MEMBERS PRESENT: ☐ Glenn Adams, Cumberland County Commissioner, JD, ☐ Cynthia Binanay, Chair, MA, BSN, ☐ Tony Braswell, Johnston County Commissioner, ☐ Heidi Carter, Durham County Commissioner, MPH, MS, ☐ George Corvin, Vice-Chair, MD, ☐ David Curro, BS, (via phone), ☐ Greg Ford, Wake County Commissioner, MA, ☐ Lodies Gloston, MA, ☐ David Hancock, MBA, MPAff, ☐ Duane Holder, MPA, (via phone), ☐ D. Lee Jackson, BA, (via phone), ☐ Donald McDonald, MSW, (via phone; exited at 4:46 pm) ☐ Lynne Nelson, BS, (entered at 4:45 pm), ☐ Gino Pazzaglini, MSW LFACHE, ☐ Pam Silberman, JD, DrPH, ☐ Lascel Webley, Jr., MBA, MHA, (via phone; exited at 5:04 pm), and ☐ McKinley Wooten, Jr., JD

GUEST(S) PRESENT: Mary Hutchings, Wake County Finance Department; and Yvonne French, NC DHHS DMH/DD/SAS (Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services)

ALLIANCE STAFF PRESENT: Michael Bollini, Executive Vice-President/Chief Operating Officer; Joey Dorsett, Senior Vice-President/Chief Information Officer; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Veronica Ingram, Executive Assistant II; Mehul Mankad, Chief Medical Officer; Jennifer Meade, Community Health and SOC 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; Erika Singleton, Administrative Assistant II; Tammy Thomas, Director of Project Portfolio Management; Sara Wilson, Director of Government Relations; Carol Wolff, General Counsel; and Doug Wright, Director of Community and Member Engagement

1. CALL TO ORDER: Chair George Corvin called the meeting to order at 4:00 p.m.

AGENDA ITEMS: DISCUSSION:

2. Announcements
   A. Board Emails: Ms. Portugal reminded Board members that effective immediately, emails will only be sent to Board members’ Alliance email addresses.
   B. Update on Property Sale: Ms. Wolff mentioned a potential change to the timeframe for the sale of the property on 3309 Durham Drive, Raleigh, as requested by the buyer. She reminded Board members that the board previously authorized the CEO to finalize this sale.
   C. Upcoming Board Orientation 2.0: Mr. Robinson reminded Board members of an upcoming orientation session on Thursday, November 14 from 2:00-4:00 pm at Alliance’s Morrisville office. Members may contact Ms. Ingram to confirm attendance.
   D. Introduction of New Staff: Mr. Robinson introduced Alliance’s new Chief Medical Officer, Dr. Mehul Mankad.

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

4. Public Comment
   There were no public comments.

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

      The committee reports were sent as part of the Board packet; Doug Wright, Director of Community and Member Engagement, presented the CFAC report. He shared about recent CFAC meetings including staff presentations and feedback from CFAC members regarding
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<td>Medicaid Transformation and pending changes due to reduced State Single Stream funding. The CFAC report is attached to and made part of these minutes.</td>
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</table>

**BOARD ACTION**

The Board received the report.

B. Finance Committee – page 47

The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Area Board. This month’s report included the draft minutes from the October 3, 2019, meeting, the Statement of Net Position, the Summary of Savings/(Loss) by Funding Source and ratios for the period ending September 30, 2019, and recommendations to the Board to approve all presented contracts over $250,000.

David Hancock, Committee Chair, presented the report. Mr. Hancock shared that all contractual ratios were met and revenues exceeded expenditures. Kelly Goodfellow, Executive Vice-President/Chief Financial Officer, presented a proposal and requested approval to submit the three-year reinvestment plan to the State; Ms. Goodfellow provided an overview of this plan. The Finance Committee report is attached to and made part of these minutes.

**BOARD ACTION**

A motion was made by Mr. Hancock to recommend approval and submission of the three-year, $21,377,494 reinvestment plan to DHB (Division of Health Benefits); motion seconded by Ms. Gloston. Motion passed unanimously.

6. Consent Agenda

A. Draft Minutes from October 3, 2019, Board Meeting – page 56
B. County Commissioners Advisory Board Report – page 61
C. Executive Committee Report – page 63
D. Human Rights Committee Report – page 66
E. Quality Management Committee Report – page 151

The consent agenda was sent as part of the 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. Pazzaglini to approve/adopt the consent agenda; motion seconded by Dr. Silberman. Motion passed.

7. Appointment Recommendation – page 155

In accordance with the By-Laws of the Board, the initial terms of some Board members were staggered. The matter before the Board is to recommend to the Durham Board of County Commissioners the appointment of Jennifer Anderson to Alliance’s Board.

**BOARD ACTION**

A motion was made by Dr. Silberman to forward Jennifer Anderson’s application to the Durham Board of County Commissioners and to request her appointment to Alliance’s Board; motion seconded by Ms. Gloston. Motion passed.
**AGENDA ITEMS:**

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<td>8. Legislative Update</td>
<td>Brian Perkins, Senior Vice-President/Strategy and Government Relations, shared about the lack of progress with finalizing the current State budget and the NC General Assembly’s (NCGA) adjournment on October 31, 2019. Sara Wilson, Government Relations Director, presented an update on Medicaid Transformation, including current progress with open enrollment for Standard Plans and implementation milestones, particularly for auto enrollment for physical health ACOs (accountable care organizations).</td>
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<tr>
<td><strong>BOARD ACTION</strong></td>
<td>The Board received the update.</td>
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<tr>
<td>9. Group Living Services Update</td>
<td>Ann Oshel, Senior Vice-President/Community Health and Well-Being, provided an update on Alliance’s residential continuum of services; this included a review in 2015 by a consultant who reviewed usage, evaluated the current services, and provided recommendations. Ms. Oshel shared about the agency’s progress to more effectively provide these services with a recovery oriented and self-determination focus. Part of the progress also included input from community stakeholders and internal, cross-departmental work groups. Ms. Oshel concluded by sharing plans and target dates for December 2019 through July 2020. Board members discussed potential challenges with this transition and planning to support people served throughout the transition; Board members also discussed housing options within Alliance’s catchment area, especially an affordable housing bond that recently passed in Durham County.</td>
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<td><strong>BOARD ACTION</strong></td>
<td>The Board received the report.</td>
</tr>
<tr>
<td>10. Chair’s Report</td>
<td>Chair Corvin reminded Board members of next month’s Board meeting, which will be at the Morrisville office and overlaps the i2i conference in Pinehurst. He encouraged Board members to participate remotely as needed.</td>
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<td>11. Closed Session</td>
<td><strong>BOARD ACTION</strong> A motion was made by Dr. Silberman to enter closed session pursuant to 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 Commissioner Carter. Motion passed. The Board returned to open session.</td>
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<td>12. Adjournment</td>
<td>All business was completed; the meeting adjourned at 6:06 p.m.</td>
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**Next Board Meeting**

*Thursday, December 05, 2019*

4:00 – 6:00 pm

Minutes approved by the Board on December 5, 2019.
ITEM: Consumer and Family Advisory Committee (CFAC) Report

DATE OF BOARD MEETING: November 7, 2019

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

REQUEST FOR BOARD ACTION: Receive draft minutes and supporting documents from the Durham October 14th, the Wake October 8th, the Johnston October 15th, the Cumberland September 26th and the October 7th Steering Committee meetings. The Cumberland Committee did not meet in November, instead hosted a showing of the “Anonymous People” at the Department of Social Services.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Dave Curro, CFAC Chair; Doug Wright, Director of Community and Member Engagement
### CFAC MEETING - REGULAR MEETING

711 Executive Place, Fayetteville, NC 28305
5:30-7:00 p.m.

**MEMBERS PRESENT:** Michael McGuire, Ellen Gibson, Dorothy Johnson, Carrie Morrisy, Jackie Blue, Jamille 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, Individual & Family Engagement Specialist, Nathania Headley.

**Dial-In Number:** (605) 472-5464

**Access Code:** 289674

1. **WELCOME AND INTRODUCTIONS:** Michael McGuire

2. **REVIEW OF THE MINUTES** – The minutes from the August 22, 2019, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; a motion was made by [Click here to enter text.] and seconded by [Click here to enter text.] to approve the minutes. Choose an item.

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<td>3. Public Comments</td>
<td>Michael and Starlett Community events and resources were provided in one document. The committee members informed everyone at the meeting about activities and events in the community.</td>
<td>Please see Star, Terrasine or Doug for any questions.</td>
<td>Ongoing</td>
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<td>4. NAMI Presentation</td>
<td>Hannah Carol presenting Crisis Intervention for Families program. Ms. Caroll spoke about being crisis ready for the individuals we are close to in our community. She explained that many times families are the first responders. Certain situations could have been avoided if parents and family were more prepared and trained on how to intervene during an emergent time or during a crisis situation. She explained that there are not many trainings like this and that NAMI wanted to make sure that our community was prepared and equipped to handle these types of things. She received input from the committee and public at the meeting. She explained that she would take the comments and suggestions back to NAMI and would let us know when the training would be available.</td>
<td>Hannah Carroll will let the committee know when the training is available.</td>
<td>Ongoing</td>
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<td>5. State Updates</td>
<td>Wes Rider- Community Engagement and Empowerment Team Updates. Wes gave updates on the items to pay attention to on the Community Engagement and Empowerment Team document. Many of the events had already passed since the Cumberland meeting happens later in the month. He asked everyone pay attention to the #CareForNC and explained what it was. Opioid Action Plan 2.0 has been released for those interested. He spoke</td>
<td>See CEET Update and emails from the State Department. Please see Star, Terrasine or Doug for any questions.</td>
<td>Ongoing</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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<td>briefly about September being Recovery Month. A newsletter is published from the department. You can get on Wes’ email to received updates. SAMHSA National Recovery Month Webpage: <a href="https://recoverymonth.gov/">https://recoverymonth.gov/</a> – There are promotional materials including PSA’s available on the SAMSHA Recovery Webpage. The State Department has been hosting webinars on Medicaid Transformation that have been well attended. However, they may have not been attended by those who need them the most. They will be covering the huge change and how to navigate the transition. There is a link that has been sent our electronically. There is a Peer Support Workshop on October 4th. Some of the committee members have gone in the past and will be there this year. Stacy Hardwood emailed before the meeting and asked to share the I2I is having a series of Medicaid Transformation websites. October 7th at 1pm and October 28th at 1pm will have webinars called Conversations on Medicaid Transformation.</td>
<td>Questions and individuals that want to go to I2I conference will be sent up to Doug.</td>
<td>October 17, 2019</td>
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<td>Starlett Davis- Pinehurst Training: Who will be going? Only one individual can go on December 4-6 and it has to be a different person from years past. The CFAC rate is $195. Michael has gone in the past and wants to pay his own way. However, he asked if Alliance could pay for his hotel stay along with the other individual going. Felisha and Ellen want to go. This will be sent to Doug to see what decision will be made.</td>
<td>Star will make sure that everyone is getting the emails from Doug about State announcements.</td>
<td>October 17, 2019</td>
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<td>Who can participate in the State to Local Call from the Cumberland from CFAC Members?</td>
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<td>Kate from the State asked for representation from Cumberland on the State to Local call. Michael inquired about being a part of the State CFAC. Wes explained the nomination forms on the website and the application process and the appointing bodies through the county commissioners, house, senate, and the secretary. The meeting is public. All the information is available on the website. The State to Local is held on the 3rd Wednesday of each month. The call is open for anyone to listen to but only the chairs and designees are only allowed to speak to be mindful of time. Any concerns, findings, and recommendations of the local CFAC’s can be sent up to the State CFAC during those meeting. It’s a good</td>
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<td>opportunity to also learn what other CFACs are doing. Those announcements should be coming from Kate and Christopher Drew. Wes urged CFAC to prepare for the call with a prepared statement. Wes offered assistance with that preparation. Star will make sure it gets out to everyone.</td>
<td>6. MCO Terrasine Gardner- DHHS Announcement- It is about the change in the Standard Plan’s implementation date. It has been moved to February 2020 for all of NC. There will no longer be phases. This was due to not having a State budget yet. The letters that the enrollment brokers have been sent out. There is a number for the enrollment broker on it. There were some questions that could not be answered. There are trainings given to the brokers as well as Alliance has been taking trainings so that we can be as beneficial as possible. Friday, we attended a training with i2i about policy change update. Medicaid Transformation, First in Family (DSS Policy Change), Rowlands Law, and Raise your Age were all discussed. It was brought up that our System of Care and CFAC were the community advocates and educators. We want CFAC to partner with the Community Collaborative to host a Community Forum. Individuals from each of the entities above and the enrollments could come and talk about the changes going on so that we can educate Cumberland County. It will most likely be at DSS. It will be like a stakeholders meeting where we invite Maximus the brokers, insurance companies like BCBS, Ameritas United Healthcare, Carolina Complete Care and Wellness to be vendors. They would set up booths like a resource fair, have them talk for a bit and have Q&amp;A.</td>
<td>CFAC and Community Collaborative will work together to hold a public forum on the Medicaid Transformation.</td>
<td>Update October 17, 2019</td>
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<td>7. Upcoming Community Events/ Community Outreach event Starlett Davis Reminder: Anonymous People Viewing room reservation update. October 17th, the Thursday has been approved. Flyer are here. Who will we be targeting? Be mindful that it is important that this information goes out to the public. We want to get it out via word of mouth as well as electronically. Starlett printed 100 flyers. More are available at the front desk. They have also been sent electronically. Starlett send it out to provider network, Community Collaborative.</td>
<td>Pass out flyers to the public for film viewing at the October meeting.</td>
<td>October 17, 2019</td>
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<td>and the Mayor’s office. I reminded them that it is the 3rd Thursday of the month and not the 4th for the next meeting.</td>
<td>Member Activity Log- Updates on activities and events the members have been a part of. Michael McGuire- Godwin Falcon Day- September 21st Junior Smith Kick Off Day: Back to School Supply Drive- Week after school started.</td>
<td>Members are to continue to participate in community events representing CFAC and report that at the meetings.</td>
<td>Ongoing</td>
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<td>8. Membership Discussion</td>
<td>Michael McGuire- Benefits of CFAC and becoming a member.</td>
<td>Continued encouragement to get the benefits of CFAC to the public.</td>
<td>Ongoing</td>
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| 9. Prep for next meeting | Michael McGuire- Discuss the next meeting agenda items. Go over expectations, reminders, etc for the next meeting. Next meeting will be 3rd Thursday, October 17th at 5:30pm at DSS. This is the film viewing. Bring a new person with you to the meetings. Please show support to other organizations that participate on the CFAC Committee. We will need 2 people to sit on a subcommittee meeting to help with the planning of the public forum. Please let Star know by Wednesday. | Invite the public to the film viewing. Bring a new person to the meetings. Send email for two people to volunteer for planning committee. | October 17, 2019
| 10. Appreciation      | Appreciation was given.                                                     | N/A                                                                       | N/A        |

