March 26, 2020

NOTICE REGARDING ALLIANCE BOARD MEETINGS AND BOARD COMMITTEE MEETINGS

Taking into consideration the CDC, NC Department of Health and Human Services, and our local government’s recommendations on social distancing and measures taken across our catchment area to include travel bans, school closures, quarantines, and event cancellations, Alliance is taking the following measures until further notice.

In line with the locally declared State of Emergency here in Wake County, there will be no public attendance at Alliance public meetings.

• Public comment will be taken digitally on all items, with the following guidelines:
  o (1) any public comment must be sent in by 5 p.m. the day before the meeting to this address VIngram@AllianceHealthPlan.org or by calling (919) 651-8466 and leaving a voicemail
  o (2) must state which agenda item you are commenting on, or if it is for informal discussion; and
  o (3) must be no more than 350 words.

• All Alliance Board members will participate in this meeting by phone, including any votes.

These mitigation efforts are in line with Durham and Wake County’s amended State of Emergency orders on and about March 25, 2020, and the nation’s effort to slow the spread of the virus and allow us to better address COVID-19’s impact on this state.

This is a temporary measure for the health and safety of everyone, as we collectively work through social distancing techniques and stay-at-home orders to prevent the spread of COVID-19.

Beginning on April 2, 2020, all Alliance Board meetings as well as Board Committee meetings will be held electronically only. Board members, participants and members of the public will be able to participate via electronic means only.

Please be aware that this guidance could change, as this is a rapidly evolving national and local health emergency.

Here is information to participate in the Alliance Board meeting on Thursday, November 5, 2020 at 4:00 pm:

• To register for this meeting, please visit https://alliancehealthplan.zoom.us/meeting/register/tJUrc-yrgTkvEIPBmbLA3Bi7h2iiW5dgcgCal. After registering, you will receive a confirmation email containing information to join the meeting.
• To improve audio quality for all participants, please mute your device when you are not speaking
Area Board Regular Meeting
(virtual meeting via videoconference)
Thursday, November 5, 2020
4:00-6:00 pm

AGENDA

1. Call to Order/Roll Call
2. Agenda Adjustments
3. Public Comments (5 minutes)
4. Chair’s Report (10 minutes)
5. CEO Report (15 minutes)
6. Consent Agenda (5 minutes)
   A. Draft Minutes from October 1, 2020, Board Meeting – page 4
   B. Client Rights/Human Rights Committee Report – page 8
   C. Executive Committee Report – page 94
   D. Quality Management Committee Report – page 96

   CEO Recommendation
   Approve the minutes; receive the reports.

7. Committee Reports
   A. Consumer and Family Advisory Committee (5 minutes) – page 101
      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 includes
      draft minutes from the October Steering, Durham, Wake, Johnston and Cumberland meetings.

   B. Finance Committee (5 minutes) – page 127
      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 2:30/3:00 p.m. prior to the
      regular Board meeting. This month’s report includes draft minutes from the October 1, 2020, meeting,
      the Statement of Net Position, the Summary of Savings/(Loss) by Funding Source, ratios for the period
      ending September 30, 2020, and recommendations to the Board to approve all presented contracts
      over $500,000, and any other applicable Finance Committee topics.

   C. Items Pulled from Consent Agenda (5 minutes)

   CEO Recommendation
   Receive the reports; consider/approve the recommendations.

8. Closed Session (30 minutes)
The Board will hold a closed session pursuant to NC General Statute 143-318.11 (a) (1) and (a) (6) to
prevent the disclosure of information that is confidential and not a public record under NCGS 122C-
126.1 and to consider the qualifications, competence, and performance of an employee.
9. Reconvene Open Session

10. Special Updates/Presentations
    A. 2020 Telehealth Provider and Member Survey (25 minutes) – page 136
       Alliance conducted a survey to understand how providers and members were impacted by the service
delivery system changes. The provider survey was done via SurveyMonkey and the member survey
was administered via phone call to members by Alliance staff. The survey results provide assurance
that members are receiving satisfactory care and that providers quickly adapted to telehealth platforms.
Sean Schreiber, Executive Vice-President/Network and Community Health, and Wes Knepper, Senior
Director of Quality Management, will present the survey results.

    B. Workforce Demographic Presentation (20 minutes) – page 152
       The Equal Employment Opportunity Policy (policy number HR-1) states the following: “Annually, the
Chief Executive Officer shall provide an organizational workforce report to include the distribution of
employees by age, race, ethnicity and gender to the Board.” Cheala Garland-Downey, Executive Vice-
President/Chief Human Resources Officer will present the report.

CEO Recommendation
   Receive the updates/presentations.

11. Adjournment

    Next Meeting: Thursday, December 3, 2020
                (via videoconference)

Estimated Time:  2 hours, 5 minutes
ITEM: Draft Minutes from the October 1, 2020, Board Meeting

DATE OF BOARD MEETING: November 5, 2020

REQUEST FOR AREA BOARD ACTION: Approve the draft minutes from the October 1, 2020, meeting.

CEO RECOMMENDATION: Approve the draft minutes from the October 1, 2020, meeting.

RESOURCE PERSON(S): Gino Pazzaglini, Board Chair; Robert Robinson, CEO
AREA BOARD REGULAR MEETING
(virtual meeting via videoconference)
4:00-6:00 p.m.

MEMBERS PRESENT: ☒Glenn Adams, Cumberland County Commissioner, JD, ☒Jennifer Anderson, MHSA, ☐Tony Braswell, Johnston County Commissioner, ☒Heidi Carter, Durham County Commissioner, MPH, MS, ☒David Curro, BS, ☒Angela Diaz, MBA, ☐Greg Ford, Wake County Commissioner, MA, ☒Lodies Gloston, MA, ☒David Hancock, MBA, MPAff, ☒Duane Holder, MPA, ☐D. Lee Jackson, BA, ☐Donald McDonald, MSW, ☐Lynne Nelson, Vice-Chair, BS, ☒Gino Pazzaglini, Board Chair, MSW LFACHE, ☒Pam Silberman, JD, DrPH, ☐McKinley Wooten, Jr., JD; ☐(vacancy representing Cumberland County); ☐(vacancy representing Durham County); ☐(vacancy representing Durham County); and ☐(vacancy representing Wake County)

GUEST(S) PRESENT: Denise Foremen, Wake County Manager’s office; Yvonne French, NC DHHS/DMH (Department of Health and Human Services/Division of Mental Health, Developmental Disabilities and Substance Abuse Services); and Mary Hutchings, Wake County Finance Department

ALLIANCE STAFF PRESENT: Brandon Alexander, Communications and Marketing Specialist II; Lisa Brockmeier, Communications and Marketing Specialist II; Joey Dorsett, Senior Vice-President/Chief Information Officer; Cheala Garland-Downey, Executive Vice-President/Chief Human Resources Officer; Kelly Goodfellow, Executive Vice-President/Chief Finance Officer; Veronica Ingram, Executive Assistant II; Mehul Mankad, Chief Medical Officer; Jennifer Meade, Community Health and System of Care Manager; Ann Oshel, Senior Vice-President/Community Health and Well-Being; Sara Pacholke, Senior Vice-President/Financial Operations; Brian Perkins, Senior Vice-President/Strategy and Government Relations; Monica Portugal, Chief Compliance Officer; Robert Robinson, Chief Executive Officer; Sean Schreiber, Executive Vice-President/Network and Community Health; Tammy Thomas, Senior Director of Project Portfolio Management; Carol Wolff, General Counsel; and Doug Wright, Director of Community and Member Engagement

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

2. Agenda Adjustments: There were no agenda adjustments.

3. Public Comment: There were no public comments.

4. Chair’s Report: Chair Pazzaglini expressed gratitude to FY (fiscal year) 2020-2021 Alliance Board Committee Chairs: David Curro (Audit and Compliance Committee Chair), David Hancock (Finance Committee Chair), Angela Diaz (Human Rights Committee Chair), Donald McDonald (Network Development and Services Committee Chair), Lodies Gloston (Policy Committee Chair), and Pam Silberman (Quality Management Committee Chair).

Also, Chair Pazzaglini announced Carol Council’s appointment to Alliance’s Board representing Durham County and pending approval from Cumberland County for the recommended applicant, Dr. John Lesica; there are two remaining vacancies: one representing Durham County and one representing Wake County.

5. CEO’s Report: Mr. Robinson mentioned the i2i conference (December 2-4, 2020), which is virtual this year. He advised Board members to contact Veronica Ingram, Executive Assistant, to register.

Mr. Robinson introduced Brian Perkins, Senior Vice-President/Strategy and Government Relations. Mr. Perkins reviewed recent communication with the NC General Assembly regarding efforts made by NC MCOs to meet member and provider needs during COVID-19; this included how CARES funding is being used.
### AGENDA ITEMS:

<table>
<thead>
<tr>
<th>6. Consent Agenda</th>
<th>DISCUSSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Draft Minutes from September 3, 2020, Board Meeting – page 4</td>
<td></td>
</tr>
<tr>
<td>B. Audit and Compliance Committee Report – page 8</td>
<td></td>
</tr>
<tr>
<td>C. Network Development and Services Committee Report – page 10</td>
<td></td>
</tr>
<tr>
<td>D. Quality Management Committee Report – page 12</td>
<td></td>
</tr>
</tbody>
</table>

The consent agenda was sent as part of the Board packet; it is attached to and made part of these minutes. There were no comments or discussion about the consent agenda.

**BOARD ACTION**

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

<table>
<thead>
<tr>
<th>7. Committee Reports</th>
<th>DISCUSSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Consumer and Family Advisory Committee – page 16</td>
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</tbody>
</table>

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

Doug Wright, Director of Community and Member Engagement, presented the report. Mr. Wright shared that each CFAC committee meeting included checking-in with members, and that one member was deceased due to COVID-19. He also shared that September was recovery month and that the direct support professional initiative is progressing across NC (to ensure sustainable pay for this service and access to this service). Mr. Wright stated that CFAC committees reviewed their charters and revised them to include TBI (traumatic brain injury) representation; committees are developing goals for the remainder of the fiscal year (through June 30, 2021). The CFAC report is attached to and made part of these minutes.

**BOARD ACTION**

The Board received the report.

| B. Finance Committee – page 54 |

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 2:30/3:00 p.m. prior to the regular Board meeting. This month's report included draft minutes from the September 3, 2020, meeting, the Summary of Savings/(Loss) by Funding Source, ratios for the period ending August 31, 2020, recommendations to the Board to approve all presented contracts over $500,000, and any other applicable Finance Committee topics.

David Hancock, Committee Chair, presented the report. Mr. Hancock noted that revenue exceeded expenditures and all contractual ratios were met except for the MLR (medical loss ratio), which was impacted by receipt of COVID funds. Sara Pacholke, Senior Vice-President/Financial Operations, reviewed plans to meet the MLR and background on requested financial commitments. The Finance Committee report is attached to and made part of these minutes.

**BOARD ACTION**

A motion was made by Mr. Hancock to approve the one-year reinvestment plan of $12,692,000 and commit $15,699,817 as of June 30, 2020, which includes $3,007,817 for the required intergovernmental transfer (one year) and $12,692,000 for the reinvestment (one
**AGENDA ITEMS:**

**DISCUSSION:**

1. **AGENDA ITEMS:**

   - **year**; motion seconded by Ms. Gloston. Motion passed unanimously.

   - A motion was made by Mr. Hancock to authorize the CEO to enter into a contract with Blaze Advisors for the development, implementation, and initial management of a behavioral health accountable care network in Cumberland County for an amount not to exceed $698,700; motion seconded by Mr. Wooten. Motion passed unanimously.

   - C. Executive Committee Report – page 66

     The Executive Committee sets the agenda for Board meetings and acts in lieu of the Board between meetings. Actions by the Executive Committee are reported to the full Board at the next scheduled meeting. This month’s report included draft minutes from the September 21, 2020, meeting.

     Chair Pazzaglini reviewed progress with sale of the property at 3309 Durham Drive in Raleigh; he reminded the Board that at the August 6, 2020, Board meeting, the Board voted to authorize the Executive Committee to take further action to sell this property in the event the current sale did not close, which it did not. At the September 21, 2020, meeting, the Committee voted to accept an offer from North Street Investments, LLC for $1,680,000 and authorized the CEO to execute the purchase agreement and closing documents.

   - **BOARD ACTION**

     The Board received the report.

2. **8. Closed Session(s)**

   - **BOARD ACTION**

     A motion was made by Vice-Chair Nelson to enter closed session pursuant to NC General Statute 143-318.11 (a) (1) and (a) (6) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1 and to consider the qualifications, competence, and performance of an employee; motion seconded by Mr. Curro. Motion passed unanimously.

3. **9. Reconvene Open Session**

   - The Board returned to open session.

4. **10. Special Update/ Presentation: Bridge Housing Program**

   - Alliance entered into a partnership to operate eight units as bridge housing at the Carolina Duke Inn located in Durham. Ann Oshel, Senior Vice-President/Community Health and Well-Being, provided an overview of the bridge housing program. The program provides safe and temporary (three to five months) housing for persons exiting homelessness; this includes support services with the goal to secure permanent supportive housing. Ms. Oshel reviewed additional community living options. The presentation is saved as part of the Board’s files.

   - **BOARD ACTION**

     The Board accepted the training/presentation.

5. **11. Adjournment**

   - All business was completed; the meeting adjourned at 5:49 p.m.
ITEM:  Client Rights/Human Rights Committee Report

DATE OF BOARD MEETING:  November 5, 2020

BACKGROUND:  The Human Rights Committee is a Board Committee with at least 50% of its membership being either consumers or family members that are not Board Members. All members and the chair are appointed by the Chair of the Alliance Board of Directors.

The Human Rights Committee functions include:

1) Reviewing and evaluating the Area Authority’s Client Rights policies at least annually and recommending needed revisions to the Area Board.
2) Overseeing the protection of client rights and identifying and reporting to the Area Board issues which negatively impact the rights of persons serviced.
3) Reporting to the full Area Board at least quarterly.

This report includes draft minutes from the October 8, 2020, meeting.

REQUEST FOR AREA BOARD ACTION:  Accept the report.

CEO RECOMMENDATION:  Accept the report.

RESOURCE PERSON(S):  Angela Diaz, Committee Chair; Doug Wright, Director of Community and Member Engagement
APPOINTED MEMBERS PRESENT: ☐ Lodies Gloston, MA, Board Member, ☒ Marie Dodson, ☐ Donald McDonald, MSW, Board Member, ☒ Dr. Michael Teague, ☒ Patricia Wells, ☒ Ira Wolfe, ☒ McKinley Wooten, Jr., JD, Board member, ☒ Lynne Nelson, ☐ Angela Diaz (Committee Chair)

APPOINTED, NON-VOTING MEMBERS PRESENT:

BOARD MEMBERS PRESENT:

GUEST(S) PRESENT: ☒ Matthew Ruppel, Senior Director of Program Integrity

STAFF PRESENT: Doug Wright, Director of Community and Member Engagement, Ramona Branch, Member Engagement Specialist, Starlett Davis, Member Engagement Specialist, Noah Swabe, Member Engagement Specialist, Todd Parker, QM, Incident & Grievance Manager

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES - The minutes from the July 9, 2020, meeting was reviewed; a motion was made by McKinley Wooten and seconded by Dr. Michael Teague 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>
</table>
| 3. Senior Director of Program Integrity | Matthew Ruppel – brief conversation about what you would like to see from his team in January: Matthew Ruppel addressed the committee, asking them what they would like to see from his team. The group responded with the following recommendations for 2021:  
- Effects that COVID has had on fraud  
- Health & Safety data due to the flexibility of services during this time  
- Is COVID changing the way we do things?  
  - Policies- Do we need to make recommendations to change current policies?  
  - Cultural issues  
- Technology & Quality of services rendered | If anyone else has any recommendations, please email them to Doug. | |
| 4. Grievance Review | Todd Parker, QM, Incident & Grievance Manager presented on the Q4 statistics for Grievances:  
  - 66 (44%) Grievance Members –Legal Guardians  
  - 59 (39%) Internal Employee Concerns – Alliance Staff  
  - 23 (15%) External Stakeholder Concerns - Outside entities  
  - 2 (1%) Compliments | Ongoing | |

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
| 5. Incident Review | Todd Parker, QM, Incident & Grievance Manager presented on the Q4 statistics for incidents: Wake County continues to have the highest percentages of incidences, followed by Durham, Cumberland, and Johnston, with the lowest. Most incidences that were reported occurred in PRTF (Psychiatric Residential Treatment Facility) and IIH (Intensive in Home) services. 83% restrictive interventions were from physical restraints 39 deaths were reported during Q4 60% of the deaths reported were due to terminal illnesses  
- No Plans of Corrections issued during Q4 due to Pandemic  
- 12 Late Incident emails sent; 3 for 2nd late.  
- 2nd Late would have resulted in POC | Ongoing |
| 6. Charter/Revisions Approval | Doug discussed the Human Rights Charter. McKinley Wooten, JD approved notes and Dr. Michael Teague second. All changes and motion was approved unanimously @ 4:50 p.m. | N/A |
| 7. Annual Human Rights Training | Doug stated the statute requires an Annual Human Rights training. Doug had sent out the statues out as a reference. Doug discussed the requirements of the Human Rights Committee. McKinley Wooten asked what does Alliance Health Compliance looks for the Human Rights Committee members. Doug will invite monitoring to discuss with the Human Rights committee at the next meeting. McKinley Wooten asked the providers are required to give their members about their rights and self-advocacy. Doug stated yes, providers are responsible to give this information to their members and have then sign a form. | Doug will schedule the trainings. |
Lynn Nelson asked for the Human Rights members who are not in attendance, will they received the annual training. Doug stated he will call each member and do the training over the phone. Lynn Nelson would like an individual who works in a PRTF to come to the Human Rights Committee and discuss their day-to-day operations for their members. Doug will look into getting someone from a PRTF to come to the committee and present.

8. Announcements/Other

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lynn Nelson thanked Doug for his continued support to the Committee. McKinley Wooten thanked Lynn for her leadership</td>
<td>N/A</td>
</tr>
</tbody>
</table>

9. **ADJOURNMENT: 5:23pm:** The next meeting will be January 14, 2021 from 4:00 p.m. to 5:30 p.m.

Respectfully Submitted by:

Ramona Branch and Stacy Guse

October 13, 2020

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

**Complaint:** *(Internal and External Stakeholders)*  
An expression of dissatisfaction about any matter other than decisions regarding requests for Medicaid services

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

**Internal Stakeholder Concern:**  
An Alliance staff member’s expression of dissatisfaction about any matter related to service provision or Alliance functions.
Complaints and Grievances Overview

Q4FY20 yielded 150 entries

• 66 (44%) Grievances – Members/legal guardians
• 59 (39%) Internal Employee Concerns – Alliance staff
• 23 (15%) External Stakeholder Concerns – Outside entities
• 2 (1%) Compliments
## 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/ Payment/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>
• Quality of Services account for 21% of all Complaints/Grievances
• Administrative issues lower but remains in top 5
• Access to services increase possibly due to COVID-19
Who submitted concerns?

