MEMBERS PRESENT: ☒Glenn Adams, Cumberland County Commissioner, JD (via phone), ☒Cynthia Binanay, Chair, MA, BSN, ☒Christopher Bostock, BSIM, ☒Heidi Carter, Durham County Commissioner, MPH, MS (via phone; exited at 5:17 pm), ☒George Corvin, Vice-Chair, MD, ☒David Curro, BS, ☒Greg Ford, Wake County Commissioner, MA, ☒Lodies Gloston, MA (via phone), ☒Duane Holder, MPA (via phone), ☒Curtis Massey, JD, ☒Donald McDonald, MSW (entered at 4:09 pm), ☒Gino Pazzaglini, MSW, ☒Pam Silberman, JD, DrPH, ☒Lascel Webley, Jr., MBA, MHA (entered at 5:00 pm), and ☒McKinley Wooten, Jr., JD

GUEST(S) PRESENT: Janet Conner-Knox, A Caring Heart, LLC; Denise Foremen, Wake County Manager’s Office; Yvonne French, NC DMH (Department of Mental Health); and Mary Hutchings, Wake County Finance Department

ALLIANCE STAFF PRESENT: Damali Alston, Director of Network Evaluation; Michael Bollini, Executive Vice-President/Chief Compliance Officer; Joey Dorsett, Senior Vice-President/Chief Information Officer; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Amanda Graham, Senior Vice-President/Operational Effectiveness; Veronica Ingram, Executive Assistant II; Ken Marsh, Medicaid Program Manager; Beth Melcher, Executive Vice-President/Care Management; Ann Oshel, Senior Vice-President/Community Relations; Sara Pacholke, Senior Vice-President/Financial Operations; Brian Perkins, Senior Vice-President/Strategy and Government Relations; Monica Portugal, Chief Compliance Officer; Robert Robinson, Chief Executive Officer; Sara Wilson, Government Relations Director; Carol Wolff, General Counsel; and Doug Wright, Director of Individual and Family Affairs

1. CALL TO ORDER: Chair Cynthia Binanay called the meeting to order at 4:02 p.m.

AGENDA ITEMS: 

<table>
<thead>
<tr>
<th>DISCUSSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Announcements</td>
</tr>
<tr>
<td>A. Matrix: Ms. Ingram distributed a form to board members. Chair Binanay asked Board members to complete this form noting areas of expertise and community connections; she asked that Board members return completed forms to Ms. Ingram.</td>
</tr>
<tr>
<td>B. All-Staff Training on September 28: Mr. Robinson provided an update from the recent all-staff training; he mentioned that the training theme was change management.</td>
</tr>
<tr>
<td>C. Cape Fear: Mr. Robinson mentioned that conversations are continuing with key stakeholders regarding use of facility-based crisis services in Cumberland County.</td>
</tr>
</tbody>
</table>

3. Agenda Adjustments
There were no adjustments to the agenda.

4. Public Comment
There were no public comments.

5. Committee Reports

A. Consumer and Family Advisory Committee – page 4
The Alliance Consumer and Family Advisory Committee (CFAC) is composed of consumers and/or family members from Durham, Wake, Cumberland and Johnston Counties who receive mental health, intellectual/developmental disabilities or substance use/addiction services. This month’s report included draft minutes from the Durham and Wake subcommittee meetings.

Dave Curro, CFAC Chair, presented the report. Mr. Curro expressed concerns for and extended condolences to those affected by Hurricane Florence. Additionally, he shared that CFAC members will utilize CFAC T-shirts during community events. He shared about ongoing education about the Department of Social Services (DSS) and accessing benefits through DSS. The CFAC report is attached to and made part of these minutes.

BOARD ACTION
The Board received the report.
**AGENDA ITEMS:**

<table>
<thead>
<tr>
<th><strong>B. Finance Committee – page 71</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Area Board. This month’s report included draft minutes from the September 6, 2018, meeting; the budget to actual report and ratios for the period ending August 31, 2018; and recommendations to the Board to approve all presented contracts over $250,000.</td>
</tr>
</tbody>
</table>

Chris Bostock, Committee Chair, presented the report. Mr. Bostock noted a year-to-date (YTD) loss of 4.3 million primarily due to the reduction in State Single Stream funding. He shared that State mandated ratios were met. He mentioned that per Alliance Policy G-10: *Delegation to the CEO*, the Finance Committee provides preliminary review of contracts over a specified amount; Mr. Bostock provided the Finance Committee’s recommendation for three contracts. The Finance Committee report is attached to and made part of these minutes.

**BOARD ACTION**

A motion was made by Mr. Massey to authorize the CEO to enter into a contract with PREST Associates for $320,000 for peer review services; motion seconded by Mr. Wooten. Motion passed unanimously.

A motion was made by Dr. Silberman to authorize the CEO to enter into a contract for audio-visual equipment and installation at 5200 West Paramount Parkway, Morrisville, NC in an amount not to exceed $410,000 in accordance with NC GS 143-129 (e) (3); motion seconded by Mr. Curro. Motion passed unanimously.

A motion was made by Mr. Bostock to authorize the CEO to enter into a contract for mental health outreach and supportive counseling services for those impacted by Hurricane Florence in an amount not to exceed $600,000 after formally bidding out the services in accordance with uniform guidance unless an exception applies, in anticipation of receiving an allocation letter; motion seconded by Dr. Silberman. Motion passed unanimously.

6. **Consent Agenda**

| **A. Draft Minutes from September 6, 2018, Board Meeting – page 79** |
| **B. County Commissioners Advisory Board Report – page 84** |
| **C. Executive Committee Report – page 86** |
| **D. Quality Management Committee Report – page 89** |

The consent agenda was sent as part of the Board packet. There were no comments or discussion about the consent agenda.

**BOARD ACTION**

A motion was made by Mr. Wooten to approve the consent agenda; motion seconded by Mr. Bostock. Motion passed unanimously.

7. **Training/Presentation(s)**

| **A. Hurricane Florence Disaster Response – page 144** |
| Sean Schreiber, Senior Vice-President/Provider Networks and Evaluation, and Ann Oshel, Senior Vice-President/Community Relations, provided an overview and summary of Alliance actions regarding disaster response activities during Hurricane Florence to include helping to ensure that our members and our providers were prepared for the storm. Also, they shared additional steps implemented to ensure the safety of high-risk members and that services to members and the community were available. A summary of ongoing support efforts was also provided. |
**AGENDA ITEMS:**

<table>
<thead>
<tr>
<th>DISCUSSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board members requested clarification regarding providers’ emergency plans; additionally they requested specifics on how many Alliance staff supported specific shelters. The presentation is attached to and made part of these minutes.</td>
</tr>
</tbody>
</table>

**BOARD ACTION**

The Board accepted the presentation; no additional action required.

B. Financial Review/Commitments – page 162

Alliance is requesting that the Board vote on financial commitments so that the final audited financial statements reflect those commitments. Kelly Goodfellow, Executive Vice-President/Chief Financial Officer, and Sara Pacholke, Senior Vice-President/Financial Operations, presented a financial review, recommendations, and potential long-term financial impact.

Ms. Pacholke shared the summary of savings and loss, and net position summary. Ms. Goodfellow mentioned the current reinvestment plan, which was approved by the Board at the June 7, 2018, Board meeting; she reviewed the financial forecast and goals and how these items were used to develop the recommendations presented.

**BOARD ACTION**

A motion was made by Mr. Bostock to commit $46,918,513 as of June 30, 2018, which includes $18,769,500 in reinvestment plan for one year; $25,141,196 in legislative reductions for one year; and $3,007,817 in intergovernmental transfers for one year; motion seconded by Mr. Webley. Motion passed unanimously.

A motion was made by Mr. Bostock to submit $41,539,500 in a three-year reinvestment plan to DMA, which includes $18,769,500 in year one; $11,335,000 in year two; and $11,335,000 in year three; motion seconded by Dr. Silberman. Motion passed unanimously.

8. Closed Session(s)

**BOARD ACTION**

A motion was made by Mr. Curro to enter closed session pursuant to NC § 143-318.11 (a) (3) to consult with General Counsel regarding current litigation; motion seconded by Mr. McKinley Wooten. Motion passed unanimously.

The Board returned to open session.

9. Adjournment

With all business being completed the meeting adjourned at 5:53 p.m.

**Next Board Meeting**

**Thursday, November 01, 2018**

**4:00 – 6:00 pm**

Robert Robinson, Chief Executive Officer

Date Approved 11/1/18
ITEM: Consumer and Family Advisory Committee (CFAC) Report

DATE OF BOARD MEETING: October 4, 2018

BACKGROUND: The Alliance Consumer and Family Advisory Committee, or CFAC, is made up of consumers and/or family members that live in Durham, Wake, or Cumberland 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.

State statutes charge CFAC with the following responsibilities:
- Review, comment on and monitor the implementation of the local business plan
- Identify service gaps and underserved populations
- Make recommendations regarding the service array and monitor the development of additional services
- Review and comment on the Alliance budget
- Participate in all quality improvement measures and performance indicators
- Submit findings and recommendations to the State Consumer and Family Advisory Committee regarding ways to improve the delivery of mental health, intellectual/other developmental disabilities and substance use/addiction services.

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, 4600 Emperor Boulevard, Durham. Subcommittee meetings are held in individual counties, the schedules for those meetings are available on our website.

The Alliance CFAC tries to meet its statutory requirements by providing you with the minutes to our meetings, letters to the board, participation on committees, outreach to our communities, providing input to policies effecting consumers, and by providing the Board of Directors and the State CFAC with an Annual Report as agreed upon in our Relational Agreement describing our activities, concerns, and accomplishments.

REQUEST FOR BOARD ACTION: Receive draft subcommittee minutes and supporting documents from the Durham and Wake committees for September. Our Johnston and Cumberland Committees were unable to meet because of the aftermath of Hurricane Florence. The Steering Committee did not meet because of the holiday.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Dave Curro, CFAC Chair; Doug Wright, Director of Consumer Affairs
MEMBERS PRESENT: ☒Steve Hill, ☒Dave Curro, ☒Tammy Shaw, ☒Latasha Jordan, ☐James Henry, ☐Joe Kilsheimer, ☐Trula Miles, ☒Brenda Solomon, ☒Chris Dale ☒Dan Shaw

BOARD MEMBERS PRESENT: None

GUEST(S): ☒Tina Barnes, ☐Susan Hertz

STAFF PRESENT: Doug Wright, Director of Individual and Family Affairs, Ramona Branch, Individual & Family Engagement Specialist

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the August 13, 2018, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; a motion was made by Dave Curro and seconded by Tammy Shaw to approve the minutes. Motion passed.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Public Comments</td>
<td>Dave Curro went over the new drug-deactivating kit (Deterra drug deactivation system) from Mallinckrodt Pharmaceuticals that is being handed out from Alliance across the catchment area. If you would like more information on this or would like to receive a kit, please contact Ramona Branch: <a href="mailto:rbranch@alliancebhc.org">rbranch@alliancebhc.org</a> 919.651.8821</td>
<td>Ongoing</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Interest in Membership/Outreach</td>
<td>Dan Shaw has been voted into to the Durham CFAC Subcommittee. Welcome Dan! Glad to have you back! Ramona completed stipend paperwork with Dan after the meeting and it has been submitted. Steve Hill updated the group on his Outreach to Kyle Reese, who has moved out of our catchment area.</td>
<td>Ongoing</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
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<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>We will miss his contributions to the Durham CFAC subcommittee.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Recovery, Self-Determination &amp; Stigma</td>
<td>Ramona went over the Recovery, Self-Determination, &amp; Stigma presentation and the group discussed information given.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
| 6. LME/MCO Updates | Doug went over the LME/MCO updates which included notes and a handout. If you have any questions please direct them to Ramona. Topics of discussion included:  
  ✓ Press Release with AmeriHealth  
  ✓ Standard Plan request for proposal  
  ✓ Alliance Cares  
  ✓ JIVA staff training  
  ✓ New i2i Initiative on Community Inclusion  
  ✓ Transportation pilot  
  ✓ Health Literacy | Ongoing | N/A |
| 7. Event Planning/Announcements | Ramona went over the status of the T-shirts, and they should be completed and able to be handed out at the October meeting.  
The next Steering committee meeting will be held on October 1, 2018 @ 5:30pm. | Ongoing | N/A |
AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME: |
--- | --- | --- | --- |
Alliance Behavioral Healthcare Corporate office. 4600 Emperor Blvd. #200 Durham NC, 27703  
CFAC name tags were handed out at this meeting. Ramona has the tags for James Henry and Trula Miles, please contact her if you would like to pick it up, or she will have them at the next meeting.  |  |  |  |

8. **ADJOURNMENT:** 7:10pm the next meeting will be October 8, 2018, at 5:30 p.m.

