; federal block grant funds; and existing state funds.

⁵⁵ U.S. Substance Abuse and Mental Health Services Administration (2020). [North Carolina 2019 Mental Health National Outcome Measures \(NOMS\): SAMHSA Uniform Reporting System \(URS\)](https://bit.ly/3Byvgww) [PDF]. <https://bit.ly/3Byvgww>

Priority Area 7: Explore Alternatives to Full Guardianship

What Does Priority Area 7 Mean?

Guardianship is a legal process utilized when a person cannot make or communicate safe or sound decisions about their person and/or property as a result of incapacity, or when they have become susceptible to fraud or undue influence. Most individuals with disabilities are capable of making responsible decisions about many areas of their lives and need only limited decision-making supports, if any. The courts, however, may lack awareness of the tools available to assist individuals with disabilities to make informed decisions about their lives, and may order full guardianship, restricting the individual's rights beyond what is needed. Supported decision-making is an alternative to guardianship. In this approach, individuals with disabilities whose decision-making autonomy might otherwise be limited or removed make and communicate their own decisions, with informal support from trusted family and friends.⁵⁶

Why Priority Area 7 is Important

Guardianship can be a barrier to realizing the intent of *Olmstead*. Nationally, people with I/DD who do *not* have a guardian are more likely to:⁵⁷

- ▶ Have a paid job
- ▶ Live independently
- ▶ Have friends other than staff or family
- ▶ Go on dates and socialize in the community
- ▶ Practice the religion of their choice

Full guardianship is the most restrictive option for legal substitute decision-making; it continues to increase in North Carolina, specifically for younger adults with disabilities.⁵⁸

The MFP staff report that guardianship can impede the ability of some eligible individuals to benefit from the MFP program by keeping them in an institutional setting. Guardians can oppose an individual's transition from institutional care to the community, overriding the individual's desire to transition. The DHHS is working with public guardians and the LME/MCOs to identify individuals living in ACHs and foster care or group homes who don't have the opportunity to live

⁵⁶ [National Resource for Supported Decision-Making](http://www.supporteddecisionmaking.org). <http://www.supporteddecisionmaking.org>

⁵⁷ Nye-Lengerman, K., Narby, C., & Pettingell, S. (2017). [*How is guardianship status related to employment status for people with IDD? Findings from the National Core Indicators Adult Consumer Survey*](https://bit.ly/3ltYjvD). ThinkWork! Institute for Community Inclusion, University of Massachusetts Boston. <https://bit.ly/3ltYjvD>

⁵⁸ North Carolina Council on Developmental Disabilities (n.d.). [*Rethinking guardianship: Building a case for less restrictive alternatives*](https://nccdd.org/guardianship.html). Retrieved October 10, 2021 from <https://nccdd.org/guardianship.html>

in an integrated setting because of guardian objections. County Clerks of Court, who make guardianship decisions, rely on varying and sometimes inconsistent sources of information to make their determination.⁵⁹

North Carolina's Priority Area 7 Efforts to Date

- ✓ Session Law 2014-100 directed the DAAS to develop a plan to evaluate complaints pertaining to wards under the care of publicly-funded guardians. The plan promotes guardians' understanding of law and policy and supports guardians to act in the best interest of the individual.
- ✓ The Rethinking Guardianship North Carolina Statewide Workgroup has been in place since 2015, with the goals of promoting less restrictive alternatives to full guardianship and creating long-term changes in the state's guardianship system.
- ✓ TCL adopted the Informed Decision-Making (IDM) tool in 2020; the DHHS presented information on the tool to all 100 counties in North Carolina, targeting county DSS guardians.

Proposed Strategies for Priority Area 7

- Educate the community at large about supported decision-making and other alternatives to guardianship.
- Work with public and private guardianship agencies on supportive decision-making and other alternatives to guardianship.
- Meet with individuals and their guardians to identify barriers to transition and the lack of opportunities to make informed choices about community-based services.
- Work with the North Carolina General Assembly to develop a Bill of Rights for individuals subject to guardianship.
- Educate individuals subject to guardianship about the process for full or partial restoration of their rights.⁶⁰
- The DSOHF will provide educational resources and peer learning opportunities for individuals with I/DD to promote better understanding of self-advocates' rights and to strengthen self-advocates' abilities to advocate for themselves.
- The DAAS will support county DSS and the Corporation of Guardianship to expand competency restoration efforts using continuous quality improvement reviews, training, and consultation.

⁵⁹ Kendall Fields, L., Salmon, M. A., Marsh, S., Climo, A., Norris, T., & Nelson, G. (2018). *Rethinking guardianship: Building a case for less restrictive alternatives – final report*. Chapel Hill, NC: Jordan Institute for Families, School of Social Work, University of North Carolina. <https://bit.ly/3mJ9m3p>

⁶⁰ See, e.g., Wood, E. & Pogach, D. (2018). *Guardianship termination and restoration of rights* [PDF]. Washington, D.C.: National Center on Law and Elder Rights, <https://bit.ly/3mDF9Tr>

- The DHHS will propose reforms to General Statute 35A to provide a description of rights for respondents and adults subject to guardianship; improve access to legal counsel; eliminate the presumption of guardianship permanence through regular reviews; and encourage the use of supported decision-making and other less restrictive options to guardianship.

Baseline Data/Targeted Measures for Priority Area 7

Baseline Data for Priority Area 7

In State Fiscal Year 2021, out of more than 6,611 adults served by a public guardian in North Carolina, 4,137 (63%) were younger adults, age 18 to 59 years old; 2,561 (75%) of these younger adults have a primary diagnosis of I/DD or mental illness.

In State Fiscal Year 2021, 37 percent of the adults served by public guardians in North Carolina were older adults; 25 percent had a primary diagnosis of I/DD or mental illness.

Between July 1, 2012 and December 31, 2015, data from the Administrative Office of the Court shows that only three percent of individuals under guardianship sought to have competency restored, but that 70 percent of these were successful in receiving restoration.⁶¹

In State Fiscal Year 2021, 27 individuals had their competency restored.

Targeted Measures for Priority Area 7

- In 2022 and 2023, the DMH/DD/SAS will educate 100 individuals with I/DD and their families each year about the benefits of supported decision-making.
- By December 31, 2023, a total of 800 individuals with SMI/SPMI will use the IDM tool.
- By December 31, 2023, there will be a five-percent increase in individuals who seek to have competency restored.

Resource Requirements for Priority Area 7

The DHHS will utilize existing federal and state funds to cover the costs of these strategies and will request additional funds from the General Assembly if necessary.

⁶¹ Conversation with Linda Kendall Fields, October 5, 2021.

Priority Area 8: Address Disparities in Access to Services

What Priority Area 8 Means

In North Carolina, there are measurable differences in access to health care and services between white people with disabilities and people of color with disabilities. Access to health care and services also varies among geographical areas of the state.

Why Priority Area 8 is Important

These differences in access contribute to the overrepresentation of people of color with disabilities in more restrictive settings. Such settings separate these individuals, especially in rural areas, from the benefits of community inclusion, as well as from opportunities to achieve their full potential.

Whites compose 62 percent of North Carolina's population, African-Americans compose 20.5 percent of the state's population, Latinx/Hispanics compose 11.3 percent of the population, and American Indians and Alaska Natives compose 1.2 percent.⁶² However, the distribution of these groups varies within the population served by publicly funded services, and intentional efforts to address these differences are warranted.⁶³ The Centers for Disease Control and Prevention (CDC) acknowledges that social and economic differences often create health differences in communities of color, and that public health emergencies can isolate communities of colors from necessary resources.⁶⁴

Regarding geographic disparities, the percentage of individuals with a behavioral health diagnosis who received at least one service intended to be responsive to that diagnosis, relative to the estimated prevalence of behavioral health disorders, is different from county to county.

⁶² U.S. Census Bureau. [CEDSCI Profile: North Carolina](https://bit.ly/321RKt4). Retrieved March 25, 2021 from <https://bit.ly/321RKt4>

⁶³ Technical Assistance Collaborative, Inc. and Human Services Research Institute (2021). [An assessment of the North Carolina Department of Health and Human Services' system of services and supports for individuals with disabilities](https://bit.ly/3uZFBPB) [PDF]. Raleigh, NC: North Carolina Department of Health and Human Services, <https://bit.ly/3uZFBPB>

⁶⁴ U.S. Centers for Disease Control and Prevention (n.d.). [Racism and health](https://bit.ly/3aFLDvL), Retrieved October 10, 2021 from <https://bit.ly/3aFLDvL>

North Carolina's Priority Area 8 Efforts to Date

- ✓ The DHHS hired a Chief Equity Officer, responsible for developing, implementing, facilitating, and embedding health equity strategic initiatives into DHHS programs, services, actions, outcomes, and internal employee culture.
- ✓ The DHHS and the Cherokee Indian Hospital Authority have entered into a contract to support the Eastern Band of Cherokee Indians in addressing the health needs of American Indian/Alaska Native Medicaid beneficiaries.⁶⁵ This Indian Managed Care Entity, the first of its kind in the nation, will reflect tribal principles providing care coordination services in a culturally congruent system.
- ✓ The DHHS 2021-2023 Strategic Plan includes the goal to "Advance health equity by reducing disparities in opportunity and outcomes for historically marginalized populations within the DHHS and across the state."⁶⁶
- ✓ Since the spring of 2020, opportunities to use telehealth have expanded significantly, increasing access to treatment and case management services for individuals residing in rural communities.

Please see [Appendix A](#) for additional North Carolina efforts to date.

Proposed Strategies for Priority Area 8

- The DHHS will provide training and technical support to increase the number of highly qualified contracted providers from historically marginalized populations.
- The DHHS will require LME/MCOs to have a Diversity, Equity and Inclusion Committee to proactively address issues related to disparities and to collect and analyze race and ethnicity data on their members and service recipients, including individuals on the Registry of Unmet Need.
- The DHHS will require Tailored Plans and Standard Plans to collect and report quality data on race and ethnicity to assist the Department in assessing disparities.
- The DHHS will identify a vendor to provide quality translation of information/materials into the foreign languages most commonly spoken in North Carolina⁶⁷, and in alternative formats that are readily accessible for individuals with disabilities.
- The DHB is actively developing a Remote Supports definition, initially for the TBI waiver renewal, followed by the Innovations waiver. Pending CMS approval, the DHB will use

⁶⁵ North Carolina Department of Health and Human Services (October 3, 2021). [Eastern Band of Cherokee Indians \(EBCI\) tribal option overview](#). Retrieved October 10, 2021 from <https://bit.ly/3iQTlrb>

⁶⁶ North Carolina Department of Health and Human Services (2021). [NC Department of Health and Human Services 2021-2023 strategic plan](#) [PDF]. <https://bit.ly/3FCpb4A>

⁶⁷ Jensen, S. (2021, August 27). [The most commonly spoken languages in the Carolinas](#). CharlotteStories.com. <https://bit.ly/3DrCkVA>

enhanced FMAP to add remote technology support to the CAP/C and CAP/DA waivers to increase access to services for individuals living in rural areas of the state.

- The Office of Rural Health will support a robust network of community health workers to connect individuals to human services in historically underserved communities.
- The DMH/DD/SAS will focus efforts to address underserved populations, for example, individuals living in rural communities.

Baseline Data/Targeted Measures for Priority Area 8

Baseline Data for Priority Area 8

Black North Carolinians utilize 27 percent of community-based mental health services funded by the DMH/DD/SAS and 32.4 percent of those funded by Medicaid but represent 50.6 percent of all state psychiatric hospitalizations.

Black North Carolinians are disproportionately represented in the utilization of crisis services, representing 30 percent of the population in some communities but 50 percent of all crisis contacts.⁶⁸

Three of seven LME/MCOs do not track the race and ethnicity of individuals who are on the Registry of Unmet Needs; one LME/MCO collects the demographic information but does not analyze or report it.⁶⁹

Among the adult substance use disorder population, Duplin County had the lowest service penetration rate, at 12 percent, while Haywood County had the highest service penetration rate, at 58 percent, nearly five times higher.⁷⁰

Targeted Measures for Priority Area 8

- The DHHS will provide up to two webinars in calendar year 2022, and again in calendar year 2023, to increase the number of highly qualified, contracted providers from historically marginalized populations.
- The DHHS will increase by five percent the number of Black North Carolinians utilizing community-based mental health services, funded by the DMH/DD/SAS and Medicaid, to reduce overrepresentation among this population in the use of crisis services and state psychiatric hospital admissions.

⁶⁸ RI International, data presented on March 17, 2021 on a national stakeholders call for crisis services.

⁶⁹ Dupuch, C., Pfau, S., & Franklin, M. (2021). [Research findings and policy solutions to address the North Carolina Registry of Unmet Needs](https://bit.ly/3mGDBbl) [PowerPoint slides]. Downloaded October 10, 2021 from <https://bit.ly/3mGDBbl>

⁷⁰ North Carolina Department of Health and Human Services (2018). [Strategic plan for improvement of behavioral health services: Session Law 2016-94, Section 12F.10.\(a-d\); Session Law 2017-57, Section 11F.6.\(a-b\)](https://bit.ly/3DYqKYK), Retrieved March 25, 2021 from <https://bit.ly/3DYqKYK>

- All LME/MCOs will collect and analyze race, ethnicity, and gender data on their members, including individuals on the Registry of Unmet Need.

Resource Requirements for Priority Area 8

LME/MCO and Tailored Plan rates have been determined to be actuarially sound to cover the administrative costs and provide the services necessary to meet the contractual requirements for members. The DHHS will seek additional state funds from the General Assembly to cover costs outside the LME/MCO Tailored Plan contracts, if necessary.

Priority Area 9: Increase Input from Individuals with Lived Experience

What Priority Area 9 Means

Individuals with lived experience have firsthand knowledge about services and supports and the systems that provide these. Individuals are able to share a point of view and to provide vital information that those who represent or seek to respond to their interests may overlook or ignore.

Why Priority Area 9 is Important

Organizations that incorporate individuals with firsthand experience in developing, designing, and delivering services are better able to deliver services that are appropriately targeted, efficient, fully integrated, culturally appropriate, and sustainable. Individuals are less likely to participate in services that do not reflect their needs and interests.

Of all stakeholders participating in the Technical Assistance Collaborative's (TAC) Services and Systems Assessment listening sessions and online survey, the individuals most directly impacted by the service system were least represented, despite efforts to solicit their participation.⁷¹

North Carolina's Priority Area 9 Efforts to Date

- ✓ The MFP program has four stakeholder engagement meetings per year, each averaging an attendance of 200 or more. In addition, the program funds the facilitation of Supported Living Levels 2 and 3 stakeholder meetings and workgroups.
- ✓ In the fall of 2021, the NCCDD issued its federally required Five-Year Plan for FY 2022–2027, based on input received from over 500 individuals and families of individuals with I/DD.

⁷¹ Technical Assistance Collaborative, Inc. & Human Services Research Institute (2021). [An assessment of the North Carolina Department of Health and Human Services' system of services and supports for individuals with disabilities](https://bit.ly/3uZFBPB) [PDF]. Raleigh, NC: North Carolina Department of Health and Human Services. <https://bit.ly/3uZFBPB>

- ✓ In 2020, leaders from the DMH/DD/SAS held virtual Town Hall meetings throughout North Carolina to hear from consumers, families, and advocates about how the behavioral health and I/DD system was working and how the DHHS can advance a system that fosters independence, improves health, and promotes well-being for all North Carolinians.
- ✓ The DHHS has included meaningful representation of individuals with lived experience on the OPSA.
- ✓ Peer Voice of North Carolina is a SAMHSA-funded, grassroots nonprofit in Mecklenburg County. Peer Voices uses the voices, experiences, and resilience of people who have overcome trauma, mental health and substance use disorders, and related barriers to elevate recovery and wellness by providing a forum for individuals to participate actively in and influence mental health reform.

Please see [Appendix A](#) for additional North Carolina efforts to date.

Proposed Strategies for Priority Area 9

- The DHHS will continue to seek active participation in the OPSA by individuals with lived experience.
- The DHHS will explore ways to recognize financial costs associated with the time that people with lived experience contribute as members of DHHS workgroups and committees.
- The DHHS will explore opportunities to fund initiatives that give voice to and empower advocacy efforts of individuals with lived experience of behavioral health disorders, I/DD, TBI, and other disabilities.
- The NCCDD will make peer support training available for people with lived I/DD experience.
- The DHHS will continue to conduct My Individual Experience surveys of HCBS recipients.⁷²
- The DHHS will increase support of consumer-operated services.
- Introduce the option for state funds to support consumer-run services.
- The DHHS will promote and educate individuals about self-direction⁷³ during annual renewals of Individual Support Plans and for individuals receiving Medicaid-funded services for the first time.

Baseline Data/Targeted Measures for Priority Area 9

Baseline Data for Priority Area 9

Thirty-one percent of the 45 members of the 2021 OPSA are people with lived experience.

⁷² North Carolina Department of Health and Human Services (n.d.). [My individual experience survey](https://hcbsinfo.ncdhhs.gov/Home/myexperience). Retrieved December 9, 2021 from <https://hcbsinfo.ncdhhs.gov/Home/myexperience>.

⁷³ Centers for Medicare and Medicaid Services (n.d.). [Self-directed services](https://bit.ly/3m54UNd). Retrieved 11/5/21 from <https://bit.ly/3m54UNd>.

The DHHS will establish baseline data on consumer-operated services that support individuals with SMI, I/DD, and TBI.

Targeted Measures for Priority Area 9

- The DHHS will increase support for organized advocacy groups led by families and individuals with lived experience.
- After establishing baseline data, the DHHS will establish a target to increase support for consumer-operated services.

Resource Requirements for Priority Area 9

The DHHS will utilize existing federal and state funds, as well as LME/MCO Tailored Plan contracts, to cover the costs of these strategies.

Priority Area 10: Reduce Transportation Burdens for Individuals with Disabilities

What Priority Area 10 Means

Individuals with disabilities and older adults often lack the financial resources to own a vehicle or to afford public transportation when it exists. Many parts of North Carolina do not have public transportation such as buses, cabs, or ride-share drivers.

Why Priority Area 10 is Important

With limited or no transportation options, individuals with disabilities are unable to visit with family and friends and to access food and clothing stores, health care providers, recreation centers, and social activities – in other words, to become integrated members of their communities. A robust service array is of little benefit if individuals are not able to access the opportunities due to the lack of transportation.

North Carolina's Priority Area 10 Efforts to Date

- ✓ The DHHS obtained CMS approval to allocate up to \$650 million in state and federal Medicaid funding. Funding will cover the cost of providing select, Healthy Opportunities Pilot services related to housing, food, transportation, and interpersonal safety. These services directly impact the health outcomes and health care costs of Medicaid members.

Proposed Strategies for Priority Area 10

- Pending CMS approval, the DHB is proposing to add remote technology support to CAP/C and CAP/DA waivers.

- The DHHS will continue to expand telehealth and scope of practice flexibilities to reduce transportation burdens.
- The DHHS will work with Standard Plans, LME/MCOs and, subsequently, Tailored Plans to enhance Medicaid coverage for Non-Emergency Medical Transportation⁷⁴ in compliance with the Consolidated Appropriations Act of 2021.⁷⁵
- The DHHS will evaluate the impact of Healthy Opportunities Pilots' investment in transportation beyond medical services to support and facilitate community inclusion for Medicaid beneficiaries.
- The DHHS will promote opportunities for Peer Support Specialists and individuals with disabilities to establish ride-share arrangements.

Baseline Data/Targeted Measures for Priority Area 10

Baseline Data for Priority Area 10

The DHHS will seek to establish baseline data on the number of individuals in rural and underserved ZIP codes served through telehealth services.

Targeted Measures for Priority Area 10

- After establishing baseline data, the DHHS will set a target for increasing the number of people served through telehealth services in rural and underserved ZIP codes.

Resource Requirements for Priority Area 10

The DHHS will utilize, pending CMS approval, enhanced FMAP for HCBS; existing federal and state funds; and LME/MCO Tailored Plan contracts to cover the costs of these strategies.