- 81 (43%) were Grievances; by Member or Legal Guardian
- 60 (40%) were submitted by MCO staff
## Complaints Against Alliance

### 19 Complaints Against Alliance

<table>
<thead>
<tr>
<th>Nature of Issue</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LME/MCO Functions</td>
<td>• Primarily complaints against Alliance staff</td>
</tr>
<tr>
<td></td>
<td>• Complaints about a change in approving enhanced rates for some IDD services</td>
</tr>
</tbody>
</table>
SERVICE BREAKDOWN
Top 3 Services Overall

- 21% from Residential Services
- 11% Outpatient Services
- 8% CST
• 5% - NC Innovations Waiver Services (43% of IDD services)
• 3% - In-Home Skill Building (25% of IDD services)
MH/SUD
(104)

- 42% - Enhanced Services
- 16% - Basic Services
- 9% - Crisis Services
- 3% - SUD Services
Incident Trends Report
Q4 FY20
Incident Report Breakdown

- 628 Reports were entered in to NC-IRIS for 554 members
- 376 children
- 252 adults

**LEVELS**
- 563 Level 2 reports
- 65 Level 3

![Graph showing incident report distribution per quarter over a year.](image-url)
Wake County submitted the largest number of Level 2 and Level 3 reports in the 4th quarter of FY2020.
• A total of 390 Incidents were reported for children: (371 L2 and 19 L3)
• A total of 238 Incidents were reported for Adults: (192 L2 and 46 L3)
Service Breakdown

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>RC911 - PRTF</td>
<td>139</td>
</tr>
<tr>
<td>H2022 - Intensive In Home</td>
<td>40</td>
</tr>
<tr>
<td>Individual Therapy</td>
<td>27</td>
</tr>
<tr>
<td>H0019 UQ - HRI Res. Level III 4 beds...</td>
<td>26</td>
</tr>
<tr>
<td>Intensive In-Home</td>
<td>20</td>
</tr>
<tr>
<td>.5600A Supervised Living Adult MH</td>
<td>18</td>
</tr>
<tr>
<td>Opioid Treatment</td>
<td>18</td>
</tr>
<tr>
<td>90806 - Individual Therapy (45-50 min)</td>
<td>16</td>
</tr>
<tr>
<td>.5600C Supervised Living Adult IDD</td>
<td>15</td>
</tr>
</tbody>
</table>

- PRTF service category remains the highest reporting service; 22% of all reports
REPORTS BY INCIDENT CATEGORY
(Primarily Human Rights Related)
155 Restrictive Interventions reported
83% of Restrictive interventions in Q4 were Physical Restraints
### Physical Restraint

#### Service Breakdown

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRTF</td>
<td>102</td>
</tr>
<tr>
<td>H2016 HI - Residential Supports Level 4/HI/</td>
<td>13</td>
</tr>
<tr>
<td>H0019 UQ - HRI Res. Level III 4 beds or less</td>
<td>5</td>
</tr>
<tr>
<td>YP660 - Day Activity</td>
<td>1</td>
</tr>
<tr>
<td>T2014 - Residential Supports Level 2</td>
<td>1</td>
</tr>
<tr>
<td>Intermediate Care Facility</td>
<td>1</td>
</tr>
<tr>
<td>Innovations Residential Supports Level IV</td>
<td>1</td>
</tr>
<tr>
<td>Innovations Day Supports</td>
<td>1</td>
</tr>
<tr>
<td>H2012 HA- Day Tx Behavioral Health Child/HA/</td>
<td>1</td>
</tr>
<tr>
<td>H0019 UR HRI Res Level IV, 5 beds or more</td>
<td>1</td>
</tr>
<tr>
<td>H0019 HK CR - HRI Res Level IV 4 beds or less/HK/CR/</td>
<td>1</td>
</tr>
<tr>
<td>Child and Adolescent Residential Treatment - Level III</td>
<td>1</td>
</tr>
</tbody>
</table>

- 81% from PRTF Programs
- 10% Residential Supports
- All 26 Seclusions were in PRTF
• 52 Total – 50 were L2; 2 were L3
• Both L3s were related to shootings; on in the media
- 70 reported in this category (11% of all Incidents)
- 3 Staff Abuse Substantiated
- 2 Neglect Substantiated (1 – Caregiver, 1 – Staff)
A total of 39 deaths were reported during the 4th quarter
17 L3; 22 L2
60% of reports due to Terminal Illnesses
Incident Report Compliance
Incident Report Compliance Process
(Q$ FY2020)

• No Plans of Corrections issued during Q4 due to Pandemic

• 12 Late Incident emails sent; 3 for 2\textsuperscript{nd} late.

• 2\textsuperscript{nd} Late would have resulted in POC
Late submissions in the 4th quarter decreased by 2 percentage points in Q4. (Q3: 14%)
Charter for Human Rights Board Committee

Purpose:
The purpose of this charter is to develop and implement a Human Rights Committee of the Board of Directors in accordance with North Carolina General Statutes and Administrative Code and the Alliance Health By-Laws. The Area Authority is responsible for client rights protections in the role as manager of public mental health, substance use disorders and intellectual and developmental disabilities services.

Responsibilities:
The Human Rights Committee shall oversee client rights protections for individuals receiving mental health, substance use disorders, intellectual and developmental disabilities services in the Alliance catchment area, to include:

1. Assurance that client rights protections are reviewed through routine provider monitoring in accordance with 10A NCAC 27G .0601-.0610;
2. Compliance with clients’ rights and advance instruction in accordance with NC G.S. 122C, Article 3;
3. Compliance with the protection of clients’ rights in the community according to 10A NCAC 27C, 27D, 27E, and 27F;
4. Assurance of confidentiality according to 10A NCAC 26B; and
5. Review of complaint and appeal data in accordance with 10A NCAC 27G .7001-.7003 and 10A NCAC 27I .0601-.0609

New members shall receive orientation training regarding this procedure and the following topics:

1. North Carolina Statutes and Administrative Rules;
2. Duties of the State and Alliance Consumer Family Advisory Committee (CFAC);
3. Principles of advocacy, self-determination and recovery; and

Annually, all members shall receive training on client rights issues related to their responsibilities serving on the Committee.

The Committee shall meet at a minimum quarterly. To enhance participation, members may participate via electronic means, e.g. telephone and video conferencing, which will be pre-arranged by the Alliance staff support person(s). Such participation includes the right to vote on issues during the course of the meeting.

Committee meetings shall follow the below structure:

1. Calling the meeting to order
2. Reviewing and approving an agenda
3. Ensuring there is a recorder and having minutes taken
4. Reviewing and approving minutes from previous meeting
5. Considering matters on the approved meeting agenda
6. Calling for motions, a second and voting on items when appropriate
7. Adjournment
When a quorum, which shall consist of the Chairperson plus fifty (50) percent of members, is present, the Chairperson can call the meeting to order. When a quorum is not met, and with unanimous consent of the members present, an informal discussion may be held. Minutes of the discussion shall be recorded and the matters discussed shall be included on the agenda for the subsequent meeting of the committee.

Emergency meetings may be called for unexpected circumstances that require immediate consideration by the Committee. Due to the urgent need, emergency meetings shall be held as soon as a quorum of the Committee can be arranged.

Relationships:

Alliance shall provide staff support to the committee, including but not limited to, collecting and analyzing information that the committee or the Area Board require to fulfill the requirements of this charter and per 10A NCAC 27G.0504.

The Human Rights Committee shall report to the Board of Directors (via the Human Rights Committee Chairperson) at least quarterly reviewing the Area Authority’s compliance with this charter.

System issues, which negatively impact the rights of persons served, shall be reported to the Board of Directors. Furthermore, the Human Rights Committee shall work with state and local agencies to protect clients’ rights for individuals receiving mental health, substance use disorders, intellectual and developmental disabilities services in the Alliance catchment area.

In accordance with 10A NCAC 26B.0209, Human Rights Committee members may have access to confidential information only upon written consent of a client or the client’s legally responsible person. Thus, clients shall not be identified in minutes or in written or oral reports.

Membership:

1. Makeup of the Committee

The Client Rights/Human Rights Committee shall consist of at least 5 members, a majority of whom shall be non-Board members. Members should include consumers and family members representing mental health, developmental disabilities and substance use disorders. The membership of the Client Rights/Human Rights Committee shall include a representative from each of the counties in the Catchment Area. One Board member shall be designated the Chairperson of the Human Rights Committee by the Board of Directors Chairperson.

Efforts shall be made to include representation that reflects differences in the population of the counties that constitute Alliance Health.
Absence from three (3) meetings without notification to the Chairperson during a 12-month period may be grounds for resignation from the Committee. The Human Rights Committee Chairperson shall notify the Board of Directors Chair, who shall make the final decision regarding the resignation.

Members will be appointed for a 3 year term with a maximum of 2 terms.

2. Conflict of Interest

Committee members must disclose a conflict or the appearance of a conflict of interest and depending on the circumstances, may be prohibited from serving or restricted in voting based on the disclosure. Furthermore, Committee members are prohibited from representing themselves as independent representatives of or act independently on behalf of the Alliance Health Human Rights Committee. Members who do not fully comply with the provisions in this charter may be subject to removal from the committee.

If the Committee cannot resolve the conflict of interest, the Chairperson of the Committee shall notify the Board of Directors Chair, who shall make the final decision regarding the disposition of all conflict of interest issues.
Human Rights Committee Training
Human Rights Committee

• Responsible for protection of human rights

• Implemented in accordance to NC General Statue, Administrative Code and Alliance Board by-laws

• Alliance staff provide support to the committee
Committee Responsibility

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

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

Members must disclose a conflict or the appearance of a conflict.

Members may not represent themselves independent.

Members may not act independent on behalf of the committee.

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

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

"Quorum? We don’t even have a pair!"
Meeting Structure

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

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

Absence from three (3) consecutive meetings without notification to the Chair or from 25% of meetings within a 12-month period are grounds for dismissal.
All members are trained annually on human rights issues

**Required Training**

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

**New Member Training**
NC Statutes & Administrative Rules

- LME/MCO Board has ultimate responsibility for assurance of human rights
- Each Board establishes at least one Human Rights Committee
- Each Governing Contract Agency required to establish Human Rights Committee
- Board must implement policy
- Committee oversees Client Rights Protections for contracted services
NC Statutes & Administrative Rules

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

<table>
<thead>
<tr>
<th>Alliance CFAC</th>
<th>State CFAC</th>
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| • Review and comment on Alliance Program Budget  
• Participate in Quality Improvement Measures & Performance Indicators  
• Submit to the State, CFAC findings and recommendations to improve MH/SUD/IDD service delivery | • Provide input and conduct oversight of the Division's operations and efforts toward strategic outcomes  
• Advises DHHS and General Assembly on planning and management of the State’s public MH/SUD/IDD service system |
Five Components of Self Advocacy

- Personal Responsibility
- Knowledge of the law & other rules
- Fact finding and documentation
- Negotiating
- Believing in oneself
Responsibility of the Self Advocate

- Be clear on what you need & want
- Always go to meetings
- Ask who is at the meeting & why
- Keep all your papers
- Never sign blank forms or copies
- Document what happens
- If you need help, take someone with you
- Know the laws that regulate your services
State and Federal Laws

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

Find out if your provider has the needed specialized training

Evidence Best Practices help to justify request for services

Request written information on what your grievances/appeal rights are
Documentation and Fact Finding

- Document what happens
- Note times, dates and who you talked to
- Write down if services aren’t provided
Is it working????

Ask questions
- When, where and how often services will happen

Keep a log
- Write down when services happen

Know who to call
- If services don’t occur, know your point of contact

Get it in writing
- Always ask for decisions/changes in writing

Use Communication skills
- Use telephone and meetings to gather information
Expressing Dissatisfaction

- Write down key points
- Stay Calm
- Brief and clear conversations
- Ask when to expect action
Tips for Negotiating

- Pay attention
- Use good listening skills
- Ask for what you want and say why
- If no agreement, suggest a compromise
- Believe in yourself & don’t give up
- Thank them
Self-Determination

The recognition of the right and need of individuals and their families to have the freedom to make their own choices and decisions
• Holistic approach
• Individuals have reclaimed their lives, are productive and active members of society
Alliance Service System

Managed care organization for public MH/DD/SUD services

Services delivered by a network of Providers

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

Ensures that individuals who seek help receive quality services and supports
Alliance Service System

Services respect & support individuals
Services respond to real life needs
Services are effective
Based on a System of Care philosophy
SOC Core Values

- Culturally-competent
- Person-centered
- Community-based
- Evidenced-based
Provider HR Committees

• Providers are required to establish HR committees
• Multiple providers can form joint committees
• Responsibilities mirror LME/MCO HR Committee
thank you
10A NCAC 26B .0101 PURPOSE AND SCOPE
(a) The purpose of the rules in this Subchapter is to set forth requirements for those who collect, store and disseminate information on individuals who are served by facilities, AS DEFINED IN G.S. 122C-3. The rules shall be used in conjunction with the confidentiality requirements specified in G.S. 122C-51 through 122C-56. Area and State facilities shall comply with all Rules in this Subchapter; however, facilities, as defined in G.S. 122C-3, except Area and State facilities, shall comply only with Rules .0103(7) and .0111 of this Subchapter.
(b) Area and State facilities governed by these Rules include offices of the Division; regional psychiatric hospitals, mental retardation centers and alcohol and drug abuse treatment centers; State special care centers; schools for emotionally disturbed children; area programs and their contract agencies; and other public and private agencies, institutions or programs which are operated by or contract with the Division for Mental Health, Developmental Disabilities or Substance Abuse Services. All employees, students, volunteers or other individuals who have access to or control over confidential information in these facilities or programs shall abide by these Rules. However, local hospitals that are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) which contract with an area facility or provide services for a State facility shall be excluded from these Rules and the confidentiality policies of that accredited hospital shall apply. In addition, education records generated by Alcohol and Drug Education Traffic Schools (ADETS) and Drug Education Schools (DES) are excluded from these Rules since the records maintained by such schools are considered public records.

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

10A NCAC 26B .0102 GENERAL PROVISIONS
(a) Area or state facilities or individuals with access to or control over confidential information shall take affirmative measures to safeguard such information.
(b) Confidential information may not be released or disclosed except in accordance with G.S. 122C-51 through 122C-56 and the rules in this Subchapter.
(c) Confidential information regarding substance abusers shall be released or disclosed in accordance with the federal regulations 42 C.F.R. Part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records", which are adopted by reference pursuant to G.S. 150B-14(c), unless the rules in this Subchapter are more restrictive in which case the rules in this Subchapter shall be followed.
(d) Confidential information regarding infants and toddlers receiving early intervention services who have or who are at risk for atypical development, developmental delay or developmental disability shall be released or disclosed in accordance with the federal regulations 34 C.F.R. Part 300, Subpart E, Sections 300.560 through 300.575, which are adopted by reference pursuant to G.S. 150B-14(c), unless the rules in this Subchapter are more restrictive in which case the rules in this Subchapter shall be followed.
(e) Questions regarding interpretation of these Rules shall be directed to the Client Records Consultant in the Institution Management Support Section of the Division.

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

10A NCAC 26B .0103 DEFINITIONS
(a) The following terms shall have the meanings specified in G.S. 122C-3, 122C-4 and 122C-53:
   (1) "Area board",
   (2) "Area facility",
   (3) "Confidential information",
   (4) "Guardian",
   (5) "Internal client advocate",
   (6) "Legally responsible person",
   (7) "Next of kin",
"Provider of support services", "Secretary", and "State facility".

(b) As used in this Subchapter, unless the context clearly requires otherwise, the following terms have the meanings specified:

1. "Client Record" means any documentation made of confidential information. For the purpose of the rules in this Subchapter, this also includes confidential information generated on an individual who was not admitted but received a service from an area or state facility.

2. "Clinical Staff Member" means a mental health, developmental disabilities or substance abuse professional who provides active treatment/habilitation to a client.

3. "Confidential information" as defined in G.S. 122C-3 includes but is not limited to photographs, videotapes, audiotapes, client records, reimbursement records, verbal information relative to clients served, client information stored in automated files, and clinical staff member client files.

4. "Delegated Employee" means anyone designated by the facility head to carry out the responsibilities established by the rules in this Subchapter.

5. "Disclosure of Information" means the dissemination of confidential information without consent.

6. "Division" means Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

7. "Legitimate role in the therapeutic services offered" means next of kin or other family member who, in the judgment of the responsible professional as defined in G.S. 122C-3, and after considering the opinion of the client, currently provides, or within the past 12 months preceding the current hospitalization, provided substantial time or resources in the care of the client.

8. "Minor Client" means a person under 18 years of age who has not been married or who has not been emancipated by a decree issued by a court of competent jurisdiction or is not a member of the armed forces.

9. "Parent" means the biological or adoptive mother or father of a minor. Whenever "parents" are legally separated or divorced or have never been married, the "parent" legally responsible for the minor shall be the "parent" granted custody or either parent when joint custody has been granted.

10. "Person Standing in Loco Parentis" means one who has put himself in the place of a lawful parent by assuming the rights and obligations of a parent without formal adoption.

11. "Release of Information" means the dissemination of confidential information with consent.

12. "Signature" means signing by affixing one's own signature; or by making one's mark; or impressing some other sign or symbol on the paper by which the signature may be identified.

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

(a) Individuals employed in area and state facilities and employees governed by the State Personnel Act, G.S. Chapter 126, are subject to suspension, dismissal or disciplinary action for failure to comply with the rules in this Subchapter.

(b) Individuals, other than employees but including students and volunteers, who are agents of the Department of Health and Human Services who have access to confidential information in an area or state facility who fail to comply with the rules in this Subchapter shall be denied access to confidential information by the facility.

10A NCAC 26B .0105 OWNERSHIP OF RECORDS

(a) All records, including those which contain confidential information which are generated in connection with the performance of any function of an area or state facility, are the property of the facility.

(b) Original client records may be removed from an area or state facility premises only under the following conditions:
in accordance with a subpoena to produce document or object or other order of the court or when client records are needed for district court hearings held in accordance with Article 5 of Chapter 122C of the N.C. General Statutes;

whenever client records are needed for treatment/habilitation or audit purposes, records may be transported within an area facility or between state facilities;

in situations where the facility determines it is not feasible or practical to copy the client record or portions thereof, client records may be securely transported to a local health care provider, provided the record remains in the custody of a delegated employee;

whenever a client expires at an area or state facility and an autopsy is to be conducted, the client record may be transported to the agency wherein the autopsy will be performed provided the agency complies with Rule .0108 of this Subchapter.

c) Area facilities shall develop written policies and procedures regarding fees for the reproduction of client records.

d) Except as otherwise provided in this Rule, state facilities shall charge uniform fees for the reproduction of client records which do not exceed the cost of reproduction, postage and handling. The uniform fee shall be five dollars ($5.00) for up to three pages and fifteen cents ($0.15) for each additional page. State facilities shall not charge for the reproduction of client records in the following types of situations:

(1) professional courtesy when records are requested by physicians, psychologists, hospital or other health care providers;

(2) third party payors when the state facility will derive direct financial benefits;

(3) providers of support services as defined in G.S. 122C-3;

(4) attorneys representing the Attorney General's office and Special Counsel;

(5) other situations determined by the state facility to be for good cause;

(6) when indigent clients request pertinent portions of their client records necessary for the purpose of establishing eligibility for SSI, SSADIB, Medicaid, or other legitimate aid;

(7) whenever state facilities utilize private photocopy services wherein the photocopy service, rather than the state facility, bills the recipient of the information based on the usual and customary fee established by the copy service.