**ADJOURNMENT:** 7:36pm

Respectfully Submitted by:

**Click here to enter text.** Date Approved

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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.
## CFAC MEETING - REGULAR MEETING

5200 W. Paramount Parkway, Morrisville, NC 27560
5:30 – 7:00 p.m.

**MEMBERS PRESENT:** Brenda Solomon, Pinkey Dunston, Trula Miles, Carole Johnson, Dave Curro, Jason Phipps, Jerry Dodson, Steve Hill, Ben Smith, Annette Smith

**BOARD MEMBERS PRESENT:** None

**GUEST(S):** Stacy Harvard, DHHS

**STAFF PRESENT:** Doug Wright, Director of Community and Member Engagement, Rob Robinson, CEO Alliance Health, Sean Scriber, EVP Network and Community Health, Ann Oshel, Sr VP, Community Health and Well Being, Terrasine Gardner, Member Engagement Manager, Stacy Guse, Individual and Family Engagement Specialist, Ramona Branch, Individual and Family Engagement Specialist, Noah Swabe, Individual and Family Engagement Specialist

Join Zoom Meeting
[https://zoom.us/j/443180511](https://zoom.us/j/443180511)

+16465588656, 443180511# US (New York)
Meeting ID: 443 180 511

### 1. WELCOME AND INTRODUCTIONS

### 2. REVIEW OF THE MINUTES – The minutes from the August 5, 2019, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; a motion was made by Jason Phipps and seconded by Steve Hill to approve the minutes. Motion passed.

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<td>3. Public Comment</td>
<td>N/A</td>
<td>County CFAC Subcommittee meetings will add discussion of priority groups to agenda for this month</td>
<td>N/A</td>
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<td>Individual/Family Challenges and Solutions</td>
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| 4. Non-Medicaid Health Plan | Rob Robinson CEO, Alliance Health introduced the Non-Medicaid Redesign. Sean Scriber, EVP Network and Community Health went over the impacts of the continued cuts to single stream funds. The main points of the presentation were:  
- We will implement a referral freeze on Intensive In-Home Therapy (IIT), Substance Abuse Comprehensive Outpatient Treatment (SACOT) and Dialectical Behavioral Therapy (DBT).  
- Assertive Community Treatment (ACT) and Community Support Team (CST) will be reserved for priority populations. A short-term freeze will be implemented to account for new spending limit.  
- Substance Abuse Intensive Outpatient Program (SAIOP) will be limited to one complete episode per year. | | |

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<td>5. Group Living</td>
<td>These changes will go into effect on December 1, 2019. Everyone impacted by the changes will be offered alternative support. Sean asked the group for feedback on who the priority group/population should be. This will be discussed during the monthly subcommittee meetings in each county during their monthly meeting and report back.</td>
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<td>Meeting to Group Home providers on October 28, 2019 @ Alliance Health, Morrisville 2pm.</td>
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<td>Ann Oshel, Sr VP, Community Health and Well Being went over the Repurposing Residential Care for Persons with Mental Illness. Over the past several years Alliance has made significant progress to build the recovery oriented service and support components necessary for a person to be successful in community living. Because of this progress we are now able to rebalance our state funded group living services for persons with mental illness to align with Olmstead and recovery supports.</td>
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<td>➢ This transition involves several phases. Beginning December 1, Alliance will change the state funded benefit package for all new admissions to all levels of group living for persons with mental illness (5600A facilities) to a 90 day authorization with no more than one 30 day extension.</td>
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<td>➢ Alliance will host a Community Inclusion Planning Meeting with the person and their support team to begin discharge planning and identify community based housing options and the needed support services.</td>
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<td>➢ For all persons wishing to transition, this process will be complete by June 30, 2020, at which point Alliance will no longer include state funded group living for persons with mental illness in our benefit plan.</td>
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<td>➢ Guardians and persons whose preference it is to remain in group living and we will certainly honor that choice even though Alliance will no longer be the payer source.</td>
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<td>6. LME/MCO Updates</td>
<td>N/A</td>
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<td>7. State Updates</td>
<td>N/A</td>
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<td>Subcommittees</td>
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<td>Quality Management</td>
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<td>9.</td>
<td>Announcements</td>
<td>Dave Curro asked the group to prepare a letter to the General Assembly regarding all of the budget cuts and have each CFAC member sign it. This will be discussed in individual county subcommittee meetings.</td>
<td>N/A</td>
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10. **ADJOURNMENT**: 7:05pm The next meeting will be November 4, 2019, at 5:30 p.m.

Respectfully Submitted by:

Ramona Branch, Individual and Family Engagement Specialist  
10.08.2019

[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.
**Wake Consumer and Family Advisory Committee**  
**Healing Transitions**  
1251 Goode St. Raleigh NC  5:30pm - 7:00 pm  

**APPOINTED MEMBERS PRESENT:**  
- Carole Johnson,  
- Megan Mason,  
- Karen McKinnon,  
- Connie King-Jerome,  
- Israel Pattison,  
- Annette Smith,  
- Ben Smith,  
- Wanda (Faye) Griffin,  
- Gregory Schweitzer,  
- Vicki Bass,  
- Anthony Saracena,  
- Jessica Larrison,  
- Bradley Garlik,  

**BOARD MEMBERS PRESENT:**  

**STAFF PRESENT:**  
- Doug Wright, Director Community and Member Engagement,  
- Terrasine Garner, Community Member and Engagement Manager,  
- Stacy Guse, Individual and Family Affairs Specialist.

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**Call-in 1 (919) 838-9800 Meeting ID# 3304 PW #3304**

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1. **WELCOME AND INTRODUCTIONS** – the meeting was called to order at 5:34

2. **REVIEW OF THE MINUTES** – The minutes from the September 10, 2019, meeting were reviewed; a motion was made by Megan Mason and seconded by Jessica m b to approve the minutes. Motion passed unanimously.

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<tr>
<th>AGENDA ITEMS:</th>
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</thead>
<tbody>
<tr>
<td>3. Public Comments</td>
<td>None</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>4. LME/MCO and State Updates.</td>
<td>Care Review changes rebranding to Community Inclusion Planning</td>
<td>Will continue to advise as changes are implemented.</td>
<td></td>
</tr>
</tbody>
</table>

Doug went over all of the LME/MCO and State Updates:

- Non-Medicaid Health Plan:
  - Impacts of the continued cuts to single stream funds. The main points of the presentation were:
    - We will implement a referral freeze on Intensive In-Home Therapy (IIH), Substance Abuse Comprehensive Outpatient Treatment (SACOT) and Dialectical Behavioral Therapy (DBT).
    - Assertive Community Treatment (ACT) and Community Support Team (CST) will be reserved for priority populations. A short-term freeze will be implemented to account for new spending limit.
    - Substance Abuse Intensive Outpatient Program (SAIOP) will be limited to one complete episode per year. These changes will go into effect on December 1, 2019. Everyone impacted by the changes will be offered alternative support.

Group Living:

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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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|              | - This transition involves several phases. Beginning December 1, Alliance will change the state funded benefit package for all new admissions to all levels of group living for persons with mental illness (5600A facilities) to a 90 day authorization with no more than one 30 day extension.  
  - Alliance will host a Community Inclusion Planning Meeting with the person and their support team to begin discharge planning and identify community based housing options and the needed support services.  
  - For all persons wishing to transition, this process will be complete by June 30, 2020, at which point Alliance will no longer include state funded group living for persons with mental illness in our benefit plan.  
  - Guardians and persons whose preference it is to remain in group living and we will certainly honor that choice even though Alliance will no longer be the payer source.  

Priority Populations Feedback:  
Feedback on who the priority group/population should be. This will be discussed during the December monthly subcommittee meeting and will be reported back.

Letter to General Assembly from CFAC members:  
Members were asked to email Stacy at sguse@alliancehealthplan.org with their concerns and how the State budget cuts and the impacts on the people we serve; include personal stories. | Vote: New member to be voted in next meeting: Diane Morris | Stacy to create a CFAC packet |  |
| 5. Interest on Membership/Outreach | Dave asked to continue the ongoing discussion what is important to our CFAC members. | Please contact Stacy with comments by mid-October |  |
| 6. CFAC | Dave Curro ask our member to develop a letter to the general assembly to stop Medicaid cuts and how those cuts will personally affect themselves or the individuals we serve. | Members to develop a letter to the general assembly regarding the state funding cuts. |  |
| 6. Community Forum Brainstorming | Resource far at Alliance with Wake and Durham counties working together to educate the community about the upcoming Medicaid transformations. Contact DSS, Maximus, First in Families, Juvenile Justice; etc. | Stacy and Ramona along with the System of Care Coordinators will connect to start planning a resource fair regarding | Ongoing |
| 7. Event Planning. | | | |

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on [Click or tap to enter a date].
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<tbody>
<tr>
<td>8. Suicide Training</td>
<td>Stacy</td>
<td>the Medicaid transformations. Stacy</td>
<td>None</td>
</tr>
<tr>
<td>9. Next meeting</td>
<td>October 8, 2019</td>
<td></td>
<td></td>
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10. ADJOURNMENT: the meeting adjourned at 7:03 p.m.; the next meeting will be November 12, 2019, from 5:30 p.m. to 7:00 p.m.
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the September 9, 2019, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; a motion was made by Dan Shaw and seconded by Brenda Solomon to approve the minutes. Motion passed.

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<tr>
<td>3. Public Comments</td>
<td>Tammy Shaw gave an overview of the NAMI conference that she attended last Friday. Pinkey Dunston stated that she enjoyed listening to Ann Oshel’s presentation on group home redesign. Trula Miles said that she was approved for weight loss surgery.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Interest in Membership/Outreach</td>
<td>Three (3) new members were voted into the Durham CFAC Subcommittee. Charlitta Burris Regina Mays Helen Castillo</td>
<td>Ramona will meet with them in the community individually to go over CFAC orientation and complete paperwork.</td>
<td>End of the week 10/18/2019</td>
</tr>
<tr>
<td>5. LME/MCO and State Updates</td>
<td>Doug went over all of the LME/MCO and State Updates: Non- Medicaid Health Plan: Impacts of the continued cuts to single stream funds. The main points of the presentation were: - We will implement a referral freeze on Intensive In-Home Therapy (IIH), Substance Abuse Comprehensive Outpatient Treatment (SACOT) and Dialectical Behavioral Therapy (DBT).</td>
<td>Priority Populations Feedback: To be discussed at the next Steering Committee Meeting, and the December CFAC Subcommittee meeting. Letter to General Assembly:</td>
<td>2 weeks</td>
</tr>
</tbody>
</table>
### AGENDA ITEMS:
- Assertive Community Treatment (ACT) and Community Support Team (CST) will be reserved for priority populations. A short-term freeze will be implemented to account for new spending limit.
- Substance Abuse Intensive Outpatient Program (SAIOP) will be limited to one complete episode per year. These changes will go into effect on December 1, 2019. Everyone impacted by the changes will be offered alternative support.

### DISCUSSION:

**Group Living:**
- This transition involves several phases. Beginning December 1, Alliance will change the state funded benefit package for all new admissions to all levels of group living for persons with mental illness (5600A facilities) to a 90 day authorization with no more than one 30 day extension.
- Alliance will host a Community Inclusion Planning Meeting with the person and their support team to begin discharge planning and identify community based housing options and the needed support services.
- For all persons wishing to transition, this process will be complete by June 30, 2020, at which point Alliance will no longer include state funded group living for persons with mental illness in our benefit plan.
- Guardians and persons whose preference it is to remain in group living and we will certainly honor that choice even though Alliance will no longer be the payer source.

**Priority Populations Feedback:**
Feedback on who the priority group/population should be. This will be discussed during the December monthly subcommittee meeting and will reported back.

**Letter to General Assembly from CFAC members:**
Members were asked to email Ramona with their thoughts and concerns on the State budget cuts and the impacts on the people we serve.

| 6. Community Forum Updates | Due to time we were unable to go over the updates on LifeCourse and the Innovations waiver Q&A. | Members will email their thoughts and concerns to Ramona no later than October 28, 2019 | Time Frame: |

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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<td>7. Roanna Newton</td>
<td>Roanna Newton, DHHS was in attendance and she will be the new technical support/liaison from the state to all of Alliance CFAC’s. She handed out a packet that included the CE&amp;E October update and went over the CFAC Composition &amp; Structure for BH/IDDD Tailored Plans. Roanna asked the group how they wanted CFAC to look moving into Tailored Plans. The group will discuss this during the December meeting.</td>
<td>This will be discussed further during the Steering Committee meeting and will be added as an agenda item for the December meeting.</td>
<td>N/A</td>
</tr>
<tr>
<td>8. Events</td>
<td>Upcoming Events</td>
<td></td>
<td>N/A</td>
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**ADJOURNMENT:** the next meeting will be December 9, 2019, at 5:30 p.m.

Respectfully Submitted by:

**Ramona Branch, Individual & Family Engagement Specialist**

10.15.2019

Date Approved
# CFAC MEETING - REGULAR MEETING

**Tuesday, October 15, 2019**  
521 North Brightleaf Boulevard, Smithfield, NC 27577  
5:30 – 7:00 p.m.

**MEMBERS PRESENT:** Jason Phipps, Cassandra Herbert, Bobby Dixon, Albert Dixon, Jerry Dodson, Marie Dodson, and Leanna George  
**BOARD MEMBERS PRESENT:** None  
**GUEST(S):** Roanna Newton  
**STAFF PRESENT:** Doug Wright, Director of Community and Member Engagement, Terrasine Gardner, Member Engagement Manager, Noah Swabe, Individual and Family Engagement Specialist

## 1. WELCOME AND INTRODUCTIONS

## 2. REVIEW OF THE MINUTES – The minutes from the September 17, 2019, Consumer and Family Advisory Committee (CFAC) meeting were reviewed; a motion was made by Leanna George and seconded by Jerry Dodson to approve the minutes. Motion passed.