Priority Area 11: Use Data for Quality Improvement

What Priority Area 11 Means

Regularly collecting and reporting data allows for objective assessment of the provision of services and progress towards achieving identified goals and measurement of outcomes, as

⁷⁴ North Carolina Department of Health and Human Services (2021, July 20). [Non-emergency transportation for NC Medicaid Managed Care](https://bit.ly/3mJcVXI). Retrieved September 30, 2021 from <https://bit.ly/3mJcVXI>

⁷⁵ Center for Medicaid and CHIP Services Informational Bulletin (July 12, 2021). [Medicaid coverage of certain medical transportation under the Consolidated Appropriations Act, 2021 \(Public Law 116-260\)](https://bit.ly/3FAGWpN) [PDF], <https://bit.ly/3FAGWpN>

opposed to strictly determining the number of services delivered. Data should be used in determining areas of service provision that need to be improved.

Why Priority Area 11 is Important

Data is essential for validating or refuting popular beliefs that, left unchecked, can create a false sense of reality, either positive or negative. However, data collection must serve a purpose. DHHS staff have reported that, in spite of ample data, they still have an incomplete picture of the quality of the services being delivered, and of the impact those services are having on recipients' lives.

There are numerous evidence-based and promising practices that demonstrate positive results. However, providers may elect not to transition to these practices absent incentives to do so. As stewards of federal and limited state funds, the DHHS should be driving service system transformation by requiring its contractors, LME/MCOs, and eventually the Tailored Plans to prioritize the expenditure of funding to develop a data-driven, service delivery system.

Finally, data analysis will be essential to determine the extent to which North Carolina is achieving its Olmstead Plan priorities.

North Carolina's Priority Area 11 Efforts to Date

- ✓ Behavioral Health I/DD Tailored Plans will be required to:
 - Develop quality management and improvement programs; quality assessment and performance improvement plans; and at least three performance improvement projects.
 - Achieve National Committee for Quality Assurance health plan accreditation with the Long-Term Services and Support Distinction for Health Plans by the end of Contract Year 3.
 - Report a wide range of quality metrics, including outcome metrics, with variations depending on whether the enrollee is receiving Medicaid- or state-funded services.
- ✓ DHHS staff are working with Manatt to develop a set of patient-reported outcomes measures (PROMs) for both Standard and Tailored Plans, intended to cover health-related quality of life, symptoms, consumer experiences, and health behaviors.
- ✓ DHHS staff are working with Mathematica to enhance TCL data quality and integration, performance measurement, and use of program data for evaluation and decision-making, and to establish a framework that can potentially assist in developing a quality assurance structure for the state's Olmstead Plan.
- ✓ The DHHS is developing a score card for LME/MCOs which will reflect data-driven performance on selected measures.
- ✓ The DMH/DD/SAS is expanding the data collected from providers who serve individuals under involuntary commitment to assess whether the commitment was necessary and appropriate.

- ✓ The DMH/DD/SAS is conducting performance audits of the LME/MCOs, targeting reviews of specific services to determine whether they are meeting service definition requirements.
- ✓ The DMH/DD/SAS is aligning financial incentives to support the delivery of research-based behavioral health services.

Proposed Strategies for Priority Area 11

- The DHHS will expand its capacity to utilize key data points, performance measures, and indicators to assess progress towards achieving Olmstead Plan priorities and revising priorities, strategies, and measures as necessary.
- The DHHS will invest in the technology needed to support more seamless data storage, integration, retrieval, and visualization across the Department.
- The DHHS will finalize a Master Patient Index to link service recipients' records across multiple datasets for more robust analyses.
- The DHHS will create a professional development series on available data resources to help staff understand the data that is available across the Department; the benefits and limitations of different data resources; how to request data from other divisions; and how to leverage data assets to inform decision-making.
- The DHHS will work with Mathematica to expand and enhance its quality assurance framework and strategies; these may apply across initiatives impacting individuals with a variety of disabilities.
- The DHHS Division of Budget and Analysis and the DHHS Office of the Controller will create a set of financial performance dashboards to promote stewardship of key funding resources, including division budgets, CARES Act funding, American Rescue Plan Act funding, and block grants, and to support management in making timely informed decisions.

Resource Requirements for Priority Area 11

The DHHS will utilize existing federal and state funds to cover the costs of these strategies. The DHHS will seek additional state funds from the General Assembly if necessary.



Plan Implementation and Oversight

Designated Olmstead Staff

While this initial Olmstead Plan reinforces North Carolina's vision for transitioning its services and systems to support individuals with disabilities in choosing integrated and inclusive community settings that meet their needs, the Department of Health and Human Services (DHHS) recognizes that effective and regular oversight will be necessary to facilitate implementation of the Plan. Therefore, the DHHS is proposing:

- To establish an Office of Olmstead Plan Implementation that will be led by the Senior Advisor on the Americans with Disabilities Act (ADA). The Senior Advisor reports directly to the Deputy Secretary for Medicaid within the DHHS. The Office will be staffed sufficiently to carry out the duties necessary to provide continued leadership and education; to monitor the implementation of Plan strategies; to assess progress towards measures; and to assist in resolving barriers and challenges that might impede implementation.
- To create an Olmstead Steering Committee, consisting of representatives from DHHS divisions and essential sister agencies, to guide and monitor North Carolina's progress in achieving the Olmstead Plan priorities.
- To appoint and staff a second iteration of the Olmstead Plan Stakeholder Advisory (OPSA) to advise the state regarding its Olmstead Plan.

Ongoing Role of the Olmstead Plan Stakeholder Advisory

In addition to its internal structure of the Olmstead Steering Committee, North Carolina is committed to achieving this Olmstead Plan's goals. The state recognizes that ongoing external stakeholder participation is key to achieving these goals and to transparency. The DHHS will continue to convene the OPSA and to seek the Advisory's regular input and feedback regarding progress in implementing the Olmstead Plan and future Plan revisions.

Making *Olmstead* Everyone's Responsibility

As the Department continues to incorporate compliance with *Olmstead* into its day-to-day operations, the ongoing assessment of progress and need for Plan modifications must become the responsibility of every division. Review of the Plan should be incorporated into the role of all relevant committees, boards, commissions, task forces, and councils. Progress must be captured in evaluation and reports, while action steps and requested resources must be included in departmental strategic plans.

In addition, the Local Management Entities/Managed Care Organizations (LME/MCOs) Tailored Plans and Standard Plans play a key role in Plan implementation and must embrace implementation of the Olmstead Plan as a shared responsibility.



Figure 1. Cycle of Olmstead Planning, TAC 2019



Conclusion

North Carolina intends for the Olmstead Plan to be a living plan and a lens through which policy, practice, and funding decisions are made. The Department of Health and Human Services (DHHS) anticipates that goals, strategies, and measures will need to be adjusted and refined as implementation proceeds. The DHHS anticipates that this plan will result in rebalancing of federal and state funds in favor of community-based services and supports. Moreover, the Plan will enhance community inclusion for people with disabilities and their families. The ability to achieve some of the plan's goals and to implement certain of its strategies will depend, in part, on the availability of additional federal and state funds. The DHHS will work closely with, and will need the full support of, its stakeholders, its sister agencies, and the North Carolina General Assembly to secure the Plan's success.

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Appendix A: North Carolina's Additional Efforts to Date in Achieving Olmstead Plan Priorities

Priority Area 1:

Strengthen Individuals' and Families' Choice for Community Inclusion through Increased Access to Home and Community-Based Services and Supports

- ✓ The North Carolina State Treasurer's Office administers [Achieving a Better Life Experience \(ABLE\) accounts](#), providing North Carolinians with disabilities – including physical, developmental, and mental health or other conditions – the opportunity to save money, while preserving their Supplemental Security Income (SSI) and Medicaid income.

Priority Area 2:

Address the Direct Support Professional Crisis

- ✓ In April 2021, the North Carolina General Assembly introduced HB 665, an act to address the staffing crisis impacting intermediate care facilities for individuals with intellectual disabilities.
- ✓ The Trillium Local Management Entity/Managed Care Organization (LME/MCO) *Choose Independence* Initiative offers funds to assist with purchases of Smart Home technology applications.

Priority Area 3: Divert and Transition Individuals from Unnecessary Institutional and Segregated Settings

Diversion

- ✓ The General Assembly has appropriated funding from the sale of the Dorothea Dix State Hospital property to the Department of Health and Human Services (DHHS) to establish state psychiatric hospital diversion services.¹ Funds have been allocated to convert existing, licensed, acute medical inpatient beds into licensed psychiatric or substance use inpatient beds or to create new licensed psychiatric or substance use inpatient beds, including in rural communities. In addition, funding was allocated to create new beds in a facility-based crisis program.
- ✓ Medicaid-eligible individuals on the waitlist for waiver services may qualify for (b)(3) Medicaid services and State Plan personal care, additional services focused on helping individuals remain in their homes or communities and avoid institutionalization or hospitalization.
- ✓ The Special Assistance/In-Home program provides cash supplements to support low-income individuals to live in the community as an alternative to institutions such as nursing facilities.
- ✓ North Carolina Systemic, Therapeutic, Assessment, Resources and Treatment (NC START) is a statewide community crisis prevention and intervention program for individuals, age six and above, with intellectual and other developmental disabilities (I/DD) and co-occurring complex behavioral and/or mental health needs. NC START crisis prevention and intervention services are provided through clinical systemic consultation, training, education, therapeutic respite, crisis response and therapeutic coaching.
- ✓ The DHHS implemented community behavioral health paramedicine pilots that use specially trained emergency medical services (EMS) staff to intervene with patients experiencing behavioral health crises. The pilots also provide incentives for the participating EMS to either treat on-scene or route those patients not needing medical treatment to lower cost alternatives instead of hospital emergency departments.²

¹ North Carolina Department of Health and Human Services (2020). [Funds for local inpatient psychiatric beds or bed days purchased in state fiscal year 2019-2020 and other department initiatives to reduce state psychiatric hospital use, Session Law 2020-78, Part IV-E, Section 4E.1](https://files.nc.gov/ncdhhs/SL-2020-78-Section-4E.1-Funds-for-Local-Inpatient-Psychiatric-Beds-or-Bed-Days--Final-.pdf). Report to the Joint Legislative Oversight Committee on Health and Human Services and Fiscal Research Division, December 21, 2020. Retrieved April 26, 2021 from <https://files.nc.gov/ncdhhs/SL-2020-78-Section-4E.1-Funds-for-Local-Inpatient-Psychiatric-Beds-or-Bed-Days--Final-.pdf>

² North Carolina Department of Health and Human Services (2016). [Final report on the Community Paramedic Mobile Crisis Management Pilot Program, Session Law 2015-241, Section 12F.8.\(d\)](#) [PDF]. Report to the Joint Legislative Oversight Committee for Health and Human Services and the Fiscal Research Division, November 1, 2016.

Transitions

- ✓ The DHHS contracts require the Behavioral Health I/DD Tailored Plans “to identify members who are receiving care in an institutional setting and help transition them to the community, if their needs can be met safely in the community.”³
- ✓ The Division of Aging and Adult Services (DAAS) has developed and piloted a Screening and Priority Services tool to be used for older adults and individuals with disabilities and their caregivers to assess their level of functioning, need for services and access to resources to establish their prioritization for services.

Priority Area 4:

Increase Opportunities for Supported Education and Pre-employment Transition Services for Youth with Disabilities, and Competitive Integrated Employment for Adults with Disabilities

Supported Education/Pre-employment Transition Services for Youth

- ✓ The Division of Vocational Rehabilitation Services (DVRS) provides pre-employment transition services and/or vocational rehabilitation services to all youth and students with disabilities to assist them in reaching their competitive integrated employment goals.
- ✓ The DVRS partners with the Youth Development Centers for adjudicated youth to provide Pre-Employment Transition Services and fosters connection to the local Vocational Rehabilitation office when returning to the home community.
- ✓ The DVRS has 113 dedicated transition positions and serves students with disabilities in all 100 North Carolina counties.
- ✓ The DVRS has recently revised its policy on supports provided for students and youth with disabilities who participate in comprehensive transition and post-secondary programs, allowing additional funding for those that meet the established criteria.

Competitive Integrated Employment

- ✓ The DVRS has funded traditional supported employment services for people with I/DD under a milestone funding structure since 2013, incentivizing outcomes over delivery of units of services.
- ✓ In 2019, the DHHS and Vaya Health developed the North Carolina Collaborative for Ongoing Recovery through Employment (NC CORE), a pilot project in which fee-for-service Medicaid reimbursement and state funding was replaced with a shared funding model. Both

³ Department of Health and Human Services Request for Applications #: 30-2020-052-DHB BH I/DD Tailored Plan, November 13, 2020.

Vaya Health and DVRS fund the achievement of milestones for the provision of Individual Placement Support – Supported Employment (IPS/SE). The Alliance LME/MCO is in the process of implementing the approach, and the Partners, Trillium, and Sand Hills LME/MCOs are engaged in planning.

- ✓ The DVRS, the Division of Health Benefits (DHB) and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) are strengthening their partnerships to support competitive, integrated employment (CIE) opportunities for North Carolinians with disabilities.
- ✓ [NC Careers.org](https://www.nccareers.org) represents a collaborative effort to produce an accessible online resource for employment training, supports, and resources available to all North Carolinians, including those with disabilities. This effort is supported by the DHHS, the Department of Commerce, the Department of Public Instruction, and the University of North Carolina.
- ✓ The DVRS has added fee-for-service benefits counseling with approved vendors to increase access to benefits counseling for vocational rehabilitation clients.
- ✓ The DMH/DD/SAS has provided funding to sponsor Individual Placement and Support – Supported Employment staff in receiving benefits counseling training through Cornell University, and has increased the state-funded IPS/SE rate for providers with a benefits counselor on the team.

Priority Area 5: Increase Opportunities for Inclusive Community Living

- ✓ In 2020, a group of advocates, assisted by the DHHS, formed the Innovations Supported Living Stakeholders Levels 2 and 3 workgroup to advance strategies that offer greater access to, and sustainability of, supported living for individuals with significant disabilities.
- ✓ In Fiscal Year 2019, the DHHS partnered with the North Carolina Housing Finance Agency to develop the Integrated Supportive Housing Program, which provides interest-free loans to community developments where up to 20 percent of the units are integrated and set aside for households participating in the Transitions to Community Living (TCL) program.⁴
- ✓ The DHHS established LME/MCO contract requirements for Housing Specialists.
- ✓ North Carolina has 3,847 federal housing vouchers targeted exclusively to people with disabilities.

⁴ The Integrated Supportive Housing Program fosters a collaboration between a local housing developer, DHHS, and the LME/MCO to increase the supply of integrated, affordable rental housing. This housing consists of independent rental units where no more than 20% of the units are required to be set aside for persons with a disabling condition. Prospective tenants will be referred by the DHHS and are anticipated to come with rental assistance and connection to supportive services. See [Integrated Supportive Housing Program: Program Guidelines](#) [PDF].

- ✓ Key Rental Assistance is funded in the amount of approximately \$5.5 million annually.
- ✓ Proposed Special Provisions for SL 2021-180 (Senate Bill 105), 2021 Appropriations Act, include eliminating the cap on the number of allowable state-county Special Assistance/In-Home payments.

Priority Area 6: Address Gaps in Services

- ✓ Since 2019, the DHB has provided research-based, behavioral health treatment as a Medicaid state plan service for individuals under the age of 21.
- ✓ The North Carolina General Assembly recently approved legislation allowing licensure of Board Certified Behavior Analysts.
- ✓ The DHHS has engaged the Alliance of Disability Advocates North Carolina to provide community inclusion supports and benefits counseling to TCL recipients in the Alliance and Eastpointe catchment area.
- ✓ The DHHS recently reallocated Single Stream Funding based on data-driven measures, successfully redistributing this state-only funding to the LME/MCOs with substantiated need.

Priority Area 8: Address Disparities in Access to Services

- ✓ The DHHS has been meeting regularly with the Latino Congress to discuss strategies for improving communication about DHHS benefits and services to the Latinx community.
- ✓ On June 1, 2021, the DMH/DD/SAS held an open dialogue to create a safe space for individuals to share their perceptions about diversity, equity, and inclusion.⁵

⁵ See also North Carolina Department of Health and Human Services (n.d.). [Diversity and inclusion](https://bit.ly/3mM4E4W). Retrieved September 30, 2021 from <https://bit.ly/3mM4E4W>

Priority Area 9: Increase Input from Individuals with Lived Experience

- ✓ TCL includes consumer satisfaction surveys as a tool for assessing the quality of services and overall success of the initiative.
- ✓ As part of its five-year plan process, in September 2020, the North Carolina Council on Developmental Disabilities (NCCDD) held statewide input sessions for adult and youth (age 30 and under) self-advocates to identify the issues that matter to them and the initiatives that the NCCDD should work on to make North Carolina a more inclusive state for people with I/DD.
- ✓ In 2019, the DHHS held numerous statewide listening sessions to obtain input from a broad range of stakeholders, including Medicaid beneficiaries, to design initiatives under Medicaid Transformation.

Appendix B: Olmstead Plan Stakeholder Advisory Membership, Committee Assignments, and Staff Work Group (November 23, 2021)

NC DHHS Mission: In collaboration with our partners, the North Carolina Department of Health and Human Services provides essential services to assist people with disabilities to reside in and experience the full benefit of inclusive communities.

Olmstead Plan Stakeholder Advisory (OPSA) Vision Statement: North Carolina champions the right of all people with disabilities to choose to live life fully included in the community.

OPSA Leadership

OPSA Community Co-Chairs:

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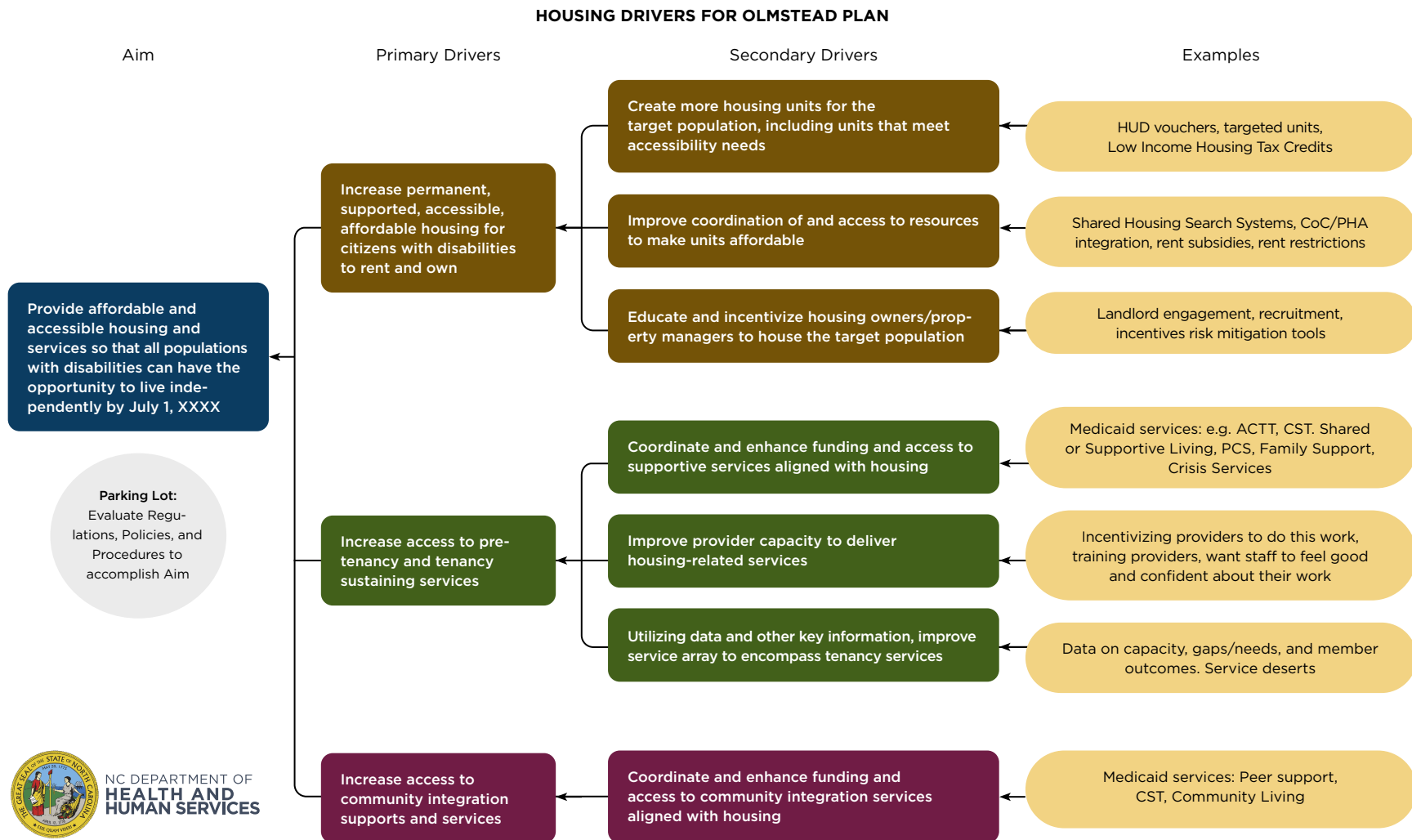
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Appendix C: OPSA Housing Committee Driver Diagram



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Appendix D: Glossary of Terms

(b)(3) Services – Additional supports for people who have Medicaid insurance. They are offered in addition to the services in the North Carolina Medicaid State Plan. These services focus on helping people remain in their homes and communities and avoid higher levels of care, such as hospitals. North Carolina's Local Management Entities/Managed Care Organizations (LME/MCOs) can offer these additional services as a result of savings from the Medicaid waivers. The term “(b)(3)” refers to the section of the federal Social Security Act that allows states to offer these services under a Medicaid waiver.