History Note:
Authority G.S. 122C-52; 122C-54; 122C-224.3; 122C-268; 122C-286; 131E-67; 143B-147;

Eff. July 1, 1979;

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

10A NCAC 26B .0106 ALTERATIONS IN THE CLIENT RECORD
A client or a client's legally responsible person may contest the accuracy, completeness or relevancy of information in the client record and may request alteration of such information. Alterations shall be made as follows:

(1) whenever a clinical staff member concurs that such alteration is justified, the area or state facility shall identify the contested portion of the record and allow the insertion of the alteration as an addendum to the contested portion of the client record; however, the original portion of the written record may not be deleted; or

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

History Note:
Authority G.S. 122C-52; 122C-53; 131E-67; 143B-147(a)(6);

Eff. July 1, 1979;

Amended Eff. March 1, 1990; February 1, 1986.

10A NCAC 26B .0107 SECURITY OF CONFIDENTIAL INFORMATION
(a) Each area or state facility that maintains records with confidential information shall provide a secure place for the storage of records and shall develop written policies and procedures regarding controlled access to those records.

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

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

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

10A NCAC 26B .0108 ASSURANCE OF CONFIDENTIALITY

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

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

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

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

10A NCAC 26B .0109 REVIEW OF DECISIONS

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

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

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

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

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

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

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

History Note: Authority G.S. 122C-52; 122C-55; 131E-67; 143B-147;

SECTION .0200 – RELEASE OF CONFIDENTIAL INFORMATION WITH CONSENT
CONSENT FOR RELEASE

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

CONSENT FOR RELEASE FORM

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

1. Client's name;
2. Name of facility releasing the information;
3. Name of individual or individuals, agency or agencies to whom information is being released;
4. Information to be released;
5. Purpose for the release;
6. Length of time consent is valid;
7. A statement that the consent is subject to revocation at any time except to the extent that action has been taken in reliance on the consent;
8. Signature of the client or the client's legally responsible person; and
9. Date consent is signed.

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

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

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

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

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

PERSONS WHO MAY SIGN CONSENT FOR RELEASE

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

1. A competent adult client;
2. The client's legally responsible person;
3. A minor client under the following conditions:
   (a) Pursuant to G.S. 90-21.5 when seeking services for veneral disease and other diseases reportable under G.S. 130A-135, pregnancy, abuse of controlled substances or alcohol, or emotional disturbances;
   (b) When married or divorced;
   (c) When emancipated by a decree issued by a court of competent jurisdiction;
   (d) When a member of the armed forces; or
personal representative of a deceased client if the estate is being settled or next of kin of a deceased client if the estate is not being settled.

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

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

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

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

### 10A NCAC 26B .0205 INFORMED CONSENT

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

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

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

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

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

### 10A NCAC 26B .0207 DOCUMENTATION OF RELEASE

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

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

### 10A NCAC 26B .0208 PROHIBITION AGAINST REDISCOLOURE

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

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

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

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

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

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

### 10A NCAC 26B .0210 RELEASE TO AREA BOARD MEMBERS
Area board members may have access to confidential information only upon written consent of the client or the client's legally responsible person or pursuant to other exceptions to confidentiality as specified in G.S. 122C-53 through 122C-55. Area board members may have access to non-identifying client information.

**History Note:** Authority G.S. 122C-52; 122C-53; 131E-67; 143B-147;

### 10A NCAC 26B .0211 RELEASE OF INFORMATION BY INTERNAL CLIENT ADVOCATES
Upon request by the Secretary, internal client advocates may disclose to the Secretary or his designee confidential information obtained while fulfilling monitoring and advocacy functions.

**History Note:** Authority G.S. 122C-53; 131E-67; 143B-147;

### SECTION .0300 – DISCLOSURE OF CONFIDENTIAL INFORMATION WITHOUT CONSENT

#### 10A NCAC 26B .0301 NOTICE TO CLIENT
(a) Each area or state facility that maintains confidential information shall give written notice to the client or the legally responsible person at the time of admission that disclosure may be made of pertinent information without his expressed consent in accordance with G.S. 122C-52 through 122C-56. This notice shall be explained to the client or legally responsible person as soon as possible.
(b) The giving of notice to the client or legally responsible person shall be documented in the client record.

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

#### 10A NCAC 26B .0302 PERSONS DESIGNATED TO DISCLOSE CONFIDENTIAL INFORMATION
The area or state facility director shall be responsible for the disclosure of confidential information but may delegate the authority for disclosure to other persons under his supervision. Such delegation shall be in writing.

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

#### 10A NCAC 26B .0303 DOCUMENTATION OF DISCLOSURE

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

#### 10A NCAC 26B .0304 PROHIBITION AGAINST REDISCLOSURE
(a) Agencies disclosing confidential information pursuant to G.S. 122C-52 through G.S. 122C-56 shall inform the recipient that redisclosure of such information is prohibited without client consent.
(b) A stamp may be used to fulfill this requirement.

*History Note:*

Authority G.S. 122C-52; 131E-67; 143B-147(a)(6);
Eff. January 1, 1984;
Amended Eff. February 1, 1986.
CLIENT RIGHTS RULES
IN COMMUNITY
MENTAL HEALTH, DEVELOPMENTAL
DISABILITIES AND SUBSTANCE ABUSE SERVICES
10A NORTH CAROLINA ADMINISTRATIVE CODE 27C, 27D, 27E, 27F

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EFFECTIVE: July 1, 2003
SUPERSEDES: APSM 95-2 (10/1/2001)

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SUBCHAPTER 27C – PROCEDURES AND GENERAL INFORMATION

SECTION .0100 – GENERAL POLICIES AND PROCEDURES

10A NCAC 27C .0101 SCOPE

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

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

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

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

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

10A NCAC 27C .0102 DEFINITIONS

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

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

1. "Abuse" means the infliction of mental or physical pain or injury by other than accidental means, or unreasonable confinement, or the deprivation by an employee of services which are necessary to the mental or physical health of the client. Temporary discomfort that is part of an approved and documented treatment plan or use of a documented emergency procedure shall not be considered abuse.

2. "Anti-psychotic medication" means the category of psychotropic drugs which is used to treat schizophrenia and related disorders. Examples of neuroleptic medications are Chlorpromazine, Thoridazine and Haloperidol.

3. "Basic necessity" means an essential item or substance needed to support life and health which includes, but is not limited to, a nutritionally sound balanced diet consisting of three meals per day, access to water and bathroom facilities at frequent intervals, seasonable clothing, medications prescribed by a physician, time for sleeping and frequent access to social contacts.

4. "Client advocate" means the term as defined in G.S. 122C-3. For the purpose of these Rules, a client advocate may be a facility employee who is not directly involved in the treatment/habilitation of a specific client, but who is assigned, in addition to other duties, to act as an advocate for that client.

5. "Consent" means acceptance or agreement by a client or legally responsible person following receipt of information from the qualified professional who will administer the proposed treatment or procedure. Consent implies that the client or legally responsible person was provided with sufficient information, in a manner that the client or legally responsible person can understand, concerning proposed treatment, including both benefits and risks, in order to make a decision with regard to such treatment.

6. "Day/night facility" means a facility wherein a service is provided on a regular basis, in a structured environment, and is offered to the same individual for a period of three or more hours within a 24-hour period.

7. "Director of Clinical Services" means Medical Director, Director of Medical Services, or other qualified professional designated by the governing body as the Director of Clinical Services.
(8) "Emergency" means a situation in which a client is in imminent danger of causing abuse or injury to self or others or when substantial property damage is occurring as a result of unexpected and severe forms of inappropriate behavior and rapid intervention by the staff is needed.

(9) "Exploitation" means the use of a client's person or property for another's profit or advantage or breach of a fiduciary relationship through improper use of a client's person or property including situations where an individual obtains money, property or services from a client from undue influence, harassment, deception or fraud.

(10) "Facility" means the term as defined in G.S. 122C-3. For the purpose of these Rules, when more than one type of service is provided by the facility, each service shall be specifically addressed by required policy and procedures when applicable.

(11) "Governor's Advocacy Council for Persons with Disabilities (GACPD)" means the council legislatively mandated to provide protection and advocacy systems and promote employment for all persons with disabilities in North Carolina.

(12) "Governing body" means, in the case of a corporation, the board of directors; in the case of an area authority, the area board; and in all other cases, the owner of the facility.

(13) "Involuntary client" means an individual who is admitted to a facility in accordance with G.S. 122C, Article 5, Parts 6 through 12.

(14) "Involuntary client" means an individual who is admitted to a facility in accordance with G.S. 122C, Article 5, Parts 6 through 12.

(15) "Isolation time-out" means the removal of a client for a period of 30 minutes or more to a separate location.

(16) "Isolation time-out" means the removal of a client for a period of 30 minutes or more to a separate location.

(17) "Minor client" means a person under 18 years of age who has neither been married nor been emancipated by a decree issued by a court of competent jurisdiction.

(18) "Neglect" means the failure to provide care or services necessary to maintain the mental or physical health and well-being of the client.

(19) "Normalization" means the utilization of culturally valued resources to establish or maintain personal behaviors, experiences and characteristics that are culturally normative or valued.

(20) "Physical Restraint" means the application or use of any manual method of restraint that restricts freedom of movement; or the application or use of any physical or mechanical device that restricts freedom of movement or normal access to one's body, including material or equipment attached or adjacent to the client's body that he or she cannot easily remove. Holding a client in a therapeutic hold or other manner that restrains his or her movement constitutes manual restraint for that client. Mechanical devices may restrain a client to a bed or chair, or may be used as ambulatory restraints. Examples of mechanical devices include cuffs, ankle straps, sheets or restraining shirts, arm splints, posey mittens, and helmets. Excluded from this definition of physical restraint are physical guidance, gentle physical prompting techniques, escorting a client who is walking; soft ties used solely to prevent a medically ill client from removing intravenous tubes, indwelling catheters, cardiac monitor electrodes, or similar medical devices; and prosthetic devices or assistive technology which are designed and used to increase client adaptive skills. Escorting means the temporary touching or holding of the hand, wrist, arm, shoulder or back for the purpose of inducing a client to walk to a safe location.

(21) "Protective device" means an intervention that provides support for a medically fragile client or enhances the safety of a self-injurious client. Such devices may include geri-chairs or table top chairs to provide support and safety for a client with a physical handicap; devices such as seizure helmets or helmets and mittens for self-injurious behaviors; prosthetic devices or assistive technology which are designed to increase client adaptive skills; or soft ties used to prevent a medically ill client from removing intravenous tubes, indwelling catheters, cardiac monitor electrodes, or similar medical devices. As provided in Rule .0105(b) of Subchapter 27E, the use of a protective device for behavioral control shall comply with the requirements specified in Rule .0104 in Subchapter 14R.

(22) "Privileged" means authorization through governing body procedures for a facility employee to provide specific treatment or habilitation services to clients, based on the employee's education, training, experience, competence and judgment.

(23) "Responsible professional" means the term as defined in G.S. 122C-3 except the "responsible professional" shall also be a qualified professional as defined in Rule .0104 of Subchapter 27G.

(23) "Restrictive Intervention" means an intervention procedure which presents a risk of mental or physical harm to the client and, therefore, requires additional safeguards. Such interventions include the emergency or planned use of seclusion, physical restraint (including the use of protective devices for the purpose or with the intent of controlling unacceptable behavior), isolation time-out, and any combination thereof.
"Seclusion" means isolating a client in a separate locked room for the purpose of controlling a client's behavior.

"Treatment" means the process of providing for the physical, emotional, psychological and social needs of a client through services.

"Treatment/habilitation plan" means the term as defined in 10A NCAC 27G .0103.

"Treatment or habilitation team" means an interdisciplinary group of qualified professionals sufficient in number and variety by discipline to assess and address the identified needs of a client and which is responsible for the formulation, implementation and periodic review of the client's treatment/habilitation plan.

"24-Hour Facility" means a facility wherein service is provided to the same client on a 24-hour continuous basis, and includes residential and hospital facilities.

"Voluntary client" means an individual who is admitted to a facility upon his own application or that of the legally responsible person, in accordance with G.S. 122C, Article 5, Parts 2 through 5.

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

SUBCHAPTER 27D – GENERAL RIGHTS

SECTION .0100 – GENERAL POLICIES AND PROCEDURES

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

(a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66.

(b) The governing body shall develop and implement policy to assure that:

   (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and

   (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications.

(c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies:

   (1) any restrictive intervention that is prohibited from use within the facility; and

   (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client.

(d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify:

   (1) the permitted restrictive interventions or allowed restrictions;

   (2) the individual responsible for informing the client; and

   (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions.

(e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes:

   (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E);

   (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and

   (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.

(f) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policies which require that:

   (1) positive alternatives and less restrictive interventions are considered and are used whenever possible prior to the use of more restrictive interventions; and
(2) consideration is given to the client's physical and psychological well-being before, during and after utilization of a restrictive intervention, including:
   (A) review of the client's health history or the comprehensive health assessment conducted upon admission to a facility. The health history or comprehensive health assessment shall include the identification of pre-existing medical conditions or any disabilities and limitations that would place the client at greater risk during the use of restrictive interventions;
   (B) continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of physical restraint throughout the duration of the restrictive intervention by staff who are physically present and trained in the use of emergency safety interventions;
   (C) continuous monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being during the use of manual restraint; and
   (D) continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention; and

(3) following the utilization of a restrictive intervention, staff shall conduct debriefing and planning with the client and the legally responsible person, if applicable, as specified in 10A NCAC 27E .0104, to eliminate or reduce the probability of the future use of restrictive interventions. Debriefing and planning shall be conducted, as appropriate, to the level of cognitive functioning of the client.

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

10A NCAC 27D .0102 SUSPENSION AND EXPULSION POLICY
(a) Each client shall be free from threat or fear of unwarranted suspension or expulsion from the facility.
(b) The governing body shall develop and implement policy for suspension or expelling a client from a service. The policy shall address the criteria to be used for an suspension, expulsion or other discharge not mutually agreed upon and shall establish documentation requirements that include:
   (1) the specific time and conditions for resuming services following suspension;
   (2) efforts by staff of the facility to identify an alternative service to meet the client's needs and designation of such service; and
   (3) the discharge plan, if any.

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

10A NCAC 27D .0103 SEARCH AND SEIZURE POLICY
(a) Each client shall be free from unwarranted invasion of privacy.
(b) The governing body shall develop and implement policy that specifies the conditions under which searches of the client or his living area may occur, and if permitted, the procedures for seizure of the client's belongings, or property in the possession of the client.
(c) Every search or seizure shall be documented. Documentation shall include:
   (1) scope of search;
   (2) reason for search;
   (3) procedures followed in the search;
   (4) a description of any property seized; and
   (5) an account of the disposition of seized property.

History Note: Authority G.S. 122C-51; 143B-147;
Eff. February 1, 1991;
10A NCAC 27D .0104 PERIODIC INTERNAL REVIEW
(a) The governing body shall assure the conduct, no less than every three years, of a compliance review in each of its facilities regarding the implementation of Client Rights Rules as specified in 10A NCAC 27C, 27D, 27E and 27F.
(b) The review shall assure that:
   (1) there is compliance with applicable provisions of the federal law governing advocacy services to the mentally ill, as specified in the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (Public Law 99-319) and amended by Public Law 100-509 (1988); and
   (2) there is compliance with applicable provisions of the federal laws governing advocacy services to the developmentally disabled, the Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. 6000 et. seq.
(c) The governing body shall maintain the three most recent written reports of the findings of such reviews.

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

SECTION .0200 -INFORMING CLIENTS AND STAFF OF RIGHTS

10A NCAC 27D .0201 INFORMING CLIENTS
(a) A written summary of client rights as specified in G.S. 122C, Article 3 shall be made available to each client and legally responsible person.
(b) Each client shall be informed of his right to contact the Governor's Advocacy Council for Persons with Disabilities (GACPD), the statewide agency designated under federal and State law to protect and advocate the rights of persons with disabilities.
(c) Each client shall be informed regarding the issues specified in Paragraph (d) and, if applicable in Paragraph (e), of this Rule, upon admission or entry into a service, or
   (1) in a facility where a day/night or periodic service is provided, within three visits; or
   (2) in a 24-hour facility, within 72 hours. Explanation shall be in a manner consistent with the client's or legally responsible person's level of comprehension.
(d) In each facility, the information provided to the client or legally responsible person shall include;
   (1) the rules that the client is expected to follow and possible penalties for violations of the rules;
   (2) the client's protections regarding disclosure of confidential information, as delineated in G.S. 122C-52 through G.S. 122C-56;
   (3) the procedure for obtaining a copy of the client's treatment/habilitation plan; and
   (4) governing body policy regarding:
      (A) fee assessment and collection practices for treatment/habilitation services;
      (B) grievance procedures including the individual to contact and a description of the assistance the client will be provided;
      (C) suspension and expulsion from service; and
      (D) search and seizure.
(e) In addition, for the client whose treatment/habilitation is likely to include the use of restrictive interventions, or for the client in a 24-hour facility whose rights as specified in G.S. 122C-62 (b) or (d) may be restricted, the client or legally responsible person shall also be informed:
   (1) of the purposes, goals and reinforcement structure of any behavior management system that is allowed;
   (2) of potential restrictions or the potential use of restrictive interventions;
   (3) of notification provisions regarding emergency use of restrictive intervention procedures;
   (4) that the legally responsible person of a minor or incompetent adult client may request notification after any occurrence of the use of restrictive intervention;
   (5) that the competent adult client may designate an individual to receive notification, in accordance with G.S. 122C-53(a), after any occurrence of the use of restrictive intervention; and
   (6) of notification provisions regarding the restriction of client rights as specified in G.S. 122C-62(e).
(f) There shall be documentation in the client record that client rights have been explained.

History Note: Authority G.S. 122C-51; 143B-147; Eff February 1, 1991; Amended Eff. January 1, 1992.
10A NCAC 27D .0202  INFORMING STAFF
The governing body shall develop and implement policy to assure that all staff are kept informed of the rights of clients as specified in 122C, Article 3, all applicable rules, and policies of the governing body. Documentation of receipt of information shall be signed by each staff member and maintained by the facility.