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<tr>
<td>3. Public Comment Individual/Family Challenges and Solutions</td>
<td>Albert reports he attended CIT training and found the training to be very informative and useful. Albert felt the community and officers in attendance were receptive and engaged.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>4. Membership</td>
<td>Marie Dodson who was formally a member of the Johnston CFAC has recently retired from Alliance Health. Marie left CFAC on good terms to accept a position within Alliance, the Johnston CFAC voted Marie back onto the committee. Welcome Back Marie!</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
| 5. LME/MCO Updates | Doug discussed Non- Medicaid Health Plan changes and impacts of the continued cuts to single stream funds. The main points of the presentation were:  
  - We will implement a referral freeze on Intensive In-Home Therapy (IIH), Substance Abuse Comprehensive Outpatient Treatment (SACOT) and Dialectical Behavioral Therapy (DBT).  
  - Assertive Community Treatment (ACT) and Community Support Team (CST) will be reserved for priority populations. A short-term freeze will be implemented to account for new spending limit.  
  - Substance Abuse Intensive Outpatient Program (SAIOP) will be limited to one complete episode per year.  
  - These changes will go into effect on December 1, 2019. Everyone impacted by the changes will be offered alternative support. | Noah will meet with Albert and Bobby to discuss their points of concern for the letter. Noah will send an email out to the rest of the CFAC and compile a list with the CFAC’s concerns and comments about state funding cuts. Then send the information to the Alliance Steering Committee. | October 31, 2019 |

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME: |
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Group Living: | | | |
This transition involves several phases. Beginning December 1, Alliance will change the state funded benefit package for all new admissions to all levels of group living for persons with mental illness (5600A facilities) to a 90 day authorization with no more than one 30 day extension. | | |
Alliance will host a Community Inclusion Planning Meeting with the person and their support team to begin discharge planning and identify community based housing options and the needed support services. | | |
For all persons wishing to transition, this process will be complete by June 30, 2020, at which point Alliance will no longer include state funded group living for persons with mental illness in our benefit plan. | | |
Guards and persons whose preference it is to remain in group living and we will certainly honor that choice even though Alliance will no longer be the payer source. | | |
Doug gave the CFAC an update on the status of Care Teams and an update on implementation of Care Teams within Mental Health and Substance Use Disorder Care Coordination | | |
David Curro, Alliance CFAC Chair requested at the October Steering Committee meeting the local CFAC’s put together a list of effects these budget cuts have to the members and the community | | |
6. State Updates | Roanna Newton with the North Carolina Department of Health and Human Services introduced herself to the CFAC. Roanna gave CFAC updates on upcoming events and updated methods of contact as well. | CFAC members will consider aspects they would like to see in the new legislation and by-laws. Noah will add CFAC’s role within Tailored Plans to next month’s agenda | November 19, 2019 |
Roanna discussed the role of CFAC as the MCO’s transition into Tailored Plans. Briefing the CFAC about 122C and asked CFAC members to consider what they want to see in the new legislation and by-laws of CFAC. Roanna explained the difference between the by-laws and legislation and what each option meant. Roanna will attend the November meeting and requested we have this subject on the agenda to gather feedback from the CFAC. | | |
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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<td>7. Guardianship Event</td>
<td>At this time the Johnston CFAC feels it is best to postpone the guardianship event until early 2020. With open enrollment now open and Medicaid Transformation in full swing the CFAC feels it would be beneficial to focus their efforts on educating the community on the coming changes.</td>
<td>Noah will notify community partners that the event has been postponed until early 2020 and will also cancel the reservation at the Johnston Medical Mall.</td>
<td>October 16, 2019</td>
</tr>
<tr>
<td>8. Medicaid Transformation Forum</td>
<td>Johnston CFAC, Johnston Child Collaborative, and Alliance Health will work together to hold a community forum in Johnston County on December 7, 2019 from 10am to 1pm. Standard Plans, Maximus, DSS, I2i, and other community partners will be invited to set up a resource table about their respective organizations. Then given 5-10 minutes on the agenda to present about their organization at the community forum. Alliance will present about Medicaid Transformation and their role as a Tailored Plan. CFAC and the Collaborative will present about their respective committee and collaborative.</td>
<td>Noah will reserve the Johnston Medical Mall for December 7, 2019 and begin contacting community partners and the standard plans.</td>
<td>November 1, 2019</td>
</tr>
<tr>
<td>9. Current Events</td>
<td>CFAC members were provided with a list of upcoming events around the region.</td>
<td>If anyone is interested in attending one of the listed events, please reach out to Noah for assistance</td>
<td>Ongoing</td>
</tr>
<tr>
<td>10. Opioid Task Force “Operation Medicine Drop”</td>
<td>Cassandra, Jason, and Albert will attend the event, representing Johnston CFAC at Temple Baptist October 26, 2019 from 10 am to 2 pm.</td>
<td>Noah will gather supplies for the event and coordinate with Cassandra and Jason for delivery</td>
<td>October 26, 2019</td>
</tr>
<tr>
<td>11. Announcements</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
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</table>

12. **ADJOURNMENT:** the next meeting will be November 19, 2019, at 5:30 p.m.

Respectfully Submitted by:

Noah Swabe, Individual and Family Engagement Specialist

[Click here to enter text.]

Date Approved
Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
To: Providers and Community Stakeholders  
From: Rob Robinson, CEO  
Re: Transition of state funded group living services for persons with mental illness  

Date: September 30, 2019

Alliance Health is committed to developing a Recovery Oriented System of Care that ensures people with disabilities have the opportunity to live, work and receive services in the communities of their choosing.

Over the past several years Alliance has made significant progress to build the recovery oriented service and support components necessary for a person to be successful in community living. We have forged partnerships with landlords, housing developers and local housing authorities to create access to safe, decent and affordable housing. We have engaged three national housing consultants to help us create quality supportive housing programs and have begun to see the positive outcomes related to a person living a life of their own choosing. Alliance has consistently met the housing requirements for the Transitions to Community Living Initiative as part of the NC DOJ Olmstead Settlement Agreement. We are funding social determinants of health to remove barriers that often prohibit a person from transitioning out of institutional or other segregated settings. As part of Medicaid transformation intensive treatment services will now include a robust tenancy support requirement. Because of this progress we are now able to rebalance our state funded group living services for persons with mental illness to align with Olmstead and recovery supports.

This transition involves several phases. Beginning December 1, Alliance will change the state funded benefit package for all new admissions to all levels of group living for persons with mental illness (5600A facilities) to a 90 day authorization with no more than one 30 day extension. Simultaneously, upon admission to a Group Living High facility, Alliance will host a Community Inclusion Planning Meeting with the person and their support team to begin discharge planning and identify community based housing options and the needed support services. We have worked closely with the Community Inclusion Center at Temple University who helped develop this process and a planning tool to work in collaboration with the person and their support team.
The next phase of this transition will start in January, 2020 when Alliance begins actively planning for the transitions of persons who wish to live in lesser restrictive settings such as Supervised Living Low or permanent supportive housing. A Certified Peer Support Specialist will provide the initial in-reach to discuss the opportunities and considerations to move from their current group home. We will use functional assessments to begin the preparation for a person to manage their own affairs in an independent setting. A multi-disciplinary transition team will be working with each person and their support team to ensure a smooth transition. For all persons wishing to transition, this process will be complete by June 30, 2020, at which point Alliance will no longer include state funded group living for persons with mental illness in our benefit plan. We know there will be guardians and persons whose preference it is to remain in group living and we will certainly honor that choice even though Alliance will no longer be the payor source.

Finally, reducing our reliance on group living settings will involve building a more comprehensive recovery oriented system of care with all the ancillary supports necessary for a person to lead a fulfilling and productive life in the community. During the next several months we will be introducing an alternative service that is focused on short term, acute stabilization while also focusing on preparation for independent living. We will be increasing the competency of our providers to provide the full range of tenancy support services that are rooted in solid clinical care.

We know this is a significant change for providers, guardians, family members and especially for the people we serve. We also know that all people should be offered the choice of where they would like to live, work and have meaningful opportunities to fully participate in the community. Alliance looks forward to partnering with all our providers and stakeholders to make sure this redesign of group living services is a success. Over the next few months you will be invited to hear more about our vision and efforts as we truly build a system of care where all roads lead to supportive housing and provide the opportunities for persons to have their best lives.
Dear Member,

You may recall that we implemented our new Care Team model on July 1, 2019. Since this time, we have worked to identify areas of improvement that can help make this program more effective.

Overall, we learned of ways to make this model more patient-centered.

1. **Adding more Care Navigators.** Care Navigators write and update your plan of care and are the central point of contact for each member and their Care Team. Adding additional Care Navigators allows this team to spend more time responding to your needs.

2. **Pairing Service Integrity Consultants (SIC) with members instead of providers.** The SIC is the individual who monitors your services in your home and community. Assigning the SIC to the member will ensure that you only have one person visiting you each month or quarter from Alliance and that you have the chance to become familiar with this individual and speak with them about how your services are going.

We will be making these changes in the coming weeks and hope that they improve the support you receive from your Care Team.

You can also find an explanation of each Care Team role attached with this letter.

Please feel free to direct any questions about this change or Care Teams to careteam@alliancehealthplan.org

Sincerely,

Walter Linney, MA
Director of Operational Integrity
Alliance Health
Care Navigator

- Main point of contact for member.
- Writes and updates Individual Support Plan (ISP).
- Checks in by phone or email to see how services are going.
- Communicates updates and submits referrals to other Care Team members.

Service Integrity Consultant (SIC)

- Monitors services monthly or every three months (depending on the service). The SIC will visit with the member wherever their services are provided (home or group home, day program, or community).

Behavioral Health Consultant

- Helps coordinate a higher level of care when someone has a behavioral health concern.

Physical Health Consultant
• Works with your healthcare provider to address physical health needs.

**Community Health Worker/Benefits Consultant**

• Helps to address unmet social service needs (housing, food, utility payments, employment, community inclusion).
• Resolves benefit issues.
Your Medicaid Health Care: Understanding the Changes & Available Support
Frequently Asked Questions (FAQ)
August 2019

There is a lot of information about changes to Medicaid in North Carolina. Some people who use Medicaid will choose a health plan soon; some people will not. Everyone who is eligible to get Medicaid will still get Medicaid.

This document provides answers to some common questions. It covers the changes to Medicaid, how they affect you, and who you can contact for help.

What is happening in NC?

How is NC Medicaid changing in 2019 and 2020?

• North Carolina is changing how most people receive Medicaid services.
• Most people will get the same Medicaid services but in a new way—through health plans.
• A health plan coordinates your health care with a group of doctors, hospitals, and other providers. They will work together to provide you with health care. Almost everything will come from the same plan. This includes physical health services, behavioral health services, and medicine your doctor prescribes for you. Some health plans will provide added services like gym memberships.

Is everyone going to receive Medicaid health care through health plans?

• Most people will receive Medicaid health care through health plans. People who do not get Medicaid health care through health plans will get the same Medicaid services through “NC Medicaid Direct” and their current Local Management Entity/Managed Care Organization (LME/MCO).

What is “NC Medicaid Direct”?

• NC Medicaid Direct is one way for people to get Medicaid health care. It is the new name for the current Medicaid fee-for-service program. It is how people get physical health services and some behavioral health services today.
• NC Medicaid Direct has many of the same services that are in health plans.
• LME-MCOs will continue to provide some services for people in NC Medicaid Direct who have a mental illness, substance use disorder, I/DD, or TBI; some of these services are not available in NC Medicaid Managed Care.

How do I know if I will get Medicaid health care through a health plan or through NC Medicaid Direct?

• In June, DHHS began sending letters to many people who get Medicaid health care today. Your letter has information about you and your family. Your letter explains what the changes mean for you. If you have questions about your letter, call 1-833-870-550 (TTY: 1-833-870-5588).
When will people start getting Medicaid health care through a health plan?

- Most people will start their new health plans in November 2019 or February 2020. When you start depends on where in the State you live and what types of health care services or treatment you need.

**How do changes in Medicaid health care impact me?**

I got a letter saying that I need to choose a primary care provider and health plan by September 13, 2019. What does this mean?

- This means that you need to choose a primary care provider (PCP). Your PCP could be your family doctor, clinic, or other health care provider. Your PCP will help you with your health care needs.
- You also need to enroll in a health plan. Not all doctors work with every health plan. Choose a health plan that works with your PCP.
- If you do not choose a health plan or PCP by September 13, Medicaid will choose one for you. If you do not choose a PCP, Medicaid will try to keep you with your current PCP.
- Call 1-833-870-5500 (TTY: 1-833-870-5588) for help choosing a health plan that works with your PCP.

I got a letter saying I will stay in NC Medicaid Direct. What does this mean?

- You do **not** need to choose a health plan. You will continue to have access to all the same Medicaid services you do now.
- You will continue to get services for your I/DD, mental illness, substance use disorder, or TBI through your current LME/MCO if that is how you access those services today.

I got a letter saying that only some members of my household need to enroll in a Medicaid health plan while others will stay in NC Medicaid Direct. Why?

- Some people with certain health care needs – such as people with a serious mental illness, severe substance use disorder, I/DD, or TBI – will continue getting their Medicaid services in NC Medicaid Direct through their LME/MCOs. Others will get all their health care needs met by enrolling in a health plan.

I get both Medicaid *and* Medicare. Do I need to pick a Medicaid health plan?

- No. You do **not** need to pick a new health plan. The way you receive services isn’t going to change.

Why did my friend or neighbor get a different letter than what I got?

- Everyone got a letter specific to his or her personal situation. You and your friend may have different health care needs.
Most, but not all, people will start getting Medicaid services from a health plan. However, some people with certain health care needs will stay in NC Medicaid Direct and access certain services through their LME/MCOs.

I got a letter to enroll in a health plan, but need a service for my I/DD, TBI, serious mental illness, or severe substance use disorder. What should I do?