811 Mainstream Program – Allows persons with disabilities to live as independently as possible in the community by subsidizing rental housing opportunities which provide access to appropriate supportive services. The U.S. Department of Housing and Urban Development (HUD) Section 811 program is authorized to operate in two ways: by providing interest-free capital advances and operating subsidies to nonprofit developers of affordable housing for persons with disabilities, and by providing project rental assistance to state housing agencies.

1915(i) State Plan Option – Allows the state to provide Medicaid coverage for certain home and community-based services (HCBS) to people with disabilities who do not meet the criteria for an institutional level of care and who have incomes lower than 150 percent of the federal poverty level.

ABLE ACT and Accounts – The North Carolina State Treasurer's Office administers the Achieving a Better Life Experience (ABLE) Act, a federal law signed in December of 2014, that allows individuals with disabilities and their families to save for the future and fund essential expenses like medical and dental care, education, community-based supports, employment training, assistive technology, housing, and transportation. ABLE accounts are tax-exempt savings accounts for qualified disability expenses.

Adult Developmental Vocational Program (ADVP) – A day/night service which provides organized developmental activities for individuals with intellectual and other developmental disabilities to prepare them to live and work as independently as possible. ADVP services may only be provided in a licensed or Vocational Rehabilitation approved facility.

American Rescue Plan Act – A \$1.9 trillion economic [stimulus bill](#) passed signed into law on March 11, 2021, building upon many of the measures in the CARES Act from March 2020.

Assertive Community Treatment – An evidence-based practice that provides community-based, multidisciplinary mental health *treatment* for individuals with severe and persistent mental illness.

Assistive Technology – Comprises both devices and services:

- Assistive technology as a device can be any item or piece of equipment that helps a person with a disability to increase, maintain, or improve their ability to function. Assistive technology as a device can range from low-tech devices, such as a cane or wheelchair, to high-tech devices, such as a software program on a computer, or screen readers. Note: Medical devices that are surgically implanted are not considered assistive technology.
- Assistive technology as a service can involve any combination of the following:
 - Evaluation of an individual's needs
 - Acquisition of assistive technology devices (e.g., purchasing, leasing, or loaner programs).
 - Selection, fitting, or repairing of a device.
 - Training an individual with a disability or their caregiver on how to use assistive technology.

Behavioral Health Disorders – Mental health disorders, substance use disorders, or co-occurring mental health and substance use disorders.

Behavioral Health I/DD Tailored Plans – North Carolina will launch the Behavioral Health and Intellectual/Developmental Disabilities Tailored Plan on December 1, 2022. This plan is an integrated health plan designed for individuals with significant behavioral health needs and intellectual and other developmental disabilities (I/DDs). The Behavioral Health I/DD Tailored Plan will also serve other special populations, including Innovations and Traumatic Brain Injury (TBI) waiver enrollees and waitlist members, and will be responsible for managing the state's non-Medicaid behavioral health, developmental disabilities, and TBI services for uninsured and underinsured North Carolinians.

CAP/C Waiver – A 1915(c) Home and Community Based Services waiver that provides services for medically fragile children under 21 who are at risk of institutional care. By providing in-home nursing care, case management, and other supports, CAP/C can help these children stay at home with their families.

CAP/DA Waiver – This waiver program provides a cost-effective alternative to institutionalization for a Medicaid beneficiary who is medically fragile and at risk for institutionalization if the Home and Community Based services approved in the CAP/DA waiver were not available. These services allow the beneficiary to remain in or return to a home- and community-based setting.

Children's Residential Redesign – An initiative to redesign the state's psychiatric residential treatment facilities to improve treatment and agency outcomes.

The Coalition – [The Coalition](#) is a group of statewide organizations in North Carolina that are committed to assuring the availability of services and supports for individuals who experience addictive diseases, mental illness, and developmental disabilities.

Coalition on Aging – A coalition whose mission is to improve the quality of life for older adults through collective advocacy, education, and public policy work. This group works to develop programs for children with autism, advocate and help families navigate services, and educate state policy makers on the needs of children with autism.

Coronavirus Aid, Relief, and Economic Security (CARES) Act – Signed into law March 27, 2020, this act provides over \$2 trillion of economic relief to workers, families, small businesses, industry sectors, and other levels of government that were hit hard by the public health crisis created by COVID-19.

Competitive Integrated Employment – Defined by the Rehabilitation Act as work that is performed on a full-time or part-time basis for which an individual is: (a) compensated at or above minimum wage and comparable to the customary rate paid by the employer to employees without disabilities performing similar duties and with similar training and experience; (b) receiving the same level of benefits provided to other employees without disabilities in similar positions; (c) at a location where the employee interacts with other individuals without disabilities; and (d) presented opportunities for advancement similar to other employees without disabilities in similar positions.

Comprehensive Transition and Postsecondary (CTP) Program – Under the Higher Education Opportunity Act of 2008 (HEOA), this is a college program created specifically for students with intellectual disabilities. The Act defined the key requirements that all CTP programs must provide to students, gave a definition of “student with an intellectual disability,” and opened up access to federal student aid for students with an intellectual disability attending an approved CTP program. Students in CTP programs do not have a standard high school diploma or matriculate towards a degree.

Coordinated Specialty Care – A team-based, collaborative, recovery-oriented, treatment team approach involving individuals who are experiencing first episode psychosis.

Consumer-Operated Services – Services that are fully independent, separate, and autonomous from other mental health agencies, with the authority and responsibility for all oversight and decision-making on governance, financial, personnel, policy, and program issues. Services are predominantly staffed by individuals with lived experience.

Direct Support Professional – Staff who work one-on-one with individuals with disabilities with the aim of assisting them to become integrated into the community or the least restrictive environment.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) – Provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services and covers a program of regular wellness visits called Health Check.

Federal Medical Assistance Percentages – The percentage rates used to determine the matching funds rate allocated annually to certain medical and social service programs in the United States.

Healthy Opportunities – An NCDHHS initiative designed to test and evaluate the impact of providing select, evidence-based, non-medical interventions related to housing, food, transportation, and interpersonal safety to high-needs Medicaid enrollees.

High Fidelity Wraparound – An evidence-informed and standardized supportive care coordination service for youth (3-20 years old) with serious emotional disturbance and youth with serious emotional disturbance plus a co-occurring substance use disorder or intellectual and other developmental disability. “In Lieu Of” service definitions have been developed to promote the use of high fidelity wraparound services across the state.

Home and Community Based Services – Health and human services that address the needs of people with functional limitations who need assistance with everyday activities, like getting dressed or bathing. HCBS are often designed to enable people to stay in their homes, rather than moving to a facility for care. Medicaid funds Home and Community Based Services through its waivers.

Housing Choice Vouchers – These vouchers assist very low-income families to afford decent, safe, and sanitary housing. Housing can include single-family homes, townhouses, and apartments and is not limited to units located in subsidized housing projects. Housing choice vouchers are administered locally by public housing agencies (PHAs). A family that is issued a housing voucher is responsible for finding a suitable housing unit whose owner agrees to rent under the program. A housing subsidy is paid to the landlord directly by the PHA on behalf of the participating family. The family then pays the difference between the amount subsidized by the program and the actual rent charged by the landlord.

Housing and Community Based Services (HCBS) Final Rule – The final HCBS regulations set forth new requirements for several Medicaid authorities (e.g., waivers) under which states may provide home and community-based long-term services and supports. The regulations enhance the quality of HCBS and provide additional protections to individuals who receive services under these Medicaid authorities. Learn more at [Home and Community Based Services Final Regulation](#).

Independent Living Rehabilitation Program – The [Independent Living Rehabilitation program](#) provides an alternative to living in a nursing home or other facility for eligible individuals. Services are person-centered and may be provided directly, purchased or coordinated through other community resources.

Individual Placement and Support / Supported Employment (IPS/SE) – An evidence-based practice that assists individuals with severe mental illness and other debilitating disorders to find competitive, integrated community employment and provides ongoing, individualized services with a focus on employment.

“In Lieu Of” Services – Alternative mental health, substance use disorder, or intellectual and other developmental disability services that are not included in the state Medicaid plan or managed care contract but that are clinically appropriate, cost-effective alternatives to State Plan services. These services are not required and are provided at the discretion of Local Management Entities/Managed Care Organizations.

Innovations Waiver – This Medicaid waiver supports children and adults with intellectual and other developmental disabilities (I/DD) who meet Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care criteria or are a risk of being placed in an ICF/IID, to live in the community.

Key Rental Assistance – This [rental assistance program](#) [PDF] is administered by the North Carolina Housing Finance Agency to make Targeting Program units/housing affordable to very low income households.

Milestone Payments – A method of payment for a service that achieves a defined stage in the client’s progression towards exiting vocational rehabilitation to Competitive Integrated Employment. This payment model is a change from paying for services at an hourly rate, regardless of the whether the client progresses towards their vocational goal.

Mobile Response and Stabilization Services – An enhanced mobile intervention targeting families and children, ages 3-21, who are experiencing escalating emotional or behavioral symptoms or traumatic circumstances that have compromised the child’s ability to function at their baseline within the family, living situation, school or community environments. This program will support the enhancement of the current mobile crisis response to be more child- and family-focused in meeting behavioral health crisis needs.

Money Follows the Person (MFP) – The MFP program helps Medicaid-eligible North Carolinians who live in inpatient facilities to move into their own homes and communities with supports. North Carolina was awarded its initial MFP grant from the Centers for Medicare and Medicaid Services (CMS) in May 2007 and began supporting individuals to transition in 2009.

North Carolina Collaborative for Ongoing Recovery through Employment (NC CORE) – The NC CORE initiative is an innovative payment structure that addresses the discrepancy between fee-for-service (FFS) and milestone payments by switching both the state and Medicaid FFS payments to milestones for supported employment services.

North Carolina – Psychiatry Access Line (NC PAL) – [NC-PAL](#) is a free telephone consultation and education program to help health care providers address the behavioral health needs of their patients.

Olmstead v. L.C – The *Olmstead* decision was the result of a United States Supreme Court case concerning discrimination against people with disabilities. The court held that under the [Americans with Disabilities Act](#), individuals with disabilities have the right to live in the community rather than in institutions if “the State’s treatment professionals have determined that community placement is

appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others" with disabilities.

Oxford House – A housing program that is designed to support people committed to a sober lifestyle, that does not include paid staff, and that is self-run by the people who live there.

Penetration Rate – The number of unduplicated eligible individuals and consumers who have received at least one billable service during the fiscal year.

Projects for Assistance in Transition from Homelessness (PATH) – Federal grant program that provides assistance to individuals who are homeless or at risk of homelessness and who have serious mental illness. PATH funds are distributed to states/territories, which contract in turn with local public or nonprofit organizations to fund a variety of services to homeless individuals, including outreach, treatment, case management, and housing supports.

Remote Supports (Remote Technology) – Utilizes two-way communication in real time, through sensors, cameras, or other devices to provide direct service by monitoring and providing supervision assistance remotely. In general, remote supports are an emerging service that combines technology and direct support for people with disabilities, including individuals with developmental disabilities, using a design approach that avoids intrusiveness.

Rethinking Guardianship – [Rethinking Guardianship](#) is a collaborative effort of the North Carolina Council on Developmental Disabilities and the University of North Carolina-Chapel Hill School of Social Work's Jordan Institute for Families. The initiative is committed to improving life for people who are experiencing guardianship or who could benefit from alternatives to guardianship that preserve more of their rights.

Substance Abuse and Mental Health Services Administration – A branch of the U.S. Department of Health and Human Services charged with improving the quality and availability of treatment and rehabilitative services to reduce illness, death, disability, and the cost to society resulting from substance use disorders and mental illnesses.

Senior Community Service Employment Program (SCSEP) – This program places individuals, 55 and older, who are economically disadvantaged into part-time community service assignments, while helping them transition into unsubsidized employment. SCSEP empowers low-income older workers to achieve economic independence. Training in community service activities assist participants in gaining marketable skills to re-enter the workforce. The Division of Aging and Adult Services and four national contractors administer SCSEP in the state.

Serious Emotional Disorders – Conditions experienced by children, birth to 18 years old, determined by DSM-IV Diagnosis and moderate to severe impairment in functioning. Also referred to as [Serious Emotional Disturbance](#).

Serious Emotional Disturbance – See "Serious Emotional Disorders."

Serious and Persistent Mental Illness – A mental illness or disorder (but not a primary diagnosis of Alzheimer's disease, dementia, or acquired brain injury) experienced by a person, 18 years of age or older, that is so severe and chronic that it prevents or erodes development of functional capacities in primary aspects of daily life, such as personal hygiene and self-care, decision-making, interpersonal relationships, social transactions, learning and recreational activities; or satisfies eligibility for Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) due to mental illness.

Sheltered Employment – A wide range of segregated vocational and nonvocational programs for individuals with disabilities, such as sheltered workshops, adult activity centers, work activity centers, and day treatment centers. These programs differ extensively in terms of their mission, services provided, and funding sources.

Single Stream Funding – Flexible funds, appropriated by the North Carolina General Assembly, to pay for services for individuals who have a diagnosis of mental illness, a developmental disability, or a substance use disorder issue, or a combination of these, but who are not eligible for Medicaid coverage. Services are delivered by providers contracted with Local Management Entities/Managed Care Organizations (LME/MCOs) which are paid via a non-Unit Cost Reimbursement (non-UCR) fee structure. LME/MCOs are required to submit claims for services rendered and the value of these claims are considered in settlement of the single stream funding account.

Smart Technology – Refers to the vast array of interconnected devices that are still designed to perform the normal functions of device usage with a greater degree of autonomy than their “non-smart” equivalents. Smart options devices generally permit decision-making through software, connect via the internet, and tend to have applications (or apps) for enhanced access or control. Smart technologies are universal devices that tend to make life easier for people without disabilities and allow increase access for individuals with disabilities. Likewise, smart houses are homes designed with multiple smart technologies built in or added to work in tandem to provide the advantage of convenience and other benefits.

Social Determinants of Health – Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of social determinants include safe housing, access to transportation, access to nutritious foods, and air quality.

Special Assistance / In Home Program – [The Special Assistance In-Home \(SA/IH\) program](#) provides low-income North Carolina residents who are eligible for Medicaid with a monthly cash benefit to help them remain living in their homes.

State Transition Team – This team consists of members from the Division of Vocational Rehabilitation Services, Department of Public Instruction representatives, college/university representatives, parents, students, and various community and advocacy organizations with a focus on the transition of students with disabilities from school to employment or post-secondary education.

Subminimum Wage – Section 14(c) of the Fair Labor Standards Act authorizes employers, after receiving a certificate from the Wage and Hour Division, to pay special minimum wages – wages lower than the federal minimum wage – to workers whose capacities for the work being performed are impaired by a physical or mental disability.

Supplemental Security Income – A federal income supplement program funded by general tax revenues to help people who are elderly, blind, or have disabilities, and who have little or no income. It provides cash to meet basic needs for food, clothing and shelter.

Supported Decision-Making – Supported Decision-Making allows individuals with disabilities to make choices about their own lives with support from a team of people they choose. In this approach, people with disabilities choose people they know and trust to be part of a support network to help with day-to-day decision-making.

Supportive Housing – Provides rental assistance and access to services that assist individuals with a disability to live independently.

Supported Living – The North Carolina Innovations waiver includes a [Supported Living service definition](#) that enables people with significant disabilities the opportunity to live in their own homes.

Systems of Care (SOC) – A philosophy supported in North Carolina in which providers work together in coordinated networks of community services and supports that are organized to meet challenges of persons with disabilities.

Targeting Program – A partnership between the North Carolina Housing Finance Agency and the North Carolina Department of Health and Human Services to provide access to affordable housing for low-income people with disabilities and/or those experiencing homelessness.

Transitions to Community Living (TCL) – The State of North Carolina entered into the TCL settlement agreement with the United States Department of Justice in 2012. The purpose of this agreement was to make sure that eligible adults with serious mental illness can live in their communities in the least restrictive settings of their choice. The DHHS has worked to develop in-reach, transition, diversion, and community-based services to support those who are in the TCL target population to remain in the community or transition from facilities to the community.

Workforce Innovation and Opportunity Act (WIOA) – Signed into law on July 22, 2014, WIOA is designed to help job seekers access employment, education, training, and support services to succeed in the labor market and to match employers with the skilled workers they need to compete in the global economy. Under the Act, each U.S. state and territory submits a Unified or Combined State Plan to the U.S. Department of Labor and Department of Education that outlines its workforce development system's four-year strategy, and updates the plan as required after two years. WIOA empowers North Carolina to train its workforce and guides how the NCWorks initiative connects job seekers to employers.



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

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NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

**RELATIONAL AGREEMENT
Between**

Alliance Health Local Management Entity / Managed Care Organization
("LME/MCO")/Tailored Plan

Deleted: Behavioral Healthcare

And

Alliance Health Board of Directors

Deleted: Behavioral Healthcare LME/MCO

And

Alliance Health Consumer and Family Advisory Committee (CFAC)

Deleted: Behavioral Healthcare

I. PARTIES. This agreement is entered into by and between Alliance Health LME/MCO/Tailored Plan, which is responsible for managing publicly-funded mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury services, with corporate offices located at 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560 (hereinafter "Alliance"), the Alliance Board of Directors (hereinafter "the Board"), and the Alliance Consumer and Family Advisory Committee (hereinafter "CFAC") (individually referred to as a Party and collectively as the Parties).

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Deleted: intellectual/ developmental disability and substance abuse ("MH/IDD/SA") services

Deleted: 4600 Emperor Boulevard, Suite 200, Durham, NC 27703

II. EFFECTIVE DATE AND TERM. This Agreement shall be effective upon complete execution by all Parties and shall continue in effect unless terminated as otherwise provided herein. All timelines in this Agreement refer to calendar days unless otherwise specified. A "business" or "working" day refers to a day on which Alliance is officially open for business.

III. PURPOSE. The Purpose of this Agreement is to establish the roles and responsibilities of each Party, channels of communication between the Parties, and a process for resolving disputes between the Parties as set forth in N.C.G.S. §122C-170.

IV. DEFINITIONS.

1. Area Board or Authority - the governing unit of the LME/MCO/Tailored Plan that includes representatives from each county in the Alliance catchment area.
2. Consumer and Family Advisory Committee (CFAC) – a legislatively mandated self-governing and self-directed organization made up of consumers and family members who represent the four disability areas of mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury services. N.C.G.S. §122C-170 requires that CFACs advise the LME/MCO/Tailored Plan and its Governing Board on "the planning and management of the local mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury service system."

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3. Contract Deliverables – Deliverables listed in the contract between the area authority and the Department of Health and Human Services

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4. Local Management Entity/Managed Care Organization (LME/MCO)/Tailored Plan – a local management entity that is under contract with DHHS to operate the combined Medicaid Waiver programs authorized. Alliance Health is a multi-county LME/MCO existing under N.C.G.S. Chapter 122C for Cumberland, Durham, Johnston, Mecklenburg, Orange and Wake counties.

Deleted: The three (3) year business plan that is required to be adopted by the Board for the management, delivery, and oversight of publicly-funded MH/IDD/SA services that, among other things, establishes how the LME/MCO will ensure the availability, quality, and effectiveness of services.