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

SECTION .0300 - GENERAL CIVIL, LEGAL AND HUMAN RIGHTS

10A NCAC 27D .0301  SOCIAL INTEGRATION
Each client in a day/night or 24-hour facility shall be encouraged to participate in appropriate and generally acceptable social interactions and activities with other clients and non-client members of the community. A client shall not be prohibited from such social interactions unless restricted in writing in the client record in accordance with G.S. 122C-62(e).

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

10A NCAC 27D .0302  CLIENT SELF-GOVERNANCE
In a day/night or 24-hour facility, the governing body shall develop and implement policy which allows client input into facility governance and the development of client self-governance groups.

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

10A NCAC 27D .0303  INFORMED CONSENT
(a) Each client, or legally responsible person, shall be informed, in a manner that the client or legally responsible person can understand, about:
   (1) the alleged benefits, potential risks, and possible alternative methods of treatment/habilitation; and
   (2) the length of time for which the consent is valid and the procedures that are to be followed if he chooses to withdraw consent. The length of time for a consent for the planned use of a restrictive intervention shall not exceed six months.
(b) A consent required in accordance with G.S. 122C-57(f) or for planned interventions specified by the rules in Subchapter 27E, Section .0100, shall be obtained in writing. Other procedures requiring written consent shall include, but are not limited to, the prescription or administration of the following drugs:
   (1) Antabuse; and
   (2) Depo-Provera when used for non-FDA approved uses
(c) Each voluntary client or legally responsible person has the right to consent or refuse treatment/habilitation in accordance with G.S. 122C-57(d). A voluntary client's refusal of consent shall not be used as the sole grounds for termination or threat of termination of service unless the procedure is the only viable treatment/habilitation option available at the facility.
(d) Documentation of informed consent shall be placed in the client's record.

10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION
(a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66.
(b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter.
(c) Goods or services shall not be sold to or purchased from a client except through established governing body policy.
(d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.
(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.

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

SUBCHAPTER 27E – TREATMENT OR HABILITATION RIGHTS
SECTION .0100 – PROTECTIONS REGARDING INTERVENTIONS PROCEDURES

10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE
(a) Each facility shall provide services/supports that promote a safe and respectful environment. These include:
(1) using the least restrictive and most appropriate settings and methods;
(2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others;
(3) providing choices of activities meaningful to the clients served/supported; and
(4) sharing of control over decisions with the client/legally responsible person and staff.
(b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include:
(1) using the intervention as a last resort; and
(2) employing the intervention by people trained in its use.

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

10A NCAC 27E .0102 PROHIBITED PROCEDURES
In each facility the following types of procedures shall be prohibited:
(1) those interventions which have been prohibited by statute or rule which shall include:
(a) any intervention which would be considered corporal punishment under G.S. 122C-59;
(b) the contingent use of painful body contact;
(c) substances administered to induce painful bodily reactions, exclusive of Antabuse;
(d) electric shock (excluding medically administered electroconvulsive therapy);
(e) insulin shock;
(f) unpleasant tasting foodstuffs;
(g) contingent application of any noxious substances which include but are not limited to noise, bad smells or splashing with water; and
(h) any potentially physically painful procedure, excluding prescribed injections, or stimulus which is administered to the client for the purpose of reducing the frequency or intensity of a behavior.

(2) those interventions determined by the governing body to be unacceptable for or prohibited from use in the facility.

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

10A NCAC 27E .0103 GENERAL POLICIES REGARDING INTERVENTION PROCEDURES
(a) The following procedures shall only be employed when clinically or medically indicated as a method of therapeutic treatment:
   (1) planned non-attention to specific undesirable behaviors when those behaviors are health threatening;
   (2) contingent deprivation of any basic necessity; or
   (3) other professionally acceptable behavior modification procedures that are not prohibited by Rule .0102 of this Section or covered by Rule .0104 of this Section
(b) The determination that a procedure is clinically or medically indicated, and the authorization for the use of such treatment for a specific client, shall only be made by either a physician or a licensed practicing psychologist who has been formally trained and privileged in the use of the procedure.

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

10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL
(a) This Rule governs the use of restrictive interventions which shall include:
   (1) seclusion;
   (2) physical restraint;
   (3) isolation time-out
   (4) any combination thereof; and
   (5) protective devices used for behavioral control.
(b) The use of restrictive interventions shall be limited to:
   (1) emergency situations, in order to terminate a behavior or action in which a client is in imminent danger of abuse or injury to self or other persons or when property damage is occurring that poses imminent risk of danger of injury or harm to self or others; or
   (2) as a planned measure of therapeutic treatment as specified in Paragraph (f) of this Rule.
(c) Restrictive interventions shall not be employed as a means of coercion, punishment or retaliation by staff or for the convenience of staff or due to inadequacy of staffing. Restrictive interventions shall not be used in a manner that causes harm or abuse.
(d) In accordance with Rule .0101 of Subchapter 27D, the governing body shall have policy that delineates the permissible use of restrictive interventions within a facility.
(e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions:
   (1) the requirement that positive and less restrictive alternatives are considered and attempted whenever possible prior to the use of more restrictive interventions;
   (2) consideration is given to the client's physical and psychological well-being before, during and after utilization of a restrictive intervention, including:
      (A) review of the client's health history or the client's comprehensive health assessment conducted upon admission to a facility. The health history or comprehensive health assessment shall include the identification of pre-existing medical conditions or any disabilities and limitations that would place the client at greater risk during the use of restrictive interventions;
(B) continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention by staff who are physically present and trained in the use of emergency safety interventions;

(C) continuous monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being during the use of manual restraint; and

(D) continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention;

(3) the process for identifying, training, assessing competence of facility employees who may authorize and implement restrictive interventions;

(4) the duties and responsibilities of responsible professionals regarding the use of restrictive interventions;

(5) the person responsible for documentation when restrictive interventions are used;

(6) the person responsible for the notification of others when restrictive interventions are used; and

(7) the person responsible for checking the client's physical and psychological well-being and assessing the possible consequences of the use of a restrictive intervention and, in such cases there shall be procedures regarding:

(A) documentation if a client has a physical disability or has had surgery that would make affected nerves and bones sensitive to injury; and

(B) the identification and documentation of alternative emergency procedures, if needed;

(8) any room used for seclusion or isolation time-out shall meet the following criteria:

(A) the room shall be designed and constructed to ensure the health, safety and well-being of the client;

(B) the floor space shall not be less than 50 square feet, with a ceiling height of not less than eight feet;

(C) the floor and wall coverings, as well as any contents of the room, shall have a one-hour fire rating and shall not produce toxic fumes if burned;

(D) the walls shall be kept completely free of objects;

(E) a lighting fixture, equipped with a minimum of a 75 watt bulb, shall be mounted in the ceiling and be screened to prevent tampering by the client;

(F) one door of the room shall be equipped with a window mounted in a manner which allows inspection of the entire room;

(G) glass in any windows shall be impact resistant and shatterproof;

(H) the room temperature and ventilation shall be comparable and compatible with the rest of the facility; and

(I) in a lockable room the lock shall be interlocked with the fire alarm system so that the door automatically unlocks when the fire alarm is activated if the room is to be used for seclusion.

(9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum:

(A) notation of the client's physical and psychological well-being;

(B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior;

(C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used;

(D) a description of the intervention and the date, time and duration of its use;

(E) a description of accompanying positive methods of intervention;

(F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions;

(G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and

(H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.

(10) The emergency use of restrictive interventions shall be limited, as follows:

(A) a facility employee approved to administer emergency interventions may employ such procedures for up to 15 minutes without further authorization;

(B) the continued use of such interventions shall be authorized only by the responsible professional or another qualified professional who is approved to use and to authorize the use of the restrictive intervention based on experience and training;
(C) the responsible professional shall meet with and conduct an assessment that includes the physical and psychological well-being of the client and write a continuation authorization as soon as possible after the time of initial employment of the intervention. If the responsible professional or a qualified professional is not immediately available to conduct an assessment of the client, but concurs that the intervention is justified after discussion with the facility employee, continuation of the intervention may be verbally authorized until an on-site assessment of the client can be made;

(D) a verbal authorization shall not exceed three hours after the time of initial employment of the intervention; and

(E) each written order for seclusion, physical restraint or isolation time-out is limited to four hours for adult clients; two hours for children and adolescent clients ages nine to 17; or one hour for clients under the age of nine. The original order shall only be renewed in accordance with these limits or up to a total of 24 hours.

(11) The following precautions and actions shall be employed whenever a client is in:

(A) seclusion or physical restraint, including a protective device when used for the purpose or with the intent of controlling unacceptable behavior: periodic observation of the client shall occur at least every 15 minutes, or more often as necessary, to assure the safety of the client, attention shall be paid to the provision of regular meals, bathing and the use of the toilet; and such observation and attention shall be documented in the client record;

(B) isolation time-out: there shall be a facility employee in attendance with no other immediate responsibility than to monitor the client who is placed in isolation time-out; there shall be continuous observation and verbal interaction with the client when appropriate; and such observation shall be documented in the client record; and

(C) physical restraint and may be subject to injury: a facility employee shall remain present with the client continuously.

(12) The use of a restrictive intervention shall be discontinued immediately at any indication of risk to the client's health or safety or immediately after the client gains behavioral control. If the client is unable to gain behavioral control within the time frame specified in the authorization of the intervention, a new authorization must be obtained.

(13) The written approval of the designee of the governing body shall be required when the original order for a restrictive intervention is renewed for up to a total of 24 hours in accordance with the limits specified in Item (E) of Subparagraph (e)(10) of this Rule.

(14) Standing orders or PRN orders shall not be used to authorize the use of seclusion, physical restraint or isolation timeout.

(15) The use of a restrictive intervention shall be considered a restriction of the client's rights as specified in G.S. 122C-62(b) or (d). The documentation requirements in this Rule shall satisfy the requirements specified in G.S. 122C-62(e) for rights restrictions.

(16) When any restrictive intervention is utilized for a client, notification of others shall occur as follows:

(A) those to be notified as soon as possible but within 24 hours of the next working day, to include:
   (i) the treatment or habilitation team, or its designee, after each use of the intervention; and
   (ii) a designee of the governing body; and

(B) the legally responsible person of a minor client or an incompetent adult client shall be notified immediately unless she/he has requested not to be notified.

(17) The facility shall conduct reviews and reports on any and all use of restrictive interventions, including:

(A) a regular review by a designee of the governing body, and review by the Client Rights Committee, in compliance with confidentiality rules as specified in 10A NCAC 28A;

(B) an investigation of any unusual or possibly unwarranted patterns of utilization; and

(C) documentation of the following shall be maintained on a log:
   (i) name of the client;
   (ii) name of the responsible professional;
   (iii) date of each intervention;
   (iv) time of each intervention;
   (v) type of intervention;
   (vi) duration of each intervention;
   (vii) reason for use of the intervention;
   (viii) positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used;
(ix) debriefing and planning conducted with the client, legally responsible person, if applicable, and staff, as specified in Parts (e)(9)(F) and (G) of this Rule, to eliminate or reduce the probability of the future use of restrictive interventions; and

(x) negative effects of the restrictive intervention, if any, on the physical and psychological well-being of the client.

(18) The facility shall collect and analyze data on the use of seclusion and physical restraint. The data collected and analyzed shall reflect for each incident:

(A) the type of procedure used and the length of time employed;
(B) alternatives considered or employed; and
(C) the effectiveness of the procedure or alternative employed.

The facility shall analyze the data on at least a quarterly basis to monitor effectiveness, determine trends and take corrective action where necessary. The facility shall make the data available to the Secretary upon request.

(19) Nothing in this Rule shall be interpreted to prohibit the use of voluntary restrictive interventions at the client's request; however, the procedures in this Rule shall apply with the exception of Subparagraph (f)(3) of this Rule.

(f) The restrictive intervention shall be considered a planned intervention and shall be included in the client's treatment/habilitation plan whenever it is used:

(1) more than four times, or for more than 40 hours, in a calendar month;
(2) in a single episode in which the original order is renewed for up to a total of 24 hours in accordance with the limit specified in Item (E) of Subparagraph (e)(10) of this Rule; or
(3) as a measure of therapeutic treatment designed to reduce dangerous, aggressive, self-injurious or undesirable behaviors to a level which will allow the use of less restrictive treatment or habilitation procedures.

(g) When a restrictive intervention is used as a planned intervention, facility policy shall specify:

(1) the requirement that a consent or approval shall be considered valid for no more than six months and that the decision to continue the specific intervention shall be based on clear and recent behavioral evidence that the intervention is having a positive impact and continues to be needed;
(2) prior to the initiation or continued use of any planned intervention, the following written notifications, consents and approvals shall be obtained and documented in the client record:
   (A) approval of the plan by the responsible professional and the treatment and habilitation team, if applicable, shall be based on an assessment of the client and a review of the documentation required by Subparagraph (e)(9) and (e)(14) of this Rule if applicable;
   (B) consent of the client or legally responsible person, after participation in treatment planning and after the specific intervention and the reason for it have been explained in accordance with 10A NCAC 27D .0201;
   (C) notification of an advocate/client rights representative that the specific intervention has been planned for the client and the rationale for utilization of the intervention; and
   (D) physician approval, after an initial medical examination, when the plan includes a specific intervention with reasonably foreseeable physical consequences. In such cases, periodic planned monitoring by a physician shall be incorporated into the plan.
(3) within 30 days of initiation of the use of a planned intervention, the Intervention Advisory Committee established in accordance with Rule .0106 of this Section, by majority vote, may recommend approval or disapproval of the plan or may abstain from making a recommendation;
(4) within any time during the use of a planned intervention, if requested, the Intervention Advisory Committee shall be given the opportunity to review the treatment/habilitation plan;
(5) if any of the persons or committees specified in Subparagraphs (h)(2) or (h)(3) of this Rule do not approve the initial use or continued use of a planned intervention, the intervention shall not be initiated or continued. Appeals regarding the resolution of any disagreement over the use of the planned intervention shall be handled in accordance with governing body policy; and
(6) documentation in the client record regarding the use of a planned intervention shall indicate:
   (A) description and frequency of debriefing with the client, legally responsible person, if applicable, and staff if determined to be clinically necessary. Debriefing shall be conducted as to the level of cognitive functioning of the client;
   (B) bi-monthly evaluation of the planned by the responsible professional who approved the planned intervention; and
   (C) review, at least monthly, by the treatment/habilitation team that approved the planned intervention.

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

10A NCAC 27E .0105 PROTECTIVE DEVICES
(a) Whenever a protective device is utilized for a client, the governing body shall develop and implement policy to ensure that:
   (1) the necessity for the protective device has been assessed and the device is applied by a facility employee who has been trained and has demonstrated competence in the utilization of protective devices;
   (2) the use of positive and less restrictive alternatives have been reviewed and documented and the protective device selected is the appropriate measure;
   (3) the client is frequently observed and provided opportunities for toileting, exercise, etc. as needed. When a protective device limits the client's freedom of movement, the client shall be observed at least every hour. Whenever the client is restrained and subject to injury by another client, a facility employee shall remain present with the client continuously. Observations and interventions shall be documented in the client record;
   (4) protective devices are cleaned at regular intervals; and
   (5) for facilities operated by or under contract with an area program, the utilization of protective devices in the treatment/habilitation plan shall be subject to review by the Client Rights Committee, as required in 10A NCAC 27G .0504. Copies of this Rule and other pertinent rules are published as Division publication RULES FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES, APSM 30-1,and may be purchased at a cost of five dollars and seventy-five cents ($5.75) per copy.
(b) The use of any protective device for the purpose or with the intent of controlling unacceptable behavior shall comply with the requirements of Rule .0104 of this Section.

History Note: Authority G.S. 122C-51; 122C-53; 122C-60; 143B-147; 
Eff. February 1, 1991; 
Amended Eff. January 4, 1993; January 1, 1992; 
Temporary Amendment Eff. January 1, 2001; 
Temporary Amendment Expired October 13, 2001; 
Amended Eff. August 1, 2002.

10A NCAC 27E .0106 INTERVENTION ADVISORY COMMITTEES
(a) An Intervention Advisory Committee shall be established to provide additional safeguards in a facility that utilizes restrictive interventions as planned interventions as specified in Rule .0104(g) of this Section.
(b) The membership of the Intervention Advisory Committee shall include at least one person who is or has been a consumer of direct services provided by the governing body or who is a close relative of a consumer and:
   (1) for a facility operated by an area program, the Intervention Advisory Committee shall be the Client Rights Committee or a subcommittee of it, which may include other members;
   (2) for a facility that is not operated by an area program, but for which a voluntary client rights or human rights committee has been appointed by the governing body, the Intervention Advisory Committee shall be that committee or a subcommittee of it, which may include other members; or
   (3) for a facility that does not meet the conditions of Subparagraph (b)(1) or (2), the committee shall include at least three citizens who are not employees of, or members of the governing body.
(c) The Intervention Advisory Committee specified in Subparagraphs (b)(2) or (3) shall have a member or a regular independent consultant who is a professional with training and expertise in the use of the type of interventions being utilized, and who is not directly involved in the treatment or habilitation of the client.

(d) The Intervention Advisory Committee shall:

(1) have policy that governs its operation and requirements that:
   (A) access to client information shall be given only when necessary for committee members to perform their duties;
   (B) committee members shall have access to client records on a need to know basis only upon the written consent of the client or his legally responsible person as specified in G.S. 122C-53(a); and
   (C) information in the client record shall be treated as confidential information in accordance with G.S. 122C-52 through 122C-56;

(2) receive specific training and orientation as to the charge of the committee;

(3) be provided with copies of appropriate statutes and rules governing client rights and related issues;

(4) be provided, when available, with copies of literature about the use of a proposed intervention and any alternatives;

(5) maintain minutes of each meeting; and

(6) make an annual written report to the governing body on the activities of the committee.

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

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

(a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.

(b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented.

(c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.

(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.

(e) Formal refresher training must be completed by each service provider periodically (minimum annually).

(f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.

(g) Staff shall demonstrate competence in the following core areas:

(1) knowledge and understanding of the people being served;

(2) recognizing and interpreting human behavior;

(3) recognizing the effect of internal and external stressors that may affect people with disabilities;

(4) strategies for building positive relationships with persons with disabilities;

(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;

(6) recognizing the importance of assisting in the person's involvement in making decisions about their life;

(7) skills in assessing individual risk for escalating behavior;

(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and

(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).

(h) Service providers shall maintain documentation of initial and refresher training for at least three years.

(1) Documentation shall include:
   (A) who participated in the training and the outcomes (pass/fail);
   (B) when and where they attended; and
   (C) instructor's name;

(2) The Division of MH/DD/SAS may review/request this documentation at any time.

(i) Instructor Qualifications and Training Requirements:

(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.

(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.

(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.

(5) Acceptable instructor training programs shall include but are not limited to presentation of:

(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee performance; and
(D) documentation procedures.

(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.

(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.

(8) Trainers shall complete a refresher instructor training at least every two years.

(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.