Respectfully Submitted by:

Ramona Branch  
Ramona Branch, Individual & Family Engagement Specialist  
Date Approved  
09.15.2018
Recovery, Self-Determination & Stigma
What is Recovery?

Working definition of recovery from mental disorders and/or substance use disorders:

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential

~SAMHSA
Recovery: The Myth

Myth: “People can’t recover from mental illness...”

Myth: “People can’t recover from a substance use disorder...”
Recovery: The Truth

• People CAN and DO recover from mental illness and substance use disorders

• What recovery means:
  ✓ Improved health and wellness
  ✓ Ability to live a self-directed life
  ✓ Opportunity to live as an active and productive member of society and reach one’s full potential
Guiding Principles of Recovery

• Recovery emerges from hope
• It is holistic and person-driven
• It occurs via many pathways
• It is supported by peers and allies, and through relationship and social networks
• It is culturally-based and influenced
• It is supported by addressing trauma
Guiding Principles of Recovery

• Recovery involves individual, family, and community strengths and responsibility

• It is based on respect
Self-Determination: The Myth

Myth:
“People with a disability can’t make their own choices about what’s best for them...”
Self-Determination: The Truth

- People with an intellectual/developmental disability have the need and right to make their own choices and decisions
  - Being empowered to speak out for one’s rights and to achieve one’s own goals and dreams
  - Having control over the services that one receives
Self-Determination: The Truth

• Includes being a valued and contributing member of one’s community
  ✓ Working and being paid competitively at a job
  ✓ Having a real choice and control over one’s own life, goals and finances
  ✓ Living in one’s own home or the home of one’s own choosing
Stigma

• A set of negative and often unfair beliefs that a group of people have about something

• It’s about disrespect and using negative labels to identify a person living with behavioral illness

• Prevents people from reaching out for the help that they need and deserve
Stigma

Myth: “People with severe mental illness are usually dangerous...”

Myth: “People choose to drink or take drugs so if they become addicted, it’s their choice.”

Myth: “Using the word ‘retarded’ doesn’t hurt anyone...”
Did You Know?

Many people would rather tell employers they served time in jail than admit to being in a psychiatric hospital.
Stigma

- Leads to fear, mistrust and violence against people living with behavioral illness and their families?
- Can cause families and friends to turn their backs on people with behavioral illness
- Is about disrespect and using negative labels to identify a person living with behavioral illness
Fighting Stigma

- Become more aware - learn the truth
- Use respectful language
- Tell someone if they express a stigmatizing attitude
- Emphasize abilities, not limitations
For more information, please contact:

**Ramona Branch BA, CSAC, CPSS**
Individual & Family Engagement Specialist
[Rbranch@AllianceBHC.org](mailto:Rbranch@AllianceBHC.org)
## Welcome and Introductions

2. **Review of the Minutes** – The minutes from the August 14, 2018, Wake Consumer and Family Advisory Committee (CFAC) Subcommittee meeting were reviewed; a motion was made by Karen McKinnon and seconded by Megan Mason to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
<th>NEXT STEPS</th>
<th>TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Comments</td>
<td>Annette and Ben expressed their enjoyment at the RCNC Rally. Carole agreed the RCNC Rally was a good event.</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>LME/MCO Updates 2018</td>
<td>Doug explained the Medicaid Transformation: standard and tailored plans. 4 large insurance counties and up to 12 provider lead entities. Doug explained Alliance Behavioral Healthcare and AmeriHealth Caritas and United HealthCare commercial health plans have partnered for a statewide standard plan teaming. Doug explained about Alliance Cares program and how each employee can utilize 4 hours once a quarter to volunteer in the community. Doug suggested CFAC members check to see if our individuals and/or provider would like to volunteer. Annette suggested if ABH can volunteer at the Miracle League. JIVA is our new management care tool to be implemented in the fall.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Event Planning</td>
<td>Committee agreed RCNC to host the movie, Stacy to confirm.</td>
<td>Stacy will check with Terri Conyers to see if March 16th or 23rd 2019 will work. Stacy will ask if we can show resilience and Doug may purchase the movie</td>
<td>Next CFAC meeting</td>
</tr>
<tr>
<td>Training: Social Security</td>
<td>Stacy presented Social Security presentation.</td>
<td>Stacy stopped at page 20 and will continue this training until next meeting</td>
<td></td>
</tr>
<tr>
<td>Announcements-Opportunities</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. **ADJOURNMENT**: the next meeting will be October 9, 2018, at 5:30 p.m.
Respectfully Submitted by:

Stacy Guse

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Click here to enter text.
**Standard Plan Request for Proposal (RFP)** - The RFP for Standard Plans for Medicaid transformation was released in August. Response are due back October 12 and are expected from commercial plans such as BCBS, CIGNA, UHC, etc. and Provider Lead Entities (PLE) usually made up of hospital groups across the state. This is for the Standard Plan, not the Tailored Plan (Alliance and other LME/MCOs) we anticipate operating. It does help to start defining the relationship between the plans and who (members) will be in each plan. Our staff are reviewing the RFP and evaluating our next steps.

**Alliance Cares** - Alliance Cares is a program that allows staff at Alliance to use up to 4 hours of their paid work time to support specific projects in their community that are centered on helping to meet unmet social needs. In August staff had the opportunity to visit schools in the area and help teachers set up their classrooms for the new year. We also donated school supplies collected at each of our sites. Our next venture will be in the Fall helping out with Habitat for Humanity.

**JIVA Staff Training** - JIVA is a new care management tool we will begin using in October. We are anticipating this system will help us to better manage care for the people we serve. There will be assessments upfront including a Social Determinants of Health tool to help us determine the needs of each individual. The system is set up to be able to tell us what the next steps should be once an assessment is done and we have identified the needs. It should help to make us more proficient and impactful on people’s lives. We are now training all staff on the new system and anticipate roll out soon.

**New i2i Initiative on Community Inclusion** - The i2i Center for Integrative Health is launching a new initiative to promote community inclusion for people with mental illness. The initiative is called I’m IN: Community Inclusion. This is a joint project of i2i Center for Integrative Health, Alliance Behavioral Healthcare, and the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The goal of I’m IN is to put into place more policies, programs, and practices that support individuals with mental illnesses so that they may participate more fully in the activities that define everyday community life. The initiative will address the harsh reality that many people with serious mental illness are unemployed and may have fragile connections to the mainstream of community life.

**Transportation Pilot** - We expect to roll out a transportation pilot on October 1st, this pilot will target individuals being discharged from hospitals and facility based crisis units such as UNC at Wakebrook in Raleigh, Roxie Street facility in Fayetteville, and the Recovery Response Center in Durham. We will be offering them transportation to their first appointment to try to ensure connection with services after a crisis event. We will also be offering transportation to individuals calling our access and information line needing urgent care (within 48 hours), again trying to ensure connection with services quickly. We will utilize a non-emergency medical transportation management company called Logisticare to manage this project. At the end of the pilot we will measure impact and make a decision about extending or even expanding the pilot.

**Health Literacy** - We have two items on the horizon, one is a wallet card designed for individuals to be able to put relevant information such as doctor, contacts, etc. It also has some reminders about healthy lifestyles and some questions to consider when visiting a provider. On the back it has a medication schedule that uses pictures to depict the time of day when something should be taken. These will be distributed soon, we are waiting for delivery from the printer and will bring them to you as soon as we have them.
We are also developing shared decision making tools that prescribers can use with the people they serve to help educate them about medication options and lifestyle changes and the risks and benefits of both. This way we hope people will be able to truly be a part of making the decision about what their care looks like going forward, therefore increasing their willingness to follow through with the treatment agreed upon. We hope to have these available and in use by the end of the calendar year.
Social Security Benefits, Finances, and Policy Options

A Primer
What is Social Security?
More than 62 million people receive Social Security each month, in one of three categories:

- Retirement insurance
- Survivors insurance
- Disability insurance

Nearly 1 in 5 Americans gets Social Security benefits.

About 1 in 4 families receives income from Social Security.
Who Receives Social Security?

- 43.1 million retired workers
- 8.6 million disabled workers
- 4.1 million widows and widowers
- 2.5 million spouses
- 1.1 million adults disabled since childhood
- 3.0 million children

SSA, 2018a.
# How Much Does Social Security Pay? (June 2018)

## By Beneficiary Type:

<table>
<thead>
<tr>
<th>Type</th>
<th>Average Monthly Benefit</th>
<th>Average Yearly Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retired workers</td>
<td>$1,413</td>
<td>$16,956</td>
</tr>
<tr>
<td>Disabled workers</td>
<td>$1,198</td>
<td>$14,376</td>
</tr>
<tr>
<td>Widows or widowers (60 or older)</td>
<td>$1,345</td>
<td>$16,140</td>
</tr>
</tbody>
</table>

## By Family Type:

<table>
<thead>
<tr>
<th>Type</th>
<th>Average Monthly Benefit for Family</th>
<th>Average Yearly Benefit for Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retired worker and spouse (62 or older)</td>
<td>$2,362</td>
<td>$28,344</td>
</tr>
<tr>
<td>Widowed mother or father (under 60) and two children</td>
<td>$2,741</td>
<td>$32,892</td>
</tr>
<tr>
<td>Disabled worker and one or more children</td>
<td>$1,849</td>
<td>$22,188</td>
</tr>
</tbody>
</table>
How Do Benefits Compare to Earnings?

Replacement Rates for Retired Worker Age 65, 2018

Career-Average Wages
Benefits

Earnings Level

"Low" $22,510 52%
$11,699

"Medium" $50,021 39%
$19,298

"High" $80,034 32%
$25,563

"Maximum taxable" $122,516 25%
$31,130

SSA, 2018c.
How Many Seniors Rely on Social Security for Most of Their Income?

- 84% of all people 65 and older get Social Security.