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5. N.C. Department of Health and Human Services (DHHS) – the State agency responsible for health and human services and designated as the single State Medicaid agency; this includes the oversight of publicly-funded mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury services in the State of North Carolina.

Deleted: intellectual/ developmental disabilities, and substance abuse services (MH/IDD/SAS)

6. Member Inclusion and Outreach Team - A team within the department of Community, Health and Well-Being of the LME/MCO that ensures that the voices and perspectives of consumers and family members are heard and integrated at all levels of the organization and empowers consumers and family members through education and exposure to resources.

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7. Within Available Resources – Refers to the limited availability of LME/MCO/Tailored Plan funding, which is subject to annual appropriation by the N.C. General Assembly and Federal appropriation by the U.S. Congress. Any and all funding and staff commitments by Alliance in this Agreement, including but not limited to the CFAC budget, are subject to this limitation.

V. ROLES AND RESPONSIBILITIES OF THE CFAC.

1. The CFAC shall review, comment on, and monitor the implementation of the contract deliverables between area authorities and the Department of Health and Human Services.

Deleted: local business plan (LBP) to Alliance, the Board, stakeholders, and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS).¶

2. The CFAC shall identify service gaps and underserved populations and make recommendations on areas of service eligibility and service array to Alliance and the Board.

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3. The CFAC shall make recommendations regarding the service array and monitor the development of additional services.

4. The CFAC shall review and comment on the area authority budget.

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5. The CFAC shall develop a collaborative and working relationship with the area authority's member advisory committees to obtain input related to service delivery and system change issues.

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6. The CFAC shall submit findings and recommendations regarding ways to improve the delivery of mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury services, including Statewide issues.

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7. The CFAC shall conduct regularly scheduled meetings that are open to any interested individual.
8. The CFAC shall develop by-laws for self-governance. These by-laws are not binding upon Alliance or the Board.
9. The CFAC shall identify CFAC members' training needs and participate in suggested training activities.
10. The CFAC shall work to recruit, appoint, retain, support and orient its membership.
11. The CFAC shall submit recommendations on CFAC appointments to the Board Chair and Alliance CEO/ Area Director for representation on the Board's Global Quality Management Committee and other Board and Alliance committees as requested by the Board and CEO/ Area Director.
12. The CFAC shall participate in Alliance committees as appropriate and as approved by the CEO/Area Director and the Board.
13. CFAC representatives appointed to such committees shall routinely share information regarding the committees' activities with the CFAC members.
14. The CFAC Steering Committee Chair or Vice-Chair or designee, with input from CFAC members, will present concerns and activities to the Board at its monthly meeting.
15. The Steering Committee of the CFAC will schedule at a minimum annual meetings with the CEO/ Area Director.
16. The CFAC agrees to submit an annual written report to the Board regarding its core functions, including a report of issues/concerns in fulfilling these core functions. This report will be submitted to the Board by the end of the first quarter of each fiscal year. The Steering Committee of the CFAC may also communicate as needed regarding the LME/MCO/Tailored Plan's policies, activities, and budget.
17. The CFAC Steering Committee, on behalf of the CFAC, will reply, in writing, to written recommendations and/or inquiries from Alliance or the Board within two (2) weeks of receipt.
18. At least once a year, the CFAC will conduct an open town hall or forum meeting to encourage and help facilitate education as well as input and dialogue from the broadest range of consumer and family members in the Alliance catchment area.
19. The CFAC will work closely with the Member Inclusion and Outreach Team to ensure the voices of consumers and family members are integrated in all departments of Alliance.

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Deleted: identify an executive committee of the CFAC to represent the CFAC through participation at the joint executive committee meetings with representatives from the Board and Alliance.

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20. No later than the last working day of February each year, the CFAC will submit its requested annual budget and justification to the Alliance Chief Financial Officer for inclusion into the overall LME/MCO budget.

21. The Alliance Board has agreed to have one seat filled by a CFAC appointee. This seat will be filled by the CFAC Chair or their designee. Once the seat is filled, the member will continue to serve as the CFAC representative until their term or terms on the Alliance Board have expired or they are no longer eligible to serve.

VI. ROLES AND RESPONSIBILITIES OF ALLIANCE.

Alliance shall:

1. Provide sufficient support to assist the CFAC in implementing its duties under N.C.G.S. §122C -170, including data for the identification of service gaps and underserved populations, training to review and comment on contract deliverables and budgets, procedures to allow participation in quality monitoring, and technical advice on rules of procedure and applicable laws.
2. Provide an annual funding allocation, based on the previous year's expenditures and within available resources, to support the CFAC to undertake its statutory responsibilities. Reimbursement for approved expenses shall be made in accordance with Alliance policies and procedures, Generally Accepted Accounting Principles, audit standards, and the DMH/DD/SAS Area Program Budgeting Procedures Manual (APSM 75-1, effective July 1, 1995 including any revisions or updates thereto). Approved expenses may include stipends, training costs (including but not limited to facility needs), and transportation/ travel expenses, and may not include reimbursement for the cost of child/ disabled adult/ elder care.
3. Provide an Alliance/CFAC liaison and clerical support to the CFAC within available resources.
4. Distribute relevant documents, reports, and information to CFAC members by appropriate methods, including presentations, electronic media, and/ or hard copy methods and alternate formats, when needed.
5. Obtain input from the CFAC regarding the annual Network Adequacy and Accessibility Analysis, and report the results of the analysis to the CFAC.
6. Include CFAC members on appropriate Alliance committees and/or collaboratives, including Quality Management, and others that involve activities required for CFAC to perform its statutory duties.
7. Notify the CFAC at least three (3) weeks in advance of the date of the annual budget retreat and provide information and documents to the CFAC members, including training activities

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designed to acquaint the CFAC with the budget development process to encourage participation.

8. Endeavor to respond in writing to issues, questions, or recommendations received in writing from the CFAC within two (2) weeks.
9. Conduct at least two (2) catchment area-wide forums each year to discuss topics such as budgets, gaps analysis, or other emerging issues.

VII. ROLES AND RESPONSIBILITIES OF THE ALLIANCE-CFAC LIAISON.

Within available resources, the Alliance-CFAC Liaison support activities shall include:

1. Assist in maintaining a current CFAC membership list with contact information as submitted in a timely fashion by the CFAC Chair/ Vice-Chair(s).
2. Identify meeting locations and send email reminders (hardcopies may be sent to members without email) to all members prior to meeting dates.
3. In coordination with the CFAC secretary, receive the meeting agenda from the CFAC Chair/ Vice-Chair(s) at least five (5) working days prior to the meeting to assure the availability of meeting materials. To the extent possible, meeting agendas, reminders and related materials will be sent to members via email messages and attachments.
4. Assist with coordinating presentations, training and other arrangements for upcoming meetings within available resources and as approved by the CEO/ Area Director.
5. Assist with financial reimbursements and refreshments for meetings, when applicable and within available resources and audit requirements.
6. Assist with transportation, funding and care arrangements for CFAC members attending conferences within available resources.
7. Assist with maintaining updated CFAC information on the Alliance website.
8. Assist with CFAC membership recruitment, within available resources.
9. Forward relevant State and other documents to CFAC members using appropriate media. This may include information regarding policy changes, upcoming training, conference opportunities, etc.
10. Coordinate with the CFAC secretary and be responsible for taking minutes of regularly scheduled CFAC meetings and provide “draft” minutes to the CFAC Chair/ Vice-Chair(s) and CFAC members for review at least ten (10) days prior to the following regularly scheduled meeting. The liaison will facilitate the placement of approved minutes on the CFAC website and distribute to CFAC members.

VIII. ROLES AND RESPONSIBILITIES OF THE BOARD.

The Alliance Board shall:

1. Officially recognize the CFAC as the body that seeks to fulfill the obligations of N.C. Gen. Stat. § 122C-170.
2. Accept and consider comment from the CFAC on substantive planning and management issues such as, but not limited to, decisions regarding service retention/elimination, new service initiatives, or any significant shift or reduction in service resources and delivery.
3. Endeavor to reply, in writing, to written questions or recommendations from the CFAC within two (2) weeks of receipt.
4. Provide at least five (5) working days' written notification of proposed actions regarding service retention/elimination, new service initiatives, or any significant shift or reduction in service resources and delivery. Whenever possible, the CFAC requests respect for its regular meeting schedule and CFAC shall in turn respect the Board's schedule. When this is not possible due to external factors, the CFAC will respond as quickly as possible within the time frame needed by Alliance.
5. Encourage its members to attend CFAC meetings, possibly on a rotating basis.

IX. JOINT RESPONSIBILITIES OF ALLIANCE, THE CFAC, AND THE BOARD.

1. Work together to achieve a public mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury service system for Alliance Members that is collaborative, accessible, responsive and efficient.
2. Work jointly to develop action plans regarding any systemic issues or concerns with systems of care, service retention/elimination, new service initiatives, or any significant shift or reduction in service resources and delivery.
3. Determine the level of professional staff participation necessary to ensure support but not control the Alliance CFAC.
4. Work together to ensure that the Alliance CFAC remains viable, is representative of all disability groups and reflect the racial, gender, and geographic differences in the catchment area.

X. DISPUTE RESOLUTION. In the event of any conflict, the Parties agree to work with the Member Inclusion and Outreach Team to try and resolve any concerns in an informal and team-oriented approach. If conflicts between the CFAC and its liaison or any Alliance staff person or the Board cannot be resolved informally, the CFAC may request a meeting with CEO/

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Area Director. If resolution is not achieved, the CFAC may request a meeting with the Board Chairperson.

If the conflict cannot be resolved, it shall be submitted to mediation, which shall focus on the needs of everyone concerned and seek to solve problems cooperatively, with an emphasis on dialogue and accommodation. Mediation shall occur in Durham or Wake County, North Carolina, before a mediator certified by the North Carolina Dispute Resolution Commission. The goal of the mediation shall be to preserve and enhance relationships by developing a mutually acceptable agreement which will fulfill the needs of everyone concerned. A Party desiring mediation may begin the process by giving the other Party a written "Request to Mediate" notice describing the issues involved and inviting the other Party to join with initiating the calling Party to name a mutually agreeable mediator and a time frame for the mediation which shall occur no more than thirty (30) days following the notice unless the Parties mutually agree otherwise. The Parties and the mediator may adopt any procedural format that seems appropriate for the particular dispute. The contents of all discussions during the mediation shall be confidential and non-discoverable. If the Parties can agree upon a mutually acceptable agreement, it shall be reduced to writing, signed by all Parties and the dispute shall be fully resolved.

XI. TERMINATION.

This Agreement may be terminated, in whole or in part, by mutual written consent of all parties or by any Party upon sixty (60) days' written notice to the other Parties.

XII. MISCELLANEOUS.

1. **INDEPENDENT CONTRACTOR.** CFAC understands and agrees that, in performing their responsibilities pursuant to this Agreement, it is acting as an independent contractor. CFAC shall not have the right to bind or obligate Alliance or the Board in any manner without prior written consent.
2. **HOLD HARMLESS.** Each Party agrees that it will be responsible for its own acts and the results thereof and shall not be responsible for the acts of the other Party and the results thereof. Each Party therefore agrees that it will assume all risk and liability to itself, its agents or employees for any injury to persons or property resulting in any manner from the conduct of its own operations and the operations of its agents or employees under this Agreement, and for any loss, cost, or damage caused thereby during the performance of this Agreement. Notwithstanding the foregoing, nothing contained in this Agreement shall be deemed to constitute a waiver of the sovereign immunity of Alliance as a local political subdivision of the State of North Carolina, which immunity is hereby reserved to Alliance.
3. **ASSIGNMENT.** Neither Party shall have the right to assign, delegate or otherwise transfer, and shall not assign, delegate or otherwise transfer, in whole or part, directly or indirectly, by operation of law or otherwise, any of its rights, obligations, or duties under this Agreement without the prior written consent of the other Party. Any purported assignment, delegation or transfer without prior written consent of either Party shall be void.

4. NO ~~THIRD-PARTY~~ RIGHTS. This Agreement and the covenants and agreements contained herein are solely for the benefit of the Parties hereto. No other person shall be entitled to enforce or make any claims, or have any right pursuant to the provisions of this Agreement.

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5. GOVERNING LAW AND VENUE. This Agreement shall be governed by and in accordance with the laws of the State of North Carolina. Subject to the requirement of mediation contained herein, any suit or action arising out of or in connection with this Agreement, or any breach hereof, shall be brought and maintained exclusively in the General Court of Justice in Durham County, North Carolina. The Parties hereby irrevocably submit to the exclusive jurisdiction of such courts for the purpose of such suit or action and hereby expressly and irrevocably waive, to the fullest extent permitted by law, any objection it may now or hereafter have to the venue of any such suit or action in any such court and any such claim that any suit or action has been brought in an inconvenient forum.

6. NOTICE. All notices, reports, records, or other communications which are required or permitted to be given to the Parties under the terms of this Agreement shall be sufficient in all respects if given in writing and delivered in person, by electronic mail, by confirmed facsimile transmission, by overnight courier, or by registered or certified mail, postage prepaid, return receipt requested, to the following address:

Alliance ~~Health~~
Attention: ~~Community and Member Engagement~~
~~5200 W. Paramount Parkway, Suite 200~~
~~Morrisville, NC 27560~~

Deleted: Behavioral Healthcare

Deleted: Consumer Affairs Department

Deleted: 4600 Emperor Boulevard

Deleted: Durham, NC 27703

7. SEVERABILITY. If any one or more provision of this Agreement contravenes any law and such contravention would thereby invalidate this Agreement, then such provision shall be limited or curtailed only to the extent necessary to make such provision valid and enforceable or declared to be invalid and unenforceable, subject to severance from the remaining portion of this Agreement and shall not affect the validity or enforceability of any other provision of this Agreement. In such event, this Agreement shall be read and construed as though it did not contain such provision in a manner to give effect to the intention of the Parties to the fullest extent possible.

8. WAIVER. The failure of any Party to seek redress for violation of or to insist upon the strict performance of any covenant or condition of this Agreement shall not constitute a waiver of such provision, and no waiver of any provision of this Agreement shall be deemed, or shall constitute, a waiver of any other provision, whether or not similar, nor shall any waiver constitute a continuing waiver. No waiver shall be binding unless executed in writing by the Party making the waiver.

9. ENTIRE AGREEMENT. This Agreement constitutes the entire agreement and understanding of the Parties as to the subject matter contained herein. There are no restrictions, promises, representations, warranties, covenants or undertakings other than those expressly set forth or referred to in such documents. This Agreement and such documents supersede all prior

agreements and understandings among the Parties and their representatives with respect to the subject matter hereof.

10. AMENDMENT. This Agreement may not be amended except by a written Agreement signed by an authorized representative of each Party.

11. CONSTRUCTION. The Parties have participated jointly in the negotiation and drafting of this Agreement. If an ambiguity or question of intent or interpretation arises, this Agreement shall be construed as if drafted jointly by the Parties, and no presumption or burden of proof shall arise favoring or disfavoring any party by virtue of the authorship of any of the provisions of this Agreement. Any reference to any federal, state, local, or foreign statute or law shall be deemed also to refer to all rules and regulations promulgated thereunder, unless the context requires otherwise. The words "include" and "including" shall mean "include" or "including" without limitation. Whenever the singular number is used in this Agreement and when required by the context, the same shall include the plural and vice versa, and the masculine gender shall include the feminine and neuter genders and vice versa.

12. CAPTIONS. The caption headings of the sections and subsections of this Agreement are for convenience of reference only, are not intended to be, and should not be construed as, a part of this Agreement, and shall not affect the construction or interpretation of any of its provisions.

13. FORCE MAJEURE. Neither Party will be deemed in default of this Agreement to the extent that performance of its obligations are delayed or prevented by reason of circumstance beyond its reasonable control, including without limitation, changes in State or Federal appropriation, acts of terrorism, labor strike, or fire, natural disaster, earthquake, accident or other acts of God.

14. COUNTERPARTS. This Agreement shall be executed in two (2) counterparts, each of which, for all purposes, shall be deemed to be an original instrument, and all of which together shall constitute a single agreement.

IN WITNESS WHEREOF, each Party has caused this agreement to be executed in multiple copies, each of which shall be deemed an original, as the act of said Party. Each individual signing below certifies that it has been granted the authority to bind that Party to the terms of this Agreement.

SIGNATURES:

| | | | |
|--|---|---------------------------------------|---|
| | <div><div></div><div>CFAC Chair</div></div> | <div><div></div><div>Date</div></div> | <div>Deleted:</div> |
| | <div><div></div><div>CFAC Vice-Chair</div></div> | <div><div></div><div>Date</div></div> | <div>Deleted:</div> |
| | <div><div></div><div>Alliance <u>Health</u> Board Chair</div></div> | <div><div></div><div>Date</div></div> | <div>Deleted: Behavioral Healthcare</div> |
| | <div><div></div><div>Alliance <u>Health</u> CEO/Area Director</div></div> | <div><div></div><div>Date</div></div> | <div>Deleted: Behavioral Healthcare</div> |

Alliance ~~Health~~ Consumer and Family Advisory Committee (CFAC) Bylaws

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Article 1. Terms.

§1-1. Name.

The name of this committee shall be the Alliance ~~Health~~ Consumer and Family Advisory Committee (also referred to as ~~“CFAC”~~ or “the committee”).

1-2 Affiliation

Pursuant to N.C.G.S. § 122C-170, the CFAC shall be a committee of the established local ~~area~~ authority.

§1-2. Definitions

1. ~~“Consumer.”~~ means an individual who is a client or a potential client of public services from a State or area facility.
2. “N.C.G.S.” shall refer to the North Carolina General Statutes including statutes that have been modified or replaced by the legislature since the adoption of these by-laws.
3. ~~“Department.”~~ shall refer to the North Carolina Department of Health and Human Services.
4. ~~“Area authority.”~~ shall refer to the area mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury services system. ~~“Catchment area.”~~ shall refer to the geographic part of the State served by a specific area authority.
5. ~~“Area board.”~~ shall refer to the area mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury services system ~~board of directors~~.
6. ~~“Local management entity/managed care organization” or “LME/MCO” or “Tailored Plan”~~ shall refer to a local management entity that is under contract with the Department to operate the combined Medicaid Waiver programs authorized.
7. ~~“Director.”~~ shall refer to the Executive Director of the LME/MCO/Tailored Plan chosen by the Area Board.
8. “Local Consumer and Family Advisory Committee (CFAC)” means a self-governing and a self-directed organization that advises the area authority in its catchment area on the planning and management of the local public mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury services system.
9. ~~“Relational Agreement”~~ shall refer to a document establishing a relationship between and agreed-upon roles within the Area ~~Board~~, Alliance Health and the Local CFAC.
10. “Advisor” refers to an eligible, willing and able individual appointed to serve on the Local Consumer and Family Advisory Committee.

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11. Steering Committee refers to the officers, the local CFAC chairs, and additional members appointed by the local CFACs to give direction to the local committees, to share information, and to communicate effectively with the LME-MCO/Tailored Plan the thoughts, ideas, and concerns of all CFAC members.

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Article 2. Area Authority.

§ 2-1. Responsibilities.

Pursuant to N.C.G.S. § 122C-170(d), the area board and the LME/MCO director shall:

1. Establish a committee made up of consumers and family members to a Local Consumer and Family Advisory Committee (CFAC).
2. Provide sufficient staff to assist the CFAC in implementing its duties pursuant to N.C.G.S. § 122C-170(c), including:
 1. Data for the identification of service gaps and underserved populations;
 2. Training to review and comment on contract deliverables and budgets;
 3. Procedures to allow participation in quality monitoring; and
 4. Technical advice on rules of procedure and applicable laws

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§ 2-2. Relational Agreement.

At the request of either the CFAC, Alliance Health or the Area Board, the CFAC, Alliance Health and the Area Board shall execute an agreement that:

1. Identifies the roles and responsibilities of each party,
2. Identifies channels of communication between the parties, and
3. Provides a process for resolving disputes between the parties

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Article 3. Consumer and Family Advisory Committee.

§3-1 Purpose.

The committee shall advise the LME/MCO/Tailored Plan on the planning and management of the local public mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury services system, pursuant to N.C.G.S. §122C-170.

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§3-2 Mission.