(1) Documentation shall include:

(A) who participated in the training and the outcomes (pass/fail);
(B) when and where attended; and
(C) instructor's name.

(2) The Division of MH/DD/SAS may request and review this documentation any time.

(k) Qualifications of Coaches:

(1) Coaches shall meet all preparation requirements as a trainer.

(2) Coaches shall teach at least three times the course which is being coached.

(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.

(l) Documentation shall be the same preparation as for trainers.

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

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

(a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually.

(b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated.

(c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions.

(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.

(e) Formal refresher training must be completed by each service provider periodically (minimum annually).

(f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.

(g) Acceptable training programs shall include, but are not limited to, presentation of:

(1) refresher information on alternatives to the use of restrictive interventions;
(2) guidelines on when to intervene (understanding imminent danger to self and others);
(3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);
(4) strategies for the safe implementation of restrictive interventions;
(5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;
(6) prohibited procedures;
(7) debriefing strategies, including their importance and purpose; and
(8) documentation methods/procedures.
(h) Service providers shall maintain documentation of initial and refresher training for at least three years.

(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where they attended; and
(C) instructor's name.

(2) The Division of MH/DD/SAS may review/request this documentation at any time.

(i) Instructor Qualification and Training Requirements:

(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.

(2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out.

(3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.

(4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.

(5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule.

(6) Acceptable instructor training programs shall include, but not be limited to, presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) evaluation of trainee performance; and
(D) documentation procedures.

(7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule.

(8) Trainers shall be currently trained in CPR.

(9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach.

(10) Trainers shall teach a program on the use of restrictive interventions at least once annually.

(11) Trainers shall complete a refresher instructor training at least every two years.

(k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.

(1) Documentation shall include:
(A) who participated in the training and the outcome (pass/fail);
(B) when and where they attended; and
(C) instructor's name.

(2) The Division of MH/DD/SAS may review/request this documentation at any time.

(l) Qualifications of Coaches:

(1) Coaches shall meet all preparation requirements as a trainer.

(2) Coaches shall teach at least three times, the course which is being coached.

(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.

(m) Documentation shall be the same preparation as for trainers.

History Note: Authority G.S. 143B-147;
Temporary Adoption Eff. February 1, 2001;
Temporary Adoption Expired October 13, 2001;
SECTION .0200 - PROTECTIONS REGARDING MEDICATIONS

10A NCAC 27E .0201  SAFEGUARDS REGARDING MEDICATIONS
(a) The use of experimental drugs or medication shall be considered research and shall be governed by G.S. 122C-57(f), applicable federal law, licensure requirements codified in 10A NCAC 27G .0209, or any other applicable licensure requirements not inconsistent with state or federal law.
(b) The use of other drugs or medications as a treatment measure shall be governed by G.S. 122C-57, and G.S. 90, Articles 1, 4A and 9A.

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

SUBCHAPTER 27F - 24-HOUR FACILITIES

SECTION .0100 - SPECIFIC RULES FOR 24-HOUR FACILITIES

10A NCAC 27F .0101  SCOPE
Article 3, Chapter 122C of the General Statutes provides specific rights for each client who receives a mental health, developmental disability, or substance abuse service. This Subchapter delineates the rules regarding those rights that apply in a 24-hour facility.

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

10A NCAC 27F .0102  LIVING ENVIRONMENT
(a) Each client shall be provided:
   (1) an atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of clients being served; and
   (2) accessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team.
(b) Each client shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles, and with respect for the physical structure. Any restrictions on this freedom shall be carried out in accordance with governing body policy.

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

10A NCAC 27F .0103  HEALTH, HYGIENE AND GROOMING
(a) Each client shall be assured the right to dignity, privacy and humane care in the provision of personal health, hygiene and grooming care. Such rights shall include, but need not be limited to the:
   (1) opportunity for a shower or tub bath daily, or more often as needed;
   (2) opportunity to shave at least daily;
   (3) opportunity to obtain the services of a barber or a beautician; and
   (4) provision of linens and towels, toilet paper and soap for each client and other individual personal hygiene articles for each indigent client. Such other articles include but are not limited to toothpaste, toothbrush, sanitary napkins, tampons, shaving cream and shaving utensil.
(b) Bathtubs or showers and toilets which ensure individual privacy shall be available.
(c) Adequate toilets, lavatory and bath facilities equipped for use by a client with a mobility impairment shall be available.

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

10A NCAC 27F .0104 STORAGE AND PROTECTION OF CLOTHING AND POSSESSIONS
Facility employees shall make every effort to protect each client's personal clothing and possessions from theft, damage, destruction, loss, and misplacement. This includes, but is not limited to, assisting the client in developing and maintaining an inventory of clothing and personal possessions if the client or legally responsible person desires.

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

10A NCAC 27F .0105 CLIENT'S PERSONAL FUNDS
(a) This Rule applies to any 24-hour facility which typically provides residential services to individual clients for more than 30 days.
(b) Each competent adult client and each minor above the age of 16 shall be assisted and encouraged to maintain or invest his money in a personal fund account other than at the facility. This shall include, but need not be limited to, investment of funds in interest-bearing accounts.
(c) If funds are managed for a client by a facility employee, management of the funds shall occur in accordance with policy and procedures that:
(1) assure to the client the right to deposit and withdraw money;
(2) regulate the receipt and distribution of funds in a personal fund account;
(3) provide for the receipt of deposits made by friends, relatives or others;
(4) provide for the keeping of adequate financial records on all transactions affecting funds on deposit in personal fund account;
(5) assure that a client's personal funds will be kept separate from any operating funds of the facility;
(6) provide for the deduction from a personal fund account payment for treatment or habilitation services when authorized by the client or legally responsible person upon or subsequent to admission of the client;
(7) provide for the issuance of receipts to persons depositing or withdrawing funds; and
(8) provide the client with a quarterly accounting of his personal fund account.
(d) Authorization by the client or legally responsible person is required before a deduction can be made from a personal fund account for any amount owed or alleged to be owed for damages done or alleged to have been done by the client:
(1) to the facility;
(2) an employee of the facility;
(3) to a visitor of the facility; or
(4) to another client of the facility.

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

DATE OF BOARD MEETING: November 5, 2020

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.

This report includes draft minutes from the October 19, 2020, meeting.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Gino Pazzaglini, Board Chair; Robert Robinson, CEO
APPOINTED MEMBERS PRESENT: ☑David Curro, BS (Audit and Compliance Committee Chair); ☑Angela Diaz, MBA (Client Rights/Human Rights Committee Chair)—entered at 4:21 pm; ☑Lodies Gloston, MA (Policy Committee Chair); ☑David Hancock, MBA, PFAff (Finance Committee Chair); ☑Donald McDonald, MSW (Network Development and Services Committee Chair); ☑Lynne Nelson, BS (Board Vice-Chair), ☑Gino Pazzaglini, MSW LFACHE (Board Chair), and ☑Pam Silberman, JD, DrPH (Quality Management Committee Chair)

BOARD MEMBERS PRESENT: None
GUEST(S): None
STAFF PRESENT: Michael Bollini, Executive Vice-President/Chief Operating Officer; Cheala Garland-Downey, Executive Vice-President/Chief Human Resources Officer; Veronica Ingram, Executive Assistant II; Brian Perkins, Senior Vice-President/Strategy and Government Relations; Robert Robinson, CEO; Sara Wilson, Senior Director of Government Relations; and Carol Wolff, General Counsel

1. WELCOME AND INTRODUCTIONS – the meeting was called to order at 4:02 pm
2. REVIEW OF THE MINUTES – The Committee reviewed minutes from the September 21, 2020, meeting; a motion was made by Dr. Silberman and seconded by Mr. Hancock to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
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<tr>
<td>3. Closed Session</td>
<td>COMMITTEE ACTION: A motion was by Mr. Curro to enter closed session pursuant to North Carolina General Statute (NCGS) 143-318.11 (a) (1) and (a) (6) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1 and to consider the qualifications, competence, and performance of an employee. Motion seconded by Vice-Chair Nelson. Motion passed unanimously.</td>
<td>None specified.</td>
<td>N/A</td>
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<tr>
<td>4. Reconvene Open Session</td>
<td>Committee returned to open session.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>5. Committee Meeting Schedule</td>
<td>Committee reviewed the meeting schedule for the upcoming year. Chair Pazzaglini noted the change to the January meetings due to a company holiday.</td>
<td>Ms. Ingram will add the schedule to the Alliance calendar of regular meetings for this Committee.</td>
<td>N/A</td>
</tr>
<tr>
<td>6. Agenda for November Board Meeting</td>
<td>Committee reviewed the draft agenda; there were no recommended changes to the draft agenda. Also, Chair Pazzaglini shared that he will not attend this meeting and Vice-Chair Nelson will chair the November 5, 2020, Board meeting.</td>
<td>Ms. Ingram forwarded the agenda to staff.</td>
<td>10/20/20</td>
</tr>
<tr>
<td>7. Updates</td>
<td>Meeting Notifications: Chair Pazzaglini requested input on how members are notified of upcoming Board meetings.</td>
<td>As directed by the Committee, Ms. Ingram will email reminders with the registration link to Board members’ personal email address starting on November 5, 2020.</td>
<td>11/5/20</td>
</tr>
</tbody>
</table>

8. ADJOURNMENT: the meeting adjourned at 5:21 pm; the next meeting will be November 16, 2020, at 4:00 p.m.

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on Click or tap to enter a date.
ITEM: Quality Management Committee Report

DATE OF BOARD MEETING: November 5, 2020

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, other stakeholders.

The Alliance Board of Directors’ Chairperson appoints the committee consisting of five voting members whereof three are Board members and two are members of the Consumer and Family Advisory Committee (CFAC). Other non-voting members include at least one MCO employee and one provider representative. 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 Medical Director, who has ultimate responsibility of oversight of quality management; the Quality Review Manager, who staffs the committee; the Quality Management Data Manager; and other staff as designated.

The Global QMC meets at least quarterly 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 draft minutes from the previous meeting are attached

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Pam Silberman, Committee Chair; Wes Knepper, Senior Director of Quality Management
This meeting was held virtually, via Zoom

**APPOINTED MEMBERS PRESENT:** ☒ David Curro, BS (Board member); ☐ Marie Dodson (CFAC), ☒ Duane Holder, MPA (Board member); ☒ Pam Silberman, JD, DrPH (Board member; Committee Chair) ☒ Israel Pattison (CFAC)

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

**BOARD MEMBERS PRESENT:**
- Mary Hutchings;
- Yvonne French (LME Liaison)

**STAFF PRESENT:**; Diane Fening, Executive Assistant I; Tia Grant, QI Manager; Wes Knepper, Quality Management Director; Mehul Mankad, Chief Medical Officer; Doug Wright, Director of Community and Member Engagement; Terrasine Gardner, Engagement Manager

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1. **WELCOME AND INTRODUCTIONS** – the meeting was called to order at 1:00 pm.
2. **REVIEW OF THE MINUTES** – The minutes from the September 3, 2020, meeting were reviewed; a motion was made by Duane Holder and seconded by Dave Curro to approve the minutes. Motion passed unanimously.

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| 3. OLD BUSINESS | • Telehealth Provider and Member Survey  
We conducted a survey to understand how providers and members were dealing with the service delivery system changes. The provider survey was done via SurveyMonkey and the member survey was administered via phone by Alliance staff. 65 providers responded and 202 members responded. 131 members who responded had providers who responded to the provider survey. 88% rated their telehealth service good or very good. 91% of members receiving in-person services rated their service good or very good. 58% of telehealth providers that participated reported improved show rate. Only 34% of providers rated outpatient services as harder. Comments that we received from the survey agree that younger children are harder to do telehealth with successfully.  
• The number of members served via telehealth chart-about 25,000 people getting services with 2/3 of them eventually getting them through telehealth. Outpatient services moved faster toward telehealth; more complex services took a while to get going.  
• Benefits of telehealth-safety, access, insight, connection, cost  
Barriers: technology, diagnosis/age, privacy, childcare, paperwork | | | |
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| Satisfaction data was compared across demographic subgroups. All subgroups with at least 40 responses were found to be proportional. Members without valid phone numbers were excluded from the survey. Claims data was reviewed to identify populations whose needs are not being met as a result of the COVID-19 pandemic. Evaluation of unrepresented populations:  
  * Members served decreased in 2020. This has come back up since this was published.  
  * New Medicaid enrollments dropped in 2020  
  * 18% of members received telehealth via phone only (which could be a problem since payers might not continue to pay for phone only)  
  * 5% of members who consistently received services from December 2019 through February 2020 have no claims after March  
Ideas we are considering about what to do next-  
  * Dig deeper into claims data to identify populations whose needs are not being met.  
  * Continue to assess on-going and long-term outcomes of the shift to telehealth for members and providers  
  * Develop strategy to support providers with transition to HIPPA compliant telehealth platforms.  
  * Assess provider training needs, best practices and training options.  
| MBHO-Managed Behavioral Healthcare Organization  
HEDIS-Healthcare Effectiveness Data and Information Set  
NCQA-National Committee for Quality Assurance  
URAQ-Utilization Review Accreditation Commission |  
| QMC Charter Revisions (Vote Needed) Pam, Doug and Wes worked on this. The charter now matches the by-laws. Duane made a motion to approval of the charter. Dave seconded it. The motion carried. | This information will be sent to Rob and Gino with the suggestion that this be shown to the board |  

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<td><strong>4. NEW BUSINESS</strong></td>
<td><strong>DRAFT Tailored Plan Measures</strong></td>
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<td>• NC Medicaid put out the first part, which is what they think they will be looking to measure. We are currently pursuing an MBHO accreditation but will be required to have a health plan accreditation after we go live with the Tailored Plan. The good news is that they overlap.</td>
<td>• At a future meeting, Wes will come back to the committee with a timetable for when we think we will be hiring a vendor to calculate these measures and when we will have the data to enter into the system to finish the calculations in advance of the go live date of July 2022.</td>
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<td>• Medicaid is still working on getting us the data feeds that we will need so that we can calculate some of these measures. These won’t be reported until after we go live as a Tailored Plan July of 2022. The following January is when we would be responsible for reporting these. We have time to get something going. Most of the gaps we have right now are around controlled substances.</td>
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<td>• We are going to need to submit audited HEDIS reports to NCQA and will need to contract with a certified NCQA outside vendor to calculate these measures for us.</td>
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<td>• Providers have to be educated in advance. Wes said that we have hired a consultant that will be working with providers to help link them with resources as well as provide data, interpret the data and build those things into workflows.</td>
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<td>• When this committee meets in November, we’ll have the RFA, and if any of this changes dramatically, Wes will let us know.</td>
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<td><strong>Performance Dashboard</strong></td>
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<td>• Wes talked about two metrics that have not been met.</td>
<td>• Wes will add an agenda item for the November and December meetings about updates on how we are responding to the quality provisions of the</td>
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<td>* Percentage of level 2 and 3 incidents reported within required timeframes—every time this isn’t met, it’s because providers haven’t submitted their reports on time and we ask them to give them to us.</td>
<td>• 11/5/20 and 12/3/20</td>
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<td>* Beneficiaries receiving waiver services within 45 days of ISP approval—this measure has come up before as not being met. We’ve submitted a root cause analysis to the State. Most are due to small numbers in individual circumstances.</td>
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<td>* Some of this reporting will go away as they roll out the Tailored Plan measures. We haven’t yet received guidance on this.</td>
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<td>* Mehul spoke about how we might use Covid money from the State. We are putting together some plans to target some of the Covid allocations to improve seven-day access for our members. This will necessitate some contract changes with our providers and that has all not been worked out yet.</td>
<td>Tailored Plan RFA.</td>
<td>Wes will organize a presentation on NCQA MBHO for the December meeting.</td>
<td>12/3/20</td>
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**NCQA Updates**
- Today we have entered our look back period. When we have submitted all of our NCQA on April 6, we will submit 6-month look back. We are hoping to be accredited a month or so after that. Big cultural shift for us. URAC is really focused on policy and procedures. They want to make sure that you have the procedure and you are following it. NCQA wants that too, but the bigger focus for them is-is that making things better? And can you show it? And if not, what are you doing about it? How are you measuring to see what you need to make better? This is a big cultural shift for us. There will probably will be a lot more data and measurement about outcomes.

**5. ADJOURNMENT:** the meeting adjourned at 2:00 pm; the next meeting will be November 5, 2020, from 1:00 p.m. to 2:30 p.m.
ITEM: Consumer and Family Advisory Committee (CFAC) Report

DATE OF BOARD MEETING: November 5, 2020

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, 5200 West Paramount Parkway, in Morrisville. Sub-committee 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 minutes to its 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.

This report includes documents from the following meetings: Draft minutes and supporting documents from the Steering Committee meeting on October 5, 2020; the Durham meeting on October 12, 2020; the Wake meeting on October 13, 2020; the Johnston meeting on October 20, 2020; and the Cumberland meeting on October 22, 2020.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Jason Phipps, CFAC Chair; Doug Wright, Director of Community and Member Engagement
MEMBERS PRESENT: Jason Phipps, Pinkey Dunston, Vicky Bass, Dr. Michael Maguire, Steve Hill, Trula Miles, Helen Castillo, Breanna Harris, Renee Lloyd, Sharon Harris, Felicia McPherson, Annette Smith, Tekkeyon Lloyd
BOARD MEMBERS PRESENT: None
GUEST(S): Stacy Harward, NCDHHS
STAFF PRESENT: Doug Wright, Director of Community and Member Engagement, Starlett Davis, Member Engagement Specialist, Stacy Guse, Member Engagement Specialist, Ramona Branch, Member Engagement Specialist

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the September 2, 2020 meeting was reviewed; a motion was made by Annette Smith and seconded by Steve Hill to approve the minutes. Motion passed unanimously.