- You can request a review of your case.
- You or your doctor can submit this request using the Request to Stay in NC Medicaid Direct and LME/MCO form.
- You or your doctor can fill out the form. To get the form, call 1-833-870-5500 (TTY: 1-833-870-5588).

Will I still be able to see my doctor?

- Call 1-833-870-5500 (TTY: 1-833-870-5588) to learn if your doctor works with your health plan. The staff at this phone number can help you find a health plan that works with your doctor.

Will it cost more for me to get my Medicaid through a health plan?

- No. Your costs will not change if you get Medicaid through a health plan.
- Like today, you may need to pay a copay for certain services, but you will not need to pay a monthly fee (premium).

What if I did not get a letter?

- Some people who have Medicaid health care got letters in June; other people who have Medicaid health care will get letters in October. When you get your letter depends where in the State you live.
- However, some people who currently have Medicaid health care will not get a letter at all. They will continue to receive their health care services as they do today. They do not need to do anything at this time.
- For example, people who have Medicaid and Medicare, as well as some other special groups, will not receive a letter at all.
- If you have questions about whether you are getting a letter, call 1-833-870-5500 (TTY: 1-833-870-5588) for help.

Who can I contact for help?

The Enrollment Broker can:

- Help you understand your options related to the Medicaid changes;
- Explain the enrollment process and help you pick a health plan and PCP; and
- Explain why you do or do not need to enroll.
- The help is FREE.
- Contact the Enrollment Broker:
  - By phone at 1-833-870-5500
  - Online at [www.ncmedicaidplans.gov](http://www.ncmedicaidplans.gov)
Creating a Recovery Oriented System of Care: Redesigning Residential Care for Persons with Mental Illness
Starting in 2015...

- Alliance contracted with the Technical Assistance Collaborative (TAC) to assess three primary areas of the residential continuum:
  - Residential capacity in terms of quality and availability of residential housing and service options
  - How these options are accessed/utilized
  - Associated costs
- Conducted assessment between March and June 2015
  - Meetings with leadership and key internal positions
  - In-person focus groups and telephone interviews
  - Review of documents and claims data over an 18 month period (Sept 2013-March 2015)
Overview of TAC Report

- Report organized by three distinct target populations
  - Adults with mental illness and/or substance use disorders
  - Individuals with IDD
  - Children/Youth with mental illness and/or substance use disorders
- Each section of the report includes:
  - Related needs and challenges
  - Recommendations to expand community based housing and services
  - Cross cutting recommendations to enhance best practice and outcomes
- Recommendations point to an overreliance on group living settings
Common Themes Across All Groups

• Assess individual and housing needs/preferences and facilitate more informed choice of housing and service options
• Establish and reinforce service standards/expectations to encourage movement toward more independent settings
• Support the financing and effective delivery of appropriate wraparound services which promote housing stability, community integration and recovery
Common Themes Across All Groups

• Provide capacity building and training to assist providers in delivering best practice housing and service interventions
• Develop and implement outcome/performance measures to monitor provider and program performance and improve individual and system level outcomes
• Reprogram some existing funding sources and develop relationships with the affordable housing system to create more desirable housing options
Since 2015...

• Administer four Permanent Supportive Housing (PSH) Programs
• Invested almost $4.5 million dollars in affordable housing creating 57 set aside units
• Continually meet and exceed the TCLI housing goals
• Developed a Bridge Housing Program in Wake Co
Since 2015...

- Partnered with three large housing authorities to access specialized permanent vouchers for people with disabilities
- Created a successful Landlord Leasing Incentive Program
- Contracted with two national housing consultants: Enterprise and Corporation for Supportive Housing
- Contracted with Community Inclusion Center at Temple University
Since 2015...

• Assumed Subsidy Administration role with TCL vouchers
  – Inspections of units
  – Housing Assistance Payments (HAP) agreements

• Continue to expend over $700,000 annually in financial assistance to address eviction prevention and rapid re-housing
  – Conduct landlord verification and debarments
And Now...

- Current focus on persons with primary mental illness residing in group living settings
- Goal is to implement a comprehensive Recovery Oriented System of Care built on:
  - Housing choice and access to safe and affordable housing
  - Wraparound services and supports that promote community inclusion and quality of life
  - Creating and funding alternative models to long term congregate living
  - Building provider competency for tenancy supports that are integrated with treatment interventions
Getting There from Here...

• Built micro-strategy report based on paid claims that show:
  – Level of residential care
  – Primary diagnosis
  – Length of stay
  – Service utilization and type
  – Accumulated cost by level of care and individual

• Conducted further analysis of key clinical data
  – Number of crisis days within past year
  – Crisis episodes by level of care
  – Crisis episodes by age
  – Crisis episodes by length of stay
Getting There from Here...

• Developed cross departmental workgroup
  – Meets every 2 weeks
  – Thorough clinical review of current state funded group living census for persons with mental illness
  – Develop policy and best practice recommendations
  – Develop procedures for housing choice and community living
• Developed in-reach process for current residents
• Developed Community Inclusion Planning Team for persons expressing a desire to transition to community living
• Developing model to repurpose select group living settings into acute transitional program
Getting There from Here...

- As of Dec. 1 new benefit plan for Group Living High  
  – 90 day authorization with no more than 30 day extension
- As of Jan. 1 all 5600A facilities must be located in the catchment area or within 30 miles
- As of Jan. 1 begin in-reach process (notification to guardians prior to in-reach)
- Starting in January begin active transition planning for those desiring to move
- July 1 Alliance will cease to be the payer of state funded group living for persons with mental illness
Why This Change and Why Now?

• Over the last several years have developed supportive housing expertise and partnerships
• Have permanent housing inventory and vouchers in our high needs counties
• Honoring the intention of the Olmstead Act of 1999
• Redirecting funds to bolster and build other parts of the ROSC
  – Supportive Living
  – Subsidies for longer term financial assistance
• New Care Management model that can support the intensity of community transitions
• Able to incorporate new thinking and emerging best practices
  – Community Inclusion
Focusing on Community Inclusion and Recovery

• What is Community Inclusion?
  – “The opportunity to live in the community and to be valued for one’s uniqueness and abilities like everyone else.” (Salzer, 2006)
  – Fully integrated and contributing member of the community
  – Unpaid supports, social connections, recreational pursuits, gainful employment, etc...
Focusing on Community Inclusion and Recovery

• What Community Inclusion is not...
  – Clustering people with severe mental illness into one home, classroom, workplace, or social center
  – Giving "special privileges" to people with severe mental illness
  – Feeling sorry for people with severe mental illness
The Importance of Community Inclusion

• Why Community Inclusion is so important
  – “Research findings clarifying that people with mental illnesses ‘would, should, and could’ participate in the mainstream of their community’s life” (Baron, 2018)
  – Members are more likely to stay engaged in all aspects of life: housing, treatment, employment, social networks, etc.
The Importance of Community Inclusion

– Community Inclusion is a necessary component of the recovery model
– Enriches overall quality of life: mentally, physically, spiritually, etc.
– Strengthens and enriches the whole community
– Community Inclusion is a human right, not a privilege
**ITEM:** Finance Committee Report

**DATE OF BOARD MEETING:** November 7, 2019

**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 p.m. prior to the regular Board Meeting. This month’s report includes the draft minutes from the October 3, 2019, meeting, the Statement of Net Position, the Summary of Savings/(Loss) by Funding Source and ratios for the period ending September 30, 2019 and recommendations to the Board to approve all presented contracts over $250,000.

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

**CEO RECOMMENDATION:** Accept the report.

**RESOURCE PERSON(S):** David Hancock, Committee Chair; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer
Finance Committee Meeting
Thursday, November 7, 2019
2:30-4:00 pm

AGENDA

1. Review of the Minutes – October 3, 2019

2. Monthly Financial Reports as of September 30, 2019
   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. Approval of Contract(s)

4. Quarterly Updates
   a. Solvency Standards
   b. PMPM
   c. Non-Medicaid Plan

5. Reinvestment Plan

6. Adjournment

Next Meeting: Thursday, December 5, 2019 from 2:30-4:00
Alliance Health
5200 W. Paramount Parkway Suite 200
Morrisville, NC 27560
**BOAND FINANCE COMMITTEE - REGULAR MEETING**
Thursday, October 03, 2019
5200 W. Paramount Parkway, Morrisville, NC 27560
3:00-4:00 p.m.

**APPOINTED MEMBERS PRESENT:** □Cynthia Binanay, MA □David Hancock, MBA, MPA (Committee Chair), □Gino Pazzaglmini, MSW, □Lascel Webley, MBA, MHA

**BOARD MEMBERS PRESENT:** George Corvin

**GUEST(S) PRESENT:** Mary Hutchings, Wake County Internal Audit, Denise Foreman, Wake County

**STAFF PRESENT:** Rob Robinson, CEO, Sara Pacholke, Senior Vice-President/Financial Operations (BS, CPA)

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

2. **REVIEW OF THE MINUTES** – The minutes from the September 5, 2019, meeting were reviewed; a motion was made by Mr. Pazzaglmini and seconded by Mr. Corvin 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>
</table>
| 3. Monthly Financial Report | 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, 2019. Ms. Pacholke discussed the monthly reports.  
  - As of 8/31/19, we have savings of $3.3M.  
  - Net position (fund balance) is $91.2M with $33.3M unrestricted  
  - We are meeting all SB208 and DMA contract ratios. | | |
| 4. 6/30/19 Net Position, Committed Funds, and FY20 Reinvestment Plan | Ms. Pacholke provided an update of the year end close.  
  - FY19 has been finalized. For the year we have a loss of $24.9M unless there are proposed audit adjustments. $25.2M was used from fund balance, which was previously committed by the Board, to cover legislative reductions, intergovernmental transfers, and reinvestments.  
  - The recommendation for committed funds is:  
    - $7,342,029 for legislative reductions, $3,007,817 for intergovernmental transfers, and $6,785,013 for reinvestments.  
  - The reinvestment plan consists of $1,200,000 for crisis renovations, $132,000 for NC Start, $500,000 for general services, and $4,953,013 for tailored plan implementation.  
  A motion was made by Mr. Corvin and seconded by Mr. Pazzaglmini to recommend to the Board to approve the one year reinvestment plan of $6,785,013 and commit $17,134,859 as of 6/30/19 which includes $7342,029 for legislative reductions (one year), $3,007,817 for the required intergovernmental transfer (one year), and $6,785,013 for reinvestment (one year). The motion passed unanimously. | | |
| 5. Policy Review | Ms. Pacholke brought the "Delegation of Authority to CEO Policy G-10 for review and approval of recommended changes." | Ms. Pacholke will make the recommended | |

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.](#)
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
</table>
| 6. Approval of Contracts | The following motions were made related to contract approvals.  
- A motion to authorize the CEO to enter into a contract with Cumberland Disaster Recovery Coalition in an amount not to exceed $1,051,170 to provide Crisis Counseling Assistance and Training Program (CCP) to assist individuals in the Cumberland community recovering from Hurricane Florence.  
- A motion to authorize the CEO to enter into a contract with Health Management Associates in an amount not to exceed $400,000 to provide consultation on overall managed care operations.  
A motion was made by Mr. Pazzaglini and seconded by Mr. Corvin to recommend to the Board to approval all contracts. The motion passed unanimously. | change and provide to the Policy Committee Staff | 10/3/19 Meeting |

7. **ADJOURNMENT:** the meeting adjourned at 3:40 pm; the next meeting will be November 7, 2019, from 3:00 p.m. to 4:00 p.m.
## Statement of Net Position - As of September 30, 2019

### ASSETS

#### Current Assets
- Cash and cash equivalents: $11,863,779
- Short term investments: $40,571,450
- Due from other governments: $19,628,797
- Accounts receivable, net of allowance for uncollectible accounts: $805,204
- Sales tax refund receivable: $239,507
- Prepaid expenses: $2,403,997

#### Total Current Assets
- $75,512,734

#### Noncurrent Assets
- Restricted Cash: $53,823,937
- Other assets: $406,495
- Capital assets, net of accumulated depreciation: $4,818,395
- Deferred Outflows of Resources: $9,931,398

#### Total Other Assets
- $68,980,226

#### Total Assets
- $144,492,960

### LIABILITIES

#### Current Liabilities
- Accounts Payable and Other Current Liabilities: $4,825,857
- Claims and other service liabilities: $33,466,561
- Unearned Revenue: $1,798,795
- Current portion of accrued vacation: $1,421,865
- Other Current Liabilities: $1,050,955

#### Total Current Liabilities
- $42,564,032

#### Noncurrent Liabilities
- Net Pension Liability: $12,490,813
- Accrued Vacation: $655,135
- Deferred Inflows of Resources: $63,361

#### Total Long-Term Liabilities
- $13,209,309

#### Total Liabilities
- $55,773,342

### NET POSITION

#### Capital Assets at Beginning of Year
- $4,946,365

#### Restricted
- $51,602,006

#### Unrestricted
- $31,425,688

#### Net Revenue over Expenses:

#### Current Year Change in Net Position
- $745,559

#### Total Net Position
- $88,719,618

#### Total Liabilities and Net Position
- $144,492,960
### Summary of Savings/(Loss) by Funding Source as of September 30, 2019

<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>$96,244,010</td>
<td>$93,707,952</td>
<td>$2,536,058</td>
</tr>
<tr>
<td>Medicaid Waiver Risk Reserve</td>
<td>$2,221,931</td>
<td>-</td>
<td>$2,221,931</td>
</tr>
<tr>
<td>Federal Grants &amp; State Funds</td>
<td>$12,144,715</td>
<td>$14,863,369</td>
<td>$(2,718,653)</td>
</tr>
<tr>
<td>Local Funds</td>
<td>$7,448,570</td>
<td>$7,378,726</td>
<td>$69,845</td>
</tr>
<tr>
<td>Administrative</td>
<td>$14,850,860</td>
<td>$16,214,481</td>
<td>$(1,363,621)</td>
</tr>
<tr>
<td>Total</td>
<td>$132,910,087</td>
<td>$132,164,527</td>
<td>$745,559</td>
</tr>
</tbody>
</table>

Committed:
- Legislative Reductions $(2,718,653)
- Intergovernmental Transfers $(751,954)
- Reinvestments-Service -
- Reinvestments-Administrative $(48,693)
Total Committed $(3,519,300)