The committee shall:

1. Be an active and constructive partner and participant in state and local mental health system development;
2. Represent the interests of consumers and families in our geographic area and state systems of care;
3. Participate in the creation and maintenance of local systems in our communities that are responsive to the needs of consumers and families;
4. Participate in the creation and maintenance of local systems in our communities in which consumers and families are an integral part of planning, management and evaluation activities;
5. Provide appropriate feedback to consumers, families, the area authority, the LME/MCO/Tailored Plan, its providers and the State regarding the system;
6. Seek to dispel myths, misinformation, and stigma regarding disabilities.

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§3-3. Vision.

The committee shall strive to:

1. Promote a community-based support system that seeks to have each person reach his or her full potential.
2. Give voice to the interests and opinions of persons with needs related to mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury.
3. Embrace the dignity of all residents in our communities so that each person may achieve his or her highest level of responsibility in the community.
4. Promote the empowerment of consumers and the active involvement of family members

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§ 3-4. Statutory Responsibilities.

Pursuant to N.C.G.S. § 122C-170, the committee shall:

1. Adopt bylaws to govern the selection and appointment of its members, their terms of service, the number of members, and other procedural matters;
2. Review, comment on, and monitor the implementation of the contract deliverables between area authorities and the Department of Health and Human Services;
3. Identify service gaps and underserved populations;
4. Make recommendations regarding the service array and monitor the development of additional services;
5. Review and comment on the area authority budget;

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6. Develop a collaborative and working relationship with the area authority's member advisory committees to obtain input related to service delivery and system change issues.; and
7. Submit to the State Consumer and Family Advisory Committee findings and recommendations regarding ways to improve the delivery of mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury services, including Statewide issues.

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§ 3-5. Additional Responsibilities.

In accordance with the provisions of these bylaws, the committee shall:

1. Meet regularly for the purpose of fulfilling its statutory responsibilities and to conduct business;
2. Adopt and publish policies and procedures regarding members':
 1. Qualifications,
 2. Leaves of absence,
 3. Resignation,
 4. Termination, and
 5. Disclosure of potential conflicts of interest;
3. Maintain the composition and membership of the committee including the recruiting and appointment of new members.

Article 4. Advisors.

§ 4-1. Rights.

1. The committee shall take no actions that impede or prevent the participation, self-determination and independent decision-making capability of its advisory members.
2. Any restriction or condition of membership established by the team shall apply equally to all individuals.
3. Each advisor is entitled to no more than one (1) vote on actions of the committee.

§ 4-2. Qualifications.

1. Pursuant to N.C.G.S. § 122C-170(b):
 1. Adult individuals are qualified to be advisory members of the committee if they or a member of their family are a consumer of mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury services.
 2. No member may serve more than three consecutive terms.
2. Employees of the area authority or the LME/MCO/Tailored Plan are not eligible for

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membership on the committee.

3. Qualified advisor candidates shall demonstrate willingness, ability and intention to comply with the duties, rights and responsibilities of team membership.
4. Advisors shall be appointed without regard to race, color, gender, national origin, age, religion, creed, disability, veteran's status, sexual orientation, gender identity or gender expression.

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§4-3 Responsibilities.

Each advisory member of the committee shall:

1. Participate openly, expressing their thoughts, ideas, and concerns without hesitation.
2. Treat each other, staff of the LME-MCO/Tailored Plan, and guests with dignity and respect.
3. Prepare for meetings by reading information sent or by doing research on items of interest to them and the group.
4. Listen to community member's concerns and relay those concerns to the committee.
5. Do their utmost to participate in at least one outreach event in their community.
6. Advocate for their community at whatever level they are most comfortable participating.
7. Honor their statutory responsibilities by focusing their energy and time in fulfilling those responsibilities.

§4-4. Fees and Remuneration.

1. Advisors are volunteers, and receive no benefits or compensation for their participation on the committee.
2. No fees, dues or assessments shall be required for membership on the committee.
3. Advisors may be reimbursed by the committee for reasonable expenses incurred while participating in approved committee activities.
4. Advisors are eligible for a stipend intended to cover any normal expenses incurred to participate in the regular, steering, or other meetings where they represent CFAC as a whole. (ex. Human Rights, Global Quality Management)

§ 4-5. Advisor Term.

Pursuant to N.C.G.S. § 122C-170(b) an advisor's term shall be three years, and no advisor may serve more than three consecutive terms.

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Article 5. Local CFAC

§ 5-3 Local CFAC Responsibilities.

Each local CFAC shall:

1. Adopt and publish procedures by which interested, qualified individuals may apply to become a member of the team.
2. Develop a charter that guides their action and tasks to be completed.
3. Local CFACs shall consist of no more than 14 official members, doing their utmost to have a fair representation of each disability category. The general public is always welcome and encouraged to participate.

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§ 5-2. Removing an Advisor.

1. Teams shall adopt and publish procedures by which an advisor may be removed from the local CFAC.
2. Local CFACs shall remove any advisor who:
 1. Fails to fulfill their duties as established by the local CFAC or committee rules; or
 2. Does not properly disclose conflicts of interest and act accordingly as required by these bylaws;
3. When the local CFAC removes a member, the former member shall be notified of the action immediately by written correspondence.

Article 6. Steering Committee

1. The Steering Committee shall be made up of duly elected officers and the chairs of each of the local CFACs.
2. Local CFACs have the right to send one additional member to the Steering Committee as a voting member monthly; the additional member attending should be determined by the local CFAC. The chair and additional member are eligible for a stipend, other members are welcome to attend but would not be eligible for a stipend.
3. The Steering Committee will meeting monthly using virtual and telephonic means.
4. A quorum will be considered one more than 50% of the officers and the local CFAC chairs.
5. The Steering Committee has the authority to take any action necessary and to act as the conduit for information to and from the LME-MCO Tailored Plan.

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Article 7. Officers.

1. The officers of the Alliance CFAC Steering Committee shall be a Chair, a Vice- Chair, Past – Chair, the CFAC Board Member and a Secretary/Treasurer. We will strive to have the Chair and the Vice-Chair from different counties.
2. Officers must have served on the CFAC for, at least, six months.
3. Officers should be limited to serve for two consecutive 1-year terms in office.
4. The Alliance CFAC Steering Committee Chair shall appoint a three-member Nominations Subcommittee that will propose a slate of officers by May of each calendar year with elections to be held in June of each calendar year.
5. Any officer may be removed from office by the affirmative vote of two-thirds of the Alliance CFAC Steering Committee at any regular or special meeting called for that purpose. Reasons for removal include conduct detrimental to the mission and purpose of the Committee, for lack of empathy with or respect for consumers/family members, or for refusal to render reasonable assistance in carrying out the Committee’s mission and purpose.
6. In the event that the Alliance CFAC Steering Committee determines it is necessary to remove a member from an office, the Alliance CFAC Steering Committee will notify the member in writing within 14 days upon removal from office.
7. In case an office becomes vacant, the majority of the members of the Alliance CFAC Steering Committee may elect an officer to fill the vacancy for the remainder of that term.

Article 8. Committees

1. The Alliance CFAC Steering Committee shall, as necessary, appoint subcommittees with a chairperson to address specific issues or tasks on behalf of the committee.
2. Subcommittee members shall be composed of CFAC members appointed by the CFAC Steering Committee chair. Subcommittees will choose the member to chair.
3. The general public is welcomed and encouraged to participate.

Article 9 Board Seat

The Alliance Board has agreed to have one seat filled by a CFAC appointee. This seat will be filled by the CFAC Chair or their designee. Once the seat is filled, the member will continue to serve as the CFAC representative until their term or terms on the Alliance Board have expired or they are no longer eligible to serve.

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Article ~~10~~
Grievances

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In the event that conflict between the Committee and its liaison, any staff person or regarding policies or procedures cannot be resolved, appeal shall be made to the CEO. If resolution is not achieved, the Committee may appeal to the Area Authority Board. If the conflict cannot be resolved at the local level, then the CFAC may involve an external mediator.

|

Article ~~11~~
Amendments

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The Alliance CFAC Steering Committee shall have power to make, alter, amend, and repeal the Bylaws as long as two-thirds of the elected members are present, whether changes are made by consensus, or an affirmative vote of the majority of the elected members of the Committee. The action shall be proposed at a regular or special meeting of the Alliance CFAC Steering Committee at which a quorum is present and adopted at a subsequent regular meeting at which at least 2/3 of the elected members are present.

|

Article ~~12~~
Dissolution

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The Alliance CFAC may voluntarily dissolve at such time as there is a two thirds affirmative vote of the current members that such action is appropriate or necessary.



Thursday, January 27, 2022

CFAC MEETING - REGULAR MEETING
(Virtual Meeting via Video Conferencing)

MEMBERS PRESENT: ☒ Michael McGuire ☒ Ellen Gibson, ☐ Dorothy Johnson ☐ Carrie Morrissey ☒ Jackie Blue ☐ Sharon Harris ☐ Briana Harris ☒ Shirley Francis
☒ Tekeyon Lloyd ☒ Tracey Glenn- Thomas ☒ Renee Lloyd ☒ Carson Lloyd Jr. ☒ Felishia McPherson ☐ Alejandro Vasquez ☐ Andrea Clementi

BOARD MEMBERS PRESENT:

GUEST(S): Shavalia Ingram CEEC

STAFF PRESENT: ☒ Doug Wright, Director of Community & Member Engagement, ☒ Starlett Davis, Member Engagement Specialist, ☒ LaKeisha McCormick, Member Inclusion & Outreach Manager

Join Zoom Meeting

<https://alliancehealthplan.zoom.us/join/tJ0scOyrpjwrE9x3eLYcqpxB0H5r6YLuY0K2>

Call in Number: +1 646 558 8656

Meeting ID: 910 6733 3915

1. WELCOME AND INTRODUCTIONS: Renee Lloyd, Co CHair

2. REVIEW OF THE MINUTES – The minutes from the November 18, 2021, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; a motion was made by Michael McGuire and seconded by Tekeyon Lloyd to approve the minutes. Motion passed.

| AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME: |
|--------------------|---|--|----------------|
| 3. Public Comments | <p>Felishia, Renee and Starlett Community events and resources. Covid 19 Check ins</p> <p>Michael McGuire informed the committee that Cumberland County received a large sum of money to have their officers trained in Mental Health and First Aid. He inquired if Alliance would be conducting some of the training and if any members could take part in it while it was free. Doug and Starlett were unsure but would find out. Starlett made an announcement about National Wear Red Day for Heart Health and the Alliance training for it. Everyone gave health updates and well wishes. Dr. Mankad will be at the February meeting. Please have questions ready about Covid.</p> | <p>Please see Doug, Felishia, Renee, and Starlett for questions.</p> | <p>Ongoing</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: |
|------------------|---|---|-------------------|
| 4. ADA Updates | Shirley Francis- ADA updated meeting information. Next meeting will be February 19, 2022, at 6pm, virtually. The guest speaker will be Amil Nazar, ADA Title 4 Rep/ City Manager Office. He will be giving updates on the city plan and how to navigate the systems challenges, i.e. housing, grievances, etc. | Please see Shirley Francis for any questions. Next ADA meeting is February 16, 2022, at 6pm virtually | February 16, 2022 |
| 5. State Updates | <p>Shavalia Ingram January CE&E Update Shavalia went over the updates. Most dates have passed. She went over the routine meetings and times. January 2022 is Get Organized Month, National Birth Defects Prevention Month, Poverty Awareness Month, Dr. MLK Jr. Day, and Slavery and Human Trafficking and Prevention Month. Felishia asked if Cumberland County could go green downtown for Mental Health Month. This means the lights and business downtown would have all green lights in honor of that month. Felishia asked how that could happen. Starlett asked her to send an email on her thoughts and she would reach out to Mayor's assistant. The committee asked questions and Shavalia gave clarity on it. Please refer to CE&E announcement sent out for additional updates.</p> <p>Registration for NC One Community in Recovery Conference is doing calls for proposals at this time. Registration will be sent out once it opens.</p> | Please see handout for information and inquire with Doug or Shavalia for questions, | Ongoing |
| 6. MCO | <p>Doug Wright MCO Updates NCMT Fact Sheet- Children and Youth Transitioning into Foster Care Ombudsman Presentation</p> <p>Mecklenburg and Orange County CFACS had their interest meetings on Tuesday, January 25, 2022. Mecklenburg had 25 people participating. Orange had 10 to 12. Applications are coming in. Alliance is asking people to fill out an application with name, disability they represent, member or family member and why they want to be in CFAC. The applications will be presented to the Steering Committee on February 7th and voted on. This will give them an initial group to start writing charters and how to build themselves up. Hopefully, the first meetings will be next month.</p> | Please see Doug or Starlett for any questions. | 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: |
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| | <p>Doug introduced Lakeisha McCormick, Membership Inclusion and Outreach Manager for Mecklenburg.</p> <p>Human Rights committee met on January 13th. WE talked to Damali Austin about provider report cards and their use to encourage service adherence and support for providers. WE also looked at grievances and incidents.</p> <p>Alliance is starting the process of returning to office on February 7th. There will be quite a few people who will not come back to the office. They are Teleworking. They will be clearing out their areas for the first two weeks. The following two weeks are for Telecommuters that are working 1 day a week in the office. They will clear out their office then. After that, the facilities will be cleaned well, rearranged, and spaces reassigned. This will be mainly for the home office. The Cumberland office hasn't started yet. The new normal will happen in May. Some people are in the office now.</p> <p>Reminder that Secretary Cohen is gone and resigned at the end of the year. Cody Kinsley is now our Secretary. We are awaiting confirmation on that. He was pretty much on board with Cohen and has similar interests. There are a lot of changes at the department. Dr. Laws left the DMH. Victor Armstrong shifted into another DEIC roll.</p> <p>Legislative Breakfast is on 2/26/2022 on a Saturday from 9am to 12. It is virtual. Seats are available. Please let us know quickly if you want to participate. Michael, Ellen, Felishia, and Jackie want to participate. Please notify Doug or Star if you want to register.</p> <p>Doug asked the committee to look over the NCMT Fact Sheet-Children and Youth Transitioning into Foster Care</p> <p>Doug presented the Ombudsmen and the role in our new system. It talks about the changes that are happen with tailored plans and all surrounding that and Medicaid reform. He also went over what is</p> | | |

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



Thursday, January 27, 2022

CFAC MEETING - REGULAR MEETING
(Virtual Meeting via Video Conferencing)

| AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME: |
|--------------------------|--|---|---|
| | not changing. Please refer to training for additional information. ***When health plan is said, it means standard plan. *** | | |
| 7. Prep for next meeting | Felishia- Discuss the next meeting agenda items. Go over expectations, reminders, etc for the next meeting. Have questions ready for Dr. Mankad for the February meeting. Felishia asked about Alliance giving out masks. Doug and Starlett informed about the State giving out free masks to organizations. The state is also giving out 4 free Covid tests if you zip code qualifies as an area of need. Biden put communication about the huge reserve of masks being sent out. Steering Committee, February 7, 2022, will have updated bylaws that needs a quorum to vote on. The Olmstead Plan will be reviewed. They both will be sent out a head of time. Please take some time to go over both, so that we can obtain feedback. | Next Steering Committee Meeting 2/7/2022 Next Local CFAC is 2/24/2022. Have questions ready for Dr. Mankad on Covid. Read Bi Laws and Olmstead Plan. | February 7, 2022 February 24, 2022 |
| 8. Appreciation | Everyone gave their appreciations | | |
| 9. | | | |

ADJOURNMENT: Motion for adjournment was given by Felishia. It was seconded by Shirley. Meeting adjourned at 6:34pm

Respectfully Submitted by:
Starlett Davis, MA Membership Inclusion and Outreach 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.

Fact Sheet

NC Medicaid

Children and Youth Transitioning from NC Medicaid Managed Care to Foster Care

Guidance for Children, Youth and their Families

The North Carolina Department of Health and Human Services (NCDHHS) transitioned most Medicaid beneficiaries to NC Medicaid Managed Care (Standard Plans) on July 1, 2021.

At the time of transition, children in foster care remained in NC Medicaid Direct without the option to choose a Standard Plan.

As of July 1, 2021, children who are enrolled in Standard Plans and enter foster care are disenrolled from their Standard Plan. This Fact Sheet addresses questions related to the Standard Plan disenrollment process for children in foster care.

WHAT HAPPENS IF I AM ENROLLED IN A STANDARD PLAN AT THE TIME I ENTER FOSTER CARE?

Once the local Department of Social Services (DSS) Medicaid program is aware that a child has entered foster care, the Medicaid caseworker adds foster care evidence in NC FAST, NCDHHS' eligibility system. This changes the child's managed care status in NC FAST. If a child is enrolled in a Standard Plan at the time they enter foster care, the child will be disenrolled from the Standard Plan and transitioned back to NC Medicaid Direct.

When the child transitions to NC Medicaid Direct, the Standard Plan works with Community Care of North Carolina (CCNC) and the Local Management Entity/Managed Care Organization (LME/MCO) to transition care management, services and supports for the child. All organizations work together to minimize any disruption of services or care.

WHAT IS THE DISENROLLMENT PROCESS TIMELINE?

After a child moves to foster care and the Medicaid caseworker adds foster care evidence in NC FAST, NC Medicaid Direct is effective retroactive to the first day of the month that the child entered foster care.

The child will receive health care services, paid through NC Medicaid Direct, retroactive to the first day of the month that the child entered foster care.



State of North Carolina • Department of Health and Human Services • Division of Health Benefits (NC Medicaid)
www.medicaid.ncdhhs.gov • NCDHHS is an equal opportunity employer and provider. DECEMBER 2021

WHAT ARE MY CHOICES AFTER I HAVE ENTERED FOSTER CARE?

After a child enters foster care, the child transitions to and remains in NC Medicaid Direct and cannot choose a Standard Plan.

WILL I LOSE ANY OF MY PROVIDERS?

Children in foster care can receive health care services from any provider who accepts NC Medicaid. This means they may continue to see the provider(s) from their Standard Plan.

For a full list of NC Medicaid providers, call **1-833-870-5500** or go to ncmedicaidplans.gov.

WHAT IF I HAVE QUESTIONS?

If you have questions about a child's **Medicaid eligibility**, you can contact your local DSS. A list of locations can be found here: ncdhhs.gov/localdss.

If you have questions about a child's **health care choices**, you can contact the NC Medicaid Enrollment Broker at **1-833-870-5500** or ncmedicaidplans.gov.



Monday, February 14, 2022

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 ☒ Vandna Munishi, ☒ Victoria Nneji

STAFF PRESENT: ☒ Doug Wright, Director of Community & Member Engagement, ☒ Ramona Branch, Member Inclusion & Outreach Manager,
☒ Douglas McDowell, Member Inclusion & Outreach Specialist

<https://alliancehealthplan.zoom.us/j/98180766572>

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the January 10, 2022, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; and motioned to be approved by Chris Dale and Dave Curro. Motion Passed.

| AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME: |
|---|---|-------------|-------------|
| 3. Public Comments/ Covid -19 Check In | The NC DHHS is giving out free KN95 masks in Raleigh- members were asked to visit DHHS website for more information | N/A | N/A |
| 4. State Updates | ShaValia Ingram, NCDHHS was in attendance and went over the State updates February CE&E: <ul style="list-style-type: none">➤ Joint DMHDDSAS & DHB Update call: Providers- Thursday, February 3rd 3:00 p.m.— 4:00 p.m➤ Joint DMHDDSAS & DHB Update call: Consumers & Family Members- Monday, February 28th 2:00 p.m.—3:00 p.m➤ The State Consumer and Family Advisory Committee (SCFAC)- Wednesday, February 9th- 9:00 a.m.— 3:00pm-virtual➤ The State to Local Collaboration Call- February 23, 2022 from 6:00 p.m.— 7:30 p.m.➤ Medicaid Hot Topics Tailored Plan and Behavioral Health Feb 17, 2022 5:30 p.m | 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"> ➤ Save the Date for Spring 2022 13th Annual NC “One Community in Recovery” Conference: Healing Together After Being Apart April 27-29, 2022 ➤ Community Inclusion and Recovery: How Community Inclusion Helped Me- Tuesday, February 22- 200pm ET/1:00 pm MT/11:00 am PT ➤ Legislative Breakfast- February 26th -Check-in starts at 7:30 AM 8:00-8:45 AM— Vendor Time and OJ reception 9:00-12:00 PM— Main Event | | |
| 5. Olmstead Plan | <p>Doug went over the Final Olmstead Plan for North Carolina Focus points on the plan priorities:</p> <ul style="list-style-type: none"> ➤ Strengthen Individuals' and Families' Choice for Community Inclusion through Increased Access to Home and Community Based Services and Supports ➤ Address the Direct Support Professional Crisis ➤ Divert and Transition Individuals from Unnecessary Institutional and Segregated Settings ➤ Increase Opportunities for Supported Education and Pre-employment Transition Services for Youth with Disabilities, and Competitive Integrated Employment for Adults with Disabilities ➤ Increase Opportunities for Inclusive Community Living ➤ Address Gaps in Services ➤ Explore Alternatives to Full Guardianship ➤ Address Disparities in Access to Services ➤ Increase Input from Individuals with Lived Experience ➤ Reduce Transportation Burdens for Individuals with Disabilities ➤ Use Data for Quality Improvement <p>Key message- Hold them accountable (the State and Alliance) for the priorities, and make sure they deliver Alliance will utilize the plan priorities to in framing their workflows</p> | Ongoing | 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: |
|-------------------------------|--|-------------|-------------|
| 6. LME/MCO Updates | Budget Retreat- March 21 st - Please gather your thoughts and submit them to Doug or Ramona for them to give to Jason Phipps, so he can submit to the Board Orange CFAC meeting- 3 members voted in- 1 st meeting- February 22 nd Mecklenburg CFAC meeting- 9 members voted in- 1 st meeting- February 28 th - the first meeting will entail developing a charter and electing officers CFAC Advocacy & Info document- please review and utilize for advocacy with legislators | | |
| 7. Steering Committee Updates | Meetings- Stay virtual? Or when would you like to resume in person? The Durham Committee voted tonight on whether to go back to in person meetings or stay virtual- The group unanimously voted on staying virtual for the next few months and will continue to revisit | N/A | N/A |
| 8. Announcements | Charlitta asked for Senator Woodard to come and talk to the group- Ramona to email his secretary and ask if he is willing to come again | N/A | N/A |

ADJOURNMENT: 7:10pm The next meeting will be February 14, 2022, at 5:30 p.m.