- Over 3 in 5 (61%) beneficiaries of Social Security get half or more of their income from Social Security.*

- About 1 in 3 (33%) beneficiaries of Social Security get almost all (90% or more) of their income from Social Security.*


*Some evidence indicates that a somewhat lower proportion of beneficiaries, about half, receive half or more of their total income from Social Security, and about 20% may get 90% or more of their income from Social Security (Bee and Mitchell, 2017).
## Reliance on Social Security By Race

Percent of beneficiary households 65 or older whose Social Security benefits make up:

<table>
<thead>
<tr>
<th>Race</th>
<th>Half or more of their income</th>
<th>90% or more of their income</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>60%</td>
<td>32%</td>
</tr>
<tr>
<td>Black</td>
<td>69%</td>
<td>45%</td>
</tr>
<tr>
<td>Asian</td>
<td>62%</td>
<td>41%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>73%</td>
<td>52%</td>
</tr>
</tbody>
</table>

## Reliance on Social Security By Gender and Family Type

### Percent of beneficiaries 65 or older whose Social Security benefits make up:

<table>
<thead>
<tr>
<th>By Gender:</th>
<th>Half or more of their income</th>
<th>90% or more of their income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unmarried women</td>
<td>61%</td>
<td>34%</td>
</tr>
<tr>
<td>Unmarried men</td>
<td>56%</td>
<td>29%</td>
</tr>
</tbody>
</table>

### Percent of beneficiary households 65 or older whose Social Security benefits make up:

<table>
<thead>
<tr>
<th>By Family Type:</th>
<th>Half or more of their income</th>
<th>90% or more of their income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married couples</td>
<td>48%</td>
<td>21%</td>
</tr>
<tr>
<td>Unmarried people</td>
<td>71%</td>
<td>43%</td>
</tr>
</tbody>
</table>

Increase in Full Retirement Age (FRA) Lowers Retirement Benefits at Any Age Claimed

Gregory et al., 2010.
Medium Earner’s Replacement Rate at 65
(after Medicare Parts B & D premiums and taxation of benefits)

<table>
<thead>
<tr>
<th>Year</th>
<th>Percent of Prior Earnings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>38%</td>
</tr>
<tr>
<td>2020</td>
<td>34%</td>
</tr>
<tr>
<td>2030</td>
<td>31%</td>
</tr>
</tbody>
</table>

Munnell, 2013.
Disability Insurance (DI) pays monthly benefits to 8.6 million workers who are no longer able to work due to illness or impairment.

- It is part of the Social Security program.

Benefits are based on the disabled worker's past earnings.

To be eligible, a disabled worker must have worked in jobs covered by Social Security.
What are the Most Common Disabilities for DI Recipients?

- Mental Impairments: 32.3%
- Musculoskeletal Conditions: 19.9%
- Circulatory System: 9.4%
- Nervous System/Sense Organ Impairments: 8.1%
- Injuries/Cancers/Other Conditions: 13%
Attributes of Disabled-Worker Beneficiaries

➢ 3 in 10 disabled workers have incomes below 125% of the poverty threshold.

➢ Disabled worker beneficiaries are more likely than other adults to be:

   ▪ older (65% are over 50);
   ▪ African-American;
   ▪ and have a lower educational attainment:
     ▪ almost half have a high school diploma or less;
     ▪ 10% did not finish high school.

Bailey and Hemmeter, 2015; SSA, 2015
Who Pays for Social Security?

- Workers and their employers pay with Social Security contributions under the Federal Insurance Contributions Act (FICA).
Workers contribute 6.2% of their earnings for Social Security.

Employers match these worker contributions (6.2%).

The total Social Security contribution is 12.4%.

Earnings above $128,400 are exempt from Social Security contributions.
It is credited to the Social Security trust funds. Of the 6.2% tax rate:

- 5.015% goes to the retirement and survivor insurance fund
- 1.185% goes to the disability insurance fund

Projections of income and outgo of the trust funds are made by the Social Security Administration actuaries.
The Financial Outlook
2017 Finances

Trust fund income = $996.6 billion
Trust fund outgo  = $952.5 billion
Increase in trust fund reserves = $44.1 billion

➢ By law, surpluses are invested in U.S. Treasury securities and earn interest that goes to the trust funds.
Where is Social Security Income From?
Shares of Income to the Trust Funds, 2017

- Workers' and employers' Social Security contributions: 87.7%
- Interest on reserves: 3.8%
- Income taxes on benefits: 8.5%

Board of Trustees, 2018: Table IV.A3.
Social Security income that is not used immediately to pay benefits and costs is invested in special-issue Treasury securities (or bonds).
The bonds earn interest that is credited to the trust funds.
The accumulated surpluses held in Treasury securities are called Social Security reserves, or trust fund assets.
The Treasury securities are secure investments that are backed by the full faith and credit of the United States government.
By law, Social Security has two separate trust funds:
- Disability Insurance (DI) trust fund
- Old-Age and Survivors Insurance (OASI) trust fund

With the Bipartisan Budget Act of 2015, Congress temporarily rebalanced the distribution of Social Security payroll contributions between OASI and DI, extending solvency of the DI trust fund.

According to the 2018 Social Security Trustees Report, the DI trust fund is projected to be able to pay full benefits until 2032.
How Large are Social Security Trust Fund Assets?

1985: $0.04 trillion

2017: $2.9 trillion

2027: $2.2 trillion (projected)
Social Security Income and Outgo

- **Amount (in billions of current dollars)**
  - 2017: $996.6, $952.5
  - 2018: $1,001.1, $1,002.8
  - 2019: $1,061.4, $1,061.5

- **Bars**
  - Green: Total income
  - Orange: Outgo
How Do Actuaries Estimate the Future?

1) Review the past: birth rates, death rates, immigration, employment, wages, inflation, productivity, interest rates.

2) Make assumptions for the next 75 years (longer than the rest of the government).

3) Three scenarios:
   - Low cost;
   - High cost;
   - Intermediate.
In 2018, revenue from payroll contributions, interest on reserves, and taxation of benefits is expected to be less than total outgo for the year. If action is not taken immediately, reserves will start to be drawn down to pay benefits this year.

In 2034, trust fund reserves are projected to be depleted. Income is projected to cover 79% of benefits due then.

By 2095, assuming no change in taxes, benefits or assumptions, revenue would cover about 75% of benefits due in that year.
Other Scenarios

**Low Cost:**
Social Security would be solvent for 75 years and beyond.

**High Cost:**
Trust fund reserves would be depleted in 2030, instead of 2034.
The share of Americans over age 65 will grow because:

- Boomers are reaching age 65
- People are living longer after age 65

Birth rates are projected to remain at replacement levels.

People 65 and older will increase from 15% to 23% of all Americans by 2095.
Percent of the Population Receiving Social Security and Percent Age 65+, 2015-2090

- **2017:** 19% Beneficiaries
- **2017:** 15% Age 65+
- **2040:** 23%
- **2095:** 24%
- **2040:** 21%
- **2095:** 23%
Can We Afford Social Security in the Future?
Social Security Outgo as a Percent of the Economy (GDP), 2015-2095

- 2017: 4.9%
- 2038: 6.1%
- 2095: 6.2%
Taxable Payroll and Social Security Outgo as a Percent of the Economy (GDP), 2015-2095

- **2017:** 35.9%
- **2024:** 36.4%
- **2037:** 6.1%
- **2095:** 6.2%

- **2015** to **2095:**
  - **Taxable payroll as % of GDP:**
  - **Social Security outgo as % of GDP:**
Strengthening Social Security
Options to Improve Adequacy

Options that would **improve the adequacy of benefits** include:

1) Updating the special minimum benefit to ensure that long-serving, low-paid workers can remain out of poverty when they retire.

2) Reinstating student benefits until age 22 for children of disabled or deceased workers (currently, benefits for these children stop at age 18-19).

3) Allowing up to 5 childcare years to count toward benefits.

4) Increasing benefits for widowed spouses in low-earning couples.

5) Modestly increasing benefits for all by changing the benefit formula (to increase the first PIA bend point by 15 percent)
Options that would help raise revenues include:

1) Lifting or eliminating the cap (now $128,400) on the earnings on which workers and their employers pay Social Security contributions.

2) Gradually increasing the Social Security contribution rate from its current level of 6.2%.

3) Subjecting income from investments to Social Security contributions.

4) Treating all salary reduction plans like 401(k)s (subjecting income paid into them to Social Security contributions).

5) Restoring estate tax to 2000 level and dedicating to Social Security.
Some proposals would reduce benefits for some or all beneficiaries in order to extend solvency.

- For example, raising the retirement age amounts to an across-the-board cut in benefits, and hence reduces the program’s cost.
- Switching to the chained CPI as the basis for Social Security’s cost-of-living adjustments (COLAs) would reduce benefits and hence program cost as well.
Public Opinion on Social Security
In 2014, the Academy conducted a multigenerational study to understand Americans’ perspectives on Social Security. In focus groups, Americans expressed concern about benefits being too low. 77% said it is critical to preserve Social Security benefits, even if it means raising taxes on working Americans.
In the trade-off analysis, the package preferred by 71% of respondents would:

- Gradually **increase taxes** in two ways:
  - for high earners by eliminating the taxable earnings cap;
  - For all workers by raising the tax rate by 1/20 of 1% per year.

- **Increase benefits** in two ways:
  - For low earners by increasing the special minimum benefit;
  - For all beneficiaries by basing COLAs on the inflation experienced by the elderly.
Majorities of Republicans, Democrats, and Independents Agree

Percent agreeing: It is critical that we preserve Social Security for future generations, even if it means ...

- ... increasing the Social Security taxes paid by working Americans
- ... increasing the Social Security taxes paid by wealthier Americans

<table>
<thead>
<tr>
<th>Percent Agreeing</th>
<th>Total</th>
<th>Republican</th>
<th>Democrat</th>
<th>Independent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>77%</td>
<td>69%</td>
<td>84%</td>
<td>76%</td>
</tr>
<tr>
<td></td>
<td>83%</td>
<td>71%</td>
<td>92%</td>
<td>84%</td>
</tr>
</tbody>
</table>

Walker, Reno, and Bethell, 2014.
Demographic Support for Package of Policy Options Preferred by 71% of Americans

- **TOTAL:** 71%
- **Generation (Year of Birth):**
  - Early Boomers & Older (Before 1956): 74%
  - Late Boomers (1956-1964): 70%
  - Generation X (1965-1979): 69%
  - Generation Y (1980 and later): 71%
- **Family Income:**
  - Under $35,000: 68%
  - $35,000-$74,999: 75%
  - $75,000 or more: 71%
- **Party Affiliation:**
  - Republican: 68%
  - Democrat: 74%
  - Independent: 73%

Walker, Reno, and Bethell, 2014.
Benefits are modest (dollars and replacement rates). Yet they are most beneficiaries’ main source of income.

Social Security benefits will replace a smaller share of earnings in the future than they do today (replacement rates are declining because of the increase in the retirement age).

Revenue increases or benefit cuts will be needed to balance Social Security’s future finances.

Lawmakers have many options to raise revenues, lower future benefits, or increase benefits to improve adequacy.

Americans value Social Security and are willing to pay for it.

Americans report they would rather pay more than see future benefits reduced.
References


References (cont.)


**ITEM:** Finance Committee Report

**DATE OF BOARD MEETING:** October 4, 2018

**BACKGROUND:** The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Board. The Finance Committee meets monthly at 3:00 p.m. prior to the regular Board Meeting. This month’s report includes the draft minutes from the September 6, 2018, meeting, the budget to actual report and ratios for the period ending August 31, 2018, and recommendations to the Board to approve all presented contracts over $250,000.