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<td>3. Public Comment</td>
<td>None</td>
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<td>Individual/Family Challenges and Solutions</td>
<td>Stacy Harward, NCDHS was in attendance for this meeting and went over the State updates. The October CE&amp;E update was sent out via email to all members. The following items were highlighted during tonight’s meeting:</td>
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<td>➢ SCOOP Trainings: The next training will be on October 12, and it will be on Observe Your Use of Substances. Members were encouraged to attend and share these meetings with their communities</td>
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<td>➢ Town Hall Meetings are still going on and the next meeting will feature the Cardinal catchment area. This meeting will take place on October 15</td>
<td>Ongoing</td>
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<td>➢ My 5 NC Challenge: Challenges individuals to reach out to 5 individuals 3 times per week for the whole month</td>
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<td>➢ Election Deadlines: Deadline to Register: October 9th</td>
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Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on Click or tap to enter a date.
## AGENDA ITEMS:

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| **1.** Start of Early Voting: October 15th  
End of Early Voting: October 31st  
Last Day to Vote: November 3rd | | |
| - The State Consumer and Family Advisory Committee (CFAC) meeting is on the 2nd Wednesday of the Month from 9 am to 1 pm (COVID-19) and is open to the public. All State CFAC meetings will be held as webinars until further notice. The October 14th call-in and virtual meeting information will be sent out in a separate email. | | |
| - Red Ribbon is a national anti-drug campaign that is celebrated annually October 23-31. During Red Ribbon, young people in communities across the nation pledge to live a drug-free lifestyle by wearing red ribbons and participating in community-wide anti-drug events! | | |
| - Pinehurst Conference is Going Virtual Plan to Participate! 2020 Conference and Exhibition December 2-4, 2020 | | |

| **2.** LME-MCO Updates | | |
| Empathy and Awareness Training: Doug played the second video in CHWB trainings. The group was asked to give comments and feedback about their thoughts on the video. | N/A | N/A |
| SWOT Analysis: The SWOT (Strength, Weakness, Opportunities, Threat) analysis is in from the questionnaires that were sent out a few months ago. Doug went over the findings and discussed the outcome with the group. | | |
| Child Facility Base Crisis Center in Fuquay Varina that was put on hold is now back on and has tentatively set an opening date of July 1, 2021. This facility will be regional, across the whole Alliance catchment area. | | |

| **3.** Innovations Waitlist | | |
| Discussion/Action: Jason Phipps opened the discussion on the innovations waiver waitlist and the number of members that Alliance currently has awaiting slots. The discussion centered around the availability of services that could be available for these members that are on the waitlist, and what providers had availability to serve these individuals. There was also discussion of how many members are currently To be added to agenda for the subcommittees meeting and revisited during November's | N/A | |

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CONSUMER AND FAMILY ADVISORY COMMITTEE - REGULAR MEETING  
5200 W. Paramount Parkway, Morrisville, NC 27560  
5:30pm – 7:00 p.m.  
Virtual Meeting Held via Video Conference

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<td>waiting slots in each county of the Alliance catchment area. The members discussed a possible approach to this matter from CFAC. It was decided that this would be an agenda item for the subcommittees to discuss and this will be addressed during the November meeting.</td>
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<td>Steering Committee meeting</td>
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<td>7. Subcommittees</td>
<td>Subcommittee Updates:</td>
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<td>• Wake</td>
<td>• Wake: Annette Smith (Chair): Vicky and Israel are participating in communications training; DSP Town Hall meeting October 20, 2020</td>
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<td>• Durham</td>
<td>• Durham: Steve Hill (Chair): Possible TBI representative open slot for membership and a LatinX member; Outreach on non-active members, and goals for the year.</td>
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<td>• Cumberland</td>
<td>• Cumberland: Felisha McPherson (Chair): NAMI collaboration and advocacy</td>
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<td>• Johnston</td>
<td>• Johnston: Marie Dodson (Chair): Charter updates, TBI representative, Advocacy</td>
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<td>• Area Board</td>
<td>Area Board: Dave Curro</td>
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<td>• Human Rights</td>
<td>Human Rights: No Meeting</td>
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<td>• Quality Management</td>
<td>Quality Management: Israel Pattison</td>
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<td>8. Announcements</td>
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<td>9. <strong>ADJOURNMENT: 7pm</strong>: The next meeting will be November 2, 2020, at 5:30 p.m.</td>
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Respectfully Submitted by:

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<td>Q1. Does your Local CFAC perform the tasks of reviewing, commenting on, and monitoring the implementation of your LME/MCO's Local Business Plan?</td>
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<td>Q2. Does your Local CFAC identify service gaps and underserved populations and provide comment regarding these to your respective governing board?</td>
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<td>Q3. Does your Local CFAC communicate to its respective governing board recommendations regarding the service array and monitor the development of additional services?</td>
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<td>Q4. Does your Local CFAC function at participating in ALL quality improvement measures and performance indicators and provide advisement to the respective governing board?</td>
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<td>Q5. Does your Local CFAC perform at submitting to the State CFAC findings and recommendations regarding ways to improve the delivery of MH/DD/SA services?</td>
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</table>
Click on the “COVID-19 (Coronavirus) N.C. Dashboard” image above to access the N.C. COVID-19 Dashboard.

Sign up for COVID-19 Text alerts to your mobile device!
Text COVIDNC to 898211.

NC 2-1-1 is now available 24/7 as a resource for assistance related to COVID-19. Dial 2-1-1 to get connected to resources in your community.

Text FOODNC to 877-877 to locate nearby free meal sites. The texting service is also available in Spanish by texting COMIDA to 877-877.

For questions, please contact the COVID-19 Hotline at 866-462-3821 or email BHIDD.COVID.Qs@dhhs.nc.gov.
Click here and submit your COVID-19 questions for BH/IDD.

NCDHHS continues to work to ensure the health and safety of all North Carolinians. Click on this link to learn more about the efforts underway in response to the COVID-19 pandemic.
https://covid19.ncdhhs.gov/

NCDHHS– DMH/DD/SAS has launched a website for guidance and resources for Behavioral Health and IDD during COVID-19.

El Futuro: ¡Nuestras puertas virtuales permanecen abiertas! El Futuro está aceptando nuevos pacientes y nuevas referencias para terapia, psiquiatría, tratamiento de uso de sustancias y servicios de DWI.

CRISIS INFORMATION

If you or someone you know is in crisis

CALL 911 if this is a medical or life-threatening emergency. If you need the police, ask for a CIT officer. They have received extra training on handling these situations.

CALL Customer Service & Community Rights at 1-855-262-1946 or 984-236-5300.

National Disaster Distress Helpline 1-800-985-5990 or text ‘TalkWithUs’ to 66746

National Suicide Prevention Lifeline 1-800-273-8255, Veterans Press 1, or Chat online at http://www.suicidepreventionlifeline.org/

National Domestic Violence Hotline: 1-800-799-7233 and TTY 1-800+787-3224

The Trevor Project (LGBTQ Youth) 1-866-488-7386 or TrevorChat confidential online instant messaging with a Trevor Counselor, text START to 678678.

El programa Hope 4 NC (Esperanza para Carolina del Norte) 1-855-587-3463 (FIND) for COVID.

www.RoccoveryAll.org – local virtual meetings and online support resources for those with SUD and Behavioral Health issues.
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https://disabilityrightsnc.org/what-we-do/our-advocacy-work/voting

**Dates to Remember**
Deadline to Register: October 9th
Start of Early Voting: October 15th
End of Early Voting: October 31st
Last Day to Vote: November 3rd

Check out the N.C. State Board of Elections website for to check your registration, find your polling place, see a sample ballot or check the status of your absentee ballot: https://www.ncsbe.gov/voting

Learn about the “REV UP” Campaign by clicking here: https://www.aapd.com/advocacy/voting/

---

**NCDHHS- DMH/DD/SAS**

Get the #SCOOP4Stress

Mondays, September - November
From 11:30 am to 12:30 pm

Stay Connected to Family and Friends | September 21st
Compassion for Yourself & Others | October 5th
Observe Your Use of Substances | October 12th
Ok to Ask for Help | October 19th
Physical Activity to Improve Your Mood | November 2nd

Register to Join:
https://tinyurl.com/SCOOP4Stress
#SCOOP4Stress

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**Division Events**

**Joint DMHDDSAS & DHB COVID-19 Update: Providers**
Thursday, October 1st at 3 pm
https://tinyurl.com/COVID19Update-Providers10

**Joint DMHDDSAS & DHB COVID-19 Update: Consumers**
Monday, October 26th at 2 pm

**LME/MCO Town Hall Meetings: Save the Dates**
UNC-TV will be assisting in the Facebook live stream of these events at Thursdays at 6 pm. Go to https://tinyurl.com/DHHSVirtualTownHallEvents

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**#SCOOP4Stress & Wellness**

In September, participants got the #SCOOP on Staying Connected from speakers Laurie Coker and Pamela Goodine. Let’s check-in: How have you been staying connected with your friends, family members and neighbors during this challenging time?

Join the #MY5NC Challenge to stay connected by emailing HelloMY5NC@gmail.com or find the challenge on Facebook.

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Local CFAC Updates

Local CFACs are meeting again in October, check with your LME/MCO to get full calendar and meeting details, including how to connect with those virtual meetings.

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

Opportunities for Input

Legislative Updates

Olmstead Listening Sessions

Learn more about NC Olmstead and get information on the ongoing listening sessions by clicking on the link:

COVID-19 News & Updates


NC DHHS awarded four contract to regional organizations to administer its new COVID-19 Support Services program. Read more by clicking on the link: https://www.ncdhhs.gov/news/press-releases/ncdhhs-announces-covid-19-support-services-program-individuals-isolation-or-travel

NCDHHS is providing extra help buying food for more than 600,000 children through the Pandemic Electronic Benefit Transfer. Read on to learn more: https://www.ncdhhs.gov/news/press-releases/ncdhhs-provide-extra-help-buying-food-more-600000-children

Need help finding food services? Click on the NCCARE360 to find resources in your area.

State CFAC

The State Consumer and Family Advisory Committee (CFAC) meeting is on the 2nd Wednesday of the Month from 9 am to 1 pm (COVID-19) and is open to the public.

All State CFAC meetings will be held as webinars until further notice. The October 14th call-in and virtual meeting information will be sent out in a separate email.

Contact Kate Barrow by email for more information.

Join by web browser: https://tinyurl.com/StateCFAC-OctoberMeeting

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

Access Code: 171 378 2076

State to Local Collaboration

The State to Local Collaboration Call has been moved to the 4th Wednesday of every month. CFAC members can use the same Phone Number and Conference ID for each meeting.

Contacts to participate by web will be sent out before each meeting. The call-in number and conference ID will not change.

https://tinyurl.com/S2L-CollaborationCall

+1-415-655-0003

Conference ID: 171 896 6313

Breast Cancer Awareness

According to the National Cancer Institute, more than 230,000 women in the United States learn that they have breast cancer each year. A Breast Cancer diagnosis can be one of the most stressful events in a person’s life and the result can have a major impact on a person’s mental health, including adding to chronic stress, anxiety and depression. Read more about the impact of Breast cancer on mental health by clicking here: https://www.apa.org/topics/breast-cancer.

According to data from the CDC, women with disabilities are less likely to have regular breast cancer screenings than women without disabilities. In a 2010 National Household Interview Survey, with CDC, 61% of women with disabilities between the ages of 50-74 reported receiving a mammogram, versus 75% of women in the same age group without disabilities.

Addressing Breast Cancer as a whole health issue is important to overall positive outcomes, both for physical health needs during treatment and mental health needs, like stress management throughout the diagnosis.

Breast Cancer Now offers information on depression, mental health and breast cancer, including access to a Helpline.

Consider also working with your cancer support team if you have had a breast cancer diagnosis, and remember it’s Ok to ask for help.
Hispanic Heritage Month is from September 15th to October 15th, and we want you to celebrate in your community. Here are some helpful resources for you and your community:

**Local:** Chatham Community Library

Each week through October 27th, the library will post a new video on their YouTube channel (https://www.youtube.com/channel/UC_1jM2C9GC-h_Ndhl穴T_E). Performers are from Spain and the programs are bilingual. Please see the attached flyer.

**Other:**

- NMSU Dr. Belinda Otukolo Saltiban & Dr. Barbara Kessel – Latinx Speaker Series @ YouTube Livestream
- UTSA Speaker Series @ YouTube Livestream
- MHTTC - A plethora of Hispanic Heritage Events (speaker series, discussions, etc.)

**Oct. 1: Afro-Latinx Panel.**

The Multicultural Student Center of the Illinois College of Lake County is hosting an Afro-Latinx Panel through Zoom, which will concentrate on the Afro-Latino experience. Thursday, Oct. 1. For more information, visit its website.


**COVID-19 Resources**

- Rachel’s deep breathing exercise in Spanish
- National Alliance on Mental Illness - COVID information and resources (Spanish)
- National Alliance on Mental Health - Identity & Cultural Dimension (English, but can click on Spanish to translate)
- Mental Health America - Spanish resources on a variety of topics
- Celebrations in the time of COVID-19 (in Spanish)
- Protecting yourself during COVID-19 (Spanish) - Diocese of Raleigh
- Frameworks Institute
  1. Show that you’re responding to the moment—not taking advantage of it.
  2. Show that bold, collective action is the only response that makes sense.
  3. Help people see this time as a moment when change is possible, necessary, and desirable.
- Here’s Frameworks Institute Immigrant specific message guidance

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### Disability Employment Month

People with Mental Health, Developmental Disabilities and Substance Use Disorders want to work and be valued for their contributions to the community. Meaningful employment is also a key component of Community Inclusion.

October is Disability Employment Awareness Month—stay tuned for a special proclamation from the Division of Rehabilitative Services.

Learn more about the various employment resources in North Carolina, whether you are looking to access employment services, learn more about employment initiatives and financial independence, or need additional assistance.

**North Carolina Council on Developmental Disabilities**

- Division of Rehabilitative Services (DVRS) https://www.ncdhrs.gov/divisions/dvrs
- Client Assistance Program https://www.ncdhrs.gov/divisions/dvrs/client-assistance-program

**Division of Mental Health, Developmental Disabilities, and Substance Abuse Services**

Individual Placement and Support (IPS) is a model of supported employment. IPS is an evidence-based practice that assists people living with serious mental illness gain and maintain competitive employment. IPS supported employment helps people living with behavioral health conditions work at regular jobs of their choosing. IPS is based on 8 practice principles. In North Carolina over the most recent quarter, 728 people are working through the assistance of IPS and Vocational Rehabilitation. DMH/DD/SAS has contracted with the UNC Institute for Best Practice. For more information about IPS click on this link (https://www.med.unc.edu/psych/cecmh/education-and-training/unc-institute-for-best-practices/individual-placement-and-support-ips/)

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### Disability Employment Awareness Month

A Conversation with Senator Tom Harkin

Follow-Up Panel Discussion with State Employees

- Oct. 13 | 10 a.m. - 12 p.m.
- www.oshr.nc.gov/deam

Take the Pledge to be drug-free and participate in the 2020 Virtual Red Ribbon Rally.

Red Ribbon is a national anti-drug campaign that is celebrated annually October 23-31. During Red Ribbon, young people in communities across the nation pledge to live a drug-free lifestyle by wearing red ribbons and participating in community-wide anti-drug events!

Learn more and download the social media toolkit by visiting https://www.justthinktwice.gov/?utm_medium=email&utm_source=govdelivery
Community Inclusion

Fundamental #7
Community inclusion is strengthened through emerging support technologies, the natural supports of families and friends, and the engagement of peer supports.

People should have access to supports that enables participation, including: programs that promote awareness of community resources and develop skills to access these; support to involve families, friends and carers; and peer support.

Learn more by visiting the Temple University Collaborative.
http://www.tucollaborative.org/community-inclusion-resources/

Community Engagement & Empowerment Team

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

Veterans, Servicemembers & Families

Want to learn more about services for Veterans in North Carolina? Go to NC Governor’s Working Group and explore the site— you’ll find out more about the Interactive Retreat Center near Fort Bragg, the monthly NCGWG meetings (including how to view them on Facebook), workshops, economic, health and COVID-19 related issues pertaining to related to Veterans and their families.

For more information, contact Jeff Smith, Military and Veterans Program Liaison, by email at Jeff.Smith@dhhs.nc.gov.

On September 22, 2020 NC DHHS launched the “SlowCOVIDNC” App to help North Carolinians to slow the spread of the virus by alerting them when they may have been exposed to someone who has tested positive. Read the full press release and get the link to download the app by clicking here: https://www.ncdhhs.gov/news/press-releases/ncdhrs-launches-slowcovidnc-exposure-notification-app-available-download-today

Watch a video about the app here: https://youtu.be/Yny36M_aqfw

To download now, click on the icon that best represents your device. Click “Install” or “Get” and follow the directions to get started.

Pinehurst Conference is Going Virtual Plan to Participate!
2020 Conference and Exhibition
December 2-4, 2020

Registration for the annual Pinehurst Conference is now open! Click on the links to learn more about the conference theme, “Challenge, Change and Choice – The Future is Now” and register.

Conference Registration Now Open CLICK HERE
Conference Brochure – CLICK HERE

MORE CONFERENCE LINKS
INNOVATION AWARD NOMINATION FORM – Deadline 10/30
EXHIBIT, SPONSORSHIP & ADVERTISING BROCHURE
ON LINE SIGN UP FOR EXHIBIT, SPONSORSHIP & ADVERTISING

Veterans Resource Guide
October is Mental Health Awareness Month: 6 COVID-Friendly Fall Wellness and Self-Care Activities

This fall, celebrations of the season will look much different due to the ongoing COVID pandemic, despite restrictions, there are many ways for all of us to enjoy the season, engage in physical activity and self-care while remaining safe.

1. Apple Picking and Pumpkin Patches

This year, COVID has caused a cancellation of the N.C. Apple Festival, but many apple orchards across the state are still open. Both orchards and pumpkin packages are typically housed in large outdoor spaces where social distancing is easy. Be sure to check online if you need to book an appointment, as many orchards and pumpkin patches are operating by appointment-only to manage crowds and ensure social distancing. Apple picking or choosing pumpkins can be especially fun for all ages.

2. Scavenger Hunts

Organizing and completing a scavenger hunt for family or whoever you are quarantining with can be a fun change of pace and source of entertainment, especially if you’re living with younger children. The CDC posted a guide on how to host your own at-home scavenger hunt. You can host your scavenger hunt outside in your yard or inside your home – no PPE needed!

3. Leaf Watching

Across North Carolina, trees are beginning to shed their leaves and turn from green into beautiful reds, oranges, and yellows. This activity is completely pandemic-friendly as you can easily appreciate the view from your car or bike. If you’re able, a day trip to the Blue Ridge Parkway or local park is well worth the beautiful views. Bring family or roommates and enjoy watching all the colors change.

4. Hiking

Soaking in the fresh autumn air and viewing the scenery is a perfect way to enjoy the season. Hiking means getting out of the house and getting active with an added bonus of wildlife and leaf viewing. Consider taking a short day trip to a hiking destination of your choice. There are plenty of hiking trails in N.C. that feature beautiful waterfalls, mountains, and other amazing scenery. I recommend bringing a face covering that you can easily cover yourself with if you come across other hikers.

5. Biking

Information about many different biking trails around Wake County can be found on the AllTrails app or website. The Walnut Creek trail is a favorite biking trail near Raleigh, for a short or lengthy bike ride depending on your preference. Additionally, the park at the North Carolina Museum of Art is a short ride which features outdoor art exhibits for your viewing pleasure. Biking is a great solution for low-impact cardio that’s fun for all ages. Getting exercise is proven to boost your mood and mental state.

6. Baking

Fall is the perfect time to break out the flour and eggs and work on your baking skills. Quarantine means more time at home, so you’ll likely have plenty of time to do quick baking prep and watch over your dessert creations. Creating and eating your own treats is perfect for self-care. Try dishes like pies and stews which are perfect comfort food. Many grocery stores are offering curbside delivery or no-contact pickup, check in with your store to see if they are offering these services.

Enjoy the season and be sure to take precautions and stay safe. Remember to carry PPE with you and wear a mask at all times when you are interacting with others. Happy Fall!
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the September 14, 2020, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; a motion was made by Dave Curro and seconded by Regina Mays to approve the minutes. Motion passed unanimously.