Respectfully Submitted by:

Ramona Branch, Member Inclusion Specialist

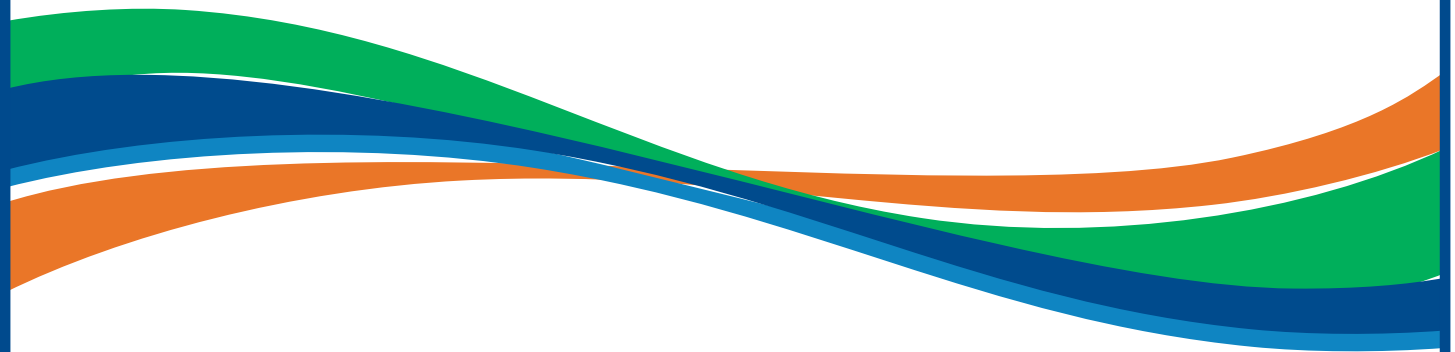
01.12.2022



Consumer and Family Advisory Committee

CFAC

Advocacy & Information



Advocacy

[ˈadvəkəsē] NOUN: public support for or recommendation of a particular cause or policy. (Oxford Dictionary 2021.)

- Self-advocacy is a skill that allows people to identify their strengths and areas they may need additional support with, know what they need to succeed and communicate that to other people. An individual is entitled to be in control of their own resources and how they are directed.
- Individual advocacy focuses on changing the situation of one person to protect his or her rights or to improve individual services. Individual advocacy involves supporting people to exercise their rights by providing assistance to: voice concerns, access information, resolve issues/ concerns.
- Systems advocacy is an effort to change policies, rules or laws which determine how services are provided. Because systems advocacy works to cause change in organizations, service systems or laws, it requires a long-term, sustained effort by a number of people. It is harder to change how an organization or system treats a whole group of persons than it is to change a decision made by one person about the situation of another.
- Systems advocacy can benefit many people and strives to prevent problems.
- There are many different types of advocacy, including: self-advocacy, group advocacy, peer advocacy, citizen advocacy, professional advocacy, and non-instructed advocacy.
- Many of the components of each type of advocacy are interchangeable; Below is information about individual and systems advocacy.

Individual Advocacy

Five components of self-Advocacy:

- Personal responsibility.
- Knowledge of the law and other rules.
- Fact finding and documentation.
- Negotiating.
- Believing in oneself.

Tips for the self-advocate:

- Realize you have rights and are entitled to equality under the law.
- Keep informed and ask questions.
- Take advantage of resources.
 - ◆ Examples include peer-run, family, and community support programs; referral/crisis hotlines; advocacy groups; informative classes; and assertiveness training groups.
- When contacting a resource insist that explanations are clear and understandable.

Responsibilities of the self-advocate:

- Be clear about what you need and want.
- Always go to meetings.
- Ask who is at your meetings and why.
- Keep all your papers.
- Never sign blank copies of forms.
- Document what happens; take notes or have someone else do it.
- Take someone along if you need help.
- Know the laws that regulate your services.

Figure out if it's working

- Ask questions about when, where, and how often the service is going to happen.
- Keep a log; write down when services happen.
- If services don't happen, know whom to call.
- Evaluate happiness with services provided.
- Always ask for any decision or change to be put in writing and wait for it.
- Use communication skills.
- Use the telephone to gather information, to keep track of progress and to let people know what you want.

Expressing dissatisfaction

- Before expressing dissatisfaction, write down the essential points.
- Stay calm.
- Make the conversation brief and clear.
- Be willing to listen.
- Ask for the name and position of the person one is talking with.
- Ask when to expect action.
- If this person can't help, ask who can.
- If necessary ask to speak to a supervisor.
- Thank the person for being helpful.
- Keep a record of the call and follow-up.

Tips for negotiating

- Pay attention, do not frown.
- Use good listening skills.
- Ask for what you want and say why.
- If the other person agrees, thank them; if not, suggest a compromise.
- If they agree with the compromise, thank them.
- Believe in yourself and do not give up.

Systems Advocacy Planning

1. Identify the problem.

- What is missing from your community?
- What areas does your community need to improve in?

2. Support your idea.

- Get the facts and data to back up the problem you have identified.
- This information can be numbers or stories.

3. Make a plan.

- SMART (specific, measurable, achievable, relevant, time-bound).
- Revise when needed.

4. Gather support.

- Who in the community feels the way you do?
- Are there community members who haven't been included in past who might be interested?

5. Adopt a positive attitude.

- Be firm, persistent, and consistent.
- Maintain your credibility.

North Carolina Department of Health and Human Services

www.ncdhhs.gov

The Department of Health and Human Services (DHHS) manages the delivery of health- and human-related services for all North Carolinians. The department works closely with healthcare professionals, community leaders and advocacy groups; local, state and federal entities; and many other stakeholders. The department is divided into 30 divisions and offices that fall under four broad service areas: health, human services, administrative, and support functions.

NC Department of Health and Human Services

Secretary Mandy Cohen, MD, MPH
2001 Mail Service Center
Raleigh, NC 27699-2000
Customer Service Center: 1-800-662-7030
Administrative office: 919-855-4800

Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS)

Deputy Secretary Kody H. Kinsley
Administrative office: 919-733-7011
Customer Service & Community Rights Team: 1-855-262-1946; drnh.advocacy@dhhs.nc.gov
Division of Health Benefits (Medicaid and Health Choice)
Deputy Secretary Dave Richard
Administrative office: 919-855-4100
Medicaid Transformation: <https://www.ncdhhs.gov/assistancejmedicaid-transformation>

State Consumer and Family Advisory Committee

The State Consumer and Family Advisory Committee (SCFAC) advises the NCDHHS and the General Assembly on the planning and management of the DMH/DD/SAS.

State CFAC meetings are held the second Wednesday of every month from 9:00 am to 1:00 pm. (Currently being held virtually).

Prior to each meeting, the agenda is posted on the DHHS DMH/DD/SAS website under councils and Committees, State Consumer and Family Advisory Committee.

State to Local CFAC conference calls are held the third Wednesday of every month from 7:00-8:30 p.m. Let Kate Barrow or Stacey Harward know ahead of time if you plan to call.

CALL-IN tt: 1-888-273-3658; ACCESS CODE: 2490768#; MUTE: *6

Regional National Alliance on Mental Illness (NAMI) Affiliates

NAMI North Carolina

(919) 788-0801

mail@naminc.org

<http://www.naminc.org>

NAMI Cumberland, Lee, and Harnett County

President: Hannah Carroll

hanncarro@aol.com

(910) 476-7164

NAMI Family Support Groups meet the 3rd Tuesday of each month at 6pm meetings are held at 109 Bradford Ave., Fayetteville, NC 28301. (Recommended to call ahead.)

NAMI Durham

President: Janelle V. Hampden

<http://namidurhamnc.org>

(919) 231-5016

Call (919) 231-5016 to find a support group to best fit your needs and location within the county or for the most up-to-date information.

NAMI Johnston

President: Richard Callahan

(919) 464-3572

namijcnc@gmail.com

<http://www.namijcnc.net>

Family Support Groups (Recommended to call ahead to confirm): Thursdays at 6:30 pm at The Study Center at Hocutt Baptist Church. 353 West Second Ave., Clayton, NC 27520 and Saturdays at 2 pm at Pathways to Life, 1420-A South Pollock St., Selma, NC 27576.

NAMI Wake

President: Andrea Chase

andrea@nami-wake.org

(919) 848-4490

admin@nami-wake.org

<http://www.nami-wake.org>

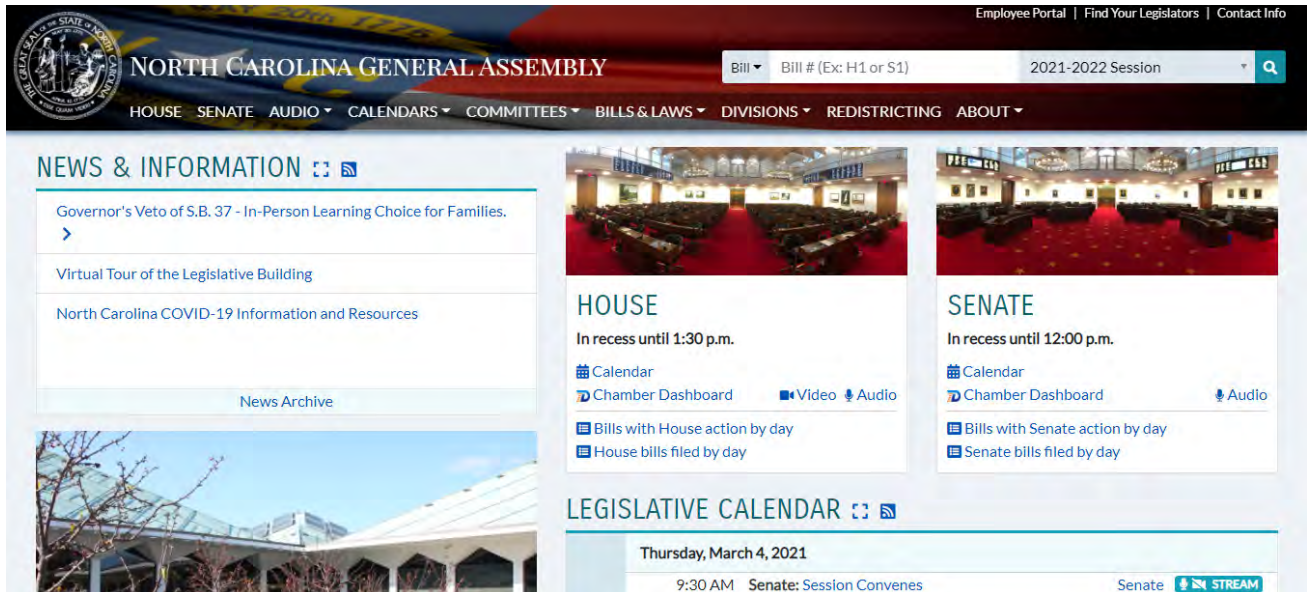
Family to Family support groups are virtual for the time being, Tuesdays from 7-8:30 pm. Register via the website.

****All dates, times, and locations subject to change due to COVID-19****

NCLEG Navigation

The North Carolina General Assembly website is full of information on the happenings in the house, senate and general assembly news. This site gives you information on the current bills in action, session audio, calendars, redistricting information and committees. Below is information on how to navigate this site to find all you need about the general assembly.

The image below is what you will see when you go to <https://www.ncleg.gov>.



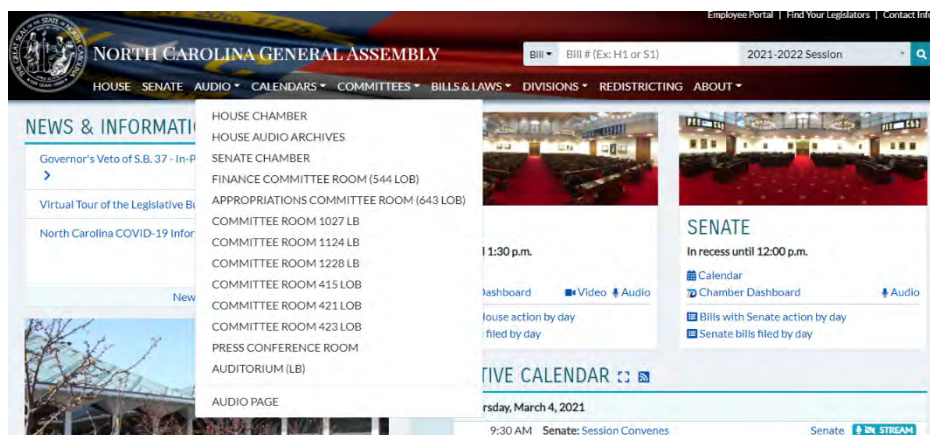
There are several tabs at the top to navigate to various items of information on the site.



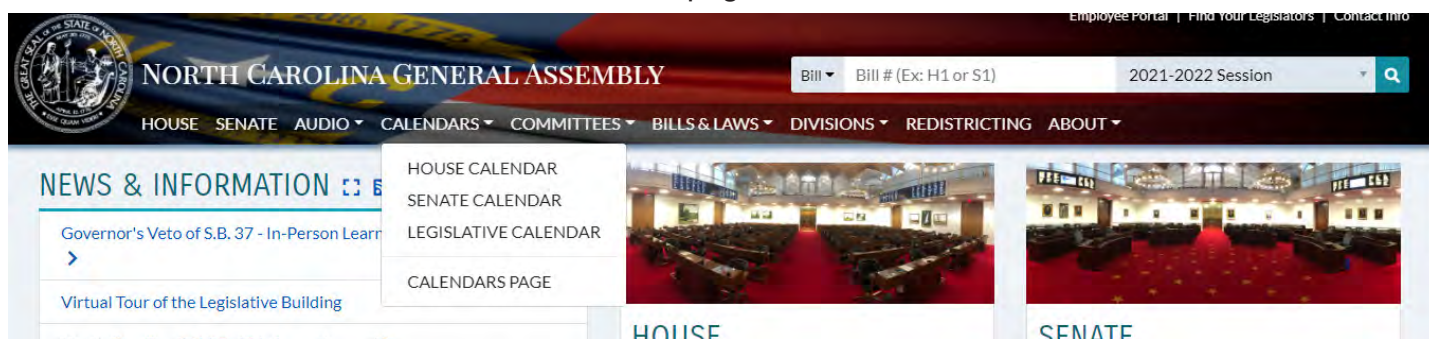
Each tab has information relative to it. For example, the House tab has information on the number of representatives, the speaker of the house, and its purpose. There are also member information, calendars, chamber information and more. The Senate tab is similar.



The Audio tab houses audio from the different sessions held. Once the tab is clicked on, you are able to select which you would like to listen to.

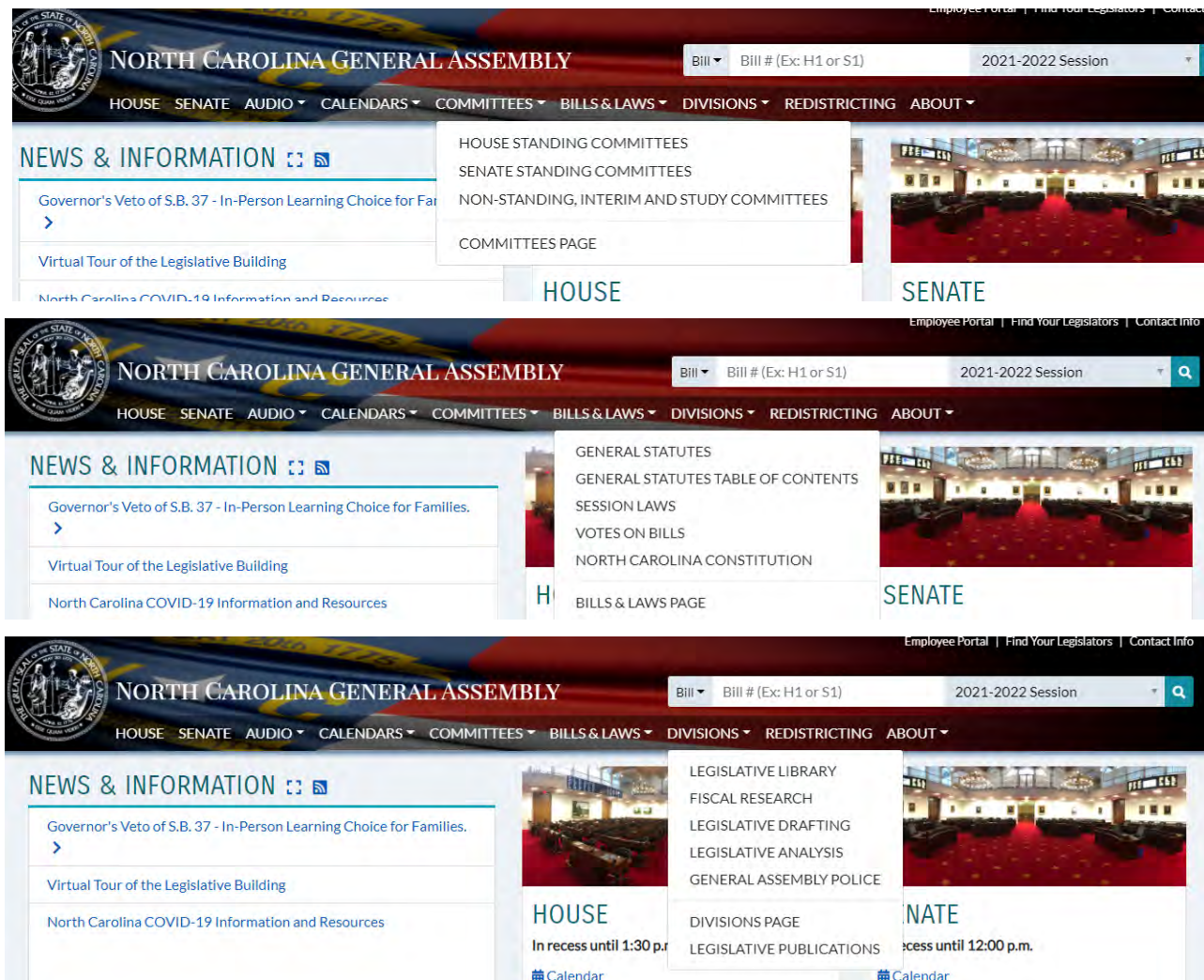


The Calendar tab lists the house, senate, and legislative calendars and you can go to the each page. There is also calendar events listed on the home page.



| LEGISLATIVE CALENDAR | | | |
|-------------------------|----------|---|-------------------------------------|
| Thursday, March 4, 2021 | | | |
| THU 3/4 | 9:30 AM | Senate: Session Convenes | Senate STREAM |
| | 10:00 AM | House: Session Convenes | House STREAM |
| | 11:00 AM | House: Local Government - Land Use, Planning and Development -- UPDATED | 1228/1327 LB STREAM |
| | 1:00 PM | House: Rules, Calendar, and Operations of the House | 1228/1327 LB STREAM |
| Friday, March 5, 2021 | | | |
| FRI 3/5 | 10:00 AM | General Statutes Commission | 544 LOB STREAM |
| Tuesday, March 9, 2021 | | | |
| TUE | 8:30 AM | Senate: Appropriations on Health and Human Services (Joint) | 421 LOB STREAM |
| | 8:30 AM | House: Appropriations, General Government (Joint) | 423 LOB STREAM |
| | 10:00 AM | House: Health | 643 LOB STREAM |

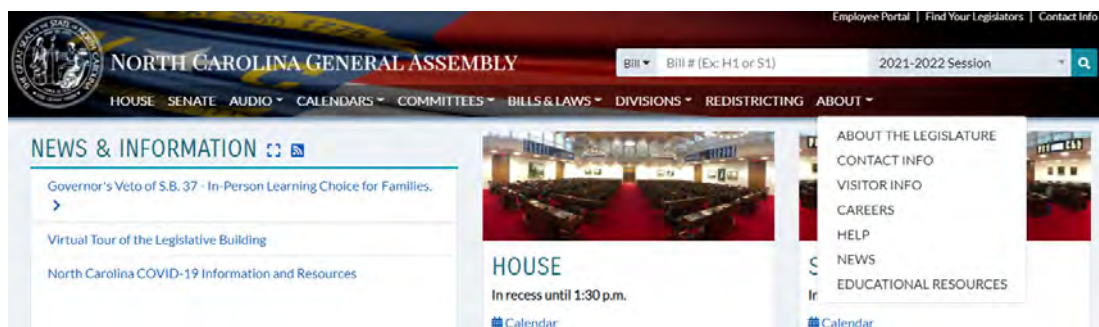
The Committees, Bills & Laws, and Divisions tabs give information on all that relates to each listing.