**REQUEST FOR BOARD ACTION:** Accept the report.

**CEO RECOMMENDATION:** Accept the report.

**RESOURCE PERSON(S):** Chris Bostock, Committee Chair; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer
Finance Committee Meeting
Thursday, October 4, 2018
3:00-4:00 pm

AGENDA

1. Review of the Minutes – September 6, 2018

2. Monthly Financial Reports as of August 31, 2018
   a. Summary of Savings/(Loss) by Funding Source
   b. Statement of Revenue and Expenses (Budget & Actual)
   c. Senate Bill 208 Ratios
   d. DMA Contractual Ratios

3. Year End Summary and Committed Funds

4. Approval of Contract(s)

5. Adjournment
**1. WELCOME AND INTRODUCTIONS**

2. **REVIEW OF THE MINUTES** – The minutes from the August 2, 2018, meeting were reviewed; a motion was made by Mr. Gino Pazzaglini and seconded by Mr. Lascel Webley to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Monthly Financial Reports</td>
<td>The monthly financial reports were discussed which includes the Summary of Savings/(Loss) by Funding Source, the Statement of Revenue and Expenses, Senate Bill 208 Required Ratios, and DMA Contract Ratios as of July 31, 2018. Ms. Pacholke discussed the monthly reports. We have a loss of $283,180 year to date which is expected due to legislative reductions. As of July 31, 2018, we need approximately $1,350,000 from fund balance to offset the state loss. The loss will continue to grow during FY19 due to legislative cuts. Alliance is meeting all SB208 and DMA contractual ratios.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Year End Update</td>
<td>Ms. Pacholke discussed that the Finance team was wrapping up fiscal year 2018. We will bring a request to commit funds as of 6/30/18 to the 10/4/18 Finance Committee meeting. The auditors will be at the 12/6/18 Board meeting to go over the audited statements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Updated Financial Forecast</td>
<td>Ms. Goodfellow went over the financial solvency standards and reinvestment plan in conjunction with an updated financial forecast. Options are to 1) stop all reinvestment and we will not meet solvency standards or 2) do some reinvestment and hope the reductions stop. If we do not meet solvency standards, we risk further cuts. The discussion was for informational purposes only with no requested action today, however, at the next meeting the Board will have to consider strategy and commit reinvestments as of 6/30/18.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Business Operation Policies</td>
<td>The Committee went over the Business Operation policies with no changes except for the fund balance policy, which was discussed and approved at the August 2, 2018 meeting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Contract Approval</td>
<td>Ms. Pacholke discussed the Alphanumeric contract for networking hardware and support licenses for the new building. Mr. Webley made a motion to recommend to the Board to approve the Alphanumeric contract for networking hardware and</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
### Summary of Savings/(Loss) by Funding Source as of August 31, 2018

<table>
<thead>
<tr>
<th>Fund Balance</th>
<th>Revenue</th>
<th>Expense</th>
<th>Savings/(Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Waiver Services</td>
<td>$ -</td>
<td>$62,252,397</td>
<td>$64,237,572</td>
</tr>
<tr>
<td>Federal &amp; State Grants</td>
<td>$3,134,926</td>
<td>$6,194,227</td>
<td>$9,329,154</td>
</tr>
<tr>
<td>Local Grants</td>
<td>-</td>
<td>$4,724,120</td>
<td>$4,724,120</td>
</tr>
<tr>
<td>Administrative</td>
<td>-</td>
<td>$9,488,799</td>
<td>$8,673,747</td>
</tr>
<tr>
<td>Total</td>
<td>$3,134,926</td>
<td>$82,659,544</td>
<td>$86,964,592</td>
</tr>
</tbody>
</table>

Less Amount from Fund Balance $3,134,926

Net Savings/(Loss) $4,305,048

### Fund Balance as of August 31, 2018

<table>
<thead>
<tr>
<th>Description</th>
<th>June 30, 2018</th>
<th>Change</th>
<th>August 31, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment in Fixed Assets</td>
<td>4,409,429</td>
<td>(84,641)</td>
<td>4,324,788</td>
</tr>
<tr>
<td>Restricted - Risk Reserve</td>
<td>43,027,793</td>
<td>1,378,251</td>
<td>44,406,044</td>
</tr>
<tr>
<td>Restricted - Other</td>
<td>9,489,261</td>
<td>2,033,428</td>
<td>11,522,689</td>
</tr>
<tr>
<td>Committed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legislative Reductions</td>
<td>25,141,196</td>
<td>(3,134,926)</td>
<td>22,006,270</td>
</tr>
<tr>
<td>Intergovernmental Transfer</td>
<td>3,007,817</td>
<td>-</td>
<td>3,007,817</td>
</tr>
<tr>
<td>Reinvestment</td>
<td>24,169,500</td>
<td>(172,539)</td>
<td>23,996,961</td>
</tr>
<tr>
<td>Total Committed</td>
<td>52,318,513</td>
<td>(3,307,465)</td>
<td>49,011,048</td>
</tr>
<tr>
<td>Unrestricted</td>
<td>3,690,942</td>
<td>(4,324,620)</td>
<td>(633,679)</td>
</tr>
<tr>
<td>Total Fund Balance</td>
<td>112,935,938</td>
<td>(4,305,048)</td>
<td>108,630,890</td>
</tr>
</tbody>
</table>
## Statement of Revenue and Expenses (Budget and Actual) - As of August 31, 2018

<table>
<thead>
<tr>
<th></th>
<th>Original Budget</th>
<th>Current Period</th>
<th>Year to Date</th>
<th>Balance</th>
<th>% Received/Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Grants</td>
<td>$39,827,390.00</td>
<td>$3,354,110.36</td>
<td>$4,724,119.75</td>
<td>$35,103,270.25</td>
<td>11.86%</td>
</tr>
<tr>
<td>State &amp; Federal Grants</td>
<td>43,802,180.00</td>
<td>2,409,964.59</td>
<td>6,194,227.42</td>
<td>37,607,952.58</td>
<td>14.14%</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>362,034,028.76</td>
<td>31,864,994.08</td>
<td>62,252,397.43</td>
<td>299,781,631.33</td>
<td>17.20%</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$445,663,598.76</td>
<td>37,629,069.03</td>
<td>73,170,744.60</td>
<td>372,492,854.16</td>
<td>16.42%</td>
</tr>
<tr>
<td><strong>Administrative</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Administration</td>
<td>437,754.19</td>
<td>33,273.38</td>
<td>66,546.71</td>
<td>371,207.48</td>
<td>15.20%</td>
</tr>
<tr>
<td>LME Administrative Grant</td>
<td>4,359,385.00</td>
<td>363,283.04</td>
<td>726,566.08</td>
<td>3,632,818.92</td>
<td>16.67%</td>
</tr>
<tr>
<td>Medicaid Waiver Administration</td>
<td>49,368,276.65</td>
<td>4,341,487.29</td>
<td>8,488,051.32</td>
<td>40,880,225.33</td>
<td>17.19%</td>
</tr>
<tr>
<td>Miscellaneous Revenue</td>
<td>500,000.00</td>
<td>106,119.44</td>
<td>207,635.17</td>
<td>292,364.83</td>
<td>41.53%</td>
</tr>
<tr>
<td>Total Administrative Revenue</td>
<td>$54,665,415.84</td>
<td>4,844,163.15</td>
<td>9,488,799.28</td>
<td>45,176,616.56</td>
<td>17.36%</td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td>$500,329,014.60</td>
<td>42,473,232.18</td>
<td>82,659,543.88</td>
<td>417,669,470.72</td>
<td>16.52%</td>
</tr>
<tr>
<td><strong>EXPENSES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Services</td>
<td>39,827,390.00</td>
<td>3,354,110.36</td>
<td>4,724,119.75</td>
<td>35,103,270.25</td>
<td>11.86%</td>
</tr>
<tr>
<td>State &amp; Federal Services</td>
<td>43,802,180.00</td>
<td>4,190,844.96</td>
<td>9,329,153.61</td>
<td>34,473,026.39</td>
<td>21.30%</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>362,034,028.76</td>
<td>33,876,103.62</td>
<td>64,237,571.75</td>
<td>297,796,457.01</td>
<td>17.74%</td>
</tr>
<tr>
<td>Total Service Expenses</td>
<td>$445,663,598.76</td>
<td>41,421,662.29</td>
<td>78,290,845.11</td>
<td>367,372,753.65</td>
<td>17.57%</td>
</tr>
<tr>
<td><strong>Administrative</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operational</td>
<td>7,011,007.67</td>
<td>363,167.08</td>
<td>871,515.94</td>
<td>6,139,491.73</td>
<td>12.43%</td>
</tr>
<tr>
<td>Salaries, Benefits, and Fringe</td>
<td>40,203,716.73</td>
<td>3,615,965.63</td>
<td>7,344,449.16</td>
<td>32,859,267.57</td>
<td>18.27%</td>
</tr>
<tr>
<td>Professional Services</td>
<td>6,950,691.44</td>
<td>309,642.64</td>
<td>457,781.98</td>
<td>6,492,909.46</td>
<td>6.59%</td>
</tr>
<tr>
<td>Miscellaneous Expense</td>
<td>500,000.00</td>
<td>-</td>
<td>-</td>
<td>500,000.00</td>
<td>0.00%</td>
</tr>
<tr>
<td>Total Administrative Expenses</td>
<td>$445,665,415.84</td>
<td>42,388,775.35</td>
<td>8,673,747.08</td>
<td>45,991,668.76</td>
<td>15.87%</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>$500,329,014.60</td>
<td>45,710,437.64</td>
<td>86,964,592.19</td>
<td>413,364,422.41</td>
<td>17.38%</td>
</tr>
<tr>
<td><strong>CHANGE IN NET POSITION</strong></td>
<td>($3,237,205.46)</td>
<td>($4,305,048.31)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Current Ratio**

The current ratio compares current assets to current liabilities. It is a liquidity ratio that measures an organization's ability to pay short-term obligations. The requirement is 1.0 or greater.

**Percent Paid**

The percent paid is the percent of clean claims paid within 30 days of receiving. The requirement is 90% or greater.
**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 (7/1/17-6/30/18).
ITEM: Draft Minutes from the September 6, 2018, Board Meeting

DATE OF BOARD MEETING: October 4, 2018

REQUEST FOR BOARD ACTION: Approve the draft minutes from the September 6, 2018, meeting.

CEO RECOMMENDATION: Approve the minutes.

RESOURCE PERSON(S): Robert Robinson, CEO; Veronica Ingram, Executive Assistant II
MEMBERS PRESENT: ☒ Glenn Adams, Cumberland County Commissioner (via phone), JD, ☒ Cynthia Binanay, Chair, MA, BSN, ☒ Christopher Bostock, BSIM, ☒ Heidi Carter, Durham County Commissioner, MPH, MS, ☒ George Corvin, Vice-Chair, MD, ☒ David Curro, BS, ☒ Greg Ford, Wake County Commissioner, MA, ☒ Lodies Gloston, MA, ☒ David Hancock, ☒ Duane Holder, MPA, ☒ Curtis Massey, JD, ☒ Donald McDonald, MSW, ☒ Gino Pazzaglini, MSW, ☒ Pam Silberman, JD, DrPH, ☒ Lascel Webley, Jr., MBA, MHA, and ☒ McKinley Wooten, Jr., JD

GUEST(S) PRESENT: Mandy K. Cohen, MD, MPH, Secretary of the NC Department of Health and Human Services; Yvonne French, NC DHHS/DMH (Department of Mental Health); Mary Hutchings, Wake County Internal Auditor; and Amanda Parks, NC Department of Health and Human Services