Unrestricted: $4,264,859
Total Amount to be Appropriated - Fund Balance $745,559

### Fund Balance as of September 30, 2019

<table>
<thead>
<tr>
<th>Fund Balance</th>
<th>June 30, 2019</th>
<th>Change</th>
<th>September 30, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment in Fixed Assets</td>
<td>$4,946,365</td>
<td>$(127,970)</td>
<td>$4,818,395</td>
</tr>
<tr>
<td>Restricted - Risk Reserve</td>
<td>$51,602,006</td>
<td>$2,221,931</td>
<td>$53,823,937</td>
</tr>
<tr>
<td>Restricted - Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Statutes</td>
<td>$5,217,343</td>
<td>-</td>
<td>$5,217,343</td>
</tr>
<tr>
<td>Prepaid</td>
<td>$858,436</td>
<td>$1,545,561</td>
<td>$2,403,997</td>
</tr>
<tr>
<td>Restricted - Other</td>
<td>$6,075,779</td>
<td>$1,545,561</td>
<td>$7,621,340</td>
</tr>
<tr>
<td>Committed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legislative Reductions</td>
<td>$7,342,029</td>
<td>$(2,718,653)</td>
<td>$4,623,376</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>$1,832,000</td>
<td>-</td>
<td>$1,832,000</td>
</tr>
<tr>
<td>Reinvestments-Administrative</td>
<td>$4,953,013</td>
<td>$(48,693)</td>
<td>$4,904,321</td>
</tr>
<tr>
<td>Total Committed</td>
<td>$17,134,859</td>
<td>$(3,519,300)</td>
<td>$13,615,559</td>
</tr>
<tr>
<td>Unrestricted</td>
<td>$8,215,050</td>
<td>$625,336</td>
<td>$8,840,386</td>
</tr>
<tr>
<td>Total Fund Balance</td>
<td>$87,974,059</td>
<td>$745,559</td>
<td>$88,719,618</td>
</tr>
</tbody>
</table>
### Statement of Revenue and Expenses (Budget and Actual) - As of September 30, 2019

<table>
<thead>
<tr>
<th></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><strong>REVENUES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Grants</td>
<td>$38,787,140</td>
<td>$2,249,997</td>
<td>$7,448,570</td>
<td>$31,338,570</td>
<td>19.20%</td>
</tr>
<tr>
<td>State &amp; Federal Grants</td>
<td>$53,383,119</td>
<td>$3,950,167</td>
<td>$12,144,715</td>
<td>$41,238,404</td>
<td>22.75%</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>$385,741,463</td>
<td>$31,452,336</td>
<td>$98,465,941</td>
<td>$287,275,522</td>
<td>25.53%</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>$477,911,722</td>
<td>$37,652,501</td>
<td>$118,059,227</td>
<td>$359,852,495</td>
<td>24.70%</td>
</tr>
<tr>
<td><strong>Administrative</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Administration</td>
<td>$387,584</td>
<td>$32,375</td>
<td>$96,975</td>
<td>$290,609</td>
<td>25.02%</td>
</tr>
<tr>
<td>LME Administrative Grant</td>
<td>$4,359,385</td>
<td>$363,283</td>
<td>$1,089,849</td>
<td>$3,269,536</td>
<td>25.00%</td>
</tr>
<tr>
<td>Medicaid Waiver Administration</td>
<td>$52,601,109</td>
<td>$4,287,665</td>
<td>$13,421,208</td>
<td>$39,179,900</td>
<td>25.52%</td>
</tr>
<tr>
<td>Miscellaneous Revenue</td>
<td>$500,000</td>
<td>$70,542</td>
<td>$242,828</td>
<td>$257,172</td>
<td>48.57%</td>
</tr>
<tr>
<td><strong>Total Administrative Revenue</strong></td>
<td>$57,848,078</td>
<td>$4,753,865</td>
<td>$14,850,860</td>
<td>$42,997,218</td>
<td>25.67%</td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td>$535,759,800</td>
<td>$42,406,366</td>
<td>$132,910,087</td>
<td>$402,849,713</td>
<td>24.81%</td>
</tr>
<tr>
<td><strong>EXPENSES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Services</td>
<td>$38,787,140</td>
<td>$2,226,716</td>
<td>$7,378,726</td>
<td>$31,408,414</td>
<td>19.02%</td>
</tr>
<tr>
<td>State &amp; Federal Services</td>
<td>$53,383,119</td>
<td>$6,235,146</td>
<td>$14,863,369</td>
<td>$38,519,750</td>
<td>27.84%</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>$385,741,463</td>
<td>$31,338,927</td>
<td>$93,707,952</td>
<td>$292,033,511</td>
<td>24.29%</td>
</tr>
<tr>
<td><strong>Total Service Expenses</strong></td>
<td>$477,911,722</td>
<td>$39,800,789</td>
<td>$115,950,046</td>
<td>$361,961,676</td>
<td>24.26%</td>
</tr>
<tr>
<td><strong>Administrative</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operational</td>
<td>$9,335,253</td>
<td>$828,583</td>
<td>$2,480,396</td>
<td>$6,854,857</td>
<td>26.57%</td>
</tr>
<tr>
<td>Salaries, Benefits, and Fringe</td>
<td>$43,819,039</td>
<td>$3,983,470</td>
<td>$12,388,230</td>
<td>$31,432,809</td>
<td>28.27%</td>
</tr>
<tr>
<td>Professional Services</td>
<td>$4,193,786</td>
<td>$347,103</td>
<td>$1,347,855</td>
<td>$2,845,931</td>
<td>32.14%</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>$57,848,078</td>
<td>$5,159,156</td>
<td>$16,214,481</td>
<td>$41,633,596</td>
<td>28.03%</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>$535,759,800</td>
<td>$44,959,946</td>
<td>$132,164,527</td>
<td>$403,595,273</td>
<td>24.67%</td>
</tr>
<tr>
<td><strong>CHANGE IN NET POSITION</strong></td>
<td>($2,553,580)</td>
<td>$745,559</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**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 (7/1/19-6/30/20).
ITEM: Draft Minutes from the October 3, 2019, Board Meeting

DATE OF BOARD MEETING: November 7, 2019

REQUEST FOR BOARD ACTION: Approve the draft minutes from the October 3, 2019, Board meeting.

CEO RECOMMENDATION: Approve the minutes.

RESOURCE PERSON(S): Robert Robinson, CEO; Veronica Ingram, Executive Assistant II
AREA BOARD REGULAR MEETING
5200 W. Paramount Parkway, Morrisville, NC 27560
4:00-6:00 p.m.

MEMBERS PRESENT: Glenn Adams, Cumberland County Commissioner, JD, Cynthia Binanay, Chair, MA, BSN, Tony Braswell, Johnston County Commissioner, Heidi Carter, Durham County Commissioner, MPH, MS, George Corvin, Vice-Chair, MD, David Curro, BS, Greg Ford, Wake County Commissioner, MA (via phone; exited at 5:41 pm), Lodies Gloston, MA (entered at 4:20 pm), David Hancock, MBA, MPAff, Duane Holder, MPA (via phone), D. Lee Jackson, BA (via phone), Donald McDonald, MSW, Lynne Nelson, BS, Gino Pazzaglini, MSW, LFACHE, Pam Silberman, JD, DrPH (exited at 5:42 pm), Lascel Webley, Jr., MBA, MHA, McKinley Wooten, Jr., JD, (vacant), (vacant), and (vacant)

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

ALLIANCE STAFF PRESENT: Brandon Alexander, Communications and Marketing Specialist II; Damali Alston, Director of Network Evaluation; Michael Bollini, Executive Vice-President/Chief Operating Officer; Joey Dorsett, Senior Vice-President/Chief Information Officer; Veronica Ingram, Executive Assistant II; 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; Erika Singleton, Administrative Assistant II; Tammy Thomas, Director of Project Portfolio Management; Carol Wolff, General Counsel; and Doug Wright, Director of Community and Member Engagement.

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

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Announcements</td>
<td></td>
</tr>
<tr>
<td>A. 12i Conference: Mr. Robinson reminded Board members of the upcoming December conference. Alliance will register interested Board members. Board members may contact Ms. Ingram for assistance registering for this conference or submitting reimbursement for lodging and mileage.</td>
<td></td>
</tr>
<tr>
<td>B. Email Changes and Application Installation: Ms. Portugal shared about pending changes to the process for sending emails to Board members. Effective October 4, 2019, emails will only be sent to Board members’ email addresses. She also shared about the opportunity presented today to install an application for Board members to review encrypted emails on their personal devices, which still complies with HIPAA requirements for confidentiality.</td>
<td></td>
</tr>
<tr>
<td>C. Board Orientation 1.0: Mr. Robinson reminded Board members of the upcoming orientation session on Tuesday, October 21 from 2:00-4:00 pm. Board members may RSVP with Ms. Ingram.</td>
<td></td>
</tr>
<tr>
<td>3. Agenda Adjustments</td>
<td></td>
</tr>
<tr>
<td>There were no adjustments to the agenda.</td>
<td></td>
</tr>
<tr>
<td>4. Public Comment</td>
<td></td>
</tr>
<tr>
<td>There were no public comments.</td>
<td></td>
</tr>
<tr>
<td>5. Committee Reports</td>
<td></td>
</tr>
<tr>
<td>A. Consumer and Family Advisory Committee – page 3</td>
<td></td>
</tr>
<tr>
<td>The Alliance Consumer and Family Advisory Committee (CFAC) is composed of consumers and/or family members from Durham, Wake, Cumberland or Johnston Counties who receive mental health, intellectual/developmental disabilities or substance use/addiction services. This month’s report included draft minutes and supporting documents from the Durham, Wake, and Johnston meetings.</td>
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</tr>
<tr>
<td>David Curro, CFAC Chair, presented the report. Mr. Curro shared about recent CFAC meetings including members discussing FAQs (frequently asked questions) from Medicaid Transformation and the revised timeframe of February 1, 2020, as a go-live date for Standard Plans. He also discussed staff attendance at recent CFAC meetings where staff answered questions, presented information</td>
<td></td>
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</tbody>
</table>
**AGENDA ITEMS:**

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>on bullying, or addressed concerns about housing. Mr. Curro reminded the Board of upcoming CFAC events. The CFAC report is attached to and made part of these minutes.</td>
<td></td>
</tr>
</tbody>
</table>

**BOARD ACTION**

The Board received the report.

B. Finance Committee – page 46

The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Area Board. This month’s report included draft minutes from the September 5, 2019, meeting, the Summary of Savings/(Loss) by Funding Source and ratios for the period ending August 31, 2019, and recommendations to the Board to approve all presented contracts over $250,000.

David Hancock, Committee Chair, presented the report. Mr. Hancock stated that revenues exceeded expenditures and all mandated ratios were met. The Finance Committee report is attached to and made part of these minutes.

Ms. Pacholke shared the Finance Committee’s recommendations for a one-year reinvestment plan, which includes $7,342,029 for legislative reductions (one year); $3,007,817 for the required intergovernmental transfer (one year); and $6,785,013 for reinvestment (one year). Mr. Hancock reviewed the Finance Committee’s recommendation to approve two contracts. The Finance Committee report is attached to and made part of these minutes.

**BOARD ACTION**

A motion was made by Mr. Wooten to approve a one-year reinvestment plan of $6,785,013 and to commit and commit $17,134,859 as of June 30, 2019, as detailed by staff; motion seconded by Mr. Hancock. Motion passed unanimously.

A motion was made by Ms. Nelson to authorize the CEO to enter into a contract with Cumberland Disaster Recovery Coalition in an amount not to exceed $1,051,170 to provide Crisis Counseling Assistance and Training Program (CCP) to assist individuals in the Cumberland community recovering from Hurricane Florence and to authorize the CEO to enter into a contract with Health Management Associates in an amount not to exceed $400,000 to provide consultation on overall managed care operations; motion seconded by Vice-Chair Pazzaglini. Motion passed unanimously.

6. Consent Agenda

A. Draft Minutes from September 5, 2019, Board Meeting – page 54
B. Audit and Compliance Committee Report – page 58
C. County Commissioners Advisory Board Report – page 60
D. Executive Committee Report – page 62
E. Network Development and Services Committee Report – page 65
F. Quality Management Committee Report – page 67

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.
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BOARD ACTION</strong></td>
<td>A motion was made by Mr. Webley to adopt the consent agenda; motion seconded by Dr. Silberman. Motion passed unanimously.</td>
</tr>
<tr>
<td><strong>7. Sale of 3309 Durham Drive, Raleigh</strong> – page 75</td>
<td>Carol Wolff, General Counsel, provided an overview of an offer and Purchase Agreement. Due to the timing of the offer and agreement, the matter was presented and approved by the Executive Committee of the Board and is recommended for ratification and authorization by the full Board.</td>
</tr>
<tr>
<td><strong>BOARD ACTION</strong></td>
<td>A motion was made by Vice-Chair Pazzaglini to approve and ratify the CEO’s execution of the Purchase Agreement for the sale of 3309 Durham Drive in Raleigh as set forth in the purchase agreement and to authorize the CEO to take the necessary legal actions to close the sale; motion seconded by Ms. Nelson. Motion passed unanimously.</td>
</tr>
<tr>
<td><strong>8. Appointment Recommendation</strong> – page 76</td>
<td>In accordance with the By-Laws of the Board, the initial terms of some Board members were staggered. Angela Diaz met with the Executive Committee on September 16, 2019, to discuss her interest in a Board vacancy. The matter before the Board is to recommend to the Wake Board of County Commissioners the appointment of Angela Diaz, whose initial term would expire March 31, 2020.</td>
</tr>
<tr>
<td><strong>BOARD ACTION</strong></td>
<td>A motion was made by Mr. Wooten to forward Angela Diaz’s application to the Wake Board of County Commissioners and to request her appointment to Alliance’s Board; motion seconded by Ms. Nelson. Motion passed unanimously.</td>
</tr>
<tr>
<td><strong>9. Training/Presentation(s): #Care for NC – page 77</strong></td>
<td>Brian Perkins, Senior Vice-President/Strategy and Government Relations, provided an update for the Board on the #CareForNC campaign, which advocates for a stronger North Carolina through effective supports for people living with mental health issues, substance use disorders and intellectual/developmental disabilities. The campaign is a partnership that includes NC LME/MCOs and two large provider groups.</td>
</tr>
<tr>
<td></td>
<td>Mr. Perkins reviewed messaging provided through this media campaign. Brandon Alexander, Communications and Marketing Specialist II, demonstrated aspects of the website (<a href="http://www.careforc.org">www.careforc.org</a> and <a href="http://www.careforc.org/toolkit">www.careforc.org/toolkit</a>) with Board members; he highlighted the videos and stories about the people served by NC LME/MCOs. Mr. Perkins encouraged Board members to view the website and share it on their social media accounts.</td>
</tr>
<tr>
<td></td>
<td>Board members, Donald McDonald and Lynne Nelson, shared personal accounts. Mr. McDonald shared about his opportunity to speak with NC legislators (at a recent House Health Committee meeting) about the importance of continued funding for the services Alliance provides; this was also the same day legislators were considering Medicaid expansion. Ms. Nelson shared about her experience with a loved one and the need for access to services and additional services for the population Alliance serves, specifically for individuals who are uninsured or underinsured who have less access to care than persons with Medicaid.</td>
</tr>
<tr>
<td></td>
<td>Board members discussed potential next steps for this campaign, including utilizing CFAC to share this campaign, sharing how the reduction in funding will impact current services and how the current budget stalemate is postponing the expansion of services.</td>
</tr>
<tr>
<td><strong>BOARD ACTION</strong></td>
<td>The Board received the training/presentation.</td>
</tr>
</tbody>
</table>
**AGENDA ITEMS:**