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<th>DISCUSSION:</th>
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<td>3. Public Comments</td>
<td>COVID-19- Check In Dave stated he had a few relatives that have test positive and have fully recovered and are back work. Regina reminded us about NC360 for those who needs assistance.</td>
<td>N/A</td>
<td></td>
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<td>4. LME/MCO Updates</td>
<td>Doug showed Alliance Health video on “Empathy and Wellness” Doug went over SWOT FY 19-20 incident graph. This graph shows the area of gaps and needs and what Alliance needs to work on FY 20-21. Doug explained the Pediatric Crisis Facility to open in Fuquay-Varina possibly 7-1-2021 which has 16 beds ages 6-12 (6 beds) and ages 13-17 (10 beds). RFA needs to be completed to the state by Nov 2, 2020 with responses due Jan 19, 202. RFA will address how we will operate as a tailored plan. State will determine how many LME/MCO’s and who will function as a tailored plan</td>
<td>N/A</td>
<td></td>
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<td>5. State Updates</td>
<td>Suzanne stated they are still looking for someone to replace Roanna. Next consumer call is Oct 26, 2020 and invites will be released soon. Next Town Hall on the Governor’s Institute will be on their Facebook page 10-22-2020, targeting Cardinal catchment area. However, anyone is welcomed to listen in. Don’t forget to vote and early voting will start soon.</td>
<td>N/A</td>
<td></td>
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<td>6. Steering Committee</td>
<td>Innovations Waitlist-General Assembly assigns how many waiver slots. 3,000 members receive waiver benefits. NC statewide has 14,000 waiting for a</td>
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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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| 6.   | waiver slot who do not receive any services unless they have private insurance  
Jason Phips is looking to start an Alliance CFAC coalition to advise NC legislators how many members on the waitlist who are not receiving necessary services. The purpose will be to inform legislators to see if money can be allotted to reduce the number of members waiting for a waiver slot. | Ongoing |  |

| 7.   | Follow Up from September  
TBI Representation & Latino membership slots:  
Members discussed and agreed adding two more members to Durham CFAC. CFAC members will consider this and will vote on it the next meeting.  
CFAC Orientation Packet:  
Ramona will check with non-active members to see if they are still interesting serving on the Durham CFAC subcommittee. Ramona to deliver Spanish leaflets to Pinky Dunston and Charlitta Burris. Brenda Solomon is requesting all of Alliance Health brochures in English and Spanish.  
Ramona will look over the CFAC packet forms and update as needed and bring them to the subcommittee to view.  
Charter Updates:  
Latino slots.  
Goals:  
Dave suggested having legislators come to Durham subcommittee meeting, suggested December meeting for a Town Hall meeting. Charlitta will reach out and invite legislator’s | Ongoing |  |

### ADJOURNMENT:
The next meeting will be November 9, 2020, at 5:30 p.m.

Respectfully Submitted by:
Stacy Guse

October 14, 2020

Date Approved
Alliance Behavioral Healthcare Consumer and Family Advisory Committee

Durham County Charter

Purpose:
The county committees are responsible for gathering information, disseminating information, and reporting to the CFAC Steering Committee concerns specific to their county and overall system concerns regarding the following statutory requirements:

- 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 area authority or county program budget.
- Participate in all quality improvement measures and performance indicators.
- Submit to the State Consumer and Family Advisory Committee findings and recommendations regarding ways to improve the delivery of mental health, developmental disabilities, and substance use disorders.

Tasks:
The Durham CFAC will achieve this responsibility by doing the following:

- Hosting at least (1) one community wide forum per year to receive input about the Mental Health/Intellectual and Developmental Disability/Substance Use Disorder service system.
- Participate in community events with the Alliance Community Relations Department at least (3) three times per year.
• Receive training and/or presentations from Alliance staff or provider agencies around relevant information and services.
• The committee will designate during the regular monthly meeting, (2) members to attend in person or telephonically the Alliance CFAC Steering Committee meeting.
• Other tasks agreed upon by the committee.
• Recruit new members for CFAC.
  Individuals that are interested in CFAC membership should come to at least (2) meetings and on the 3rd meeting they are eligible to be voted in.

**Composition:**

The Durham CFAC is made up of individuals and family members that reside in Durham County. Members of the public are encouraged to attend and participate where appropriate.

**Meetings:**

• Meetings will be held on the second Monday night of each month at TROSA (1820 James Street Durham NC).
• The chair will construct an agenda with assistance from Alliance staff.
• The chair will designate someone to take minutes.
• The chair or designee will facilitate the meeting.
MEMBERS PRESENT: ☐ Carole Johnson, ☒ Megan Mason, ☒ Karen McKinnon, ☒ Connie King-Jerome, ☒ Israel Pattison, ☒ Annette Smith ☒, Ben Smith ☐, Wanda (Faye) Griffin, ☒ Diane Morris, ☒ Jessica Larrison, ☒ Vicky Bass, ☒ Gregory Schweitzer, ☒ Bradley Gavriluk

BOARD MEMBERS PRESENT:
GUEST(S): ☒ Suzanne Thompson, DHHS
STAFF PRESENT: ☒ Doug Wright, Director of Individual and Family Affairs, ☐ Terrasine Garner Engagement Manager, ☒ Stacy Guse Individual and Family Engagement Specialist

Please sign-up for each meeting via: Please Right Click on the below link and press “OPEN HYPERLINK” to register
https://alliancehealthplan.zoom.us/meeting/register/tJAkcuCppjwuHdYUd1ysZRT4HEYXeJzWzNY8

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the September 8, 2020, Wake Consumer and Family Advisory Committee (CFAC) Subcommittee meeting were reviewed; a motion was made by Karen McKinnon and seconded by Gregory Schweitzer 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. Public Comments Individual and Family Challenges</td>
<td>COVID19 Check-in: No Comments.</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>4. State updates</td>
<td>Tailored Plan Updates 10-21-2020 @2pm for Consumer and Family changes. The updated changes will be posted on the Medicaid website. State CFAC will be held tomorrow. Early voting starts Thursday, make your voice counted. Annette asked Suzanne if transportation will be provided for those who are physically unable to go to a voting site. Suzanne will check into this issue and will get back to Annette.</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>5. LME/MCO updates</td>
<td>Doug showed video #2 of Alliance Health “Changing Hearts and Minds” trainings that have been posted on “YouTube” on empathy and awareness. Video shown was “Changing Hearts and Mind”. Doug provided a link to the videos during this meeting. Doug went over SWOT FY 19-20 incident graph. This graph shows the area of gaps and needs and what Alliance needs to work on FY 20-21. Doug explained the Pediatric Crisis Facility to open in Fuquay-Varina possibly 7-1-2021 which has 16 beds ages 6-12 (6 beds) and ages 13-17</td>
<td>None</td>
<td>N/A</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>
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</tr>
</thead>
<tbody>
<tr>
<td>(10 beds). Annette inquired how families apply for admission and Doug explained this is a crisis facility and those admitted are stabilized and then referred to another facility. Typical stay will be 3-5 days. Annette inquired who will pay for this facility, and Doug explained this will be operated through Medicaid. RFA needs to be completed to the state by Nov 2, 2020 with responses due Jan 19, 202. RFA will address how we will operate as a tailored plan. State will determine how many LME/MCO’s and who will function as a tailored plan. Letters for standard plans will go out November 1, 2020. Doug suggested Glenda Clare read the state law 122c is what the MCO’s follow. Care Management Model for whole-person care’s new model will be coming out I a couple of weeks. Care Coordination will go to our providers. An advanced medical home care agency will do a pilot in 2021 and will go live in July 2022. Hope4NC line is still active 1-855-587-3463.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Steering Committee</td>
<td>Innovations Waitlist Innovations Waitlist-General Assembly assigns how many waiver slots. 3,000 members receive waver benefits. NC statewide has 14,000 waiting for a waiver slot who do not receive any services unless they have private insurance Jason Phips is looking to start an Alliance CFAC coalition to advise NC legislators how many members on the waitlist who are not receiving necessary services. The purpose will be to inform legislators to see if money can be allotted to reduce the number of members waiting for a waiver slot.</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>7. Announcements/ Event planning</td>
<td>DSP Town hall (see enclosed flyer to register). 10 legislators (out of 30) have confirmed to attend. Rebekah to be added to next agenda to be voted in as a Wake CFAC member.</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>8. Follow-up from September 8, 2020 meeting</td>
<td>Israel made a suggestion about Communicating the community. Israel and Vicky will collaborate about technology. This collaboration will be held off until 2021. Charter Updates-see Wake CFAC Charter. Member Engagement team members will collaborate to update the CFAC membership packet forms.</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>9. Training</td>
<td>Mental Health Awareness Month and 6 tips to boost morale-Stacy</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.
Responsibilities:
The purpose of this committee is to support the work of the Alliance CFAC at the county level by:
1. Electing a chair to serve annually and participate as a member of the CFAC Steering Committee.
2. Setting meeting agendas.
3. Assist the Alliance CFAC meet its statutory responsibilities.
4. Monitor and make recommendations regarding services provided.
5. Community outreach.
6. Communicate the concerns of the CFAC members and the community to the CFAC Steering Committee on a monthly basis.
7. Report any activities undertaken to the CFAC Steering Committee.
8. Provide relevant training to the CFAC, Wake Committee.
9. Appoint members in addition to the Chair to represent the Wake Committee and CFAC Steering Committee.

Authority:
The committee is authorized by the by-laws and led by the CFAC Wake County Sub-committee Chairperson. The Chairperson will make effective use of the time during meetings.

Sub-committee members shall:
1. Prepare for meetings ahead of time.
2. Communicate needs to the Chairperson or Alliance Liaison.
3. Respect each other.
4. Be on time to meetings or notify the chair when unable to attend.
5. Support the decisions of the CFAC Steering Committee.

Composition: The Wake County Sub-committee is made up of members of the Alliance BHC CFAC who reside in Wake County.

Meetings:
1. These meetings are open to the public and the public is encouraged to attend.

Meetings will be conducted as follows:
1. The second Tuesday of every month at 5:30 until 7:00 PM. The Chairperson retains the authority to change the meeting date and time due to conflicts and weather conditions with reasonable notice to all members.
2. The Chairperson will construct the meeting agenda with the assistance of the Alliance BHC staff.
3. The Chairperson will designate a member to take the minutes of the meeting.
4. A quorum will consist of 50% of membership or more.
5. The Chairperson will facilitate the meeting.

Approved: 02/11/2020
6. The Wake CFAC Subcommittee shall members not exceed more than 14 members, to include a TBI member.
7. Members who exceed more than 3 absences consecutively, this could be cause for dismissal from the Wake Subcommittee. This rule can be discussed on a case-by-case circumstance (i.e., illness for family emergency).
MEMBERS PRESENT: Marie Dodson, Cassandra Herbert-Williams, Jerry Dodson, Jason Phipps  
BOARD MEMBERS PRESENT: None  
GUEST(S): Suzanne Thompson  
STAFF PRESENT: Doug Wright, Director of Community & Member Engagement, Noah Swabe, Member Engagement Specialist

Join Zoom Meeting  
https://alliancehealthplan.zoom.us/j/91713107422?pwd=anpzbzBVYYpuVU10ZzJzWHRZVHRxdz09

Meeting ID: 917 1310 7422  
Passcode: 802269  
Call In: +1 646 558 8656

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – September minutes were reviewed, a motion was made by Jason, seconded by Jerry, Motion Passed.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
</table>
| 3. Public Comment Individual/Family Challenges and Solutions | Check In- COVID-19  
Members shared challenges they have and continue to experience since the COVID-19 pandemic began. | Ongoing | None |
| 4. LME/MCO Updates | Doug showed Alliance Health video on “Empathy and Wellness”. Doug explained the Pediatric Crisis Facility to open in Fuquay-Varina possibly 7-1-2021 which has 16 beds ages 6-12 (6 beds) and ages 13-17 (10 beds). RFA needs to be completed to the state by Nov 2, 2020 with responses due Jan 19, 202. RFA will address how we will operate as a tailored plan. State will determine how many LME/MCO’s and who will function as a tailored plan | Alliance staff will continue to provide updates | None |
| 5. State Updates | Next consumer call is Oct 26, 2020 and invites will be released soon. Next Town Hall on the Governor’s Institute will be on their Facebook page 10-22-2020, targeting Cardinal catchment area. However, anyone is welcomed to listen in. | Ongoing | None |
| 6. Membership and Training | Noah discussed possible trainings the CFAC would find helpful and if the CFAC was interested in having regular trainings again. CFAC members felt the trainings were helpful and suggested call center/access to care, grievance and complaint, and appeals training. Members felt these trainings would better equip CFAC members to assist members and families in the | Continue to promote CFAC membership and begin trainings in January | Ongoing |

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME:
---|---|---|---
community. The suggestion was to begin introducing the trainings again in January.
CFAC members discussed possible ways to increase and recruit membership during the pandemic. Members and Alliance staff will continue to promote the CFAC and encourage members and families to participate in CFAC.
7. December Meeting | With the current COVID-19 pandemic and not being able to gather for the holidays, Johnston CFAC members voted to cancel the December meeting. Members will still meet next month in November. | None | None
8. Announcements

9. **ADJOURNMENT**: Next Meeting November 17, 2020 at 5:30pm via Zoom

Respectfully Submitted by:

Noah Swabe, Member Engagement Specialist

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
MEMBERS PRESENT: ☐Michael McGuire ☐Ellen Gibson, ☒Dorothy Johnson ☐Carrie Morrisy ☒Jackie Blue ☒Sharon Harris ☒Briana Harris ☒Shirley Francis ☒Tekeyon Lloyd ☐Tracey Glenn- Thomas ☒Renee Lloyd ☒Carson Lloyd Jr. ☒Felishia McPherson ☐Alejandro Vasquez ☐Andrea Clementi

BOARD MEMBERS PRESENT:

STAFF PRESENT: ☒Doug Wright, Director of Community & Member Engagement, ☐Terrasine Gardner, Member Engagement Manager, ☒Starlett Davis, Member Engagement Specialist, ☒Syreeta Davis, Family Navigator

Join Zoom Meeting
https://alliancehealthplan.zoom.us/meeting/register/tJ0scOyrpjwrE9x3eLYcqpxB0H5r6YLuY0K2

Meeting ID: 991 7538 7198
Passcode: 935256
Dial by your location
+1 646 558 8656 US (New York)

1. WELCOME AND INTRODUCTIONS: Felishia McPherson

2. REVIEW OF THE MINUTES – The minutes from the September 24, 2020, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; a motion was made by Renee Lloyd and seconded by Jackie Blue to approve the minutes. Motion passed.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
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<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Public Comments</td>
<td>Renee, Doug and Starlett Community events and resources. Covid 19Check ins</td>
<td>See Starlett, Terrasine or Doug for questions.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>4. ADA Updates</td>
<td>Shirley Francis- ADA updated meeting information. Starlett will give update of quarterly meeting times once she gets them.</td>
<td>Starlett and Shirley will keep the committee updated.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>5. State Updates</td>
<td>Stacy Harward went over the October CE&amp;E Update Please refer to the digital update for events and resources.</td>
<td>See Starlett, Terrasine or Doug for questions.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>6. Legal Aid Fair Housing and Tenants Rights</td>
<td>Training: Legal Aid of NC Fair Housing and Tenants Rights- Starlett Davis presented the information she obtained in a training on the</td>
<td>Please see Starlett Davis for any questions.</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>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>7. MCO</td>
<td>Doug Wright MCO Updates &lt;br&gt;Doug went over the SWOT analysis that was done last year with the state. It goes through the questions that CFAC are asked to do. It is basically how CFAC is doing with fulfilling their responsibilities. Doug went over the results. The Local Business plan is done every 3 years so we try to report out each year on things that can be improved. We also get your advisement on needs and gaps. Each year, members are invited to the Board of Directors retreat. These needs and gaps are taken and presented. Doug went over the quality management and improvements. Two CFAC members sit on that board. The State CFAC findings are reported by the chairs on what the committees have done and accomplished. Changing Hearts and Minds training. &lt;br&gt;Child Facility based crisis in Fuquay Varina. It was supposed to open a few years back but budget cuts happened and it was put on hold. It is starting up again. Open date is July 1 2021. It is a children’s facility. There will be 10 beds 13-17 year olds adolescent and 6 beds for 6 to 12 year olds, children. &lt;br&gt;RFA- Request for application for tailored plan. The Medicaid transformation process has started again. The Tailored and Standard plans will be starting. The RFA is an application process that Alliance has to show what we intend to do and what we have already done. It is due January 19th. It is a very extensive process. We are looking forward to getting that done. We will share what we can and get input from you as well. &lt;br&gt;Stacey, our State rep, mentioned a help line. Definitely utilize that if you have some needs.</td>
<td>See Starlett, Terrasine or Doug for questions.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>AGENDA ITEMS:</td>
<td>DISCUSSION:</td>
<td>NEXT STEPS:</td>
<td>TIME FRAME:</td>
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<tr>
<td>Care Management model has shifted a bit. The state wants 80% of it done by provider networks. This means that the providers will be doing the majority of that. We were just rewarded a pilot for Monarch to get a feel for how that will function and work. We are also rethinking our Care Management Model and that will come out within the next week or two.</td>
<td></td>
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<tr>
<td>8. Prep for next meeting</td>
<td>Renee- Discuss the next meeting agenda items. Go over expectations, reminders, etc for the next meeting. Will we meet in November and December? Committee decided that the next meeting will be January 28, 2021. The November and December meetings will be canceled. Updates will obtained from the November and December Steering Committee meetings. Renee asked everyone to reach out to at least one member before the next subcommittee meeting. Everyone agreed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>No meeting until January 28, 2021. Each member will reach out to at least one member before the January 2021 meeting.</td>
<td>January 28, 2021</td>
</tr>
<tr>
<td>9. Appreciation</td>
<td>Everyone gave their appreciations.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

ADJOURNMENT: Motion made by Renee Lloyd to adjourn. Seconded by Dorothy Johnson. Meeting adjourned at 6:40pm.

Next CFAC Steering Committee meetings are November 2nd and December 7th. Next CFAC Subcommittee meeting is January 28 2021.

Respectfully Submitted by:

Click here to enter text.  

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

DATE OF BOARD MEETING: November 5, 2020

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 2:30/3:00 p.m. prior to the regular Board Meeting.

This month’s report includes draft minutes from the October 1, 2020, meeting, the Statement of Net Position, the Summary of Savings/(Loss) by Funding Source, ratios for the period ending September 30, 2020, and recommendations to the Board to approve all presented contracts over $500,000, and any other applicable Finance Committee topics.

REQUEST FOR AREA BOARD ACTION: Accept the report. Approve presented contracts.

CEO RECOMMENDATION: Accept the report. Approve presented contracts.