ALLIANCE STAFF PRESENT: Brandon Alexander, Communications and Marketing Specialist; Damali Alston, Director of Network Evaluation; George Begg, Director of IT Infrastructure & Security; Lisa Brockmeier, Communications and Marketing Specialist; Margaret Brunson, Hospital Relations Director; Lori Caviness, Community Relations Manager; Vaughn Crawford, Director of System Engagement; Joey Dorsett, Senior Vice-President/Chief Information Officer; Cathy Estes, Director of Provider Network Operations; Anita Foreman, Healthcare Network Project Manager; Doug Fuller, Director of Communications; Cheala Garland-Downey, Senior Vice-President/Human Resources; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Amanda Graham, Senior Vice-President/Organizational Effectiveness; Carlyle Johnson, Director of Provider Network Strategy and Initiatives; Wes Knepper, Director of Quality Management; Ken Marsh, Medicaid Program Director; Beth Melcher, Executive Vice-President/Care Management; Heidi Middendorf, Associate Medical Director; Sara Pacholke, Senior Vice-President/Financial Operations; Jeff Payne, IDD Care Coordination Director; Brian Perkins, Senior Vice-President/Strategy and Government Relations; Monica Portugal, Chief Compliance Officer; Alison Rieber, Integrated Care Director; Matt Ruppel, Director of Program Integrity; Sean Schreiber, Senior Vice-President/Provider Network and Evaluation; Lisa Sullivan, Claims Director; Tammy Thomas, Director of Business Process Management; Kat Weis, Independent Living Initiative Coordinator; Sara Wilson, Government Relations Director; Carol Wolff, General Counsel; and Doug Wright, Director of Consumer Affairs

1. CALL TO ORDER: Chair Cynthia Binanay called the meeting to order at 4:01 p.m.

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Announcements</td>
<td>Mr. Robinson informed Board members of an agreement and press release between the Advancing NC Whole Health Coalition and United Healthcare Community Plan of North Carolina to collaborate on the delivery of integrated behavioral health, physical health and pharmacy services to beneficiaries in the State’s new Medicaid managed care program, slated to launch in the fall of 2019. Chair Binanay introduced David Hancock, a new member of the Board representing Wake County.</td>
</tr>
<tr>
<td>3. Agenda Adjustments</td>
<td>There were no adjustments.</td>
</tr>
<tr>
<td>4. Public Comment</td>
<td>There were no public comments.</td>
</tr>
<tr>
<td>5. Presentation</td>
<td>Mr. Robinson introduced NC DHHS Secretary Mandy Cohen. Chair Binanay welcomed her on behalf of the Board. Secretary Cohen provided a summary of pending changes to healthcare in NC with a focus on whole person care and the role of LME-MCOs following the passage of HB (House Bill) 403, as well as the role of payer agencies in a more integrated health system. She stated that DHHS is committed to transparency as they go forward with Standard and Tailored plans. Secretary Cohen shared DHHS’s goal of closing the Medicaid coverage gap in the next year via Medicaid Expansion. Other states that expanded Medicaid coverage may serve as models for the benefits of expansion.</td>
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**AGENDA ITEMS:**

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<th>DISCUSSION:</th>
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<tr>
<td>Secretary Cohen invited the Board to ask questions regarding the anticipated shift to Standard and Tailored Medicaid plans. Board members asked how the transition might affect people receiving services and those providing or managing services, including LME/MCOs and county social services agencies. Secretary Cohen also spoke to the Department’s intention to integrate screening tools and social determinants of health, and the process for evaluating individuals to be entered into, or moved between, Standard and Tailored plans.</td>
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<tr>
<td><strong>BOARD ACTION</strong></td>
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<tr>
<td>The Board received the report.</td>
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6. Committee Reports

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<tr>
<th><strong>AGENDA ITEMS:</strong></th>
<th>DISCUSSION:</th>
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<tr>
<td>A. Consumer and Family Advisory Committee – page 3</td>
<td>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 August draft minutes for the Steering Committee, and the Wake, Durham, and Johnston subcommittees; it also included July minutes from the Cumberland subcommittee meeting. Dave Curro, CFAC Chair, presented the report; he shared that the most recent Steering Committee meeting was canceled due to the Labor Day holiday and that DHHS Secretary Cohen spoke at the most recent State CFAC meeting. The CFAC report is attached to and made part of these minutes.</td>
</tr>
<tr>
<td><strong>BOARD ACTION</strong></td>
<td>The Board received the report.</td>
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B. Finance Committee – page 61

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<tr>
<th><strong>AGENDA ITEMS:</strong></th>
<th>DISCUSSION:</th>
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<tr>
<td>The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Area Board. This month’s report included draft minutes from the August 2, 2018, meeting, the Summary of Savings/ (Loss) by Funding Source, Statement of Revenue and Expenses (budget to actual) report and ratios for the period ending July 31, 2018. Chris Bostock, Committee Chair, presented the report. He shared that the Committee is finalizing FY18 reports, which will be presented to the Board at a later date. The Committee reviewed operational policies and will forward these to the Board's Policy Committee for review. Additionally, Mr. Bostock presented the Finance Committee’s recommendation related to the Alphanumeric contract. The Finance Committee report is attached to and made part of these minutes.</td>
<td></td>
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<tr>
<td><strong>BOARD ACTION</strong></td>
<td>A motion was made by Mr. Bostock to approve the Alphanumeric contract for networking hardware and support licenses in accordance with GS 143-129e3; motion was seconded by Dr. Silberman. Motion passed unanimously.</td>
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C. Policy Committee Report – page

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<th><strong>AGENDA ITEMS:</strong></th>
<th>DISCUSSION:</th>
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<tr>
<td>Per Alliance Behavioral Healthcare Area Board Policy &quot;Development of Policies and Procedures&quot;, the Board reviews all policies annually. The Policy Committee reviews a number of policies each quarter in order to meet this requirement. This month’s report included minutes from the April 26, 2018, meeting, Policies recommended for continued use, and Policies with recommended revisions.</td>
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DRAFT
**AGENDA ITEMS:**

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<tr>
<th>Discussion</th>
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<tr>
<td>Lodies Gloston, Committee Chair, presented the report. Ms. Gloston asked that the Board approve all governance and administrative policies as submitted. The following policies were submitted and recommended for continued use without revisions: GA2: Strategic Planning; GA3: Reporting of Abuse, Neglect, Dependency and Exploitation; GA4: Health and Safety Policy; GA 5: Emergency Management Plan; GA 6: Internal Control; GA 7: Business Continuity Plan; GA 8: Corporate Communications; G1: Board of Directors Conflict of Interest; G2: Board of Directors Member Meeting Attendance Compensation; G3: Board of Directors Processes; G4: Development of Policies and Procedures; G7: Evaluation of Chief Executive Officer; G8: Board of Directors Code of Ethics; G10: Delegation of Authority to the Chief Executive Officer; G11: Guidelines for Public Comment at Board of Directors Meetings; G13: Board of Directors Media Policy; and G14: Dispute Resolution. The following policies were submitted with recommended revisions: GA1: Management of Service Delivery; G6: Chief Executive Officer Compensation; G9: Consumer, Family Advisory Committee; G12: Area Authority Relations with Catchment Area County Boards of Commissioners; and B1: By-Laws; B1: By-Laws was approved by the Board on June 7, 2018. The Policy Committee report is attached to and made part of these minutes.</td>
</tr>
</tbody>
</table>

**BOARD ACTION**

A motion was made by Mr. Pazzaglini to approve the policies submitted for continued use and the policies submitted with recommended revisions; motion seconded by Commissioner Ford. Motion passed unanimously.

7. Consent Agenda

| A. Draft Minutes from August 2, 2018, Board Meeting – page 121 |
| B. Executive Committee Report – page 126 |
| C. Quality Management Committee Report – page 129 |
| D. Alphanumeric Systems Contract – page |

The consent agenda was sent as part of the Board packet. There were no comments or discussion about the consent agenda.

**BOARD ACTION**

A motion was made by Ms. Gloston to approve the consent agenda; motion seconded by Mr. Massey. Motion passed unanimously.

8. Legislative Update

| Brian Perkins, Senior VP for Government Relations, and Sara Wilson, Government Relations Director, gave a brief legislative update and shared that Alliance announced a partnership with Mallinckrodt Pharmaceuticals as a part of the Alliance for Action on Opioids campaign. Mallinckrodt has given Alliance 30,000 pouches to distribute through the Care Management team, community networks, and other partnerships throughout the catchment area. To date, 12,000 pouches have been distributed. |

**BOARD ACTION**

The Board accepted the training as presented; no additional action required.

9. Chair’s Report

| Chair Binanay presented a request to reschedule the location of the November 1 Board meeting; it was originally scheduled to be held at Alliance’s Johnston County office. |

**BOARD ACTION**

A motion was made by Mr. Wooten to postpone holding a board meeting at the Johnston site location until 2019; motion seconded by Mr. Bostock. Motion passed unanimously.
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<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
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<tbody>
<tr>
<td>10. Closed Session(s)</td>
<td><strong>BOARD ACTION</strong>&lt;br&gt;A motion was made by Chair Cynthia Binanay to enter closed session pursuant to NC General Statute 143-318.11(a)(5) to instruct staff concerning the price and other material terms of a proposed contract for the acquisition of real property and pursuant to NC General Statute 143-318.11 (1) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1.; motion seconded by Commissioner Greg Ford. Motion passed unanimously.</td>
</tr>
<tr>
<td>11. Adjournment</td>
<td>With all business being completed the meeting adjourned at 6:44 p.m.</td>
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</table>

**Next Board Meeting**<br>**Thursday, October 04, 2018**<br>**4:00 – 6:00 pm**
ITEM: County Commissioners Advisory Board Report

DATE OF BOARD MEETING: October 4, 2018

BACKGROUND: As stated in Alliance’s by-laws, the County Commissioner Advisory Board’s duties include serving as the chief advisory board to the area authority and to the director of the area authority on matters pertaining to the delivery of services for individuals with mental illness, intellectual or other developmental disabilities and substance abuse disorders in the catchment area. Draft minutes from the September 6, 2018, meeting are attached.

REQUEST FOR BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Robert Robinson, CEO; Denise Dirks, Administrative Assistant II
1. **ANNOUNCEMENTS** - None

2. **REVIEW OF THE MINUTES** – The minutes from the March 1, 2018, Committee meeting were reviewed; a motion was made by Commissioner Heidi Carter and seconded by Commissioner Greg Ford to approve the minutes. Motion passed unanimously.

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<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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<tr>
<td>3. Legislative Update</td>
<td>Sara Wilson reviewed the PowerPoint presentation from the August 2, 2018 meeting of the North Carolina Association of County Commissioners (NCACC). The PowerPoint and audio are available online at NCACC’s website AT <a href="https://www.ncacc.org/622/Medicaid">https://www.ncacc.org/622/Medicaid</a>. Discussion followed of Essential Providers re: Health Departments.</td>
<td>Mr. Robinson will email link of PowerPoint and audio of discussed presentation to the Commissioners.</td>
<td>Immediately</td>
</tr>
<tr>
<td>4. County-Specific Concerns to be Addressed</td>
<td>All Wake Commissioners are up for election. Commissioner Ford would like Alliance to come back to Wake County after the elections to present another update and hold another discussion about Medicaid transformation.</td>
<td>None specified.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

5. **ADJOURNMENT**: next meeting will be held December 6, 2018, from 3:00 p.m. to 4:00 p.m.

Respectfully Submitted by:

Carol Wolff, General Counsel

Date Approved

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

DATE OF BOARD MEETING: October 4, 2018

BACKGROUND: The Executive Committee sets the agenda for Board meetings and acts in lieu of the Board between meetings. Actions by the Executive Committee are reported to the full Board at the next scheduled meeting. Attached are the draft minutes from the September 18, 2018, meeting.