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Legislative Update</td>
<td>Brian Perkins, Senior Vice-President/Strategy and Government Relations, presented the legislative update. He shared that the NC House overrode the Governor’s veto, which is now before the Senate. Mr. Perkins reminded Board members of how the current State budget standoff has delayed the Standard Plan go-live date to February 1, 2020. He also reviewed the current timeframe for Standard Plan implementation and discussion about Medicaid expansion.</td>
</tr>
<tr>
<td>11. Chair’s Report</td>
<td>The Board received the update.</td>
</tr>
<tr>
<td>12. Closed Session(s)</td>
<td><strong>BOARD ACTION</strong> A motion was made by Mr. Curro to enter closed session pursuant to North Carolina General Statute (NCGS) 143-318.11 (a) (1) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1; motion seconded by Vice-Chair Corvin. Motion passed unanimously. The Board returned to open session.</td>
</tr>
<tr>
<td>13. Adjournment</td>
<td>All business was completed; the meeting adjourned at 5:53 p.m.</td>
</tr>
</tbody>
</table>

**Next Board Meeting**

Thursday, November 07, 2019
4:00 – 6:00 pm

Minutes approved by Board on [Click or tap to enter a date].
ITEM: County Commissioner’s Advisory Board Report

DATE OF BOARD MEETING: November 7, 2019

BACKGROUND: As stated in Alliance’s by-laws, the County Commissioner Advisory Board’s duties include serving as the chief advisory board to the area authority and to the director of the area authority on matters pertaining to the delivery of services for individuals with mental illness, intellectual or other developmental disabilities and substance abuse disorders in the catchment area. The draft minutes from the October 4, 2019 meeting are attached.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Robert Robinson, CEO
COUNTY COMMISSIONERS ADVISORY BOARD - SPECIAL MEETING  
5200 W. Paramount Parkway, Morrisville, NC 27560  
9:00 - 10:00 a.m.

APPOINTED MEMBERS PRESENT: ☒ Glenn Adams, JD (Cumberland County Commissioner)-via phone, ☐ Tony Braswell (Johnston County Commissioner), ☒ Heidi Carter, MPH, MS (Durham County Commissioner)-via phone, and ☒ Greg Ford, MA (Wake County Commissioner)-via phone

BOARD MEMBER(S) PRESENT: None
GUEST(S) PRESENT: None
STAFF PRESENT: Brian Perkins, Senior Vice-President/Strategy and Government Relations; Robert Robinson, CEO; Erika Singleton, Administrative Assistant II; Sara Wilson, Government Relations Director; and Carol Wolff, General Counsel

1. WELCOME AND INTRODUCTIONS – the meeting was called to order at 9:02 am

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Child Crisis Facility Update</td>
<td>Mr. Robinson provided an update on the progress of the child crisis facility. Phase I of the renovation is underway, Phase II is on hold due to funding limitations. At the request of Commissioner Adams the CCAC discussed next steps and the interest of the Counties to fund the remaining start-up costs. Mr. Robinson reviewed a potential partnership with the General Assembly, as well as funding updates for the crisis facility. Prior to this meeting, a funding proposal was submitted to the commissioners for review. The commissioners discussed the proposal and agreed to share it with their colleagues on their respective boards.</td>
<td>The Commissioners will share the funding proposal and discuss with their respective boards.</td>
<td>2 weeks</td>
</tr>
</tbody>
</table>

3. ADJOURNMENT: the meeting adjourned at 9:25am; the next meeting will be October 18, 2019, from 9:00 a.m. to 10:00 a.m.
ITEM: Executive Committee Report

DATE OF BOARD MEETING: November 7, 2019

BACKGROUND: The Executive Committee sets the agenda for Board meetings and acts in lieu of the Board between meetings. Actions by the Executive Committee are reported to the full Board at the next scheduled meeting. Attached are the draft minutes from the October 21, 2019, meeting.

REQUEST FOR BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Dr. George Corvin, Board Chair; Robert Robinson, CEO
BOARD EXECUTIVE COMMITTEE - REGULAR MEETING
5200 W. Paramount Parkway, Morrisville, NC 27560
3:00-4:00 p.m.

APPOINTED MEMBERS PRESENT: □Cynthia Binanay, MA (Previous Board Chair); □George Corvin, MD (Board Chair); □Lodies Glaston, MA (Policy Committee Chair) via phone; □David Hancock, MBA, PFAff (Finance Committee Chair); □Donald McDonald, MSW (Network Development and Services Committee Chair) via phone; □Lynne Nelson, BS (Human Rights Committee Chair) via phone, □Gino Pazzaglini, MSW LFACHE (Board Vice-Chair), □Pam Silberman, JD, DrPH (Quality Management Committee Chair) via phone; and □Lascel Webley, Jr., MBA, MHA (Audit and Compliance Committee Chair) via phone

APPOINTED, NON-VOTING BOARD MEMBERS PRESENT: None

BOARD MEMBERS PRESENT: None

GUEST(S): None

STAFF PRESENT: Robert Robinson, CEO; Erika Singleton, Administrative Assistant II; and Carol Wolff, General Counsel

1. WELCOME AND INTRODUCTIONS – the meeting was called to order at 4:01 pm

2. REVIEW OF THE MINUTES – The minutes from the September 16, 2019, meeting were reviewed; a motion was made by Vice-Chair Pazzaglini and seconded by Mr. Hancock to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
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<th>NEXT STEPS</th>
<th>TIME FRAME</th>
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</thead>
</table>
| 3. Updates   | Legislative Update:  
Mr. Robinson provided a legislative update. The State announced that if there is not a State budget by November 15, 2019 there is the likely hood they will have an extended delay for go-live for the Standard Plans.  
Medicaid Transformation:  
Mr. Robinson discussed the status of Medicaid Transformation. A contract is in place with HMA. Contractors are onsite to work in partnership with Alliance to evaluate and determine how they can provide assistance. | None specified. | N/A |
| 4. Budget Retreat | Mr. Robinson provided a tentative for the budget retreat as March 17, 2020. Board members did not object to this date. | Veronica Ingram, Executive Assistant, will add this meeting to the draft calendar of 2020 Board meetings. The calendar will be presented to the Board for approval in December. | December 2019 |
| 5. Applicant Interviews | a) The Executive Committee interviewed an applicant for a Cumberland county seat. The committee has expressed their concerns regarding possible conflict of interest.  
b) The Executive Committee interviewed an applicant for the vacant Durham county seat. | a) Applicant was referred back to staff for a conflict of interest analysis.  
b) None specified. | N/A |

COMMITTEE ACTION:

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date; minutes approved on Click or tap to enter a date.
BOARD EXECUTIVE COMMITTEE - REGULAR MEETING  
5200 W. Paramount Parkway, Morrisville, NC 27560  
3:00-4:00 p.m.  

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<thead>
<tr>
<th>AGENDA ITEMS:</th>
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<th>TIME FRAME:</th>
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<tbody>
<tr>
<td>6. Agenda for November Board Meeting</td>
<td>Committee reviewed the draft agenda and provided input. The Committee also discussed adding board email addresses to the agenda.</td>
<td>Ms. Ingram will forward the agenda to staff.</td>
<td>10/22/2019</td>
</tr>
</tbody>
</table>
| 7. Closed Session | COMMITTEE ACTION:  
A motion was by Mr. Hancock to enter closed session pursuant to North Carolina General Statute (NCGS) 143-318.11 (a) (1) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1. Motion seconded by Vice-Chair Pazzaglini. Motion passed unanimously.  
Committee returned to open session. | None specified. | N/A |

8. ADJOURNMENT: the meeting adjourned at 5:57 pm; the next meeting will be November 18, 2019, from 4:00 p.m. to 6:00 p.m.
ITEM: Human Rights Committee Report

DATE OF BOARD MEETING: November 7, 2019

BACKGROUND: The Human Rights Committee shall include consumers and family members representing mental health, developmental disabilities and substance abuse.

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.

The Human Rights Committee shall meet at least quarterly.

The Human Rights Committee is required by statute and by your by-laws. The Committee meets at least quarterly and reports to you by presenting the minutes of the meetings as well as through Quality Management Reports reviewing grievances and incidents.

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. Draft minutes for the October 10, 2019, meeting are attached.

REQUEST FOR BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Lynne Nelson, Committee Chair; Doug Wright, Director of Community and Member Engagement
APPOINTED MEMBERS PRESENT: □Ladies Gloston, MA, Board member, □Sally Hunter, □Donald McDonald, MSW, Board member, □Dr. Michael Teague, □Patricia Wells, □Ira Wolfe, □McKinley Wooten, Jr., JD, Board member, □Lynne Nelson (Committee Chair)

APPOINTED, NON-VOTING MEMBERS PRESENT:

BOARD MEMBERS PRESENT:

GUEST(S) PRESENT:

STAFF PRESENT: Doug Wright, Director of Community and Member Engagement, Ramona Branch, Individual and Family Engagement Specialist, Wes Knepper, Director of Quality Management

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES - The minutes from the July 11, 2019, meeting were reviewed; a motion was made by Dr. Michael Teague and seconded by Patricia Wells to approve the minutes. Motion passed unanimously.

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<tr>
<th>AGENDA ITEMS:</th>
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<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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<tbody>
<tr>
<td>3. Grievance Review</td>
<td>Wes filled in for Todd Parker who is on vacation. Wes reviewed the Grievance report for the 4th quarter. Clarification was given over the difference between abuse, neglect, and exploitation. Questions were fielded around different services, what are enhanced services and the different kind of residential services. A request was made to bring a 4 quarter rolling trend on the number of grievances received. Another request was made for some sort of reporting of when QM sends a letter to providers because they have seen a trend that was concerning. The committee understands the importance of respecting confidentiality rights of members and providers and are more interested in the types of concerns coming in versus the specific providers. It was noted how the grievance staff would refer cases to the Special Investigative Unit and a request was made to have SIU present to the committee next quarter. Reviewed that grievances reported have gone down and are in line with other LME/MCOs by not including internal concerns.</td>
<td>Present at the next meeting a rolling 4 quarter trend on the number of grievances received. Discuss trends that were of concern to QM enough to contact providers for resolution. Schedule SIU to present at the next meeting.</td>
<td>January 9, 2020</td>
</tr>
<tr>
<td>4. Incident Review</td>
<td>Wes reviewed the 4th quarter Incident Trends Report with the committee. Adult and children were compared as well as types of incidents. Special attention was given to Restrictive Interventions, Injuries, Abuse/Neglect/Exploitation, and deaths. The committee ask for a rolling 4 quarter comparison for total numbers.</td>
<td>Present at the next meeting a rolling 4 quarter trend of incidents.</td>
<td>January 9, 2020</td>
</tr>
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</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
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<tr>
<th>AGENDA ITEMS:</th>
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<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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<tbody>
<tr>
<td>5. Annual Human Rights Training</td>
<td>Doug delivered the annual Human Rights training to all members present. Each member received a copy of the training as well as the statutes and rules relevant to human rights at the LME/MCO level and at the provider level.</td>
<td>Use the information to perform duties and support members, ask questions if they arrive and receive the training annually.</td>
<td>October 2020</td>
</tr>
<tr>
<td>6. Future agenda items</td>
<td>Special Investigative Unit, possibly something about the changing demographics of our population.</td>
<td>Schedule SIU for next quarter.</td>
<td>January 9, 2020</td>
</tr>
</tbody>
</table>

7. **ADJOURNMENT:** next meeting will be January 9, 2020 from 4:00 p.m. to 5:30 p.m.

Respectfully Submitted by:

Doug Wright

Click here to enter text: Date Approved

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

- 711 Reports were entered in to NC-IRIS for 487 members
- 457 reports involved children, 254 involved adults

**LEVELS**

- 628 Level 2 reports
- 83 Level 3
Wake County submitted the largest number of Level 2 (344) and Level 3 (45) reports in the 4th quarter of FY19.
A total of 462 Incidents were reported for children: (433 L2 and 29 L3)
A total of 249 Incidents were reported for Adults: (195 L2 and 54 L3)
This chart represents the 10 services represented in Q4 reports.