RESOURCE PERSON(S): David Hancock, Committee Chair; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer
Finance Committee Meeting
Thursday, November 5, 2020
2:30-4:00 pm

AGENDA

1. Review of the Minutes – October 1, 2020

2. Monthly Financial Reports as of September 30, 2020
   a. Statement of Net Position
   b. Summary of Savings/(Loss) by Funding Source
   c. Statement of Revenue and Expenses (Budget & Actual)
   d. Senate Bill 208 Ratios
   e. DMA Contractual Ratios

3. Audit Presentation
   a. Audit report as of 6/30/20 will be presented at the December 3, 2020 Board meeting

4. Approval of Contract(s)
   a. Motion to recommend the Board award IFB 21-003, Alliance Child Crisis Center – Renovation Phase D, to Engineered Construction Company in accordance with N.C.G.S. §143-129 and authorize the CEO to execute the contract with Engineered Construction Company for renovation of the child facility based crisis building in Fuquay-Varina in an amount not to exceed $5,063,574.

5. Quarterly Updates
   a. Reinvestment Plan
   b. Solvency Standards
   c. PMPM
   d. Non-Medicaid Reporting

6. Adjournment
APPOINTED MEMBERS PRESENT: ☒Jennifer Anderson, MHSA, ☒David Hancock, MBA, MPA (Committee Chair), and ☐D. Lee Jackson, BA

BOARD MEMBERS PRESENT: Gino Pazzaglini

GUEST(S) PRESENT: Mary Hutchings, Wake County, Vicki Evans, Cumberland County

STAFF PRESENT: Robert Robinson, CEO (LCAS); Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Sara Pacholke, Senior Vice-President/Financial Operations (BS, CPA), Ashley Snyder, Director of Accounting and Finance, Sean Schreiber Executive Vice-President Network and Community Health

1. WELCOME AND INTRODUCTIONS – the meeting was called to order at 3:03 PM

2. REVIEW OF THE MINUTES – The minutes from the September 3, 2020, meeting were reviewed; a motion was made by Ms. Anderson and seconded by Mr. Hancock to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>3. Monthly Financial Report</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 August 31, 2020. Ms. Pacholke discussed the monthly reports. • As of 8/31/20 we have savings of $11.8M • We are meeting all SB208 ratios • We are meeting the defensive interval required in the DMA contract, however the MLR is currently below the 85% threshold (80.6%). Alliance is monitoring this ratio and working on a spending plan to increase spending, especially related to COVID revenue.</td>
<td></td>
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<tr>
<td>4. 6/30/20 Net Position, Committed Funds and FY21 Reinvestment Plan</td>
<td>Ms. Pacholke provided an update of the year end close. • FY20 has been finalized. For the year, we have savings of $23,374,864, unless there are any proposed audit adjustments. The majority of the savings is related to Medicaid savings. • The recommendations for committed funds is: o $3,007,817 for intergovernmental transfers and $12,692,000 for the reinvestment plan. A motion was made by Ms. Anderson and seconded by Mr. Hancock to recommend to the Board to approve the one year reinvestment plan of $12,692,000 and commit $15,699,817 as of 6/30/20 which includes: • $3,007,817 for the required intergovernmental transfer (one year) • $12,692,000 for reinvestment (one year) The motion passed unanimously.</td>
<td></td>
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</tbody>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on Click or tap to enter a date..
5. **Approval of Contracts**

Mr. Schreiber discussed a new accountable care organization (ACO) pilot in Cumberland County with Blaze Advisors. Blaze Advisors will be responsible for developing, implementing, and providing initial management and oversight of a behavioral health ACO in Cumberland. Blaze Advisors has already successfully deployed a similar network in Wake County.

A motion was made by Ms. Anderson and seconded by Mr. Hancock to recommend to the Board to authorize the CEO to enter into a contract with Blaze Advisors for the development, implementation, and initial management of a behavioral health accountable care network in Cumberland County for an amount not to exceed $698,700. The motion passed unanimously.

---

5. **ADJOURNMENT**: the meeting adjourned at 3:40 PM; the next meeting will be November 5, 2020, from 2:30 p.m. to 4:00 p.m.
## ASSETS

### Current Assets
- Cash and cash equivalents: $6,525,287
- Restricted cash: $2,966,038
- Short term investments: $88,821,428
- Due from other governments: $17,904,846
- Accounts receivable, net of allowance for uncollectible accounts: $44,018
- Sales tax refund receivable: $166,050
- Prepaid expenses: $3,034,309

Total Current Assets: $119,461,975

### Noncurrent Assets
- Restricted Cash: $63,546,805
- Other assets: $321,460
- Capital assets, net of accumulated depreciation: $4,705,709
- Deferred Outflows of Resources: $8,990,392

Total Other Assets: $77,564,367

Total Assets: $197,026,342

## LIABILITIES

### Current Liabilities
- Accounts Payable and Other Current Liabilities: $6,146,736
- Claims and other service liabilities: $38,226,866
- Unearned Revenue: $6,579,694
- Current portion of accrued vacation: $1,497,168
- Other Current Liabilities: $751,954

Total Current Liabilities: $53,202,418

### Noncurrent Liabilities
- Net Pension Liability: $16,092,140
- Accrued Vacation: $1,161,094
- Deferred Inflows of Resources: $0

Total Long-Term Liabilities: $17,253,234

Total Liabilities: $70,455,653

## NET POSITION

### Capital Assets at Beginning of Year
- Restricted: $63,889,910
- Unrestricted: $42,612,255

Total Capital Assets: $106,502,165

### Net Revenue over Expenses:
- Current Year Change in Net Position: $15,221,766

Total Net Position: $126,570,689

Total Liabilities and Net Position: $197,026,342
# Summary of Savings/(Loss) by Funding Source as of September 30, 2020

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Revenue</th>
<th>Expense</th>
<th>Savings/(Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Waiver Services</td>
<td>$116,123,026</td>
<td>$103,530,581</td>
<td>$12,592,446</td>
</tr>
<tr>
<td>Medicaid Waiver Risk Reserve</td>
<td>2,622,933</td>
<td>-</td>
<td>2,622,933</td>
</tr>
<tr>
<td>Federal Grants &amp; State Funds</td>
<td>18,126,347</td>
<td>18,646,981</td>
<td>(420,635)</td>
</tr>
<tr>
<td>Local Funds</td>
<td>4,865,934</td>
<td>5,316,234</td>
<td>(450,300)</td>
</tr>
<tr>
<td>Administrative</td>
<td>17,396,948</td>
<td>16,519,646</td>
<td>877,301</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$159,135,188</strong></td>
<td><strong>$143,913,423</strong></td>
<td><strong>15,221,766</strong></td>
</tr>
</tbody>
</table>

Committed:
- Intergovernmental Transfers: $751,954
- Reinvestments-Service: $169,587
- Reinvestments-Administrative: $916,460
  - **Total Committed**: $1,838,001

Restricted:
- 4,192,485

Unrestricted:
- 12,867,282
  - **Total Fund Balance Change**: $15,221,767

---

# Fund Balance

<table>
<thead>
<tr>
<th></th>
<th>June 30, 2020</th>
<th>Change</th>
<th>September 30, 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment in Fixed Assets</td>
<td>4,846,758</td>
<td>(141,050)</td>
<td>4,705,709</td>
</tr>
<tr>
<td>Restricted - Risk Reserve</td>
<td>60,923,872</td>
<td>2,622,933</td>
<td>63,546,805</td>
</tr>
<tr>
<td>Restricted - Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Statutes</td>
<td>7,005,672</td>
<td>-</td>
<td>7,005,672</td>
</tr>
<tr>
<td>Prepaids</td>
<td>873,407</td>
<td>2,160,902</td>
<td>3,034,309</td>
</tr>
<tr>
<td>Cumberland</td>
<td>2,966,038</td>
<td>(450,300)</td>
<td>2,515,738</td>
</tr>
<tr>
<td>Restricted - Other</td>
<td>10,845,117</td>
<td>1,710,602</td>
<td>12,555,719</td>
</tr>
<tr>
<td>Committed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intergovernmental Transfer</td>
<td>3,007,817</td>
<td>(751,954)</td>
<td>2,255,863</td>
</tr>
<tr>
<td>Reinvestments-Service</td>
<td>500,000</td>
<td>(169,587)</td>
<td>330,413</td>
</tr>
<tr>
<td>Reinvestments-Administrative</td>
<td>12,192,000</td>
<td>(916,460)</td>
<td>11,275,540</td>
</tr>
<tr>
<td><strong>Total Committed</strong></td>
<td><strong>15,699,817</strong></td>
<td><strong>(1,838,001)</strong></td>
<td><strong>13,861,816</strong></td>
</tr>
<tr>
<td>Unrestricted</td>
<td>19,033,358</td>
<td>12,867,282</td>
<td>31,900,640</td>
</tr>
<tr>
<td><strong>Total Fund Balance</strong></td>
<td><strong>$111,348,023</strong></td>
<td><strong>$15,221,767</strong></td>
<td><strong>$126,570,689</strong></td>
</tr>
</tbody>
</table>
### Statement of Revenue and Expenses (Budget and Actual) - As of September 30, 2020

<table>
<thead>
<tr>
<th>REVENUES</th>
<th>Budget</th>
<th>Current Period</th>
<th>Year to Date</th>
<th>Balance</th>
<th>% Received/Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Grants</td>
<td>$38,239,101</td>
<td>$1,625,073</td>
<td>$4,865,934</td>
<td>$33,373,167</td>
<td>12.73%</td>
</tr>
<tr>
<td>State &amp; Federal Grants</td>
<td>$75,783,536</td>
<td>$6,340,596</td>
<td>$18,126,347</td>
<td>$57,657,189</td>
<td>23.92%</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>$399,202,069</td>
<td>$39,685,981</td>
<td>$118,745,960</td>
<td>$280,456,109</td>
<td>29.75%</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td><strong>$513,224,706</strong></td>
<td><strong>$47,651,650</strong></td>
<td><strong>$141,738,240</strong></td>
<td><strong>$371,486,465</strong></td>
<td><strong>27.62%</strong></td>
</tr>
<tr>
<td>Administrative</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Administration</td>
<td>$382,104</td>
<td>$32,300</td>
<td>$96,900</td>
<td>$285,204</td>
<td>25.36%</td>
</tr>
<tr>
<td>LME Administrative Grant</td>
<td>$4,359,385</td>
<td>$363,283</td>
<td>$1,089,847</td>
<td>$3,269,538</td>
<td>25.00%</td>
</tr>
<tr>
<td>Medicaid Waiver Administration</td>
<td>$54,436,646</td>
<td>$4,122,348</td>
<td>$16,196,033</td>
<td>$38,240,612</td>
<td>29.75%</td>
</tr>
<tr>
<td>Miscellaneous Revenue</td>
<td>$500,000</td>
<td>$3,734</td>
<td>$14,167</td>
<td>$485,833</td>
<td>2.83%</td>
</tr>
<tr>
<td><strong>Total Administrative Revenue</strong></td>
<td><strong>$59,678,135</strong></td>
<td><strong>$5,811,665</strong></td>
<td><strong>$17,396,948</strong></td>
<td><strong>$42,281,187</strong></td>
<td><strong>29.15%</strong></td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td><strong>$572,902,841</strong></td>
<td><strong>$53,463,315</strong></td>
<td><strong>$159,135,188</strong></td>
<td><strong>$413,767,653</strong></td>
<td><strong>27.78%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXPENSES</th>
<th>Budget</th>
<th>Current Period</th>
<th>Year to Date</th>
<th>Balance</th>
<th>% Received/Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Services</td>
<td>$38,239,101</td>
<td>$2,075,373</td>
<td>$5,316,234</td>
<td>$32,922,867</td>
<td>13.90%</td>
</tr>
<tr>
<td>State &amp; Federal Services</td>
<td>$75,783,536</td>
<td>$6,670,978</td>
<td>$18,546,961</td>
<td>$57,236,575</td>
<td>24.47%</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>$399,202,069</td>
<td>$35,382,117</td>
<td>$103,530,581</td>
<td>$295,671,488</td>
<td>25.93%</td>
</tr>
<tr>
<td><strong>Total Service Expenses</strong></td>
<td><strong>$513,224,706</strong></td>
<td><strong>$44,128,468</strong></td>
<td><strong>$127,393,776</strong></td>
<td><strong>$385,830,930</strong></td>
<td><strong>24.82%</strong></td>
</tr>
<tr>
<td>Administrative</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operational</td>
<td>$7,145,971</td>
<td>$584,761</td>
<td>$1,994,806</td>
<td>$5,151,165</td>
<td>27.92%</td>
</tr>
<tr>
<td>Salaries, Benefits, and Fringe</td>
<td>$46,037,119</td>
<td>$4,455,729</td>
<td>$12,851,316</td>
<td>$33,185,806</td>
<td>27.92%</td>
</tr>
<tr>
<td>Professional Services</td>
<td>$5,995,045</td>
<td>$933,836</td>
<td>$1,673,524</td>
<td>$4,321,521</td>
<td>27.92%</td>
</tr>
<tr>
<td>Miscellaneous Expense</td>
<td>$500,000</td>
<td>$0</td>
<td>$0</td>
<td>$500,000</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Total Administrative Expenses</strong></td>
<td><strong>$59,678,135</strong></td>
<td><strong>$5,974,326</strong></td>
<td><strong>$16,519,646</strong></td>
<td><strong>$43,158,489</strong></td>
<td><strong>27.68%</strong></td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td><strong>$572,902,841</strong></td>
<td><strong>$50,102,794</strong></td>
<td><strong>$143,913,423</strong></td>
<td><strong>$428,989,418</strong></td>
<td><strong>25.12%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHANGE IN NET POSITION</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>$3,360,521</strong></td>
<td></td>
<td></td>
<td><strong>$15,221,766</strong></td>
<td></td>
</tr>
</tbody>
</table>
Senate Bill 208 Ratios - As of September 30, 2020

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

**Percent Paid** = Percent of clean claims paid within 30 days of receiving. The requirement is 90% or greater.
**Defensive Interval** = Cash + Current Investments divided by average daily operating expenses. This ratio shows how many days the organization can continue to pay expenses if no additional cash comes in. The requirement is 30 days or greater.

**Medical Loss Ratio (MLR)** = Total Services Expenses plus Administrative Expenses that go towards directly improving health outcomes divided by Total Medicaid Revenue. The requirement is 85% or greater cumulative for the rating period (7/1/20-6/30/21).
ITEM: 2020 Telehealth Provider and Member Survey

DATE OF BOARD MEETING: November 5, 2020

BACKGROUND: Alliance conducted a survey to understand how providers and members were impacted by the service delivery system changes. The provider survey was done via SurveyMonkey and the member survey was administered via phone call to members by Alliance staff. The survey results provide assurance that members are receiving satisfactory care and that providers quickly adapted to telehealth platforms.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Wes Knepper, Senior Director of Quality Management
2020 Provider and Member Telehealth Survey Analysis
To better understand the impact of the COVID-19 pandemic on services, Alliance conducted a member survey and provider survey to identify barriers, benefits, and gaps related to telehealth services.
Provider Survey

Hosted on Surveymonkey.com

Providers were notified via email

6/17/2020 – 7/13/2020

Member Survey

Administered via phone by Alliance staff

Sample based on telehealth eligible services received between March – July

6/12/2020 – 7/29/2020
Limitations

Members without a valid phone number could not be reached for participation

Low number of responses when looking at subpopulations

Due to claims lag, there may be several weeks between the members’ service and survey
65 providers responded that they had provided services via telehealth between March – July 2020.

202 members responded that they had received telehealth services since March – July 2020.
131 members received services from a participant of the provider survey, so the two surveys were merged for those members.
Of the **member respondents** that received telehealth services, **88% rated their service good or very good.**

Survey Results

<table>
<thead>
<tr>
<th></th>
<th>Telehealth</th>
<th>In-person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neutral</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td>Poor</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td><strong>91%</strong></td>
<td><strong>91%</strong></td>
</tr>
</tbody>
</table>
Of the telehealth providers that participated in the survey:

- 78% believe their members are satisfied
- 85% new to telehealth
- 55% want more telehealth training
- 68% work from home
- 58% report improved show rates
- 80% most members had no challenges with platform
- 68% report the same or increased member engagement
- Zoom and Doxy.me were the most frequently used telehealth platforms
Enhanced services were rated as harder to provide via telehealth than in-person by more than half of providers. However, only 34% of providers rated outpatient services as harder.
The number of **members served via telehealth increased** significantly during the COVID-19 pandemic. Of members that received telehealth eligible services between March – August, **62% received at least one telehealth service**.
Although the number of members served has decreased slightly in 2020, the ability to provide services via telehealth has made a huge impact on our ability to serve our members during the COVID-19 pandemic.
**Benefits**

**Safety**
- Less contact with others

**Access**
- Transportation barriers eliminated, more flexibility, better engagement from parents, less time off work, less need for childcare

**Insight**
- Provides better insight into members’ home environment

**Connection**
- Gives members opportunities to engage with others outside of household during isolation

**Cost**
- Reduced company expenses for travel and vehicle maintenance. Reduced childcare and travel cost for members

**Barriers**

**Technology**
- Members lack access to technology, poor connections in rural areas, equipment for providers

**Diagnosis/Age**
- Disability and age makes participation and effectiveness difficult for some

**Privacy**
- Difficult for some who don’t want family to know they are receiving services

**Childcare**
- Although some benefit from less childcare, others find it difficult to engage without interruptions

**Paperwork**
- More difficult to collect copayments and paperwork
Satisfaction data was compared across demographic subgroups including race, age, county, ethnicity, disability group, language, funding, service, provider, telehealth platform, provider training, and provider experience. All subgroups with at least 40 responses were found to be proportional.
Evaluation of unrepresented populations

A limitation of the survey is that members without valid phone numbers were excluded from the sample. Claims data was reviewed to identify populations whose needs are not being met as a result of the COVID-19 pandemic.

Members served decreased in 2020

Medicaid new enrollments dropped in 2020

18% of members that received telehealth services have used phone only

5% of members who consistently received services from Dec 2019 – February 2020 have no claims after March – consistent with the previous year
<table>
<thead>
<tr>
<th>Ideas to Consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leverage stakeholder insight and dig deeper into claims data to identify populations whose needs are not being met.</td>
</tr>
<tr>
<td>Continue to assess on-going and long-term outcomes of the shift to telehealth for members and providers.</td>
</tr>
<tr>
<td>Develop strategy to support providers with transitioning to HIPAA compliant telehealth platforms.</td>
</tr>
<tr>
<td>Assess provider training needs, best practices, and training options.</td>
</tr>
</tbody>
</table>
ITEM: FY20 Workforce Demographic Presentation

DATE OF BOARD MEETING: November 5, 2020

BACKGROUND: The Equal Employment Opportunity Policy (policy number HR-1) states the following: “Annually, the Chief Executive Officer shall provide an organizational workforce report to include the distribution of employees by age, race, ethnicity and gender to the Board.”

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Cheala Garland-Downey, Executive Vice-President/Chief Human Resources Officer