REQUEST FOR BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Cynthia Binanay, Board Chair; Robert Robinson, CEO
**APPOINTED MEMBERS PRESENT:** ☒ Cynthia Binanay, MA (Board Chair); ☒ Christopher Bostock, BSIM (Previous Board Chair, Finance Committee Chair) – via phone; entered at 4:09 pm; ☒ George Corvin, MD (Board Vice-Chair); ☒ Dave Curro, BS (Quality Management Committee Chair); ☒ Lodies Gloston, MA (Policy Committee Chair) – via phone; ☒ Donald McDonald, MSW (Network Development and Services Committee Chair); ☒ Lascel Webley, Jr., MBA, MHA (Audit and Compliance Committee Chair) – via phone; and ☒ McKinley Wooten, Jr., JD (Human Rights Committee Chair) – entered at 4:09 pm

**APPOINTED NON-VOTING MEMBERS PRESENT:** None

**NON-VOTING BOARD MEMBERS PRESENT:** None

**GUEST(S):** None

**STAFF PRESENT:** Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Veronica Ingram, Executive Assistant II; Brian Perkins, Senior Vice-President/Chief Financial Officer; Robert Robinson, CEO; Sara Wilson, Government Relations Director; and Carol Wolff, General Counsel

### 1. WELCOME AND INTRODUCTIONS

### 2. REVIEW OF THE MINUTES – The minutes from the August 21, 2018, Executive Committee meeting were reviewed; a motion was made by Vice-Chair Corvin and seconded by Mr. Curro to approve the minutes. Motion passed unanimously.

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| 3. Updates | **a)** MEDICAID REFORM/NC LEGISLATION: Mr. Perkins mentioned that an official question and answer period for the Medicaid Transformation Standard Plan RFP was held and an addendum was provided by the DHHS since the last update to the board.  
**b)** BOARD VACANCIES/RECRUITMENT: Chair Binanay mentioned that there are two vacancies representing Wake County and two vacancies representing Johnston County. She mentioned receipt of one application for a Johnston County seat. The application is going through the screening process.  
**c)** HURRICANE RESPONSE: Mr. Robinson reported on Alliance’s Hurricane Florence’s preparation and response activities to include contacting providers to ensure they were ready to assist in the community and responding to needs of people in shelters and the community. He also mentioned Alliance’s involvement within our communities to provide assistance with Red Cross, County efforts and the State. He provided recent statistics about Alliance and provider response, which included fifty Alliance staff who volunteered within the community.  
**d)** PENETRATION/PREVALENCE RATE RESPONSE: Mr. Robinson mentioned the agency’s submission of a response to the State’s behavioral health strategic plan. | a) None specified.  
b) None specified.  
c) Topic will be part of the October board meeting.  
d) None specified. | a) N/A  
b) N/A  
c) 9/18/18  
d) N/A |
| 4. Financial Review | Ms. Goodfellow provided a financial review including the current reinvestment plan and financial projections for the next two fiscal years. This topic was presented to the Board’s Finance Committee on September 6, 2018. Committee members discussed recommendations and potential next steps. | Ms. Goodfellow will present this topic at the next Finance Committee meeting and Board meeting. | 10/4/18 |

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
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<tr>
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<tr>
<td>5. October 4, 2018, Area Board Draft Agenda</td>
<td>The Committee reviewed the agenda and provided input. Chair Binanay reminded Committee members that the October Board meeting is at 4600 Emperor Boulevard in Durham.</td>
<td>Ms. Ingram will forward the agenda to staff.</td>
<td>9/18/18</td>
</tr>
<tr>
<td>6. Closed Session</td>
<td>COMMITTEE ACTION:</td>
<td>None specified.</td>
<td>N/A</td>
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<td></td>
<td>A motion was made by Vice-Chair Corvin to enter closed session pursuant to NC § 143-318.11 (a) (1) and (a) (3) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1 and to consult with General Counsel regarding current litigation. Motion seconded by Mr. Curro; Motion passed unanimously.</td>
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<td>The Committee returned to open session.</td>
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7. **ADJOURNMENT:** the next Committee meeting will be October 16, 2018, at 4:00 p.m.

Respectfully Submitted by:

Robert Robinson, CEO
ITEM: Global Quality Management Committee Report

DATE OF BOARD MEETING: October 4, 2018

BACKGROUND: The Global QMC is the standing committee that is granted authority for Quality Management by the MCO. The Global QMC reports to the MCO Board of Directors which derives from General Statute 122C-117. The Quality Management 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. The Alliance Board of Directors’ Chairperson appoints the committee consisting of five voting members consisting of Board members and consumers and/or their family members. Other non-voting members include at least one MCO employee and at least two provider representatives. The MCO employees typically assigned are the Director of the Quality Management (QM) Department who has the responsibility for overall operation of the Quality Management Program; the MCO Chief Medical Officer, who has ultimate responsibility of oversight of quality management; the Quality Review Manager, who staffs the committee; and other staff as designated. The Global QMC meets at least six times each fiscal year and provides ongoing reporting to the Alliance Board. The Global QMC approves the MCO’s annual Quality Improvement Projects, monitors progress in meeting Quality Improvement goals, and provides guidance to staff on QM priorities and projects. Further, the Committee evaluates the effectiveness of the QM Program and reviews and updates the QM Plan annually. The QM Committee shall review statistical data and provider monitoring reports and make recommendations to the Board of Directors or other Board committees. The QM Committee serves as the Board’s Monitoring and Evaluation Committee charged with the review of statistical data and provider monitoring reports. The goal of the QM Committee is to ensure quality and effectiveness of services and to identify and address opportunities to improve Alliance operations and local service system with input from consumers, providers, family members, and other stakeholders. The draft minutes and materials for the August meeting are attached.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Dave Curro, Committee Chair and Wes Knepper, Quality Management Director
**VOTING MEMBERS PRESENT:** ☒ David Curro, Committee Chair (Area Board); ☐ Cynthia Binanay (Area Board Chair); ☒ Duane Holder (Area Board); ☒ Pam Silberman (Area Board); ☐ Joe Kilsheimer, MBA (CFAC);

**NON-VOTING MEMBERS PRESENT:** ☒ Diane Murphy (Provider Representative, I/DD); ☒ Dava Muserallo (Provider Representative, MH/SUD); ☒ Beat Steiner, (Provider Representative, Integrated Care)

**STAFF PRESENT:** ☒ Wes Knepper, LPC (Quality Management Director); ☒ Damali Alston (Director of Network Evaluation); ☐ Vacant (Chief Medical Officer); ☒ Doug Wright (Director Individual & Family Affairs); ☒ Tina Howard, MA (Quality Review Manager); ☒ Linda Losiniecki, (Executive Assistant)

**GUEST(S) PRESENT:** George Corvin, MD (Area Board); Yvonne French (Director & Liaison DMH/DD/SAS); Mary Hutchings (Wake Co. Internal Audit); Israel Pattison (CFAC)-via Phone; Davida Jones (Appeals Coordinator-Alliance BHC); Todd Parker (QM Incident & Grievance Manager-Alliance BHC); Carlyle Johnson, (Director Provider Network Strategy & Initiatives-Alliance BHC)

**REVIEW OF THE MINUTES:** Motion made by Duane Holder to approve the May 3, 2018 meeting minutes, seconded by Joe Kilsheimer, minutes were approved.

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<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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<tbody>
<tr>
<td>1. Welcome &amp; Introductions:</td>
<td>Welcome: Dave Curro opened the meeting and welcomed guests and new member</td>
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<tr>
<td>2. Old Business:</td>
<td>QM Evaluation &amp; Plan Vote (Wes)</td>
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<tr>
<td></td>
<td>Motion was made by Pam and second by Duane to approve the QM Evaluation &amp; Plan,</td>
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<td>with the following provisions:</td>
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<td>Requirements as part of the RFP for the Standard Plan. Staff will review the new</td>
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<td>Measurers identified in the Standard Plan and that Alliance is in line with the</td>
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<td>new requirements.</td>
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<td>All Ayes, motioned carried.</td>
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<td>3. New Business:</td>
<td>Appeals Report (Davida)</td>
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<td>Davida reviewed the Appeals Data from the previous fiscal year. The data is</td>
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<td>divided up by population and the services received. The IPRS appeals have gone</td>
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<td>down, made the 7-day turnaround time.</td>
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### Complaints/Incidents Annual Reports (Todd)

An overview of the Grievances for FY18 I/DD Innovation Services were the highest with Enhanced Services following with 45%. Concerns about Alliance were 73, which 12 were confirmed, with 2 being compliments. The issues are categorized, the data showed that they were more children than adults. The highest category for I/DD Incidents was ICMR at 120.

TROSA incidents are separated out from the rest of the incidents reported because of work-related incidents that get reported.

Levels for incident reporting are determined of how someone needs to respond to the incident and how it was handled.

### QIP Updates (Tina)

Currently there is 7 open QIP Projects. Opened 3 new projects. Proposing to close one QIP Project.

**Successes:**
- First Responder – Reached Benchmark for a second time.
- Access to Care-Emergent – Great Improvement, from 52% to 64%.
- Access to Care-Routine/Urgent – Some Improvement

**Red Flags:**
- Access to Care-Routine/Urgent – Routine care for 14 days decreased. New intervention being implemented to refer callers to appointments rather than walk-in.

**Interventions:**
- Urgent Callers – Move most CJ population to Routine and categorizing the timeframe for a needed evaluation to either 8 hours or 48 hours. Utilizing Mobile Crisis Teams for needing an appointment within 8 hours.

Transportation pilot beginning October 1, 2018 targeted to individuals who need Urgent Care or those being discharged from hospitals.
First Responder – Interventions have been successful, and have met the benchmarks for the second time. Request to close this QIP:

**Vote:**
Motion made by Pam to close the First Responder QIP, seconded by Duane, all ayes, motion carried.

**Annual Gaps and Needs (Carlyle)**
The Needs Assessment is conducted one time annually. A new name for the report is now called the Network Adequacy and Accessibility Analysis Report. Evaluation includes Access to Services, Appointment Times, Referrals. Geographic’s, Demographics, and Diversity is also looked at, for those with language barriers and other disabilities.

Meeting the needs by having adequate amount of Providers. Obtaining feedback from the community and consumers through surveys and focus groups.

Community Survey: Includes other stakeholders (DPSS, Homeless Shelters, Hospital ED), members, family members, providers and staff. Survey include Access to Services, Linguistic Access and the Barriers.

Provider Survey: Specific to providers. Survey includes Providers who are closed to admissions and why they are not taking new referrals, Language Barriers, Wait Time for Appointments, Utilizing the Slot Scheduler and other barriers to timely access.

**Gaps:**
Location Based – For child/adolescent Day Treatment Services, not enough choice in Cumberland County, trying to get the school system on a new program.
Substance Comprehensive Outpatient Treatment – Not enough Choice Providers
Opioid Treatment – State Funded Services are depleted. Gap in Cumberland County.
Day Supports and Specialized I/DD Services – Not being met.

**Next Steps:**
Network Develop Plan – How we will be address the gaps Strategic Goals that meet a Tailored Plan.
<table>
<thead>
<tr>
<th>Working with other Counties.</th>
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<tbody>
<tr>
<td><strong>Performance Dashboard (Wes)</strong></td>
<td>Not Discussed</td>
</tr>
<tr>
<td><strong>TCLI Year End Report (Wes)</strong></td>
<td>Huge progress to placing individuals to living on their own.</td>
</tr>
</tbody>
</table>

**Upcoming Meeting:**

Next meeting is scheduled for October 4, 2018 (Time: 2:00 – 3:30 pm)

**Location:** Home Office

New Topics of Discussion: RFP for Quality Measurers

E-mail any comments, questions and new suggestions to Wes at: wknepper@alliancebhc.org

**Adjournment:**

Meeting adjourned at 3:30 p.m.
2013 – 2016 Medicaid Appeals Analysis

For Fiscal Year 18, the average rate of appeals was 3.60%. This is a slight decrease in the rate of appeal from Fiscal Year 17. There is no one indicator for decreased number of appeals.