- PRTF service category remains the highest reporting service; 18% of all reports.
REPORTS BY INCIDENT CATEGORY
(Human Rights Related)
• 96% of Restrictive interventions in Q4 were Physical Restraints
Restrictive Intervention Breakdown

- 61% from PRTF Programs
- 31% from Day Treatment Programs
- Higher numbers/percentages in Child and Adolescent programs
- 65 Total - All Member Injury reports were Level II Incidents
- 62 – L2; 3 – L3
- Unknown injuries reported/discovered after the fact
- 99 reported in this category
- Substantiated: **8 Staff Abuse, 1 Sexual Abuse by Staff**
- Staff and Caregiver Abuse were the most commonly reported in the category
  (51% of reports in this category)
• A total of 35 deaths were reported during the 4th quarter
• 54% of reports due to Unknown Causes
  • Could be downgraded to L2 when the OCME report is received
  • OMT (Opioid Maintenance Therapy) are included in Unknown Death reports
Incident Report Compliance
Incident Report Compliance Process
(Implemented during the 2nd Quarter FY2019)

• 14 Late Incident Report emails were sent out in Q4
  • 27 sent during Q3

• No Plans of Corrections (POC) were issued for late reports in Q4

• 2 POCs were closed from FY19 during Q4
Late Incident Report Submission

- Late submissions in the 4 quarter decreased by 6 percentage points in Q4. (Q3: 17%)
Q4 Complaint Analysis
QM Quality Assurance
Overview

Q4 FY19 yielded 206 entries

- 91 (44%) Grievances – Members/legal guardians
- 83 (40%) Internal Employee Concerns – Alliance staff
- 32 (16%) External Stakeholder Concerns – Outside entities
<table>
<thead>
<tr>
<th>Reporting Category</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td><strong>Abuse, Neglect and Exploitation</strong></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>
Nature of Issue/Type
(Top 4)

- Quality of Services: 78
- Administrative Issues: 25
- Authorization/ Payment/ Billing: 24
- Access to Services: 23
Source: Who submitted concerns?

![Bar chart showing sources of concerns]

- MCO Staff: 82
- Member: 53
- Guardian: 38
- Provider: 10
- Parent: 7
- Other: 6
- Anonymous: 5
- Family Member: 5
# Complaints Against Alliance

## 13 Complaints Against Alliance

<table>
<thead>
<tr>
<th>Nature of Issue</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 LME/MCO Functions</td>
<td>Complaints related to Care Coordination (staff), housing, changes in care</td>
</tr>
<tr>
<td></td>
<td>management, and Innovations wait list</td>
</tr>
<tr>
<td>5 Authorization/Payment/Billing</td>
<td>Complaints related to denials for services, improper billing of members,</td>
</tr>
<tr>
<td></td>
<td>guardian’s concerns for budget letter reductions</td>
</tr>
</tbody>
</table>
Service Breakdown

(Top 3 Services)

- 17% from Residential Services
- 11% Outpatient Service
- 10% from ACTT Services
  - All others represented 9% or less or were non-service related
Service Breakdown

(IDD Services)

- 8% - NC Innovations Waiver Services
- 3% - IDD Care Coordination
- 1% - Developmental Therapies
Service Breakdown

MH/SUD Services

- 39% - Enhanced Services
- 19% - Basic Services
- 11% - Crisis Services
- 1% - SUD Services
- <1% - MH/SUD Care Coordination
Human Rights Complaints

- Abuse/Neglect/Exploitation: 20
- Client Rights: 6
- Basic Needs: 3
- Confidentiality/HIPAA: 1
HR Grievances - Service Breakdown

Abuse/Neglect/Exploitation

- Substance Abuse Comprehensive Outpatient Tx: 1
- Residential Services (Including Innovations): 1
- Peer Support Services: 1
- Outpatient Services: 1
- Innovations Services (Non-Residential): 1
- Child & Adolescent Day Treatment: 1
- IDD Care Coordination: 1
- Assertive Community Treatment (STR): 2
- Other: 2
- Intensive In-Home: 2
- Crisis - 3-Way Beds: 2
- Access/Screening, Triage and Referral (STR): 2
- Unknown: 3
# HR Grievances - Service Breakdown

| Assertive Community Treatment Team (ACTT) | 1 |
| Clinical Intake | 1 |
## HR Grievances - Service Breakdown

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Services (Including Innovations)</td>
<td>2</td>
</tr>
<tr>
<td>Psychiatric Services</td>
<td>1</td>
</tr>
<tr>
<td>Intermediate Care Facility (ICF)</td>
<td>1</td>
</tr>
<tr>
<td>Innovation Services (Non-Residential)</td>
<td>1</td>
</tr>
<tr>
<td>Nature of Issue</td>
<td>Description</td>
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<td>-------------------------</td>
<td>-----------------------------------------------------------------------------</td>
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</tbody>
</table>
| Abuse/Neglect/Exploitation | 16 – Potential licensing rule violations  
3 – Sexual Assault/Inappropriate Sexual Behavior  
8 – Abuse in Residential Facility  
2 – Improper supervision  
6 – Perceived medication errors | 16 – Referred to Division of Health Services Regulations (DHSR)  
8 – Worked with provider for solution/Corrective action  
4 – Information/Technical Assistance to provider. |
| Client Rights           | 3 – Members felt rights were violated during IVC  
2 – Not satisfied with Group Home services  
1 – Former employee reporting perceived Client Rights violations | 1 - Referred to DHSR  
2 – Worked with provider for resolution  
3 – Information/Technical Assistance to provider |
| Basic Needs             | All three related to basic needs in residential settings.                   | 2 – Referred to DHSR  
1 – Worked with provider for resolution |
| Confidentiality/HIPAA   | Wrong demographic information on member’s plan that was sent to another MCO | Assisted staff with filing completing Breach incident report and risk assessment |
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
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.
Required Training

New Member Training

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

All members are trained annually on human rights issues
NC Statutes & Administrative Rules

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

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

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

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

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

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

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

Find out if your provider has the needed specialized training

Evidence Best Practices help to justify request for services

Request written information on what your grievances/appeal rights are
Documentation and Notes:

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

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

Available free on the internet at:
http://www.dhhs.state.nc.us/mhddasas/manuals

Printed version available for a fee of $ 3.00
Make check out to Division of Mental Health and send to:
DMH Communications & Training Section
3022 Mail Service Center
Raleigh, NC 27699-3022

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

The NC Department of Health and Human Services does not discriminate on
the basis of race, color, national origin, sex, religion, age or disability in
employment or provision of services.
SUBCHAPTER 27C – PROCEDURES AND GENERAL INFORMATION

SECTION .0100 – GENERAL POLICIES AND PROCEDURES

10A NCAC 27C .0101 SCOPE

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

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

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

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

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

10A NCAC 27C .0102 DEFINITIONS

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

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

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

2. "Anti-psychotic medication" means the category of psychotropic drugs which is used to treat schizophrenia and related disorders. Examples of neuroleptic medications are Chlorpromazine, 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) "Governing body" means, in the case of a corporation, the board of directors; in the case of an area authority, the area board; and in all other cases, the owner of the facility.

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

(13) "Intervention Advisory Committee" means a group established by the governing body in a facility that utilizes restrictive interventions as specified in Rule .0104 of Subchapter 27E.

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

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

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

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

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

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

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

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

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

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


10A NCAC 27D.0102 SUSPENSION AND EXPULSION POLICY
(a) Each client shall be free from threat or fear of unwarranted suspension or expulsion from the facility.
(b) The governing body shall develop and implement policy for suspension or expelling a client from a service. The policy shall address the criteria to be used for an suspension, expulsion or other discharge not mutually agreed upon and shall establish documentation requirements that include:

(1) the specific time and conditions for resuming services following suspension;

(2) efforts by staff of the facility to identify an alternative service to meet the client's needs and designation of such service; and

(3) the discharge plan, if any.

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

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

(1) scope of search;

(2) reason for search;

(3) procedures followed in the search;

(4) a description of any property seized; and

(5) an account of the disposition of seized property.

History Note: Authority G.S. 122C-51; 143B-147; Eff February 1, 1991; Amended Eff. January 1, 1992.
10A NCAC 27D .0104 PERIODIC INTERNAL REVIEW
(a) The governing body shall assure the conduct, no less than every three years, of a compliance review in each of its facilities regarding the implementation of Client Rights Rules as specified in 10A NCAC 27C, 27D, 27E and 27F.
(b) The review shall assure that:
   (1) there is compliance with applicable provisions of the federal law governing advocacy services to the mentally ill, as specified in the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (Public Law 99-319) and amended by Public Law 100-509 (1988); and
   (2) there is compliance with applicable provisions of the federal laws governing advocacy services to the developmentally disabled, the Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. 6000 et. seq.
(c) The governing body shall maintain the three most recent written reports of the findings of such reviews.

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

SECTION .0200 -INFORMING CLIENTS AND STAFF OF RIGHTS
10A NCAC 27D .0201 INFORMING CLIENTS
(a) A written summary of client rights as specified in G.S. 122C, Article 3 shall be made available to each client and legally responsible person.
(b) Each client shall be informed of his right to contact the Governor's Advocacy Council for Persons with Disabilities (GACPD), the statewide agency designated under federal and State law to protect and advocate the rights of persons with disabilities.
(c) Each client shall be informed regarding the issues specified in Paragraph (d) and, if applicable in Paragraph (e), of this Rule, upon admission or entry into a service, or
   (1) in a facility where a day/night or periodic service is provided, within three visits; or
   (2) in a 24-hour facility, within 72 hours. Explanation shall be in a manner consistent with the client's or legally responsible person's level of comprehension.
(d) In each facility, the information provided to the client or legally responsible person shall include;
   (1) the rules that the client is expected to follow and possible penalties for violations of the rules;
   (2) the client's protections regarding disclosure of confidential information, as delineated in G.S. 122C-52 through G.S. 122C-56;
   (3) the procedure for obtaining a copy of the client's treatment/habilitation plan; and
   (4) governing body policy regarding:
      (A) fee assessment and collection practices for treatment/habilitation services;
      (B) grievance procedures including the individual to contact and a description of the assistance the client will be provided;
      (C) suspension and expulsion from service; and
      (D) search and seizure.
(e) In addition, for the client whose treatment/habilitation is likely to include the use of restrictive interventions, or for the client in a 24-hour facility whose rights as specified in G.S. 122C-62 (b) or (d) may be restricted, the client or legally responsible person shall also be informed:
   (1) of the purposes, goals and reinforcement structure of any behavior management system that is allowed;
   (2) of potential restrictions or the potential use of restrictive interventions;
   (3) of notification provisions regarding emergency use of restrictive intervention procedures;
   (4) that the legally responsible person of a minor or incompetent adult client may request notification after any occurrence of the use of restrictive intervention;
   (5) that the competent adult client may designate an individual to receive notification, in accordance with G.S. 122C-53(a), after any occurrence of the use of restrictive intervention; and
   (6) of notification provisions regarding the restriction of client rights as specified in G.S. 122C-62(e).
(f) There shall be documentation in the client record that client rights have been explained.

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

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

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;

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;

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

History Note: Authority G.S. 122C-51; 122C-57; 143B-147;
Eff. February 1, 1991;
Amended Eff. January 4, 1993; January 1, 1992;
Temporary Amendment Eff. January 1, 2001;
Amended Eff. August 1, 2002.
10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION
(a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66.
(b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter.
(c) Goods or services shall not be sold to or purchased from a client except through established governing body policy.
(d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.
(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.

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

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

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


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;
T10A 27E .0100

(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;
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;

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

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

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

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

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

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

(A) those to be notified as soon as possible but within 24 hours of the next working day, to include:

(i) the treatment or habilitation team, or its designee, after each use of the intervention; and

(ii) a designee of the governing body; and

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

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

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

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

(C) documentation of the following shall be maintained on a log:

(i) name of the client;

(ii) name of the responsible professional;

(iii) date of each intervention;

(iv) time of each intervention;

(v) type of intervention;

(vi) duration of each intervention;

(vii) reason for use of the intervention;

(viii) positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used;
(ix) debriefing and planning conducted with the client, legally responsible person, if applicable, and staff, as specified in Parts (e)(9)(F) and (G) of this Rule, to eliminate or reduce the probability of the future use of restrictive interventions; and

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

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

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

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

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

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

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

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

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

(A) description and frequency of debriefing with the client, legally responsible person, if applicable, and staff if determined to be clinically necessary. Debriefing shall be conducted as to the level of cognitive functioning of the client;

(B) bi-monthly evaluation of the planned by the responsible professional who approved the planned intervention; and

(C) review, at least monthly, by the treatment/habilitation team that approved the planned intervention.

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

10A NCAC 27E .0105 PROTECTIVE DEVICES

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

(1) the necessity for the protective device has been assessed and the device is applied by a facility employee who has been trained and has demonstrated competence in the utilization of protective devices;

(2) the use of positive and less restrictive alternatives have been reviewed and documented and the protective device selected is the appropriate measure;

(3) the client is frequently observed and provided opportunities for toileting, exercise, etc. as needed. When a protective device limits the client's freedom of movement, the client shall be observed at least every hour. Whenever the client is restrained and subject to injury by another client, a facility employee shall remain present with the client continuously. Observations and interventions shall be documented in the client record;

(4) protective devices are cleaned at regular intervals; and

(5) for facilities operated by or under contract with an area program, the utilization of protective devices in the treatment/habilitation plan shall be subject to review by the Client Rights Committee, as required in 10A NCAC 27G .0504. Copies of this Rule and other pertinent rules are published as Division publication RULES FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES, APSM 30-1, and may be purchased at a cost of five dollars and seventy-five cents ($5.75) per copy.

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

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

10A NCAC 27E .0106 INTERVENTION ADVISORY COMMITTEES

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

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

(1) for a facility operated by an area program, the Intervention Advisory Committee shall be the Client Rights Committee or a subcommittee of it, which may include other members;

(2) for a facility that is not operated by an area program, but for which a voluntary client rights or human rights committee has been appointed by the governing body, the Intervention Advisory Committee shall be that committee or a subcommittee of it, which may include other members; or

(3) for a facility that does not meet the conditions of Subparagraph (b)(1) or (2), the committee shall include at least three citizens who are not employees of, or members of the governing body.
(c) The Intervention Advisory Committee specified in Subparagraphs (b)(2) or (3) shall have a member or a regular independent consultant who is a professional with training and expertise in the use of the type of interventions being utilized, and who is not directly involved in the treatment or habilitation of the client.

(d) The Intervention Advisory Committee shall:

1. have policy that governs its operation and requirements that:
   (A) access to client information shall be given only when necessary for committee members to perform their duties;
   (B) committee members shall have access to client records on a need to know basis only upon the written consent of the client or his legally responsible person as specified in G.S. 122C-53(a); and
   (C) information in the client record shall be treated as confidential information in accordance with G.S. 122C-52 through 122C-56;
2. receive specific training and orientation as to the charge of the committee;
3. be provided with copies of appropriate statutes and rules governing client rights and related issues;
4. be provided, when available, with copies of literature about the use of a proposed intervention and any alternatives;
5. maintain minutes of each meeting; and
6. make an annual written report to the governing body on the activities of the committee.