The Redistricting tab holds the legislative and congressional redistricting information for the state house, senate, and congressional redistricting as well as ideal district populations and resources.



The final tab on the navigation bar is the About tab. It gives an overview of other pertinent information relative to the public in the NC General Assembly.



The site also provides news and information that is relative to current events.



The bottom of the page gives you a way to quickly link to the top tabs as well as a help resource and careers.





Tuesday, February 15, 2022

Johnston CFAC MEETING - REGULAR MEETING
Virtual Meeting via Zoom
5:30 – 7:00 p.m.

MEMBERS PRESENT: Jason Phipps, Marie Dodson, Jerry Dodson, Leanna George, Marilyn Lund, and Albert Dixon

BOARD MEMBERS PRESENT: None

GUEST(S): ShaValia Ingram, DHHS

STAFF PRESENT: Doug Wright, Director of Community & Member Engagement, Ramona Branch, Member Inclusion & Outreach Manager, Noah Swabe, Member Inclusion Specialist

Zoom Link: <https://alliancehealthplan.zoom.us/j/97531673591>

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from January were reviewed a motion was made by Jason, seconded by Leanna, motion passed.

| AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME: |
|--|---|--|-------------|
| 3. Public Comment Individual/Family Challenges and Solutions | Albert provided the CFAC with community updates surrounding “Recovery Alive” with Temple Baptist Church. Albert participated in an event with Temple to raise money for the program, Albert reports the event raised over \$1000 dollars. | None | None |
| 4. LME/MCO Updates | <p>Doug reviewed the Final Olmstead Plan for North Carolina</p> <p>Focus points on the plan priorities:</p> <ul style="list-style-type: none">• Strengthen Individuals’ and Families’ Choice for Community Inclusion through Increased Access to Home and Community Based Services and Supports• Address the Direct Support Professional Crisis• Divert and Transition Individuals from Unnecessary Institutional and Segregated Settings• Increase Opportunities for Supported Education and Pre-employment• Transition Services for Youth with Disabilities, and Competitive Integrated Employment for Adults with Disabilities• Increase Opportunities for Inclusive Community Living• Address Gaps in Services• Explore Alternatives to Full Guardianship• Address Disparities in Access to Services• Increase Input from Individuals with Lived Experience• Reduce Transportation Burdens for Individuals with Disabilities• Use Data for Quality Improvement | Alliance staff will continue to provide updates as they become available | None |

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



Tuesday, February 15, 2022

Johnston CFAC MEETING - REGULAR MEETING
Virtual Meeting via Zoom
5:30 – 7:00 p.m.

| AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME: |
|------------------|---|---|-------------|
| | <p>General LME/MCO Updates</p> <ul style="list-style-type: none">Budget Retreat- March 21st- Please gather your thoughts and submit them to Doug, Ramona, or Noah for them to give to Jason Phipps, so he can submit to the BoardOrange CFAC meeting- 3 members voted in- 1st meeting- February 22ndMecklenburg CFAC meeting- 9 members voted in- 1st meeting- February 28th- the first meeting will entail developing a charter and electing officersCFAC Advocacy & Info document- please review and utilize for advocacy with legislators | | |
| 5. State Updates | <p>ShaValia Ingram reviewed the February CE&E update covering the following:</p> <ul style="list-style-type: none">Joint DMHDDSAS & DHB Update call: Consumers & Family Members- Monday, February 28th 2:00 p.m.—3:00 p.mThe State Consumer and Family Advisory Committee (SCFAC)- Wednesday, February 9th- 9:00 a.m.— 3:00pm-virtualThe State to Local Collaboration Call- February 23, 2022 from 6:00 p.m.– 7:30 p.m.Medicaid Hot Topics Tailored Plan and Behavioral Health Feb 17, 2022 5:30 p.mSave the Date for Spring 2022 13th Annual NC “One Community in Recovery” Conference: Healing Together After Being Apart April 27- 29, 2022Community Inclusion and Recovery: How Community Inclusion Helped Me- Tuesday, February 22- 200pm ET/1:00 pm MT/11:00 am PT | <p>Please let Noah know if any events are of interest</p> | <p>None</p> |

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



Tuesday, February 15, 2022

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">Legislative Breakfast- February 26th -Check-in starts at 7:30 AM 8:00-8:45 AM— Vendor Time and OJ reception 9:00-12:00 PM— Main Event | | |
| 6. Guardianship Video | Jason and Noah will work on putting together a one pager complete with links and resources to promote the Guardianship Video. Making it easily accessible for community partners to access and use as a resource for members and families. | Create one pager and review with the CFAC at the March meeting | March 15, 2022 |
| 7. Meeting Location | Johnston CFAC will remain virtual for the upcoming March meeting | Johnston CFAC will evaluate in person meetings again at the March meeting | March 15, 2022 |
| 8. Announcements | None | None | None |

9. **ADJOURNMENT:** Next Meeting March 15, 2022 at 5:30pm via Zoom

Respectfully Submitted by:

Noah Swabe, Member Inclusion 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.

MEMBERS PRESENT: ☒ Annette Smith, ☐ Rebekah Bailey, ☒ Trula Miles, ☒ Karen McKinnon, ☒ Benjamin Smith,
☐ Vicky Bass, ☒ Jessica Larrison, ☒ , ☐ Bradley Gavriluk, ☒ Faye Griffin

BOARD MEMBERS PRESENT: None

GUEST(S): ☒ ShaValia Ingram DHHS; LaNarda Williams, Brian Williams, Alicia Jones, Rasheeda McAllister

STAFF PRESENT: ☒ Doug Wright, Director of Community & Member Inclusion; Ramona Branch Inclusion and Outreach Manager;
☒ Erica Asbury, Member Inclusion Specialist; ☒ LaKeisha McCormick, Manager- Member Inclusion and Outreach Mecklenburg; ☒ Eileen Bennett,
Member Inclusion Specialist; Douglass McDowell, Member Inclusion Specialist

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the January 11, 2022, Consumer and Family Advisory Committee (CFAC) meeting were motioned by A. Smith and second by T. Miles.

| AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME: |
|----------------------------|---|-------------|-------------|
| 3. Public Announcements | <p>A.Smith opened the meeting by asking all of the guest on the call to introduce themselves.</p> <p>A.Smith shared that there is a provider that is interested in moving to NC and is sending out her resume out. She also shared that there are many job openings on the NCDHHS website and that she hopes that the pertinent ones get filled soon.</p> | Ongoing | N/A |
| 4. State Updates-S. Ingram | <p>ShaValia Ingram, NCDHHS was in attendance and went over the State updates February CEE:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heart Health Month and recipes and ideas to jumpstart your fitness are linked. Black History Month as well. <input type="checkbox"/> Joint DMHDDSAS & DHB Update call: Providers 2/3/22 from 3 pm - 4 pm <input type="checkbox"/> Joint DMHDDSAS & DHB Update call: Consumers & Family Members Monday, 2/28/2022 from 2 pm - 3 pm <input type="checkbox"/> Regional CFAC Meetings have NOT been scheduled at this time | Ongoing | 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"> <input type="checkbox"/> State to Local Collaboration Meeting o Next Call: 2/23/22 6-7:30pm <input type="checkbox"/> A new pilot program is being developed related to TBI. The next Brain Advisory Council meeting will be on 3/9/3033 9am-1pm please send and email to request for meeting access. <input type="checkbox"/> Advanced Medical Home Plus has completed desk reviews. Information about it may be found in the Tailored Care Management Updates 1/28/22. <input type="checkbox"/> NCTIDE Behavioral Health Conference will be 4/25-4/27/2022 in Wilmington NC. <input type="checkbox"/> The NC Medicaid Hot Topic Series is every 3rd Thursday and the next one will be on 2/17/22 at 5:30 pm <input type="checkbox"/> The Resource Guide for Veterans may be viewed electronically but hard copies may be requested through CEE team <input type="checkbox"/> Community Inclusion and Recovery: How Community Inclusion Helped Me will be on 2/22/22 at 2pm and will support peer specialists <input type="checkbox"/> The 2022 CIT Conference will be in Raleigh 2/24/22 9-4:30. <input type="checkbox"/> One Community in Recovery will be April 27th-29th at the GTCC Colfax, NC it will be offered both in person and virtual <input type="checkbox"/> The Women's Recovery Conference will be 5/4-5/6/2022 <input type="checkbox"/> The Legislative Breakfast registration ends 2/26/2022 <input type="checkbox"/> The State of the Child Conference is May 11,2022 <p>S. Ingram requested that the February CEE be sent out to members.</p> | | |
| 5. MCO/LME update | <p>D. Wright welcomed and announced Ramona Branch as the new Member Inclusion and Outreach Manager effective 2/7/22.</p> <p>D. Wright emphasized that getting the information out and sharing it about the NC Olmstead plan is everyone's responsibility and challenged the attendees to go through the document and to spend time understanding it.</p> <p>The board budget retreat is upcoming, and Alliance would like to here from local CFAC. Please share your thoughts and concerns with staff.</p> <p>The Tailored Plan will have a stakeholder group that will include Alliance staff, providers, members and families. This will be a great opportunity to give</p> | Ongoing | 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: |
|-----------------------|--|-------------|-------------|
| | <p>feedback. A. Smith suggested that reports from/about providers should be monitored to be cognizant of things that need to be updated or changed.</p> <p>A. Jones shared that collecting information from families and connecting with families in certain areas is still difficult based on lack of technology. A. Smith also suggested that Alliance remain aware of the fact that many families cannot be linked through social media and to keep traditional means of sharing information current.</p> <p>Bylaws have been changed to update names and marked changes based on the tailored plan.</p> <p>The Human Rights Committee reports have been published and made available. Please review them in detail and contact us if you have any questions or concerns.</p> | | |
| 6. Steering Committee | <p>D. Wright shared that during the meeting on 2/7/22 the steering committee was presented with the names of eight members from Mecklenburg and three members from Orange to begin their new CFAC Subcommittees.</p> <p>The Bylaws were entered in and voted on and approved. There was emphasis and discussion related to the reminder that the subcommittee chair and one member are expected to participate in the steering committee.</p> <p>Steering committee meetings will continue to remain virtual.</p> | N/A | N/A |
| 7. Announcements | <p>L. Williams introduced herself and her son Brian.</p> <p>A. Smith reminded everyone of the importance of having both a chair and co chair for CFAC. She asked that people give serious consideration to becoming a co-chair. Discussion was given to the number of times that a person needed to attend meetings before being voted in as a member. D. Wright stated that the Wake County CFAC Subcommittee bylaws do not have a specific number related to attendance to be voted in as a member.</p> | | |

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



Tuesday, February 08, 2022

Wake CFAC MEETING - REGULAR MEETING

Virtual meeting via videoconference

| AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME: |
|---------------|--|-------------|-------------|
| | <p>T. Miles asked if the meetings would remain virtual. D. Wright stated that the March meeting will be virtual and that will be the time to discuss when meetings will return to in person or hybrid.</p> <p>E. Asbury shared that member Gregory Schweizer had passed away and moments were given to honor both him and his family.</p> <p>.</p> | | |
| | | | |

ADJOURNMENT: F. Griffin motioned to adjourn and A. Smith second. A. Smith adjourned the meeting at 7:00pm. The next meeting will be March 8, 2022, at 5:30 p.m.

Respectfully Submitted by:

Erica Asbury, Member Inclusion Specialist

02.17.22

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: Finance Committee Report

DATE OF BOARD MEETING: March 3, 2022

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): Request approval to authorize the CEO to enter into a contract with Acero Health Technologies for IT consulting including application development and quality assurance related to the BH/IDD Tailored Plan contract requirements for an amount not to exceed \$1,000,000.

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

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Finance Committee Meeting

Thursday, March 3, 2022

3:00-4:00 pm

AGENDA

- 1. Review of the Minutes – February 3, 2022**
- 2. Monthly Financial Reports as of January 30, 2022**
 - a. Summary of Savings/(Loss) by Funding Source
 - b. Statement of Revenue and Expenses (Budget & Actual)
 - c. Senate Bill 208 Ratios
 - d. DHB Contractual Ratios
- 3. Contract(s)**
 - a. A **motion** to recommend the Board authorize the CEO to enter into a contract with Acero Health Technologies for IT consulting including application development and quality assurance related to the BH/IDD Tailored Plan contract requirements for an amount not to exceed \$1,000,000.
- 4. FY23 Budget Retreat – March 21, 2022**
- 5. Adjournment**

Next Meeting: Thursday, April 7, 2022 from 3:00-4:00

Alliance Health

Hybrid meeting available in person and via Zoom



Thursday, February 03, 2022

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 (Committee Chair-designee), and ☒ Vicki Evans

BOARD MEMBERS PRESENT: n/a

GUEST(S) PRESENT: Pamela Wade, 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, Ashley Snyder, Director of Accounting and Finance,

1. WELCOME AND INTRODUCTIONS – the meeting was called to order at 3:04 PM

2. REVIEW OF THE MINUTES – The minutes from the December 2, 2021, meeting were reviewed; a motion was made by Ms. Council and seconded by Ms. Evans 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 the Summary of Net Position, Summary of Savings/(Loss) by Funding Source, the Statement of Revenue and Expenses, Senate Bill 208 Required Ratios, and DHB Contract Ratios as of December 31, 2021.</p> <p>Ms. Pacholke discussed the following:</p> <ul style="list-style-type: none">• As of 12/31/21, we have total assets of \$325M, total liabilities of \$111.3M and total net position of \$213.6M• Through 12/31/21, we have savings of \$73.2M with \$47.3M being a transfer received from Cardinal for our share of Mecklenburg and Orange risk reserve (restricted fund balance)• We are meeting all SB208 and DHB contractual ratios. | | |
| 4. FY22 Budget Amendment | <p>Ms. Pacholke shared a FY22 budget amendment 1 presentation. The budget is increasing from the approved budget of \$573,948,623 to \$923,449,490 for a total increase of \$349,500,867. Ms. Pacholke discussed the significant reasons for increases by funding source including the county realignment, increase in Medicaid eligible lives, additional allocation letters from the State, appropriations from fund balance, and increase in local funds.</p> <p>Ms. Pacholke shared that our financial information is continually changing. We already have notification of changes that will be required in the next amendment. Ms. Pacholke detailed the reasons for a future amendment by funding source.</p> <p>A motion was made by Mr. Jackson and seconded by Ms. Council to recommend the Board approve the FY22 amendment 1 to increase the budget by \$349,500,867 bringing the total FY22 budget to \$923,449,490. Motion passed unanimously.</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, February 03, 2022

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: |
|----------------|---|-------------|-------------|
| 5. FY23 Budget | Ms. Goodfellow reminded the committee of the upcoming budget retreat in March. The meeting will be in person, but virtual attendance is available. The agenda currently includes a high-level review of the FY23 draft rate book, information on key cost drivers, as well as an update on where we are financially year to date. Any suggestions or requests on other topics to include can be shared. Ms. Goodfellow also shared that Alliance made a request to each county that provides local funding to increase the administrative funds from 1% to 2%. Alliance provided justification for the request. | | |

6. **ADJOURNMENT:** the meeting adjourned at 3:40 PM; the next meeting will be March 3, 2022, from 3:00 p.m. to 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..](#)



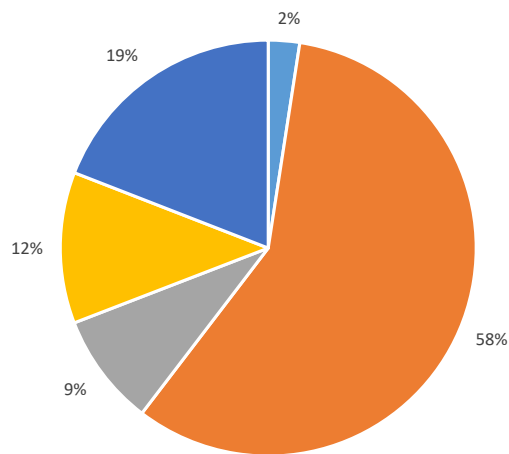
Summary of Savings/(Loss) by Funding Source as of January 31, 2022

| | Revenue | Expense | Savings/(Loss) |
|------------------------------|----------------|----------------|----------------|
| Medicaid Waiver Services | \$ 325,480,162 | \$ 298,043,296 | \$ 27,436,866 |
| Medicaid Waiver Risk Reserve | 54,947,294 | - | 54,947,294 |
| Federal Grants & State Funds | 48,277,862 | 48,597,864 | (320,002) |
| Local Funds | 16,365,367 | 16,365,367 | - |
| Administrative | 49,794,298 | 54,081,813 | (4,287,515) |
| Total | \$ 494,864,983 | \$ 417,088,340 | \$ 77,776,643 |

Fund Balance

| | June 30, 2021 | Change | January 31, 2022 |
|----------------------------|----------------|---------------|------------------|
| Investment in Fixed Assets | 5,031,938 | 282,500 | 5,314,438 |
| Risk Reserve | 71,494,795 | 54,947,294 | 126,442,089 |
| Other | 17,654,564 | 1,439,974 | 19,094,538 |
| Total Restricted | 89,149,359 | 56,387,268 | 145,536,627 |
| Committed | 33,939,808 | (8,286,559) | 25,653,248 |
| Unrestricted | 12,274,370 | 29,393,437 | 41,667,807 |
| Total Unrestricted | 46,214,178 | 21,106,878 | 67,321,055 |
| Total Fund Balance | \$ 140,395,474 | \$ 77,776,646 | \$ 218,172,120 |

January 31, 2022 Actual



■ Investment in Fixed Assets ■ Restricted - Risk Reserve ■ Restricted - Other ■ Total Committed ■ Unrestricted

Reinvestment Detail

| | Committed Funds FY22 | Spent January 31, 2022 | Balance to Spend |
|---|-------------------------|---------------------------|------------------|
| General Expenses | \$ 2,000,000 | - | \$ 2,000,000 |
| Child Facility Based Crisis Center | 4,000,000 | 731,953 | 3,268,047 |
| Total - Services | 6,000,000 | 731,953 | 5,268,047 |
| Administration | | | |
| Tailored Plan planning and implementation | 24,945,355 | 5,807,843 | 19,137,512 |
| Total - Administrative | 24,945,355 | 5,807,843 | 19,137,512 |
| Total Service and Administration | \$ 30,945,355 | \$ 6,539,795 | \$ 24,405,559 |