Appeal trends by service population continue to be consistent with FY17 with a slight deviation in I/DD due to Intensive Review Committee (IRC) and increased number of partial denials.
In comparing with the data below Community Living and Support, Day Supports, Peer Support, Intensive In-Home and PSR continue to remain in the top 5 services appealed.
There rate of outcomes for Upheld decisions during the reconsideration process continue to be consistent. The current rate of upheld outcomes is 97.7%.

There were 7 Invalid Appeal Request and 7 request that were withdrawn during the appeal process during FY18. These request were not clinically reviewed and not included in the appeals outcome numbers above. The number of invalid request decreased dramatically from 2016.
The total number of appeals that reaches SFH level continues to remain constant. However, the number of I/DD appeals reaching the SFH level continues to increase.

Mediation typically resolves 80% of the State fair hearing appeals, however in FY18 approximately 64% were overturned, with 1 case being resolved and 1 case withdrawn during pre-trial.
IPRS Data

FY18 State Funded Appeals

There continues to be a significant decrease in the rate of appeals from 2013 thorough FY18. This decrease is attributed to both the decreased number of appeals received.
FY18 Annual Complaint Analysis
QM Quality Assurance
Overview

• FY18 yielded 825 entries
• 73 were regarding ABH (143 in FY17)
• Topics discussed in this report:
  • Nature of Issue
  • Source
  • Service Breakdown
  • ABH Concerns
  • Actions Taken For Confirmed Issues
  • Resolution Status
43% (348) of concerns entered were related to the Quality of Services
Source – who submitted the concern?

- 38% (312) were submitted by MCO staff
- 25% (202) were submitted by Consumers
- 24% (195) were submitted by Guardians
MH/SA Service Breakdown

Enhanced Services: 301 (45%)
Basic Services: 200 (30%)
SA Services: 83 (13%)
Crisis Services: 68 (10%)
MH/SA Care Coordination: 11 (2%)
I/DD Service Breakdown

- NC Innovations Waiver Services: 66
- Respite: 13
- Adult Day Vocational Program: 10
- IDD Care Coordination: 10
- Developmental Therapies: 12
- Intermediate Care Facilities (ICF): 6
- NC IPRS Services: 5
- Community Guide: 4
- In-Home Skill Building: 3

Bar chart showing the breakdown of service categories and their respective counts.
ABH Complaints

- 73 entries involved ABH
  - 12 were confirmed
    (there was a problem to address)
  - 33 were nonissues
    (there was an issue but ABH followed appropriate policies or procedures in handling the issue)
  - 2 were compliments
    (a compliment about ABH staff was submitted)
  - 20 were for tracking
  - 6 were undetermined
The 2 confirmed ABH issues resulted in ABH initiating corrective actions.
Actions Taken For Confirmed Issues

239 of the 825 entries were confirmed issues and resulted in the following actions:

- Provider Initiated Corrective Actions: 215
- Referral and/or TA by an ABH Dept.: 12
- External Referral (DSS/DHSR): 4
- Revert Claims: 6
Resolution Status

Complaints were resolved in the following time frames:

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Count</th>
</tr>
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<tbody>
<tr>
<td>0-15</td>
<td>580</td>
</tr>
<tr>
<td>16-30</td>
<td>242</td>
</tr>
<tr>
<td>30+</td>
<td>3</td>
</tr>
</tbody>
</table>

*The State requires all complaints to be resolved in 30 days or less*
# Nature of Issue Definitions

<table>
<thead>
<tr>
<th>Reporting Category</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse, Neglect and Exploitation</td>
<td>Any allegation regarding the abuse, neglect and/or exploitation of a child or adult as defined in APSM 95-2 (Client Rights Rules in Community Mental Health)</td>
</tr>
<tr>
<td>Access to Services</td>
<td>Access to Services as any complaint where an individual is reporting that he/she has not been able to obtain services</td>
</tr>
<tr>
<td>Administrative Issues</td>
<td>Any complaint regarding a Provider’s managerial or organizational issues, deadlines, payroll, staffing, facilities, etc.</td>
</tr>
<tr>
<td>Authorization/Payment Issues/Billing PROVIDER ONLY</td>
<td>Any complaint regarding the payment/financial arrangement, insurance, and/or billing practices regarding providers</td>
</tr>
<tr>
<td>Basic Needs</td>
<td>Any complaint regarding the ability to obtain food, shelter, support, SSI, medication, transportation, etc.</td>
</tr>
<tr>
<td>Clients Rights</td>
<td>Any allegation regarding the violation of the rights of any consumer of mental health/developmental disabilities/substance abuse services. Clients Rights include the rights and privileges as defined in General Statutes 122C and APSM 95 -2 (Client Rights Rules in Community Mental Health)</td>
</tr>
<tr>
<td>Confidentiality/HIPAA</td>
<td>Any breach of a consumer’s confidentiality and/or HIPAA regulations.</td>
</tr>
<tr>
<td>LME/MCO Functions</td>
<td>Any complaint regarding LME functions such as Governance/ Administration, Care Coordination, Utilization Management, Customer Services, etc.</td>
</tr>
<tr>
<td>LME/MCO Authorization/Billing</td>
<td>Any complaint regarding the payment/financial arrangement, insurance, and/or billing practices of the LME/MCO</td>
</tr>
<tr>
<td>Provider Choice</td>
<td>Complaint that a consumer or legally responsible person was not given information regarding available service providers.</td>
</tr>
<tr>
<td>Quality of Care – PROVIDER ONLY</td>
<td>Any complaint regarding inappropriate and/or inadequate provision of services, customer services and services including medication issues regarding the administration or prescribing of medication, including the wrong time, side effects, overmedication, refills, etc.</td>
</tr>
<tr>
<td>Service Coordination between Providers</td>
<td>Any complaint regarding the ability of providers to coordinate services in the best interest of the consumer.</td>
</tr>
<tr>
<td>Other</td>
<td>Any complaint that does not fit the above areas.</td>
</tr>
</tbody>
</table>
FY2018

- 2528 Reports were entered in to NC-IRIS for 1657 ABH consumers
- 1484 reports involved Children, 1044 involved adults
- 298 fewer reports were submitted during FY2018 than FY2017 (2826)

LEVELS
- 2316 Level 2 reports (325 fewer than FY2017)
- 212 Level 3 (27 more than FY2017)

*Increase in Level 3 reports most likely due to change in requirements to report Allegations of Abuse as Level 3
The largest number of Level 2 reports (641) submitted during Q1
The largest number of Level 3 reports (75) submitted during Q4
Wake County submitted the largest number of Level 2 (1233) and Level 3 (124) reports in FY2018.
Adults vs. Children (By Quarter)

- 59% of reports submitted were for Children
- 41% of reports submitted were for Adults
1652 incidents involving MH/SU consumers were submitted during FY2018.

Reports represented 80 different service types.

Those representing at least 2% of the reports submitted are represented in the chart. Other services represented f<1% of the 80 the service.

HRI Res Level III submitted the highest number of incident reports.
• 463 incidents involving IDD consumers were submitted during FY2018
• Reports represented 30 service categories
• ICFMR submitted the highest number of incidents (210)
Level 2 & 3 Incident Definitions

- Level 2 incident categories and behaviors
  - Consumer Death – Terminal Illness or Natural Cause
  - Restrictive Intervention – Emergency/Unplanned use or planned use that has exceeded authorized limits
  - Consumer Injuries – Any injury that requires treatment by a licensed health professional
  - Allegations of Abuse – Any allegations of abuse, neglect or exploitation including domestic violence
  - Medication Errors – Any error that threatens the consumer’s health or safety
  - Consumer Behavior – Suicidal behavior, sexual behavior (exhibited by the consumer), consumer act (involves aggressive, destructive or illegal act that results in a report to law enforcement that is potentially harmful to the consumer or others), consumer absence (greater than 3 hours over what is specified in the consumer’s plan or requires police contact)
  - Other – Suspension, Expulsion and Fire

- Level 3 incident categories and behaviors – all are categorized as any that results in permanent physical or psychological impairment or if there is perceived to be a significant danger to the community
  - Death – Suicide, Accident, Homicide, Unknown, Opioid
  - Restrictive Intervention
  - Consumer Injury
  - Abuse/Neglect/Exploitation – includes all sexual assaults
  - Medication Error
  - Behavior
  - Other
Quality Improvement Projects

Presentation to the Global Quality Management Committee (September 2018)
Quality Improvement Projects

Summary:
- Open/Active: 7 projects (includes the 3 new projects approved at meetings in May and June)
- Proposing to Close: 1 project
Quality Improvement Projects

Successes:

- First Responder – Reached benchmark (for 2<sup>nd</sup> time): 94% successful test calls due to implementation of new interventions (quicker referral to compliance, training, outreach)

- Access to Care-Emergent – Greatly improved percent of callers showing for care within 2 hours (from 52% in Q2 to 67% in Q4, 100% in June)

- Access to Care-Routine/Urgent – Some improvement in percent of callers showing for care within 2 days, Mobile Crisis a successful intervention (88% accepting referral received timely care)
Quality Improvement Projects

Red Flags:

- Access to Care Routine/Urgent QIP: Percent showing for Routine care (14 days) decreased (from 48% in Q2 to 40% in Q4), implementing new intervention of referring callers to appointments instead of walk-in care.
Detailed Results for QIPs
Access to Care - Emergent

Goal:

- 77% of callers identified as needing Emergent Care show for the care within 2:15 hours (state benchmark, which we feel is unreasonable, is 97%)

Interventions:

- Improve internal coding and data entry (start: January 2017)
- Revise urgency criteria (called Clinical Decision Support Tool) to better reflect best practices (fully implemented: July 2018)
Results (Baseline – 67%):

- Clinical Decision Support Tool (CDST) revised (beta-tested in May, formally approved in July) to better reflect best practices

*The timeframe for receiving timely care was changed from 2:15 hours from start of call to 2 hours from start of call for all individuals who have Medicaid starting in this quarter (Quarter 3 of FY 18). This was changed based on feedback from Alliance leadership.*
Goals:

- Increase consumer initiation in services after phone call based on need—63% within 14 days for Routine and 62% in 2 days for Urgent callers
Urgent Callers: Results

Measure #1: Percent of Urgent callers who show for care within 2 days

- **Goal:** 62%

**Interventions:**
- Training on adding appointments, feedback letters
- Meetings with providers
- Feedback letters to providers, reminder letters to inmates
- Action plan created
- CDST change, use of MCT

Action plan, with multiple interventions, was created due to no improvement in performance. Plan tasks include: Working with criminal justice partners to improve show rate of individuals releasing from prison (participate in Re-Entry Councils, outreach to faith community working with population and new Public Safety case management program, and partner with Wake County Probation in MH Probation Pilot); expand appointments particularly in Wake County and on Fridays and Saturdays; streamline credentialing process; pilot rideshare initiative to address transportation to initial care; and revise Clinical Support Decision tools to better reflect best practices.