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

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

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

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

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

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

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

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

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

1. knowledge and understanding of the people being served;
2. recognizing and interpreting human behavior;
3. recognizing the effect of internal and external stressors that may affect people with disabilities;
4. strategies for building positive relationships with persons with disabilities;
5. recognizing cultural, environmental and organizational factors that may affect people with disabilities;
6. recognizing the importance of and assisting in the person's involvement in making decisions about their life;
7. skills in assessing individual risk for escalating behavior;
8. communication strategies for defusing and de-escalating potentially dangerous behavior; and
9. positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).

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

1. Documentation shall include:
   (A) who participated in the training and the outcomes (pass/fail);
   (B) when and where they attended; and
   (C) instructor's name;
2. The Division of MH/DD/SAS may review/request this documentation at any time.

(i) Instructor Qualifications and Training Requirements:

1. Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.
2. Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.

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

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

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

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

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

(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.
   (1) Documentation shall include:
      (A) who participated in the training and the outcomes (pass/fail);
      (B) when and where attended; and
      (C) instructor's name.
   (2) The Division of MH/DD/SAS may request and review this documentation any time.

(k) Qualifications of Coaches:
   (1) Coaches shall meet all preparation requirements as a trainer.
   (2) Coaches shall teach at least three times the course which is being coached.
   (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.

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

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

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

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

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

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

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

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

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

(g) Acceptable training programs shall include, but are not limited to, presentation of:
   (1) refresher information on alternatives to the use of restrictive interventions;
   (2) guidelines on when to intervene (understanding imminent danger to self and others);
   (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);
   (4) strategies for the safe implementation of restrictive interventions;
   (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;
   (6) prohibited procedures;
   (7) debriefing strategies, including their importance and purpose; and
   (8) documentation methods/procedures.
(h) Service providers shall maintain documentation of initial and refresher training for at least three years.

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

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

(i) Instructor Qualification and Training Requirements:

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

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

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

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

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

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

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

   (8) Trainers shall be currently trained in CPR.

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

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

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

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

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

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

(l) Qualifications of Coaches:

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

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

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

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

History Note: Authority G.S. 143B-147; Temporary Adoption Eff. February 1, 2001; Temporary Adoption Expired October 13, 2001; Eff. April 1, 2003.
SECTION .0200 - PROTECTIONS REGARDING MEDICATIONS

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

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

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) to 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.
SUBCHAPTER 26B – CONFIDENTIALITY RULES

SECTION .0100 – GENERAL RULES

10A NCAC 26B .0101 PURPOSE AND SCOPE
(a) The purpose of the rules in this Subchapter is to set forth requirements for those who collect, store and disseminate information on individuals who are served by facilities, AS DEFINED IN G.S. 122C-3. The rules shall be used in conjunction with the confidentiality requirements specified in G.S. 122C-51 through 122C-56. Area and State facilities shall comply with all Rules in this Subchapter; however, facilities, as defined in G.S. 122C-3, except Area and State facilities, shall comply only with Rules .0103(7) and .0111 of this Subchapter.

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

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

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, audiobooks, client records, reimbursement records, verbal information relative to clients served, client information stored in automated files, and clinical staff member client files.
4. "Delegated Employee" means anyone designated by the facility head to carry out the responsibilities established by the rules in this Subchapter.
5. "Disclosure of Information" means the dissemination of confidential information without consent.
6. "Division" means Division of Mental Health, Developmental Disabilities and Substance Abuse Services.
7. "Legitimate role in the therapeutic services offered" means next of kin or other family member who, in the judgment of the responsible professional as defined in G.S. 122C-3, and after considering the opinion of the client, currently provides, or within the past 12 months preceding the current hospitalization, provided substantial time or resources in the care of the client.
8. "Minor Client" means a person under 18 years of age who has not been married or who has not been emancipated by a decree issued by a court of competent jurisdiction or is not a member of the armed forces.
9. "Parent" means the biological or adoptive mother or father of a minor. Whenever "parents" are legally separated or divorced or have never been married, the "parent" legally responsible for the minor shall be the "parent" granted custody or either parent when joint custody has been granted.
10. "Person Standing in Loco Parentis" means one who has put himself in the place of a lawful parent by assuming the rights and obligations of a parent without formal adoption.
11. "Release of Information" means the dissemination of confidential information with consent.
12. "Signature" means signing by affixing one's own signature; or by making one's mark; or impressing some other sign or symbol on the paper by which the signature may be identified.

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

10A NCAC 26B .0104 LIABILITY OF PERSONS WITH ACCESS TO INFORMATION
(a) Individuals employed in area and state facilities and employees governed by the State Personnel Act, G.S. Chapter 126, are subject to suspension, dismissal or disciplinary action for failure to comply with the rules in this Subchapter.
(b) Individuals, other than employees but including students and volunteers, who are agents of the Department of Health and Human Services who have access to confidential information in an area or state facility who fail to comply with the rules in this Subchapter shall be denied access to confidential information by the facility.

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

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; or

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

History Note: Authority G.S. 122C-52; 122C-54; 122C-224.3; 122C-268; 122C-286; 131E-67; 143B-147(a)(6);
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; 122C-55; 131E-67; 143B-147;

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; 122C-55; 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
10A NCAC 26B.0201 CONSENT FOR RELEASE

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

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

10A NCAC 26B.0202 CONSENT FOR RELEASE FORM

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

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

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

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

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

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

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

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

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

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

1. a competent adult client;
2. the client's legally responsible person;
3. a minor client under the following conditions:
   (a) pursuant to G.S. 90-21.5 when seeking services for 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
(4) personal representative of a deceased client if the estate is being settled or next of kin of a deceased client if the estate is not being settled.

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

10A NCAC 26B .0204 VERIFICATION OF AUTHORIZATION IN CASES OF DOUBT
Whenever the validity of an authorization is in question, an area or state facility employee shall contact the client or the client's legally responsible person to confirm that the consent is valid. Such determination of validity of the consent shall be documented in the client record.

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

10A NCAC 26B .0205 INFORMED CONSENT
Prior to obtaining a consent for release of confidential information, a delegated employee shall inform the client or his legally responsible person that the provision of services is not contingent upon such consent and of the need for such release. The client or legally responsible person shall give consent voluntarily.

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

10A NCAC 26B .0206 PERSONS DESIGNATED TO RELEASE CONFIDENTIAL INFORMATION
The area or state facility director shall be responsible for the release of confidential information but may delegate the authority for release to other persons under his supervision. The delegation shall be in writing.

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

10A NCAC 26B .0207 DOCUMENTATION OF RELEASE
Whenever confidential information is released with consent, a delegated employee shall ensure that the release is placed in the client record.

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

10A NCAC 26B .0208 PROHIBITION AGAINST REDISCLOSURE
(a) Area or state facilities releasing confidential information shall inform the recipient that redisclosure of such information is prohibited without client consent.
(b) A stamp may be used to fulfill this requirement.

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

10A NCAC 26B .0209 RELEASE TO HUMAN RIGHTS COMMITTEE MEMBERS
(a) Human Rights Committee members may have access to confidential information only upon written consent of the client or the client's legally responsible person.
(b) A delegated employee shall release confidential information upon written consent to Human Rights Committee members only when such members are engaged in fulfilling their function as set forth in 10A NCAC 28A .0207, and when involved in or being consulted in connection with the training or treatment of the client.

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

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

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

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

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

SECTION .0300 – DISCLOSURE OF CONFIDENTIAL INFORMATION WITHOUT CONSENT

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

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

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

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

10A NCAC 26B .0303 DOCUMENTATION OF DISCLOSURE

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

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

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

DATE OF BOARD MEETING: November 7, 2019

BACKGROUND: The Global QMC is the standing committee that is granted authority for Quality Management by the MCO. The Global QMC reports to the MCO Board of Directors which derives from General Statute 122C-117. The Quality Management Committee serves as the Board’s monitoring and evaluation committee charged with the review of statistical data and provider monitoring reports. The goal of the committee is to ensure quality and effectiveness of services and to identify and address opportunities to improve LME/MCO operations and local service system with input from consumers, providers, family members, and other stakeholders.

The Alliance Board of Directors’ Chairperson appoints the committee consisting of five voting members 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 and materials 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, Director of Quality Management
### 1. WELCOME AND INTRODUCTIONS – the meeting was called to order at 2:01 pm

### 2. REVIEW OF THE MINUTES – The minutes from the September 5, 2019, meeting were reviewed. A motion was made by George Corwin and seconded by Dave Curro to approve the minutes. The motion passed unanimously.

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<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
<th>NEXT STEPS</th>
<th>TIME FRAME</th>
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<td><strong>3. OLD BUSINESS</strong></td>
<td><strong>Quality Work Plan Review</strong> – Wes did a check in on the quality work plan watch measures (we set targets). Three are contract performance super measures (targets are 40%). Three are HEDIS measures that were identified as targets for us trying to move towards measuring physical health, which relates to our current work as well as getting ready for the Tailored Plan. These are watch measures. There are no penalties assigned to these. The targets for these were selected based on the most recent Medicaid national average. Quality Improvement Project Updates – Wes reviewed the Alliance QIP summary. Access to Care is continuing to trend up over the last couple of quarters. Routine callers measure continues to struggle, but urgent callers measure is getting better and better. Routine callers measure gets plagued with dropping denominators. Wes thinks this will change with the Tailored Plan. MHSUD care coordination clinical contacts haven’t had another measurement period since then. The same with the utilization management expedited care QIP. The provider profiles have been updated. Have been reaching out to providers that are not keeping current profiles. Working with IT to fix some things. Call Center timeliness – response in one business day. There were a lot more calls coming in than we anticipated. There was a misunderstanding of what the requirements were. We thought every call had to be responded to in 24 hours, but they do not. We are now focusing on health information calls. Performance Dashboard – DMH is uninsured, DHB is Medicaid.</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.
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<th>AGENDA ITEMS:</th>
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<td>1-30 days watch measures benchmarks are not set. We have not yet had any intervention measures with the HEDIS measures. We've brought together QM, Medical Management and Provider Networks documents and formed a workgroup to identify how we can intervene on this. Biggest gap between the benchmark and us is the diabetes screening for adults that are prescribed anti-psychotics.</td>
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<td><strong>4. NEW BUSINESS</strong></td>
<td><strong>Performance Standards Dashboard</strong> – This document has been reviewed by the CQI committee. It has more updated data than the 7-day performance sheet. <strong>Overview of UM – April</strong> The UM plan for this past year had many of our initiatives that we were doing throughout the organization. EQR likes our model. The UM plan evaluation looked at how we did on those initiatives. Some of those looked at are repetitive from years past. We are in the process of writing UM plan for 2020. We are looking at what our TP population will look like. We are not yet talking about how we are going to do UM for physical health side. That will be on the agenda for our consultants and will be doing that soon. Evidence based models for at risk youth not enough funding for all of the models. Over/under utilization-360 look at service utilization. We look at targeted service lines. Looking at reports for key cost drivers like in-patient length of stay, and building that into our dashboard. We would monitor the effectiveness of our interventions. Look at what contributing factors are of overspending or underspending. Crisis services is another area we are monitoring closely. Duane asked if there was a condensed version of the CST changes. The state has a draft definition that they put out for public comment. We are waiting for a second version. The major emphasis change was around supportive housing. Over/under is a strong partnership with QM and the UM committee. They bring a lot of data and follow up on questions. We are trying to look at outcomes for individuals, if a change happens and there is a shift in utilization, we want to see if it is driving the outcomes that we want, and if not, what we can do to shift. Next month the Standard Plan impact on quality initiatives was going to be on the agenda. Since Standard Plan is not going live, we’ll push that back. Provisionally we'll move to February or March. Maybe do a preliminary one in Feb final one in March</td>
<td>Wes will go back and figure out which month has most meaningful, solid data (that Wes trusts) for performance dashboard data and continue to get something like the DMH/DHB page. Wes will pull up top 6 measures and differentiate them from others</td>
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<td>AGENDA ITEMS:</td>
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<td>Requests for future agenda topics:</td>
<td>Pam wants at some point to get update on what effect cuts have had. Put this on future watch list. George will be looking for data on this so he can talk to State. Duane wants to know what impact the delay on the crisis center in Cumberland is having on services. Pam thinks we should be monitoring cuts affecting NC START. Dave talked about a community support group meeting that he attended. Rob and Sara Wilson were there also. Dave spoke to some level 3 support parents who said that at the current rate they cannot sustain services for their children at home and are stopped from opening a group home to combine the three. Dave asked why are we not allowing parents who already have a home from creating a group home and bringing in services, combining assets and possibly reducing costs. Michael will talk to Sara and Rob.</td>
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<td>NEXT STEPS:</td>
<td>Michael will ask Sara Wilson and Rob about who would talk to these level 3 parents interested in creating a group home.</td>
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<td>TIME FRAME:</td>
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5. **ADJOURNMENT:** the meeting adjourned at 2:04 pm; the next meeting will be November 7, 2019, from 1:00 p.m. to 2:30 p.m.
ITEM: Appointment Recommendation

DATE OF BOARD MEETING: November 7, 2019

BACKGROUND: In accordance with the By-Laws of the Board, the initial terms of some Board members were staggered. Jennifer Anderson met with the Executive Committee on October 21, 2019, to discuss her interest in a Board vacancy representing Durham County. The matter before the Board is to recommend to the Durham County Board of Commissioners the appointment of Jennifer Anderson to Alliance’s Board. If appointed, Ms. Anderson’s initial term would expire March 31, 2022.

REQUEST FOR AREA BOARD ACTION: The Board is requested to recommend to the Durham Board of County Commissioners the appointment of Jennifer Anderson to Alliance’s Board.

CEO RECOMMENDATION: The Board is requested to recommend to the Durham Board of County Commissioners the appointment of Jennifer Anderson to Alliance’s Board.

RESOURCE PERSON(S): George Corvin, MD, Board Chair; Robert Robinson, Chief Executive Officer