Fund Balance Detail

| | June 30, 2021 | Change | January 31, 2022 |
|------------------------------|----------------|---------------|------------------|
| Investment in Fixed Assets | 5,031,938 | 282,500 | 5,314,438 |
| Restricted - Risk Reserve | 71,494,795 | 54,947,294 | 126,442,089 |
| Restricted - Other | | | |
| State Statutes | 12,686,096 | - | 12,686,096 |
| Prepays | 842,976 | 1,791,426 | 2,634,402 |
| State | 351,452 | (351,452) | - |
| Cumberland | 3,002,823 | - | 3,002,823 |
| Durham | 771,217 | - | 771,217 |
| Restricted - Other | 17,654,564 | 1,439,974 | 19,094,538 |
| Committed | | | |
| Intergovernmental Transfer | 2,994,453 | (1,746,764) | 1,247,689 |
| Reinvestments-Service | 6,000,000 | (731,953) | 5,268,047 |
| Reinvestments-Administrative | 24,945,355 | (5,807,843) | 19,137,512 |
| Total Committed | 33,939,808 | (8,286,559) | 25,653,248 |
| Unrestricted | 12,274,370 | 29,393,437 | 41,667,807 |
| Total Fund Balance | \$ 140,395,475 | \$ 77,776,646 | \$ 218,172,120 |
| Restricted | | | 56,669,768 |
| Unrestricted | | | 21,106,878 |
| Total Fund Balance Change | | \$ | 77,776,646 |

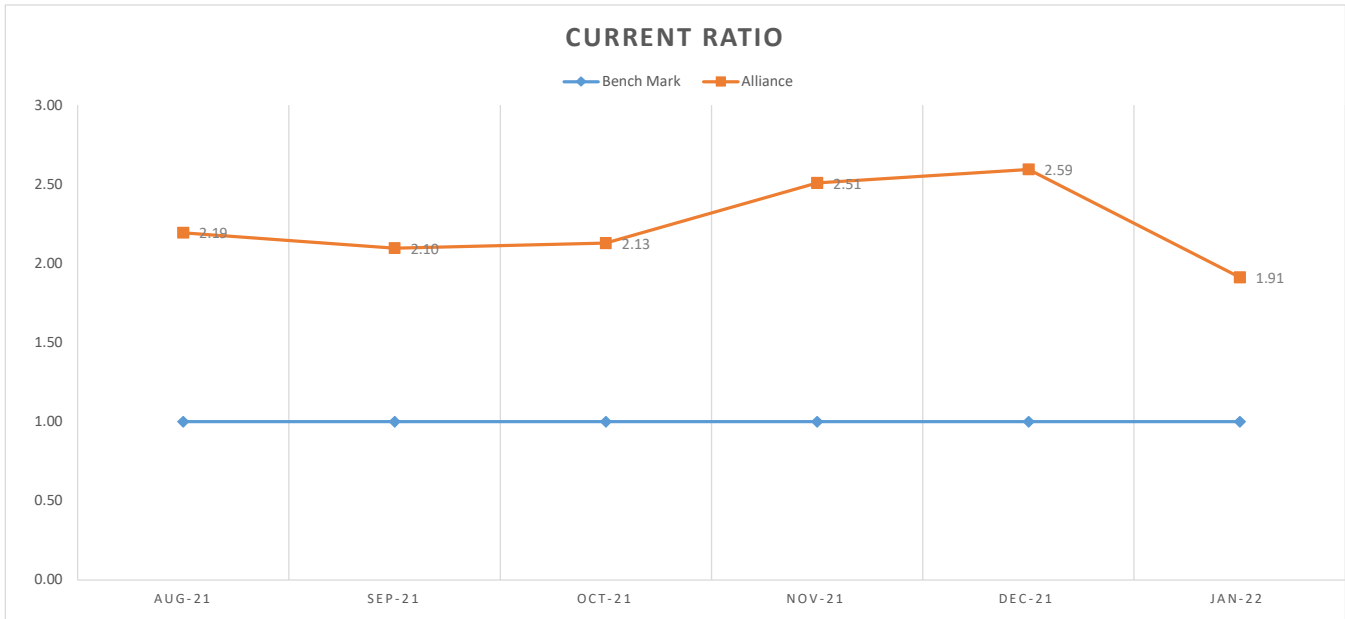


Alliance Health
Statement of Revenue and Expenses
As of January 31, 2022

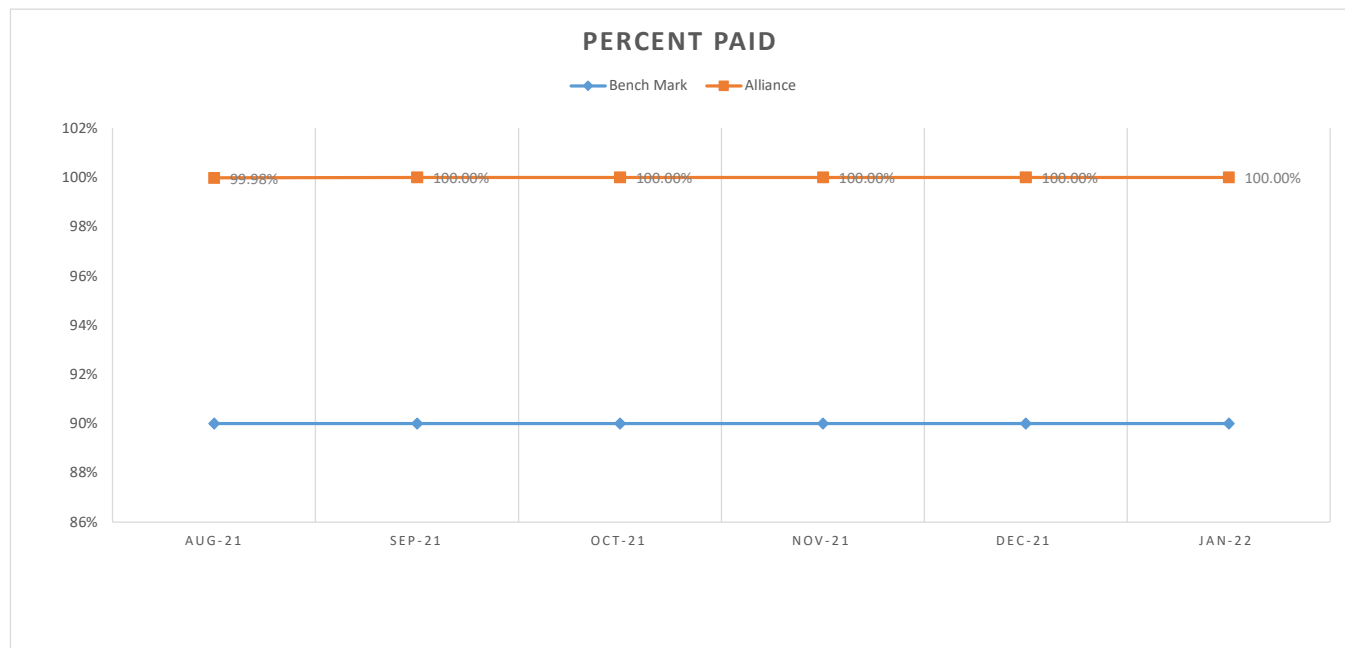
| | For the Month of July 31, 2021 | For the Month of August 31, 2021 | For the Month of September 30, 2021 | For the Month of October 31, 2021 | For the Month of November 30, 2021 | For the Month of December 31, 2021 | For the Month of January 31, 2022 | Year to Date Actual January 31, 2022 | Current Year Budget June 30, 2022 | Budget Remaining June 30, 2022 Remaining Budget |
|-------------------------------------|-----------------------------------|-------------------------------------|---|--------------------------------------|--|--|--------------------------------------|--|---|--|
| Revenue | | | | | | | | | | |
| Service Revenue | | | | | | | | | | |
| Medicaid Waiver Service | 39,557,391 | 39,745,949 | 40,871,739 | 39,002,996 | 40,172,618 | 116,271,670 | 64,805,092 | 380,427,456 | 670,548,729 | 290,121,273 |
| State and Federal Grants | 5,488,603 | 5,649,902 | 8,189,174 | 6,534,098 | 5,781,516 | 8,067,474 | 8,567,095 | 48,277,862 | 92,471,700 | 44,193,838 |
| Local Grants | 1,622,939 | 3,161,254 | 1,459,907 | 3,411,637 | 1,944,963 | 2,560,903 | 2,203,765 | 16,365,367 | 45,612,184 | 29,246,817 |
| Total Service Revenue | 46,668,933 | 48,557,105 | 50,520,820 | 48,948,731 | 47,899,097 | 126,900,047 | 75,575,952 | 445,070,685 | 808,632,613 | 363,561,928 |
| Administrative Revenue | | | | | | | | | | |
| Medicaid Waiver | 5,431,782 | 5,352,163 | 5,558,069 | 4,713,528 | 6,097,050 | 9,393,278 | 8,840,462 | 45,386,332 | 106,009,045 | 60,622,712 |
| State and Federal | 395,692 | 395,692 | 395,693 | 395,693 | 395,692 | 663,343 | 663,343 | 3,305,147 | 6,321,860 | 3,016,714 |
| Local | 32,545 | 32,545 | 32,545 | 32,545 | 32,545 | 32,545 | 32,545 | 227,815 | 390,540 | 162,725 |
| Other Lines of Business | 121,286 | 121,286 | 121,286 | 121,286 | 121,286 | 121,286 | 121,286 | 849,002 | 1,595,432 | 746,430 |
| Miscellaneous | 1,893 | 1,931 | 1,857 | 1,692 | 14,035 | 1,983 | 2,609 | 26,002 | 500,000 | 473,998 |
| Total Administrative Revenue | 5,983,198 | 5,903,617 | 6,109,450 | 5,264,744 | 6,660,608 | 10,212,435 | 9,660,245 | 49,794,298 | 114,816,877 | 65,022,579 |
| Total Revenue | 52,652,131 | 54,460,722 | 56,630,270 | 54,213,475 | 54,559,705 | 137,112,482 | 85,236,197 | 494,864,983 | 923,449,490 | 428,584,507 |
| Expenses | | | | | | | | | | |
| Service Expense | | | | | | | | | | |
| Medicaid Waiver Service | 40,281,037 | 34,775,309 | 36,330,734 | 31,983,862 | 30,909,801 | 64,148,709 | 59,613,843 | 298,043,296 | 670,548,729 | 372,505,433 |
| State and Federal Service | 5,488,707 | 5,679,369 | 8,388,288 | 7,071,611 | 5,644,604 | 7,758,192 | 8,567,095 | 48,597,864 | 92,471,700 | 43,873,836 |
| Local Service | 1,622,939 | 3,161,253 | 1,459,907 | 3,411,636 | 1,944,964 | 2,560,902 | 2,203,764 | 16,365,367 | 45,612,183 | 29,246,816 |
| Total Service Expense | 47,392,683 | 43,615,931 | 46,178,929 | 42,467,109 | 38,499,369 | 74,467,803 | 70,384,702 | 363,006,527 | 808,632,612 | 445,626,085 |
| Administrative Expense | | | | | | | | | | |
| Salaries and Benefits | 5,189,467 | 4,881,026 | 5,298,774 | 5,152,425 | 5,793,815 | 7,283,006 | 7,112,293 | 40,710,804 | 86,560,740 | 45,849,936 |
| Professional Services | 370,303 | 732,071 | 877,426 | 912,691 | 856,144 | 997,357 | 805,825 | 5,551,818 | 13,660,867 | 8,109,049 |
| Operational Expenses | 680,911 | 774,999 | 896,301 | 784,108 | 1,422,620 | 858,388 | 2,404,749 | 7,822,074 | 14,095,271 | 6,273,197 |
| Miscellaneous Expense | (3,301) | 14 | 514 | (515) | 159 | 447 | (203) | (2,883) | 500,000 | 502,883 |
| Total Administrative Expense | 6,237,380 | 6,388,110 | 7,073,015 | 6,848,709 | 8,072,738 | 9,139,198 | 10,322,664 | 54,081,813 | 114,816,878 | 60,735,065 |
| Total Expenses | 53,630,063 | 50,004,041 | 53,251,944 | 49,315,818 | 46,572,107 | 83,607,001 | 80,707,366 | 417,088,340 | 923,449,490 | 506,361,150 |
| Current Year Change in Net Position | (977,931) | 4,456,681 | 3,378,325 | 4,897,657 | 7,987,599 | 53,505,481 | 4,528,831 | 77,776,643 | - | (77,776,644) |



Senate Bill 208 Ratios - As of January 31, 2022



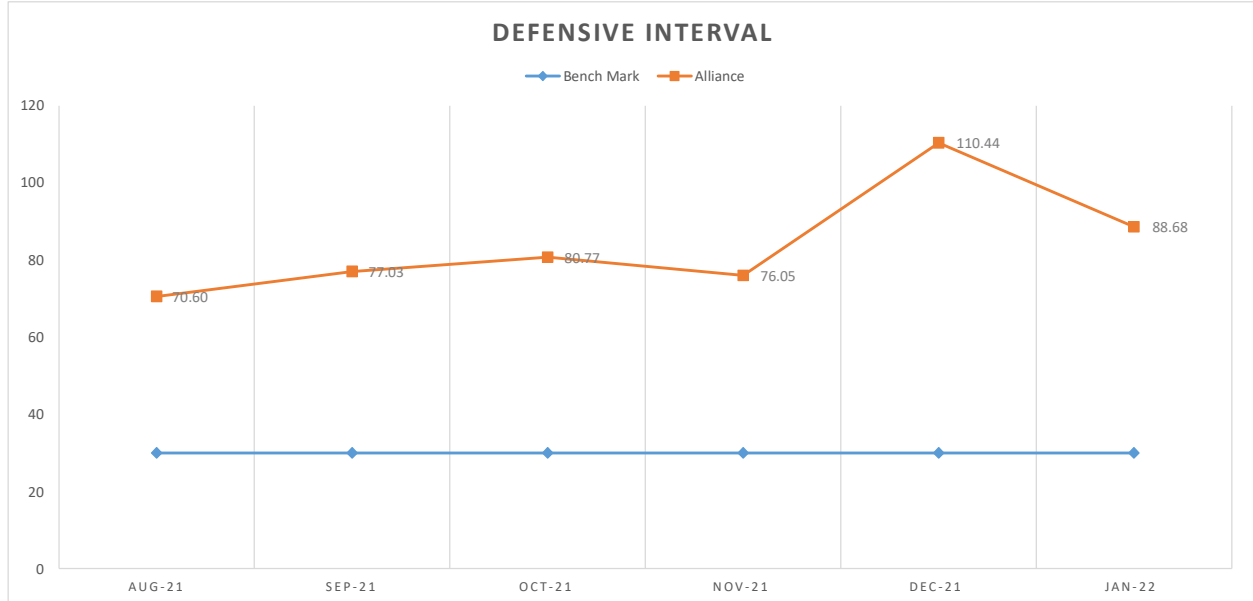
Current Ratio = Compares current assets to current liabilities. Liquidity ratio that measures an organization's ability to pay short term obligations. The requirement is 1.0 or greater.



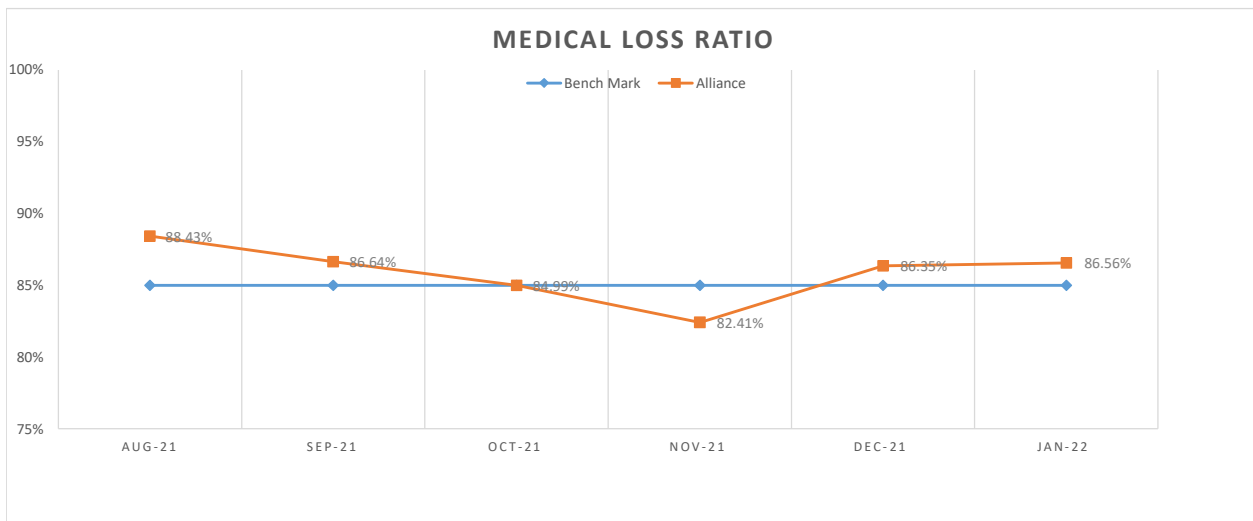
Percent Paid = Percent of clean claims paid within 30 days of receiving. The requirement is 90% or greater.



Division of Health Benefits Ratios - As of January 31, 2022



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).



1) Acero Health Technologies Contract

Alliance Health has been working with Acero Health for IT consulting, requirements gathering, and documentation, application development, and quality assurance activities related to the BH/IDD Tailored Plan Contract requirements.

Alliance is entering into a new contract for the period of March 1, 2022 through February 28, 2023. The work in this contract is focused on system analysis, the creation of detailed system design documents, application development and integrated testing activities associated with rapidly changing system and business requirements coming directly from the Department.

The contract is a time and materials contract with the hours not to exceed 10,000 hours. These hours are needed to supplement the work being done by the internal Alliance Development Staff.

Below are descriptions of the projects and estimated completion dates:

| Project Description | Target Completion Date |
|---|-------------------------------|
| Alliance Unified Provider Portal using Okta Authentication – Phase 1 Alliance Claims System, DOJ Supported Employment, and Independent Living Initiative Portals - Implementation (documentation, training materials, configuration, testing and migration to production environment) | 5/1/2022 |
| Unified Provider Portal - Phase 1 Go-Live Support (bug fixes/issue resolution, training) | 6/1/2022 |
| Unified Provider Portal - Phase 2 Provider Portal Implementation - Jiva Provider Portal Integration | 8/1/2022 |
| PCP and AMH+/CMA Assignments Logic Updates to Meet the New Detailed State Assignment Logic Requirements | 5/1/2022 |
| Pharmacy Administered Drug Program (PDP) Integration into the Alliance Claims System to Support State Clinical Coverage Policy 1B | 6/30/2022 |
| Alliance Member Portal – Integration of Jiva Member Portal and Alliance Claims System | 8/1/2022 |

| | |
|---|------------|
| Functionality to Meet Recently Provided Department Tailored Plan Requirements | |
| Development and Integration of Alliance Systems to Support WellCare Outsourced Care Management and Utilization Management Functionality – Receipt of Prior Authorization from WellCare Sub-Delegates into the Claims System Using EDI 278 Data Exchange | 10/30/2022 |
| Unified Provider Portal - Phase 3 Integration of WellCare UM and Other Sub-Delegated Portals into Alliance Unified Provider Portal; Incorporate Required Provider Training Module and the Inovalon-HEDIS Provider Portal Integration | 10/30/2022 |
| Other Projects that are Identified in the Ongoing Business Review Discussions with the Department that are needed to meet State Tailored Plan System Requirements | 12/1/2022 |
| Tailored Plan Go-Live Support as Requested by Alliance | 2/28/2023 |

Not to Exceed Amount: \$1,000,000

Contract Period: March 1, 2022 – February 28, 2023



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

ITEM: Special Update/Presentation: How Members Access Services

DATE OF BOARD MEETING: March 3, 2022

BACKGROUND: Alliance has an interest in promoting a positive consumer experience for those members interested in access to behavioral healthcare. Dr. Mehul Mankad will review the current approaches to behavioral healthcare access. He will provide examples of the “no wrong door” approach used by Alliance in terms of member inclusion and engagement in care.

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): Mehul Mankad, MD, Chief Medical Officer

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