*Initial analysis, data on claims incomplete due to lag in submitting claims and report anomalies.*
Urgent Callers: Interventions

What Worked:
• Changes to Clinical Decision Support Tool (CDST) – move most of CJ population to Routine, divide into two categories: Evaluation needed in 8 hours, evaluation needed in 48 hours
• Use of Mobile Crisis Teams for callers needing evaluation within 8 hours (88% show in 2 days-self report, 58%-claims)
• Expanded appointments for Medicaid population (from 709 to 852)- 65% of callers with Medicaid had timely appt (9% > Q3)
• Engagement of Medicaid population (40% from 24%, 33%- outpatient, 81%-Mobile Crisis)

What Did Not Work:
• Encouraging providers to put more slots in Slot Scheduler – more efficient for Call Center, but did not result in better outcomes (to date)
Urgent Callers: Interventions

Actions still in planning phase:
• Working with criminal justice partners to improve show rate of individuals releasing from prison (participate in Re-Entry Councils, outreach to faith community working with population and new Public Safety case management program, and partner with Wake County Probation in MH Probation Pilot)-now mostly Routine
• Pilot rideshare initiative to address transportation to initial care (planned start date: October 1)

No longer applicable:
• Streamline credentialing process-there was not as much of a difference between self report and claims
Urgent Callers: Interventions

Next Steps:
• Pilot: Refer callers to appointments instead of open access/walk in care (Medicaid, non-Medicaid-where possible given limited availability), start: August 1
• Considering proposal to use a community-based assessment model
Routine Callers: Results

Measure #2: Percent of Routine callers who show for care within 14 days

Goal: 63%

*Initial analysis, data on claims incomplete due to lag in submitting claims and report anomalies.
Routine Callers: Results

What Worked:
• Better show rate for callers referred to appointments vs. walk in care (45%-appointments, 33%-open access/walk in)

What Did Not Work:
• Changes to Clinical Decision Support Tool (CDST) – Almost all CJ and some callers with SUD moved to Routine, reduced performance
• Encouraging providers to put more slots in Slot Scheduler – more efficient for Call Center, but did not result in better outcomes (to date)
• Email reminders – We are currently not collecting information and there’s no where in Alpha to put it
• Increase use of in-home assessments – Only 3 additional callers referred to in home assessment

*Initial analysis, data on claims incomplete due to lag in submitting claims and report anomalies.
Routine Callers: Results

Actions still in planning phase:
• Working with criminal justice partners to improve show rate of individuals releasing from prison (participate in Re-Entry Councils, outreach to faith community working with population and new Public Safety case management program, and partner with Wake County Probation in MH Probation Pilot)-now mostly Routine

No longer applicable:
• Streamline credentialing process—there was not as much of a difference between self report and claims
Next Steps:

• Pilot: Refer callers to appointments instead of open access/walk in care (Medicaid, non-Medicaid-where possible given limited availability), start: August 1
• Considering proposal to use a community-based assessment model
Update:

- MH/SUD Care Coordination is changing business practices to improve customer service to individuals in our system, including frequency of contacts. Thus, this measure was no longer applicable.
- The Project Advisory Team agreed to continue this QIP with a different measure and interventions, which are currently being developed, to better align with new practices.
Test crisis lines of providers after business hours

**Goals:** 85% of calls meet standard for satisfactory (call goes through successfully and it is answered live or returned within 1 hour)

**Interventions:**

- Providers assigned to “Tiers” based on previous performance (some called more frequently, others less)-validate by calling all providers at same frequency for one year
- Written feedback to all providers, written feedback and outreach calls to poor performers after calls
- Refer to Compliance those providers who continue to score “unsatisfactory”, issue Plan of Correction if poor performance continues
- Training
First Responder

Results:

Measure #1: Percent of crisis line tests that are answered satisfactorily

Interventions:

- Providers with 3 unsatisfactory calls refer to Compliance, continue call tiers, test SAIOP/SACOT providers based on claims
- Results/ brief training to provider groups
- Outreach calls to providers with 2 unsatisfactory calls
- Outreach calls to all providers with unsatisfactory calls, refer to Compliance after 2 unsatisfactory calls, training, validate call tiers
- Webpage on project updated

Recommendation: Close project because benchmark met for two measurement periods
New: UM Turn Around Time QIP

UM Turn-Around Time (TAT) for Innovations requests – Reduce average TAT for Innovations requests, meets URAC requirement for UM project *(approved at May meeting)*

**Interventions:**

- Use of checklist for Care Coordinators to ensure all required paperwork being submitted
- Staffing patterns changed
- Data used in supervision with staff
New: UM Turn Around Time QIP

Results:

Innovations - Average SAR TAT

- SAR Volume

<table>
<thead>
<tr>
<th>Month</th>
<th>Average SAR TAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov-17</td>
<td>8.25</td>
</tr>
<tr>
<td>Dec-17</td>
<td>7.88</td>
</tr>
<tr>
<td>Jan-18</td>
<td>8.99</td>
</tr>
<tr>
<td>Feb-18</td>
<td>8.19</td>
</tr>
<tr>
<td>Mar-18</td>
<td>8.10</td>
</tr>
<tr>
<td>Apr-18</td>
<td>8.08</td>
</tr>
<tr>
<td>May-18</td>
<td>6.97</td>
</tr>
<tr>
<td>Jun-18</td>
<td>5.34</td>
</tr>
<tr>
<td>Jul-18</td>
<td>6.97</td>
</tr>
</tbody>
</table>
New: UM Turn Around Time QIP

Conclusion:
- Decrease in TAT since start of project and interventions
- Caution: Results may not be due to interventions alone, Project Team requested continuing analysis for a few more months
- Individual Service Plan changes expected October 1 – changes may negatively impact project (increase TAT)
New: UM Expedite Care QIP

UM Expedite Care Requests – Expedite requests for services following acute stabilization (ED, inpatient, crisis)

(approved at May meeting)

Interventions:

- Increase awareness of Expedited (within 3 days) authorization review process
- Provide feedback to providers on time from discharge to care, authorization requests that could have qualified for an Expedited review
New: UM Expedite Care QIP

Data:

Reduce Authorization Review Turn Around Time for Post-Discharge Requests*

*Inpatient requests are excluded from average

May – July data not yet available due to claims lag for inpatient and ED discharges, expect May data shortly.
New: TCLI Timely Housing QIP

Description: Improve timeliness of housing for individuals in TCLI, meets contract requirement

(approved at June meeting)

Goal: Increase percent of individuals who are housed within 90 days of housing slot assignment to 60%
New: TCLI Timely Housing QIP

Data:

% of Individuals Transitioned in 90 days

Goal: 60%

B-Apr-Jun 18

Jul-Sep 18

Oct-Dec 18
ITEM: Hurricane Florence Planning and Response

DATE OF BOARD MEETING: October 6, 2016

BACKGROUND: The presentation will provide an overview and summary of the steps Alliance implemented to ensure that the agency and providers were prepared for the storm, ensure the safety of high risk members, ensure services to members and the community were available and could be provided with little to no disruption and support our members and communities in the immediate aftermath of the storm. A summary of ongoing efforts to support our members and communities will also be provided.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Sean Schreiber, Senior Vice-President/Provider Networks and Evaluation, Ann Oshel, Senior Vice-President/Community Relations
Alliance Response to Hurricane Florence

Presentation to the Alliance Board of Directors
October 4, 2018
Areas of Review

• Alliance responsibilities during a disaster
• Pre-storm preparation
• Initial and intermediate response
• Community recovery support
Responsibilities During a Disaster

- Consistent with our Community Disaster Response Plan and contractual requirements:
  - Ensure 24/7 access to behavioral health support through our Access and Information Center
  - Ensure members and community partners are aware of and can access crisis services with an emphasis on availability of mobile crisis
  - Have a Disaster Response Coordinator and team to coordinate with the state, counties and Red Cross disaster personnel
Responsibilities During a Disaster

• Consistent with our Community Disaster Response Plan and contractual requirements:
  o Ensure consumer access to providers
  o Recruit providers to aid in local disaster response
  o Support our members and anyone experiencing a BH issue before, during and after the disaster
  o Implement disaster response in accordance with our written Disaster Plan which is shared with the state and county
Pre-Storm Preparation

• Internal planning to prepare to implement our Community Disaster Plan and internal Business Continuity Plan

• Disaster Coordinator met with local emergency management personnel

• Discussion with Alliance Provider Advisory Council about volunteer need and registering with the Red Cross

• Outreach to all residential providers to check-in regarding disaster preparedness planning and to offer important information related to member relocation
Pre-Storm Preparation

• Emailed updates to providers regarding disaster preparedness information and began requesting licensed clinician volunteers

• Educated stakeholders to access mobile crisis and other crisis response through the Access and Information Center

• Supported State plan to address methadone access and shared with Access and Care Coordination

• Care Coordinators outreached to 389 medically-fragile members to ensure safety
Initial and Intermediate Storm Response

- Remained in contact with local EOCs
- Alliance Disaster Coordinator and members of Disaster Response Team began shelter visits
- Alliance community support and clinical staff provided support at Cumberland, Durham and Wake shelters
Initial and Intermediate Storm Response

• Responded to county requests to increase availability of behavioral health support

• Recruited providers to provide behavioral health support to shelters in Cumberland and Wake shelters

• Met with Red Cross in Cumberland to enhance available mental health support

• Care Coordination ensured Innovations members had access to supplies and durable medical equipment
Initial and Intermediate Storm Response

• Care Coordination checking in with members in impacted areas, ongoing

• Partnered with UnitedHealthcare to donate supplies to Salvation Army in Cumberland

• Alliance donation supply drive for Cumberland County as part of #CumberlandStrong
Initial Response Statistics

• 24 Alliance staff members provided support in 20 shelters in Cumberland, Durham and Wake counties

• Three Alliance staff provided support in the State Medical Shelter

• One Alliance staff member provided support at a State Mass Evacuation Shelter

• Access and Information Center received 27 storm-related calls
Initial Response Statistics

• Nine provider agencies provided 61 staff, including three psychiatric prescribers, to support in local shelters
  o Total of over 500 hours
  o Identifying funding to reimburse providers
Community Recovery Support

• Increased Independent Living Initiative funds for emergency assistance and long term rental assistance

• Partnering with Legal Aid and NC Justice Center to help protect tenant rights post disaster

• Will implement FEMA/SAMHSA Hope4NC Crisis and Outreach Counseling Program
  - Immediate response with FEMA Operation Centers
  - Longer-term outreach until anniversary of Hurricane Florence
Community Recovery Support

• Debrief sessions with providers to review response and create a provider disaster response team

• Participating in Back@Home rapid rehousing approach
Back@Home Rapid Rehousing

• NC initiative to help families still in disaster shelters or in unsafe/unstable living arrangement quickly return to safe and sustainable longer-term housing

• $12 million for six months and longer-term financial assistance

• Three areas of focused funding
  o Housing Navigators and case management
  o Move-in
  o Rental/utility assistance
Back@Home Rapid Rehousing

• Eligibility criteria for first phase of funding
  o Not eligible for FEMA assistance
  o Still residing in the shelter
  o Homeless prior to the storm or as a result of the storm
Back@Home in Cumberland

- Red Cross Shelter closing on Tuesday
- Assessing shelter residents for housing status and current needs
- Assessing for available affordable housing inventory
- Conducting landlord outreach and unit inspections
- Assisting with lease signing/housing barriers
- Goal to rapidly rehouse 75 households by Tuesday
Long-Term Recovery

• A very long process
  o Two years after Hurricane Matthew Cumberland has still not fully recovered

• Too many people became homeless and never exited homelessness after Matthew
  o Need to ensure tenancy supports after rapid rehousing period

• Symptoms of distress and trauma prolonged by housing displacement

• Adequate funding for long haul including service dollars
ITEM: Financial Review

DATE OF BOARD MEETING: October 4, 2018

BACKGROUND: Alliance is requesting that the Board vote on financial commitments so that the final audited financial statements reflect those commitments. A financial review will be presented as well as recommendations and the long term financial impact.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Robert Robinson, CEO; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer