Alliance Behavioral Healthcare
Area Board Meeting
Thursday, April 3, 2014
4:00 p.m. – 6:00 p.m.

DRAFT MINUTES

PLACE: Alliance Behavioral Healthcare, 4600 Emperor Blvd., Room 208, Durham, NC 27703.

MEMBERS PRESENT: Cynthia Binanay, Christopher Bostock, Dr. George Corvin, Kenneth Edge, James Edgerton, Lodies Gloston, Phillip Golden, Dr. John Griffin, George Quick, Rev. Michael Page, Robert Robinson, Vicki Shore, William Stanford, Caroline Sullivan, Scott Taylor, Amelia Thorpe and Lascel Webley, Jr., Chairman

MEMBERS ABSENT: Ann Akland

GUESTS PRESENT: Yvonne French, NC Division of MH/DD/SAS

STAFF PRESENT: Michael Bollini, Hank Debnam, Doug Fuller, Stacy Gill, Suzanne Goerger, Kelly Goodfellow, Amanda Graham, Carol Hammett, Veronica Ingram, Geyer Longenecker, Janis Nutt, Ann Oshel, Monica Portugal, Al Ragland, Sean Schreiber, and Doug Wright

1. CALL TO ORDER:
Chairman Lascel Webley called the meeting to order at 4:00 p.m.

2. ANNOUNCEMENTS
A. Introduction of General Counsel, Carol Hammett
Chairman Webley introduced Alliance’s new General Counsel, Carol Hammett. Ms. Hammett has worked with Durham County for thirteen years and served as Deputy County Attorney.

B. Board Applicant Interviews
Chairman Webley mentioned that applicant interviews for the Wake and Durham County seats are scheduled for Tuesday, April 8, 2014, as part of the Executive Committee meeting. Chairman Webley invited all Board members to attend the Executive Committee meeting; it starts at 4:00 p.m. and the interviews will begin at 4:30 p.m.

Chairman Webley welcomed Robert Robinson, new Chief Executive Officer, to the Board.

Additionally, Chairman Webley expressed gratitude and best wishes to current Chief Financial Officer, Kelly Goodfellow, whose resignation is effective at the end of April 2014. Robert Robinson, Chief Executive Officer, expressed gratitude to Doug Fuller, Director of Communications, for completion and publication of the 2013 Annual Report.
Mr. Robinson mentioned the April 3, 2014, NAMI Luncheon where Board member, Cynthia Binanay and her son, were guest speakers.

3. **AGENDA ADJUSTMENTS**
   None

4. **PUBLIC COMMENT**
   None

5. **FINANCE COMMITTEE REPORT**
   The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Area Board. The Finance Committee meets monthly at 3:00 p.m. prior to the regular Board Meeting. This month’s report includes the budget to actual report and ratios for the period ending January 31, 2014, and the draft minutes of the March Finance Committee meeting.

   Finance Committee Chair, George Quick, presented the report. Mr. Quick referred to information included in the Board packet including revenues and expenses. Mr. Quick mentioned a budget adjustment recommendation due to an increase in covered lives. Board members discussed the recommendation to adjust the budget.

**BOARD ACTION**
A Motion was made by Mr. George Quick to adjust the budget expenditures by 19.3 million to reflect an increase in covered lives; seconded by Dr. George Corvin. Motion passed.

A Motion was made by Dr. John Griffin to accept the Finance Committee report as presented; seconded by Mr. James Edgerton. Motion passed.

6. **APPOINTMENT OF INTERIM FINANCIAL OFFICERS**
   A. Interim Budget Officer
   General Statute 159-9 requires that each local government or public authority shall appoint a budget officer to serve at the will of the governing board.

   B. Interim Finance Officer
   General Statute 159-24 requires that each local government or public authority shall appoint a finance officer to hold office at the pleasure of the appointing board or official.

   Finance Committee Chairman, George Quick, introduced the recommendation to appoint Robert Robinson as Interim Budget Officer and Stacy Gill as Interim Finance Officer.

**BOARD ACTION**
A Motion was made by Mr. George Quick to appoint Robert Robinson as Interim Budget Officer and Stacy Gill as Interim Finance Officer; seconded by Mr. Christopher Bostock. Motion passed.
7. COMMITTEE REPORTS
   A. Quality Management Report
   B. Human Rights Committee Report
   C. Consumer and Family Advisory Committee Report
   D. Executive Committee Report
   E. Policy Committee Report

Chairman Webley mentioned that Board members received the reports as part of the Board packet.

BOARD ACTION
A Motion was made by Mr. William Stanford to accept the committee reports as presented; seconded by Dr. George Corvin. Motion passed.

8. CONSENT AGENDA
   A. Draft Board minutes from the March 6, 2014, Board meeting

Chairman Webley stated that the Board received the consent agenda in the Board packet.

BOARD ACTION
A Motion was made by Mr. George Quick to approve the consent agenda as presented; seconded by Ms. Lodies Gloston. Motion passed.

9. BOARD TRAINING:
   Alliance is charged with providing care coordination to individuals with special health care needs, including individuals who are considered high risk or high cost based on a mix of diagnosis, service utilization and clinical complexity.

   A. Care Coordination I/DD
   Suzanne Goerger, Director of Intellectual/Developmental Disability (I/DD) Care Coordination, presented a detailed presentation depicting Alliance’s I/DD care coordination model including populations served, staffing and key responsibilities. Board members discussed the details of the presentation including qualifications for Care Coordinators. Ms. Goerger noted that each Care Coordinator is a Qualified Professional with a minimum of a Bachelor’s degree, licensure is not required for this position, and Care Coordinators work at each of the four local sites.

   B. Care Coordination MH/SA
   Dr. Michael Bollini, Director of Mental Health/Substance Abuse (MH/SA) Care Coordination, presented a detailed presentation which included Alliance’s MH/SA care coordination model noting populations served and key program metrics. Dr. Bollini noted changes in Care Coordination since Alliance’s inception and unification of four separate organizations to one. Board members discussed the details of the presentation. Dr. Bollini clarified the case load volume for MH/SA Care Coordinators compared to the case load for I/DD Care Coordinators; he mentioned that the consumer’s level of care impacts the case load for each MH/SA Care Coordinator.

BOARD ACTION
The Board received the trainings. No further action required.
10. **UPDATE**

**MCO Consolidation/Medicaid Reform**

Robert Robinson, Chief Executive Officer, presented an update of the MCO Consolidation/Medicaid Reform plan which the Medicaid Advisory Committee discussed on February 26, 2014, and the Department of Health and Human Services presented in March. Board members discussed the details of the presentation. Mr. Robinson noted the emphasis on appropriate and cost effective care; the plan includes MCOs, a standardized process, and integrating behavioral and physical healthcare. Mr. Robinson mentioned the current plan is to have four merged MCOs by July 2016. Additionally, Mr. Robinson mentioned a plan is being introduced to target consumers currently on the Registry of Unmet Needs.

**BOARD ACTION**

The Board accepted the update. No further action required.

11. **CHAIRMAN’S REPORT**

Chairman Webley announced that the following Board members agreed to serve on the Nominations Committee: Lodies Gloston, Phillip Golden, Vicki Shore, and Dr. George Corvin. Dr. Corvin will serve as chair of this committee. The Committee’s recommendations for the next Chair and Vice-Chair of Alliance’s Board will be presented at the Tuesday, April 8, 2014, Executive Committee meeting.

12. **CLOSED SESSION**

The Area Board entered into closed session in accordance with General Statute 143-318.11 (a) (3) to consult with legal counsel regarding Essential Support Services, LLC v. Alliance and Fidelity Community v. Alliance.

**BOARD ACTION**

A Motion was made by Mr. William Stanford to enter into closed session; seconded by Dr. George Corvin. Motion passed.

A Motion was made by Commissioner Kenneth Edge to return to open session; seconded by Dr. George Corvin. Motion passed.

13. **ADJOURNMENT**

With all business being completed the meeting adjourned at 5:58 p.m.

**Next Board Meeting**

**Thursday, May 1, 2014**

4:00 – 6:00

Respectfully submitted:

[Signature]

5/1/2014

Robert Robinson, Chief Executive Officer

Date Approved
ITEM: Finance Committee Minutes from March 6, 2014 meeting

DATE OF BOARD MEETING: April 3, 2014

BACKGROUND:
The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Area Board. The Finance Committee meets monthly at 3:00 PM prior to the regular Area Board Meeting. The budget to actual report and ratios for the period ending January 31, 2014 and the draft minutes of the March Finance Committee meeting are attached.

REQUEST FOR AREA BOARD ACTION:
Accept the report as presented.

CEO RECOMMENDATION:
Accept the report as presented.

RESOURCE PERSON(S):
Rob Robinson, Kelly Goodfellow, Sara Pacholke
Alliance Behavioral Healthcare  
Finance Committee Minutes  
March 6, 2014

Members Present: Phillip Golden, BS, Lascel Webley, Jr, MBA, MHA, George Quick, MBA, Chris Bostock, Jim Edgerton, BS

Members Absent: Ann Akland, Vicki Shore

Guest Present: William Stanford (Board Member, guest of Finance Committee)

Staff Present: Ellen Holliman, BS, Kelly Goodfellow, MBA, Sara Pacholke, BS, CPA, Rob Robinson, LCAS

Staff Absent: N/A

Opening: Meeting opened by George Quick at 3:01 at Alliance Behavioral Healthcare’s corporate office

Approval of Minutes: Phil Golden made a motion to approve the minutes from the February 6, 2014 meeting with a second from Jim Edgerton.

Agenda Items

Financial Statements and Ratios

Sara Pacholke presented the January 2014 Statement of Revenue and Expenses and ratios. Revenues and expenses were in line with expectations for the seventh month of the year and there is currently a surplus of revenues over expenses for the year. Alliance currently meets the financial ratios required by Senate Bill 208 and the ratios monitored by DMA. We discussed the 90 day time limit for submitting claims and exceptions to the limit.

Budget Retreat

Kelly Goodfellow discussed the upcoming budget retreat. It will cover a financial update, data review and priorities for the upcoming year based on a Network and Service Continuum discussion that was held at Alliance in February.

Board Stipends

George Quick recommended that board members receive their stipends via electronic funds transfer. The staff at Alliance supports this. It will be recommended to the Board.

Loan Deferment

Ellen Holliman gave an update on the loan deferment request. The loan deferment request is not for the current year, rather for FY15 and FY16. The deferment is requested is to help with the Medicaid reform and anticipated merger.
# Alliance Behavioral Healthcare
## Statement of Revenue and Expenses - Actual and Budget
### For the Seven Months Ending January 31, 2014

<table>
<thead>
<tr>
<th></th>
<th>Original Budget</th>
<th>Q2 Budget Amendment</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>
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<tr>
<td><strong>Service</strong></td>
<td></td>
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<tr>
<td>County</td>
<td>$35,860,112.00</td>
<td>$35,854,086.00</td>
<td>$10,456,372.91</td>
<td>$28,242,052.37</td>
<td>$7,612,033.63</td>
<td>78.77%</td>
</tr>
<tr>
<td>State</td>
<td>37,673,396.00</td>
<td>39,357,964.00</td>
<td>2,790,110.61</td>
<td>20,842,886.19</td>
<td>18,515,077.81</td>
<td>52.96%</td>
</tr>
<tr>
<td>Federal</td>
<td>7,640,334.00</td>
<td>7,170,888.00</td>
<td>554,267.41</td>
<td>3,237,801.92</td>
<td>3,933,186.08</td>
<td>45.15%</td>
</tr>
<tr>
<td>Medicaid Waiver</td>
<td>308,126,720.00</td>
<td>312,525,545.00</td>
<td>27,631,839.66</td>
<td>190,463,878.10</td>
<td>122,061,866.90</td>
<td>60.92%</td>
</tr>
<tr>
<td>Miscellaneous Revenue</td>
<td>89.50</td>
<td></td>
<td>308,126,720.00</td>
<td>312,525,545.00</td>
<td>27,631,839.66</td>
<td>60.92%</td>
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<tr>
<td><strong>Total Service Revenue</strong></td>
<td>389,300,562.00</td>
<td>394,908,582.00</td>
<td>41,432,590.59</td>
<td>242,786,508.08</td>
<td>152,122,073.92</td>
<td>61.48%</td>
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<tr>
<td><strong>Administrative</strong></td>
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<tr>
<td>County</td>
<td>1,017,828.00</td>
<td>1,815,854.00</td>
<td>319,987.59</td>
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<td>State</td>
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<td>4,588,482.00</td>
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<td>Medicaid Waiver</td>
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<td>31,747,176.00</td>
<td>2,830,939.65</td>
<td>19,338,462.35</td>
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<td>In Kind Revenue</td>
<td>1,130,287.00</td>
<td>1,130,287.00</td>
<td>143,430.00</td>
<td>986,857.00</td>
<td>12.69%</td>
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<td>Miscellaneous Revenue</td>
<td>25,000.00</td>
<td>98,900.00</td>
<td>533.25</td>
<td>50,094.19</td>
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<td><strong>Total Administrative Revenue</strong></td>
<td>38,068,135.00</td>
<td>39,380,699.00</td>
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<td>23,424,948.38</td>
<td>15,955,750.62</td>
<td>59.48%</td>
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<tr>
<td><strong>Total Revenues</strong></td>
<td>427,368,697.00</td>
<td>434,289,282.00</td>
<td>45,076,488.18</td>
<td>266,211,456.46</td>
<td>168,077,825.40</td>
<td>61.30%</td>
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<td><strong>EXPENDITURES</strong></td>
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<tr>
<td><strong>Service</strong></td>
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<tr>
<td>County</td>
<td>36,047,755.00</td>
<td>36,047,755.00</td>
<td>1,628,400.75</td>
<td>18,976,167.76</td>
<td>17,071,587.24</td>
<td>52.64%</td>
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<tr>
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<td>122,061,866.90</td>
<td>60.92%</td>
</tr>
<tr>
<td><strong>Total Service Expenditures</strong></td>
<td>389,488,205.00</td>
<td>395,102,250.00</td>
<td>28,150,285.23</td>
<td>223,215,122.65</td>
<td>171,887,127.35</td>
<td>56.50%</td>
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<tr>
<td><strong>Administrative</strong></td>
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<tr>
<td>Operational</td>
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<td>6,963,066.00</td>
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<td>1,849,334.91</td>
<td>5,113,731.09</td>
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<td>Salaries, Benefits, and Fringe</td>
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<td>26,033,266.00</td>
<td>1,991,961.74</td>
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<td>Professional Services</td>
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<td>35.23%</td>
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<tr>
<td>In Kind Expenses</td>
<td>1,130,287.00</td>
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<td>143,430.00</td>
<td>986,857.00</td>
<td>12.69%</td>
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<td>168,077,825.40</td>
<td>61.30%</td>
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</table>

**REVENUES OVER EXPENDITURES**

<p>| | | | | | | |</p>
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<tbody>
<tr>
<td></td>
<td>0.00</td>
<td>0.00</td>
<td>14,207,455.04</td>
<td>25,592,283.32</td>
<td>0.00</td>
<td>0.00</td>
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</tbody>
</table>
Meeting adjourned at 3:38 pm.

Respectfully submitted,

Sara Pacholke
Finance Director
Alliance Behavioral Healthcare
Benchmark Ratios
As of January 31, 2014

**CURRENT RATIO**
-Bench Mark - 1.0
-Alliance

**PERCENT PAID**
-Bench Mark - 90%
-Alliance

**DEFENSIVE INTERVAL**
-Bench Mark - 30 Days
-Alliance

**MEDICAL LOSS**
-Bench Mark - > 80%
-Alliance
DATE OF BOARD MEETING: April 3, 2014

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.

In FY 14 members of the committee were:
George Corvin, MD, Chair (Area Board Member)
Lascel Webley, Jr. (Chair, Area Board)
Joe Kilsheimer (CFAC-Durham member)
Vacant (CFAC member)
Bill Stanford, Jr. (Area Board Member)
John Griffin (Area Board Member)
Amy Neufeld (MH/SA Provider representative)
Lakisha Perry-Green (I/DD Provider representative)

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 final minutes from the December meeting is attached. The committee did not meet in January or February 2014. All committee members re-signed confidentiality statements.
announced URAC’s re-accreditation of Alliance Health and Utilization, along with initial accreditation of the Health Network and Call Center modules. The committee received presentations on the results of audits and monitoring—62 agencies have been monitored. The committee received an overview on MH/SA performance measures and an update on Quality Improvement Projects. The Perception of Care survey results and action plan for improvements were discussed.

**REQUEST FOR AREA BOARD ACTION:**
Accept the report as presented.

**CEO RECOMMENDATION:**
Accept the report as presented

**RESOURCE PERSON(S):**
Geyer Longenecker, Director of Quality Management
# Alliance Behavioral Healthcare
## Quality Management Committee Minutes – Final

<table>
<thead>
<tr>
<th>Committee name:</th>
<th>Global Quality Management Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting date:</td>
<td>December 19, 2013</td>
</tr>
<tr>
<td>Report submitted by:</td>
<td>Tina Howard, MA; George Corvin, MD (Acting Chair)</td>
</tr>
<tr>
<td></td>
<td>Date: ______________________________</td>
</tr>
<tr>
<td>Members Present:</td>
<td>George Corvin, MD (Acting Chair); Bill Stanford; Joe Kilsheimer, MBA; Lascel Webley, Jr., BS, MBA, MHA (via conference call); Amy Neufeld (Provider Representative); Lakisha Perry-Green (Provider Representative)</td>
</tr>
<tr>
<td>Members Absent:</td>
<td>John Griffin, EdD</td>
</tr>
<tr>
<td>Staff Present:</td>
<td>May Alexander, MS, LMFT, QM Data Manager; Tina Howard, MA, Quality Review Manager; Bill Young, Provider Network Evaluator; Lena Klumper, PhD, Quality Management Director; Khalil Tanas, MD, Medical Director</td>
</tr>
<tr>
<td>Staff Absent:</td>
<td>None</td>
</tr>
<tr>
<td>Community Providers Present:</td>
<td>None</td>
</tr>
<tr>
<td>Community Providers Absent:</td>
<td>None</td>
</tr>
<tr>
<td>Guests:</td>
<td>None</td>
</tr>
</tbody>
</table>

**Topic:** Approval of September Minutes

**Brief description of Topic:** Minutes were brought to December meeting because November meeting did not have a quorum. Minutes were approved as written. Moved by Joe, seconded by Amy

**Follow-up items:** None

**Announcements:** None

**Next steps:** None
<table>
<thead>
<tr>
<th>Topic: Approval of November Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description of Topic: Minutes were approved as written. Moved by Bill, seconded by Joe</td>
</tr>
<tr>
<td>Follow-up items: None</td>
</tr>
<tr>
<td>Announcements: None</td>
</tr>
<tr>
<td>Next steps: None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Topic: New Business</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description of Topic:</td>
</tr>
<tr>
<td>Committee Schedule Committee agreed to return to schedule of meeting monthly prior to the Board meeting on the first Thursday from 2 – 3:30.</td>
</tr>
<tr>
<td>Confidentiality Statements All committee members present signed confidentiality statements.</td>
</tr>
<tr>
<td>URAC Review URAC conducted on-site visit on December 9 and 10. They found no compliance issues. Reviewers are recommending full accreditation for three years in all three modules (Health Network, Call Center, and Health Utilization Management).</td>
</tr>
<tr>
<td>Staffing Updates There will be several staffing changes in QM resulting in a vacancy in the positions of Administrative Assistant, Grievance Specialist, and Quality Review Coordinator. All positions will be filled as quickly as possible. Tina was given permission to announce Lena’s departure effective January 17.</td>
</tr>
<tr>
<td>Mercer visit Alliance continues to prepare for visit by the State and Mercer, scheduled for February 13 and 14.</td>
</tr>
<tr>
<td>Actions Taken: None.</td>
</tr>
<tr>
<td>Next steps: Tina will email calendar e-vites to committee members and follow up with Lascel to obtain signature on confidentiality statement.</td>
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<tr>
<td>Topic:</td>
</tr>
<tr>
<td>---</td>
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</tbody>
</table>
| Brief description of data reviewed: | The Global Quality Management Committee is required by the DMHDDSAS contract to review data on audits and monitoring. Bill reported that the monitoring process is expected to change. In the meantime, they are continuing with Gold Star Monitoring, a combination of post-payment and quality reviews. Provider must score 85% overall to pass. Initially the agencies chosen to monitor were based on type of service then changed to smaller agencies due to large agency concerns about multiple MCOs monitoring same agency. From June-November 2013, 62 agencies have been monitored:  
- 44 passed  
- 17 in process (60 day follow up not complete or agency is under Plan of Correction)  
- 1 agency closed between monitoring and follow up  
- 30 agencies required recoupment  
Follow up required because: clients rights issues, records concerns, personnel, and post-payment concerns.  
Monitoring resulted in 12 investigations:  
- 2 in process  
- 10 completed, 8 resulted in findings substantiated (requiring Plan of Correction), 3 resulted in referral freeze |
| Actions Taken: | Bill asked for feedback from committee on how data should be presented next time. |
| Next steps: | Committee liked presentation of data. They suggested continuing to present overview, numbers monitored and break down of type of monitoring, lessons learned.  
Questions asked by committee (Bill will follow up with Alison):  
Do we have authority to monitor agencies in Johnston County?  
Do we share monitoring results with other LME-MCOs? |

<table>
<thead>
<tr>
<th>Topic:</th>
<th>MH/SA Performance Measures (Tina Howard)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description of data reviewed:</td>
<td>Tina showed raw data sent to the state on statewide MH/SA performance measures. Data submitted yesterday.</td>
</tr>
<tr>
<td>Actions Taken:</td>
<td>None.</td>
</tr>
<tr>
<td>Next steps:</td>
<td>Committee recommended that, in the future, data be summarized and red flags highlighted.</td>
</tr>
</tbody>
</table>
### Topic: Perception of Care Report (Tina Howard)

**Brief description of data reviewed:**
Tina presented results from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services’ Perception of Care survey. The surveys were completed by 563 consumers (estimated return rate of 38.7%). Questions related to four domains—demographics, perception of care, perception of MCO, and physical health. Major results:

- Majority of consumers felt their health was good
- 71% of consumers indicated they had seen a medical doctor in last 12 months
- 48% reported smoking everyday
- High percentage indicated satisfaction overall (adults: 100% satisfied/very satisfied, adolescents: 100% satisfied with providers, parents of children receiving services: 94% satisfied/very satisfied)

**Recommendations:**
- Access to care needs to improve
- Consumers need better access to hard copies of consumer handbook and other materials

**Actions Taken:**
Alliance’s local business plan includes strategies for improvement.

**Next steps:**
Alliance will: develop strategies to engage consumers, develop brochure about how to obtain consumer handbook, continue crisis reduction plans in all four counties, expand same day appointments offered and providers offering them.

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### Topic: Update on QIPs (Tina Howard)

**Brief description of data reviewed:**
Tina provided an update on implementation of Quality Improvement Projects. For most of the projects, post-intervention data is being collected through the end of January. She reminded the committee about the delay in the Intensive In-Home project and asked for approval to remove the “Executive Walk-Through” initiative within the Mystery Caller QIP. Due to delays and changes in the scope, she proposed that the “Executive Walk-Through” project continue as a Consumer Affairs initiative.

**Actions Taken:**
The Committee agreed to the proposed change to the Mystery Caller QIP.
| **Next steps:** | Data on impact of interventions will be analyzed by end of March. Tina will present another update on QIPs at March meeting. |

The next meeting is scheduled for February 6 at 2.
NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS)

Perception of Care Survey of Alliance Consumers Fiscal Year 2014
Background Information

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) conducted a survey from June 24 through July 12, 2013 to assess consumers’ perception of care of services received from mental health, substance abuse, or developmental disability service providers. The results of the survey are used by local and state agencies to assess and improve the quality of services provided to consumers, as well as to satisfy state and federal requirements to report consumer perception of care.

Methodology

DMH/DD/SAS allocated 1,450 surveys to Alliance Behavioral Healthcare LME/MCO with instructions to disseminate the survey materials to providers contracted with the MCO. Providers were to, in turn, distribute the survey materials to LME/MCO consumers, and return the completed surveys to the LME/MCO by July 12, 2013. To meet state and federal standards, Alliance Behavioral Healthcare was required to return at minimum of 400 completed surveys.

Providers

Providers eligible to participate were those that served at least 25 LME/MCO consumers and provided and billed for publically funded services within 60 days of the survey’s administration. The 30 providers who received surveys were randomly selected from a list of eligible providers generated from claims data for the months of May and June of 2013.

Consumers

Eligible participants were any active LME/MCO consumer who received publically funded services, Medicaid or IPRS, for behavioral health issues during the past 12 months. The number of surveys providers received varied from 20-140 based proportionally on the unduplicated client count LME/MCO consumers served by the participating providers.

Survey Instrument

Three survey instruments were used in the FY2014 administration:

1. The 2013 North Carolina Consumer Perception of Care Survey (Adults, all ages)
2. The 2013 North Carolina Consumer Perception of Care Survey (12-17 years of age)
3. The 2013 North Carolina Consumer Perception of Care survey for Families (YSS, families of children 0-11 years of age)

Surveys were distributed in both Spanish and English for each of the three instruments.
Each instrument included the following four sections:

I. **Background Information**: consumer demographic information, primary reason for seeking services, length of time served by provider, help seeking practices (Adults and Adolescents), number of hospitalizations (Adults and Adolescents), height and weight (Adults only)

II. **Perception of Care**: consumer perception of care, provider staff, and quality of life outcomes related to services received

III. **MCO/Network Provider**: consumer perception of routine and emergent services provided by MCO staff

IV. **Comments**: additional consumer feedback and request for follow-up from DMH/DD/SAS

Consumers 18 years and older were asked to respond to an additional section that addressed consumer physical health:

V. **Physical Health**: general perception of health, recent routine physical and/or dental examinations, medical conditions, tobacco use, physical activity

Consumers used a five-item Likert-type scale to demonstrate their level of agreement with the surveys’ statements (e.g., “Strongly Agree”, “Agree”, “I am Neutral”, “Disagree”, “Strongly Agree”, “N/A”). The survey instrument also included yes/no, multiple choice, and short answer questions to best capture the consumers’ background information, physical health, and perception of the MCO/network provider.

**Consumer Privacy**

Identifying consumer information (ex. name, social security number) was not included in any of the survey material. Providers were asked to offer consumers a sealable envelope and privacy while completing their surveys. Providers were also instructed to assure consumers that survey participation is voluntary and their responses will have no repercussion on the services they receive.
Findings

Twenty-nine providers returned 563 completed consumer surveys during the designated collection period, with a 38.7% response rate. The following is a summary of the participants’ feedback.

Child/Parent

I. Background Information:

Ninety-six parents responded on behalf of their children. The majority of children engaged in services had relatively new relationships with their providers, with over one-half of consumers receiving services with their current provider for 5 months or less.

Twenty-one percent (21%) of parents reported seeking health services for their children through the emergency department (ED) for physical health care, with an average of 3 visits per consumer. Two consumers reported using ED services for mental health care for a total of 3 visits.

Figure 1. Parent Response to survey question, “How long has your child been receiving services here, at this provider site, for his/her current problem?” (N=95)
II. Perception of Care:
Participants reported overwhelming satisfaction with the services their children receive from providers. “Strongly Agree” and “Agree” were the top-two responses for 100% of questions addressing consumer satisfaction with providers.

![Figure 2. Parent response to survey statement, “Overall I am satisfied with the services my child received” (N=95)](image)

Parents reported feeling involved in their children’s treatment with 76% of parents responding that they helped select their children’s services and treatment goals. Participants expressed high satisfaction with providers’ rapport with consumers and their families, especially in terms of feeling “understood” and “respected” by provider staff.

III. MCO/Network Provider:
When asked if they received a consumer handbook in the mail within 14 days of starting services with Alliance Behavioral Healthcare, 41% of consumers reported that they did not.

For those individuals who contacted the LME/MCO for an emergency related to mental health, 43% responded that a network provider did not see them within 2 hours. Likewise, 41% reported not being seen by a network provider for urgent (but not emergent) services within 48 hours of contacting Alliance Behavioral Healthcare. However, 85% of consumers seeking routine appointments with providers were seen within 14 calendar days of communicating with Alliance Behavioral Healthcare staff.

Parents noted that cost/availability of transportation, availability of telephone access, and cost of services were the most common barriers to treatment for their children.
Adolescent

I. Background Information:
Ninety-seven adolescents submitted Perception of Care Surveys. Adolescent participants tended to have more established relationships with their providers, with 50% reporting that they have received services from their current provider for over a year.

More than half of adolescent participants (61%) reported voluntarily engaging in services. Those who felt forced into treatment reported that they were “pressured by family to go to treatment” (16%), their treatments were “court ordered” (16%), or an outside agent, such as their school or social worker, encouraged them to seek treatment.

![Pie chart showing the response to the question: "Did you voluntarily come for services?"

Figure 3. Adolescent Response to question, “Did you voluntarily come for service” (N=95)

Twenty percent (21%) of adolescents reported seeking ED services for physical health care, with an average of 2 visits per consumer within the last 12 months. Nineteen percent (19%) of adolescents also reported visiting the ED for mental health care, with an average of 3 visits within the past 12 months. Two (2) consumers disclosed seeking ED treatment for substance abuse in the past 12 months, averaging one visit per consumer.
II. Perception of Care:
Adolescent consumers expressed high satisfaction with their service providers. “Strongly Agree” and “Agree” were the number one and two responses for 100% of all statements related to service providers. However, adolescents felt they were included less in choosing their services than either parent or adult survey participants.

![Figure 4. Adolescent response to question statement, “I helped choose my services” (N=96)](image)

There was wider response variation with regard to questions addressing consumer quality of life. More so than children or adults, adolescents reported higher rates of dissatisfaction with their relationships with friends, family, and work/school life.

![Figure 5. Adolescent Response to survey statement, “I am satisfied with my family life right now” (N=95)](image)
III. **MCO/Network Provider:**

When asked if they received a consumer handbook in the mail within 14 days of starting services with Alliance Behavioral Healthcare, 51% of adolescent participants said that had **not**.

For those individuals who contacted Alliance Behavioral Healthcare for an emergency related to mental health or substance use, 52% responded that a network provider did not see them within 2 hours.

Likewise, 66% reported **not** being seen by a network provider for urgent (but not emergent) services within 48 hours of contacting Alliance Behavioral Healthcare.

Seventy-two percent (72%) of adolescent participants seeking routine appointments with Alliance Behavioral Healthcare providers noted that they were seen within 14 calendar days of speaking to LME/MCO staff.

Adolescents reported that that cost/availability of transportation, availability of telephone access, and providers’ office hours were their most common barriers to treatment.

*Figure 6. Adolescent response to survey statement, “I do better in school and/or work” (N=96)*
Adults

I. Background Information:
Three-hundred-seventy (370) adults submitted Consumer Perception of Care Surveys. Unlike child and adolescent consumers, adult participants generally maintained long-term relationships with their providers. More than half (69%) of participants reported being with their current provider for at least 6 months, and 49% stated they have received services from their provider for over a year.

The majority of adult participants reported voluntary engagement in services. About one third (26%) felt pressured into help-seeking practices by friends and family or were court ordered to enter treatment.

![Figure 7. Adult response to survey question, “Did you voluntarily come to service?” (N=70)](image)

"Did You Voluntarily Come to Service?"

- Yes: 74%
- No, I was pressured by my family to come for services: 4%
- No, my treatment was court ordered: 2%
- Other: 3%

Adult consumers relied on ED services significantly more than children and adolescents. In the past 12 months, about a third (37%) of adult participants reported seeking ED services for physical health care, averaging 3 visits per person; 16% reported visiting the ED for mental health care, averaging 3 visits per person. Only 5% of adult participants reported visiting the ED for self-reported care related to substance use. However, these consumers averaged 3 visits each for the past 12 months.

II. Perception of Care:
Adult consumers reported high degrees of satisfaction with their current service providers. As was the case for parent/child survey participants, all survey statements addressing issues of perception of care received “Strongly Agree” and “Agree” as the most frequent responses. Nearly all adults –86%–stated that given other choices, “[they] would still get services from
[their provider] agency”; and 90% “would recommend [their provider agency] to a friend or family member”.

Adult participants expressed feeling well supported by agency staff. They reported that they received services that were appropriate for their individual needs at times that were convenient for their schedule and were able to communicate with providers in a timely manner.

Most notably, adult consumers felt that because of the services received with their current provider, they enjoyed a higher quality of life. Consumers reported improved relationships with family members, feeling more in control of their lives, and also reported a decrease in the severity of symptoms related to their illnesses.

III. Physical Health:
Overall, the majority of adult participants believed that they were in good health with only one third of participants reporting that their health was fair to poor. In the past 12 months, nearly three-fourths (71%) of adult consumers were able to visit a medical doctor for routine physical exam and slightly over half (51%) of consumers visited a dentist for routine care.

Despite the generally positive self-assessment of consumer health, there were several negative health behaviors reported by consumers. Nearly half (48%) of the participants admitted to smoking every day and another 10% reported smoking at least some days throughout the week. Additionally, based on the consumers’ reported height and weight, more than two-thirds of participants have a Body Mass Index (BMI) Score that place them in an unhealthy weight range.

Figure 8. Adult consumer response to survey question, “In general would you say your health is _____?” (N=354)
IV. MCO/Network Provider:
When asked if they received a consumer handbook in the mail within 14 days of starting services with Alliance Behavioral Healthcare, 48% of adult participants said that had not. For those individuals who contacted Alliance Behavioral Healthcare for an emergency related to mental health or substance use, over half (52%) responded that a network provider did not see them within 2 hours.

For adult participants in need of urgent (but not emergent) services, 45% reported not being seen by a network provider for within 48 hours of contacting Alliance Behavioral Healthcare.

Seventy percent (70%) of adult consumers seeking routine appointments with LME/MCO providers noted that they were seen within 14 calendar days of speaking to Alliance Behavioral Healthcare staff.

Cost/availability of transportation, cost of medication, and cost of services were adult respondents’ most frequently reported barriers to treatment.
Conclusions

1. Alliance Behavioral Healthcare had a successful return rate of this survey with 563 (of 1,450) surveys returned for a 38.7% return rate.

2. A high percentage of all respondents indicated satisfaction with services overall, and that they would continue with their current providers and refer to friends or family if asked. A high percentage also indicated feeling respected by and understood by their providers.

3. A moderate percentage of consumers are utilizing the ED for physical health care services. According to consumer self-report, 21% of children, 16% of adolescents, and 37% of adult participants have visited the ED at least once in the past 12-months primarily for physical health treatment. Adult consumers are also seeking ED treatment in large numbers for behavioral health problems. Sixteen percent (16%) of adult consumers reported receiving treatment for mental health symptoms within the past 12-months and 5% visited the ED for health problems around substance use. Both of these consumer groups visited the ED an average of 3 times in the past year.

**Recommendation:** Alliance Behavioral Healthcare should develop strategies to engage consumers in continuous and integrated treatment to reduce health care emergencies. Alliance may consider a collaboration effort with hospital emergency department staff to improve discharge planning in order to direct consumers to more appropriate levels of care as well as to reduce inappropriate hospital admissions.

**Strategies:**

1. Each county will have a local crisis collaborative with representation from local hospitals/EDs, the MCO, Law Enforcement, EMS, Crisis Facilities, network providers, shelters and other key stakeholders that meets monthly to identify and address issues and barriers and develop collaborative plans and agreements. The groups will receive data reports regarding the use of the crisis system and identify trends and needs.

2. In collaboration with inpatient facilities in Cumberland County, develop a 24/7 crisis and assessment center that can receive consumers on IVC. Funding has been allocated for this project and implementation is underway.

3. Expand facility based crisis/non-hospital detoxification beds in Cumberland County from 8 to 16 beds. Ensure 24 hours access to this facility. Funding has been allocated and planning is underway.

4. Improve connections to outpatient and follow-up psychiatric services for consumers leaving the EDs and inpatient services.
   a. Develop an open access outpatient/psychiatric clinic in Cumberland County. Will improve post ED and inpatient connection to aftercare. Funding has been allocated and hiring and limited appointments have been offered and should be fully operational within 4 months.
b. Expand use of open access and walk-in clinics in the four Alliance communities with a goal of discharge follow-up available within 24 hours. (See Local Initiative on Open Access)

c. Implement Wake Crisis Facility/ACTT pilot Alliance wide. Currently, the crisis facility in Wake County contacts ACTT providers directly when they have determined that a consumer has a history of accessing crisis and inpatient services. The ACT teams come to the assessment center before the consumer leaves to enhance engagement.

d. Improve the rate in which EDs and crisis facilities contact Alliance Access and Information Center to determine if consumers presenting at these facilities are linked with providers or need a provider post discharge.
   i. Provide education and continued outreach to EDs and crisis facilities
   ii. Ensure accurate call coding in the Alliance MIS system to better track all calls from these facilities in order to report progress and ensure facilities are following established protocols.
   iii. Ensure each community has Alliance ED liaisons who are available to assist in the linkage of high utilizers to services and to assist EDs with system navigation
   iv. Ensure each local inpatient unit has an assigned Alliance liaison to assist with discharge planning and better community linkage

4. Communication with consumers new to services should be given more information with their welcome letter. Since nearly half of the respondents indicated not receiving a consumer handbook, a brochure or other document should accompany the letter.

**Recommendation:** Alliance staff to send a one page brochure with the welcome letter that describes rights and responsibilities, in addition to the information about the Alliance Behavioral Healthcare website.

**Strategy:** As of November 1, 2013, a one page brochure is now accompanying the welcome letter to consumers.

5. Access to care within timelines required by contract need to be improved, per self-report of consumers. Almost half (43%) indicated they were not seen within 2 hours due to an emergent request, and 41% were not seen by provider for an urgent request within 48 hours.

**Recommendation:** Alliance staff to review barriers to being seen for appointments. Some are due to lack of telephone access, costs and availability of transportation. In addition, review internal processes with providers to ensure that appointments are
being scheduled appropriately and that mobile crisis is seeing consumers within the 2 hour window of time.

**Strategy:** Alliance staff has worked with providers in the network to improve timely access to treatment services. There are now several providers in the Alliance catchment area that offer walk-in and same day appointments—meaning on the day a consumer contacts Alliance seeking services they can be seen. Additionally, several of these providers also offer same day access to a prescriber, so not only can they receive a comprehensive assessment, treatment can begin on the very same day. Results are already showing improvements as in early spring 2013, it took an average of 17 days in Wake County for a consumer to receive an outpatient assessment; whereas, since August 2013, the average time is now 4 days. Alliance will continue to support providers in the transition to an open access model of care and reduce administrative burdens where possible.

**Next Steps**

1. Results of the Consumer Perception of Care Survey will be discussed with the Alliance Behavioral Healthcare Continuous Quality Improvement (CQI) Committee before end of December 2013 to develop an internal plan to address identified issues and recommendations.
2. Results will be shared with the Alliance Behavioral Healthcare Provider Advisory Committee and CFAC.
3. Strategies will be tracked and included in the Annual Gaps and Needs Assessment.
Update on Quality Improvement Projects

December 2013

Serving Durham, Wake, Cumberland and Johnston Counties
Quality Improvement Projects

Reduce visits to Emergency Rooms

- Critical project for Alliance
- Project Team: Clinical Dir, Community Relations, Care Coordination, Asst. MD, IT
- Plan has been created for every county:
  - Durham – Top 25 pilot-Includes intensive care coordination, access to primary care, ED Liaisons, notification to providers, results=80% of consumers in pilot showed reduction in ED visits within 6 months. Other initiatives-review data regularly, expand CIT, expand case conference model, increase Mobile Crisis Team utilization-technical assistance team (Durham & Wake) meeting on regular basis
Quality Improvement Projects

Reduce visits to Emergency Rooms

- Plan has been created for every county:
  - **Cumberland** – Create walk-in assessment center (opening in Dec 2013), increase CIT training, co-locate Care Coordination in ED, review real-time ED data on daily basis, expand Mobile Crisis Team to county, reduce repeat admissions
  - **Johnston** – review data daily & on regular basis, co-locate Care Coordinator in ED, monitor engagement, develop medically monitored detox
Quality Improvement Projects

Reduce visits to Emergency Rooms

- Plan has been created for every county:
  - Wake – collect & review ED admissions daily, expand CIT, transition county services to UNC/private providers, improve consumer engagement in treatment services, increase Mobile Crisis Team utilization-technical assistance team (Durham & Wake) meeting on regular basis

- Project Advisory Team-Collecting data and discussing ideas for next year’s project
Quality Improvement Projects

Mystery Shopper—Mystery review of internal and external processes, ensure consumer health/safety

- Project Team (Call Center, IT, Consumer Affairs)

- **Review of recorded calls to Access & Information** – 20 randomly selected calls reviewed:
  - 8 from providers/professionals requesting information
  - In 17, Access staff informed caller of QA monitoring
  - All calls answered quickly, transfers efficient, staff polite and courteous
  - Suggestions: Explain role of Alliance/services earlier in call, decrease/eliminate use of acronyms, elaborate on choices of providers. Action plan created and tracked.

*Serving Durham, Wake, Cumberland and Johnston Counties*
Quality Improvement Projects

Mystery Shopper—Mystery review of internal and external processes, ensure consumer health/safety

- **Review of Call Center Delegated Contractor**—calls notes from 2 dates randomly selected:
  - Notes from 11 calls reviewed
  - 40% of calls followed Alliance procedures (only 5 calls applicable)
  - Suggestions: Give updated resource information to contractor, increase amount of information in call notes
Quality Improvement Projects

Mystery Shopper – Mystery review of internal and external processes, ensure consumer health/safety

  - Goals - increase in plans meeting quality criteria, reduction in plans forwarded to Senior Management due to health & safety concerns
  - Interventions – I/DD: Immediate feedback to Care Coordinators, training, clinical consultations emailed to Supervisors; MH/SA: Clinical consultations emailed to Clinical/UM Directors for review/care management, Feedback letters to providers
Quality Improvement Projects

First Responder – test crisis lines of providers

- Project Team assembled (Compliance, UM, Call Ctr)
- Aug 2013 – tested 100% of agencies with first responder responsibilities in all four counties (117 agencies)
- Results:
  - 92% answered within 6 rings (by person or voicemail)
  - 53% answered by person, 48% by voicemail/answering service
  - 11% answered by someone NOT a QP
  - 50% greeting included respondent’s name, title, agency name
  - 95% rated as courteous, 89% rated as helpful
Quality Improvement Projects

First Responder – test crisis lines of providers

Next Steps:

- Agencies that did not respond or those who allowed non-QP to answer call will be referred to Corporate Compliance

- New After-Hours requirements to be placed on website and in Provider Newsletter. Training provided at All-Provider meeting December 18

- Re-Test in January
Quality Improvement Projects

Inter-rater Reliability – test consistency between UM Care Managers & among Call Center staff

- Project Advisory Team - UM Committee

- Interventions: Training, group & individual supervision; Goal: 85% agreement

- Results from Spring 2013 study: UM – 67% (moderate agreement), Call Center – 75% (substantial agreement)

  Additional tests in December

- August study results:
  - MH/SA UM – 55% (changes: testing vignettes prior to study, administer at staff meeting)
  - Call Center – 84% (substantial agreement)
Quality Improvement Projects

Inter-rater Reliability – test consistency between UM Care Managers & among Call Center staff

- August “mini” study results (only 5 questions):
  - I/DD UM – 58% agreement, moderate agreement

- December study results:
  - MH/SA UM – 76% agreement, substantial agreement

- I/DD UM & Call Center – will be conducted in late December/early January
Quality Improvement Projects

Intensive In-Home—Improve quality of IIH services

- Project Team – Dr. Arrington (Chair), UM, UM Appeals, Provider Networks

- Goals: Increase # of providers offering EBPs, reduce use of crisis services & law enforcement involvement

- Baseline data: 209 youth authorized in Feb/Mar - collecting data on avg. LOS, crisis admits, law enforcement, outcomes

- Use of Evidence-Based Practices – data collected from 46 agencies, 72% use CBT, 35% use MI, 33% use family-systems

- Interventions: RFP for services issued late Sept, proposals being reviewed, Information collected used to inform RFP
Quality Improvement Projects

Intensive In-Home— Improve quality of IIH services

- Re-Evaluation: Pull data for another sample of youth receiving services after new contracts implemented, monitor fidelity of models used by providers

- Project will be delayed, recommend continuation in FY 15
Substance Abuse Engagement—improve consumer engagement in Durham SA services

- Project originally included interventions to increase Care Coordination & improve monitoring of providers

- During 12 month post follow up, engagement of consumers found to have decreased, below baseline, in FY 13

- Next steps: Met with Provider Networks—recommend evaluating impact of RFPs issued for SAIOP, assemble project team to monitor results

- Collecting data on sample of consumers receiving services April – June 2013, compare to sample in 2014
Durham Center QIPs Continued

DCA Discharge Planning—improve discharge planning at DCA

- Original intervention included revised discharge plan, Discharge Plan Coordinator added when funding became available

- Follow Up Review (April/May 2013) – indicated new plan not implemented until March 2013 & limited use (30%) of new discharge plan, 85% of adult plans & 72% of youth plans 75% complete, only 2 adults plans 100% complete, 38% seen by provider within 5 days of discharge, turnover of Coordinator position

- Next steps: Training for DCA staff, POC issued, review of charts (Dec-Jan), youth readmissions being analyzed
ITEM: Human Rights Committee Report

DATE OF BOARD MEETING: April 3, 2014

BACKGROUND:
The Human Rights Committee shall include consumers and family member 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.
4) Submitting an annual report to the Area Board which includes, among other things, a review of the Area Authority’s compliance with NCGS 122C, Article 3, DMHDDSAS Client Rights Rules (APSM 95-2) and Confidentiality Rules (APSM 45-1).

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. The Committee is currently chaired by Mr. Scott Taylor.

REQUEST FOR AREA BOARD ACTION:
Draft minutes for February 25th are attached along with second quarter grievances and incident reports. Also attached is the Provider Dispute Resolution procedure being considered for approval by the committee. The committee meets again on April 1st to complete annual training and review procedure as well as consider future activities of the committee.

AREA DIRECTOR RECOMMENDATION:
Receive the information.

RESOURCE PERSON(S):
Doug Wright, Scott Taylor, May Alexander
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES: Minutes were deferred for an e-mail approval; Doug will send out with the attachments.

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<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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<tbody>
<tr>
<td>Provider Dispute Resolution Procedure Review and Approval</td>
<td>No one had any concerns about the procedure. Questions arose about why the Human Rights Committee was approving this procedure and not the Quality Management Committee. It was recommended that we clarify who approves and why and bring back that information to the next meeting.</td>
<td>Doug will check with Monica Portugal about why this committee and report back to the Human Rights Committee at its next meeting.</td>
<td>March Meeting</td>
</tr>
<tr>
<td>Grievances and Incidents</td>
<td>May Alexander presented the 2nd quarter incidents and grievance reports. Lots of questions arose around wanting more detail than was available in the reports. It was noted that these numbers only reflect grievances received by Alliance specifically. Providers receive grievances from consumers and families but resolve them at that level utilizing their procedures and their Client’s or Human Rights Committee. Copies of their minutes are forwarded to Alliance on a quarterly basis. Admittedly, trying to pull usable data from the minutes in a timely and worthwhile way has not been successfully done. We have begun talking about what kind of data set we could require through our contract that would be worthwhile, easily imported and used at the QM level. The Committee would like for us to find a reasonable solution to this challenge. We also talked in depth about, is this the right information to look at to ensure the rights of our consumers are not violated, should we be looking at more detail or more specific circumstances? Staff acknowledged that</td>
<td>Doug will follow up with our compliance department about what information can and should be shared at this committee. Doug and May will begin to look for a solution in getting worthwhile data on grievances from the provider network.</td>
<td>March Meeting</td>
</tr>
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<td>Updates as available</td>
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the information is broad and systematic in nature and that our legal and compliance departments have recommended this level of detail as appropriate. The Committee stated although this may meet the expectation of the statute, additional detail could possibly be shared. One possible solution was to have the current meeting schedule expanded with the quarterly information presented; allow for questions and requests for drill downs on specific data points; then come back the next month and review that information. That would increase the meeting schedule to 8 meetings annually. The Committee acknowledged the hard work of staff and look forward to figuring out how best to function and protect the rights of the people we serve.

### Annual Training

There is a requirement for members to have an initial orientation, then annual training on the Human Rights Committee and its statutory responsibilities. We began the training and got through the 21st slide. The training, derived from statute that has been in place since before MCOs, continued to raise questions about what the committee should be looking at and in how much detail. Our Go To Meeting closed out by mistake, so we decided to stop the training at 6:00pm and schedule another meeting next month to finish the training and to talk about other concerns.

Doug will get with Scott and schedule a meeting for next month. The same day and time of the month appeared to be acceptable to all.

#### February 28, 2014

### Next Meeting

March 25 is the 4th Tuesday but not good for staff or CFAC members; suggesting April 1st as an alternative.

Doug and Scott will confer.

February 28, 2014
GRIEVANCE REPORT

SECOND QUARTER FY 13-14

Data pulled 2.17.14
Q2 Background information

- There was a 20% decrease in the number of grievances/concerns received. This is attributed to the holiday season.

- During data analysis it was discovered that No Provider is a default setting. Q1 data is being reexamined to account for this issue.
**Background:**
At the time a grievance is logged, it is placed in the category that best describes the nature of the concern. These categories are: Grievance, Internal Employee Concern, External Stakeholder Concern, Compliment and Other.

**Analysis and Trends:**
Overall volume decreased 20% from Q1. Grievances received was about the same from last quarter (43%) There was a 4% increase of internal concerns logged and a 6% decrease in external concerns. Compliments increased 100% from 1-2%.

**Follow up:**
Continue to provide guidance to Alliance staff about proper categorization and data elements needed for reporting.
Background:
Alliance Behavioral Healthcare is responsible for addressing grievances related to publicly-funded, behavioral health services. Grievances/Concerns are logged from consumers, providers, and/or service team members when dissatisfaction with services is reported.

Analysis and Trends:
Consumer filing has remained about the same as Q1 (43%). MCO staff reporting has increased slightly 4%. Provider reporting is down 3%.

Follow up:
None at this time. Reporting trends will continue to be monitored.
**Background:**
This chart reflects consumer grievances.

**Analysis and Trends:**
The majority of complaints continued to be focused on Quality of Services followed by Access to Services. There was an increase in complaints in the areas of Client’s Rights, Authorization/Payment/Billing.

**Follow-up:**
These categories are defined by the Division of Mental Health Intellectual/Developmental Disabilities and Substance Abuse Services. They were included in the training materials.
**Background:**
Detail of areas of concern expressed by MCO staff

**Analysis and Trends:**
The largest area of concern was Quality of Services down 10% from Q1, Authorization/Billing/Payment was the next largest area of concern up 5% followed by Access to Service up 9%.

**Follow-up:**
These categories are defined by the Division of Mental Health Intellectual/Developmental Disabilities and Substance Abuse Services. They were included in the training materials.

![Pie chart showing distribution of concerns among MCO staff.](chart.png)
Background:
Grievances/Concerns presented by service to identify trends

Analysis and Trends:
Percentage wise the service breakdown is very similar to Q1. Enhanced Benefit concerns remained the same as last quarter with the highest number of reports related to residential services (33) followed by ACTT (26) and IIH which also increased from last quarter. Basic benefits (outpatient) was the next largest category. Different from previous quarters was the third highest service category which was equal between IDD and Other. Crisis services which had decreased significantly in Q1 have begun to increase again/

Next Steps:
Work is continuing to be done on residential type reporting.
**Background:**
Grievances must be resolved within 15 working days (of the date filed), but may be extended if issues require additional attention, or the grievance requires the attention of an external regulatory agency. Frequently, QM staff work to resolve the issue within 5 days. Previously, data had to be presented in increments of 15. Current data is presented in increments of 7 to more accurately represent the resolution time. Alpha data is calculated in calendar days.

**Analysis and Trends:**
Of the 237 issues that were resolved, 220 (92%) were resolved within 21 calendar days (15 working days) of the Grievances. This was a 10% increase from Q1. The number resolved over 30+ days decreased by 7%, Those over 30 days have typically been referred to external agencies.

**Next Steps:**
Monitor trends
**Background:**
QM staff use various methods to resolve issues.

**Analysis and Trends:**
Resolution by providing technical assistance to complainant or working with the provider for a resolution account for 92% of all resolution methods. Four percent of the complaints were referred to investigations.

**Follow-up:**
Based on several provider trends, referrals have been made to Compliance, Network Development Specialists, and Network Development Evaluators.

**Resolution Time N-237**

- **156, 66%** Resolved/Completed
- **63, 26%** Resolved/Completed Info or Tech assist provided to complainant
- **9, 4%** Resolved/Completed Referred to External Lic or State Agency
- **9, 4%** Resolved/Completed Worked with Provider for resolution
**Background:**
Grievances were reviewed to begin baseline data for the top providers against whom grievances/complaints were filed.

**Analysis and Trends:**
Both HHH and Carolina Outreach are no longer in the Top providers with the most complaints. The data appears to show the Alliance has had a sufficient increase, however, when analyzing the data it was noted that No Provider was indicated a significant amount of times, upon further investigation it was realized that this is a default setting and frequently a Provider is listed in the complaint.

**Next Steps:**
QM staff have been made aware of this issue and will be monitoring data entry more closely going forward. Additionally, the semi-annual report of complaint data will be made after corrections are made.
**Background:**
Previously, demographic and population data have not been included; it is now being included to identify ongoing areas of training need.

**Analysis and Trends:**
Of the disability areas identified, Substance Abuse showed an increase over Q1, missing data decreased by 5%. The Grievances/Concerns missing an age category dropped from Q1 by 6%.

**Next Steps:**
Continue to work with staff who enter Grievances/Concerns to correctly identify both age and disability groups.
**Background:**
In February 2013, Alliance began serving 4 counties.

**Analysis and Trends:**
Rate of reporting has been graphed based on number of consumers served in each county. If all counties were reporting at the same rate, the line would be flat. Q2 shows a higher number of complaints filed in Durham. This graph includes grievances, external stakeholder concerns, compliments and other. (Internal concerns are not included as they skew the numbers.)

**Next Steps:**
Alpha has now made the county field required. Future data presentations will show a more accurate picture of where the volume of complaints and grievances originate.

**Grievance Trends by County**

- **Population N-91**
  - Cumberland
  - Durham
  - Johnston
  - Wake

- **Count N-148**
  - Cumberland: 16
  - Durham: 35
  - Johnston: 53
  - Missing: 3
  - Other: 1
  - Unknown: 3
  - Wake: 34
**Background:**
Quality of Services comprised the majority of Grievances/Concerns.

**Analysis and Trends:**
There was a 17% decrease between Q1 and Q2 in total Grievances/Concerns, likely due to the holiday season. Quality of services continues to be the highest category accounting for 47% of Grievances/Concerns. This is a slight decrease from Q1.

**Next Steps:**
Volume of grievances has reached staffing capacity.
Alliance Behavioral Healthcare
OPERATIONAL PROCEDURES

<table>
<thead>
<tr>
<th>SUBJECT: Provider Dispute Resolution</th>
<th>PROCEDURE #: 3044</th>
</tr>
</thead>
<tbody>
<tr>
<td>LINES OF BUSINESS: Provider Network, Compliance, Legal</td>
<td>BOARD POLICY #: G-5</td>
</tr>
<tr>
<td>RESPONSIBILITY: Area Board/ Area Director Compliance Network Development and Evaluation Business Operations Medical Director/Chief Clinical Officer Legal</td>
<td>URAC: CORE, v. 3.0, Standard 4; N-NM, v. 7.0, Standards 7 &amp; 13-17</td>
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<tr>
<td></td>
<td>REFERENCE: 10A NCAC Subchapter 27G; N.C.G.S. §108D</td>
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<tr>
<td></td>
<td>PROCEDURE APPROVAL DATE: 8/20/2013</td>
</tr>
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<tr>
<td></td>
<td>LATEST REVIEW DATE:</td>
</tr>
<tr>
<td></td>
<td>PROCEDURE APPROVAL AUTHORITY: Ellen J. Hoffman</td>
</tr>
<tr>
<td></td>
<td>Area Director</td>
</tr>
</tbody>
</table>

PURPOSE

The purpose of this procedure is to ensure Alliance Behavioral Healthcare implements a fair, consistent, respectful, timely and impartial process for Network Providers to appeal contract disputes, administrative actions or sanctions. Alliance must ensure that provider dispute mechanisms are implemented consistent with its written agreements to address alleged violations by Network Providers of the requirements of the organization. These mechanisms must include the following: Disputes Concerning Professional Competence or Conduct; Disputes that Impact the Provider’s Status within the Closed Network; Disputes Involving Other Contract or Compliance Actions; and Network Provider Suspension Mechanism for Patient Safety. Consumer appeals of medical necessity determinations are not included within the scope of this procedure and are addressed in the Alliance Due Process – Appeals of Medical Necessity Determinations Procedure. This procedure outlines the process for resolving disputes with Network Providers, sets forth a clear description of the dispute resolution process, and defines explicit time frames from initiation of the dispute resolution mechanism through a written notification of the outcome to the Network Provider.

DEFINITIONS

**Administrative Action** means an action taken against a Network Provider that does not impact the Network Provider’s status within the Closed Network.

**Applicant** means as defined in N.C.G.S. §108D-1(1), i.e. a provider of MH/I-DD/SA services who is seeking to participate in the Alliance Closed Network.

**Closed Network** means as defined in N.C.G.S. §108D-1(2), i.e. the network of providers that have contracted with Alliance to furnish MH/I-DD/SA services to Alliance consumers.

**First level panel** means a panel consisting of three individuals who were not involved in the original decision, one of whom must be a Network Provider randomly selected by or from the Alliance Provider Advisory Committee who is not otherwise involved in network management and who is a clinical peer of the provider that filed the dispute.

**Network Provider** means as defined in N.C.G.S. §108D-1(13), i.e. an appropriately credentialed provider of MH/I-DD/SA services that has entered into a contract for participation in the Alliance Closed Network.

**Sanction** means an action taken against a Network Provider that impacts the Network Provider’s status within the Closed Network.
Second level panel means a panel consisting of three individuals who were not involved in the original decision or first level panel decision, one of whom must be a Network Provider randomly selected by or from the Alliance Provider Advisory Committee who is not otherwise involved in network management and who is a clinical peer of the provider that filed the dispute.

Written Agreement or Network Contract means the document signed by all Parties in accordance with the Alliance Network Contract Procedure that specifies the terms and conditions of a relationship between Alliance and a Network Provider. This term may include a contract or agreement and any attachments or addenda.

Note: All timelines in this procedure refer to calendar days unless otherwise noted. “Working day” or “business day” means a day on which Alliance is officially open to conduct its affairs.

PROCEDURES

Provider dispute mechanisms only apply to Alliance Network Providers. Alliance does not offer the opportunity to appeal to Applicants who are denied participation in the Closed Network. Not all Network Provider disputes are subject to the dispute process. Network Providers may not appeal a decision by Alliance not to renew or extend a Network Contract beyond its original term, and may not appeal contract termination or suspension based on the following: notification to Alliance of exclusion from participation in federally-funded health care programs by the U.S. HHS Office of Inspector General, Immediate Jeopardy finding issued by the Centers for Medicare and Medicaid Services, action taken by the NC Department of Health and Human Services or any of its Divisions, loss of required facility or professional licensure, accreditation or certification, or Federal, State or local funds allocated to Alliance are revoked or terminated in a manner beyond the control of Alliance for any part of the Contract period.

A. Types of Sanctions, Actions, and Disputes

The Alliance Corporate Compliance Committee has the authority to take a variety of Administrative Actions and Sanctions against Network Providers, which are more fully described in the Alliance Provider Sanctions, Administrative Actions, and Suspensions to Ensure Patient Safety Procedure. The Alliance Medical Director and Chief of Clinical Operations also have the authority to take emergency suspension actions against a Network Provider to protect the life, health, safety or welfare of any consumer. Other Departments may also take Administrative Actions against Network Providers, such as Claims Denials. Network Providers have the opportunity to request reconsideration of any of the following actions or sanctions, subject to the limitations discussed above.

1. Sanctions that Impact Network Participation
   a. Limiting Referrals
   b. Suspension of Referrals
   c. Payment Suspension
   d. Suspension from Closed Network (including Emergency Suspension to Protect Consumer)
   e. Site or Service Specific Termination
   f. Termination from Closed Network
   g. Exclusion from Participation in Closed Network

2. Administrative Actions that do not Impact Network Participation
   a. Decrease in Gold Star Provider Performance Profile Level
   b. Moratorium on Expansion of Sites or Services
   c. Warning/ Educational letter
   d. Plan of Correction
   e. Probation (increased monitoring)
   f. Identification, Recovery or Recoupment of overpayments
3. Actions or Disputes Related to the Network Provider’s Professional Competence or Conduct

Examples of Actions or Disputes Related to the Network Provider’s Professional Competence or Conduct include but are not limited to those disputes or actions based on: actions by the Network Provider’s licensure board, ethics, clinical boundaries, dual relationships, quality of care, professional competence to perform contracted services, or a determination by the Alliance Medical Director or Chief of Clinical Operations that a Network Provider is engaged in behavior or practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of any consumer.

D. General Requirements

1. The Alliance appeal process is available to any Network Provider who wishes to initiate it in response to an Alliance notification of Administrative Action or Sanction. Any notification of Administrative Action or Sanction to a Network Provider will include the basis for the Alliance decision, an explanation of how to request reconsideration and how to submit additional information, and the timelines for doing so. A Reconsideration Request Form is available on the Alliance website.

2. A Network Provider has twenty-one (21) days to request reconsideration from receipt or attempted first delivery of the Alliance notification of Administrative Action or Sanction. Network Providers must submit a formal written request via certified mail, return receipt requested, using the Reconsideration Request Form, signed by the sole practitioner or an Owner/Operator/Managing Employee of a provider organized as a corporation, partnership or limited liability company. Formal Requests must be sent to:

   Alliance Behavioral Healthcare
   ATTN: COMPLIANCE – PROVIDER RECONSIDERATIONS
   4600 Emperor Boulevard, Suite 200
   Durham, NC 27703

   The Alliance decision shall be considered final if a reconsideration request is not received within twenty-one (21) days from the receipt or first attempted delivery of the notification of Administrative Action or Sanction. The Network Provider must provide any additional information at the time the Request for Reconsideration is filed on a flash drive in a PDF format via USPS certified mail. The flash drive must be in compliance with HIPAA requirements. The Network Provider must submit four (4) duplicate flash drives, but will be given the option to submit four (4) duplicate paper copies if the provider can demonstrate it lacks the information technology capability to prepare and submit flash drives.

3. Alliance provides written notification to the Network Provider of all Administrative Actions, Sanctions, and Reconsideration Outcomes. All notifications are sent via email. If the Network Provider does not signify acceptance of the email within one (1) business day, the notification is sent via trackable mail. The trackable mail receipt will be maintained as part of the file. The timeframe for requesting reconsideration begins upon the provider’s acknowledgement of email receipt or first attempted mail delivery.

4. There are two tracks for provider dispute resolution. One track is for disputes involving professional competence/ conduct or Sanctions that impact the Network Provider’s status in the Closed Network. The other track is for Administrative Actions that do not involve professional competence/ conduct or impact the Network Provider’s status in the Closed Network.

5. Reimbursement may continue during the Reconsideration Process except in the following circumstances:

   a. The provider is cited for gross negligence or serious quality of care concerns; or
   b. The provider is suspected of committing fraud or abuse; or
   c. Alliance believes continued reimbursement is likely to increase any overpayment amount due.
E. Corporate Compliance Committee and Informal Meeting Process

The Alliance Corporate Compliance Committee is responsible for making decisions and recommendations about Administrative Actions and Sanctions against Network Providers in accordance with the Alliance Provider Sanctions, Administrative Actions, and Suspensions to Ensure Patient Safety Procedure. Administrative Actions are considered final upon issuance by the Compliance Department, and the Network Provider may initiate the dispute resolution process upon receipt of a Notice of Administrative Action. The Notice will include instructions for how to initiate the dispute resolution process.

Sanctions recommended by the Alliance Corporate Compliance Committee are not considered final until the Network Provider has been offered the opportunity for an in-person meeting with the Alliance CEO or designee, unless the sanction is based on: (1) notification to Alliance of exclusion from participation in federally-funded health care programs by the U.S. HHS Office of Inspector General; (2) loss of required facility or professional licensure, accreditation or certification; (3) Immediate Jeopardy finding issued by the Centers for Medicare and Medicaid Services; (4) action taken by the NC Department of Health and Human Services or any of its Divisions; or (5) Federal, State or local funds allocated to Alliance are revoked or terminated in a manner beyond the control of Alliance for any part of the Contract period. If the Sanction is considered final, it will be specified in the written notification to the Network Provider, and the Network Provider may initiate the dispute resolution process upon receipt.

If the Sanction is not considered final, the Network Provider will be given an opportunity to participate in an informal meeting with the CEO or designee. The Network Provider will be required to notify Alliance if they choose to participate and whether they intend to bring legal representation. Alliance legal counsel will participate at the invitation of the CEO or Compliance Officer or if the provider chooses to bring their legal counsel. At this informal meeting, the Network Provider will be given the opportunity to present any documentation or other evidence supporting why Alliance should not take the recommended action. Following the informal meeting, but in no more than seven (7) days, the Network Provider will be notified of Alliance’s final determination in writing by the Compliance Department. If the final determination upholds the Compliance recommendation, the notice will include instructions for how to initiate the dispute resolution process.

F. Reconsideration Process for Sanctions or Other Actions Related to the Network Provider’s Professional Competence or Conduct

1. Upon receipt of a timely request for reconsideration of a sanction or action related to the Network Provider’s Professional Competence or Conduct, Alliance will convene a first level panel. If the Network Provider does not request a reconsideration review within twenty-one (21) days from receipt of the final notification of Administrative Action or Sanction, the decision shall become final.

2. A first level panel meeting will be scheduled at the Alliance Headquarters no later than fourteen (14) days from the receipt of the request for reconsideration. The Corporate Compliance Committee designee will provide each panel member with a summary of the dispute/problem; identification of panel members, including indication of which member of the panel is the clinical peer of the Network provider who is the subject of the dispute; and a HIPAA-compliant flash drive containing the supporting documentation submitted by the Network Provider.

3. The Network Provider is informed of the date, time and place of the meeting at least three (3) days in advance and invited to appear in person or by telephone and to present arguments and documentation to the first level panel. The Network Provider must notify Alliance in advance if they intend to bring legal counsel to the panel meeting. The Network Provider must provide any additional written documentation to be considered during the Reconsideration Process at the time the Request for Reconsideration is filed.

4. The first level panel will notify the Compliance Department of their decision no later than seven (7) days following the panel meeting. The Compliance Department will issue a written decision to the Network Provider no later than seven (7) days following the panel decision.
5. If not satisfied with the first level panel decision, the Network Provider may request reconsideration by a second level panel within seven (7) days from receipt or attempted first delivery of the first level panel decision as set forth in D.2. above. If the Network Provider does not request a second level panel review within seven (7) days from receipt of the first level panel decision, the decision shall become final.

6. The second level panel will conduct a Desk Review of the first level panel decision within fourteen (14) days of receipt of the request for a second level review, and may consider any additional documentation submitted by the Network Provider along with the second request for reconsideration.

7. The second level panel will notify the Compliance Department of their decision no later than seven (7) days from completion of the Desk Review. The Compliance Department will issue a final written decision to the Network Provider no later than seven (7) days following the panel decision. The second level panel decision is final and there is no right to appeal beyond the second level panel.

8. If the Network Provider challenges the final Alliance decision in any administrative, State or federal court, Legal Counsel will contract with outside counsel or begin preparing a defense of the case. In the event of an appeal, the Compliance Department will be required to prepare a case summary and gather relevant documents, and Alliance staff involved in the audit, review, investigation or sanction determination will participate at all levels of the appeal process as deemed necessary by Legal Counsel.

G. Reconsideration Process for Administrative Actions

1. Upon receipt of a request for timely reconsideration of an Administrative Action, Alliance will convene a reconsideration panel consisting of three Alliance employees who were not involved in the original decision. If the Network Provider does not request a reconsideration review within twenty-one (21) days from receipt or attempted delivery of the Alliance final notification of Administrative Action or Sanction, the decision shall become final.

2. The reconsideration panel will meet at the Alliance Headquarters no later than fourteen (14) days from the receipt of the request for reconsideration. The Network Provider will be invited to appear in person or by telephone and to present arguments and documentation to the reconsideration panel. The Network Provider must provide any additional written documentation to be considered during the Reconsideration Process at the time the Request for Reconsideration is filed.

3. The reconsideration panel will notify the Compliance Department of their decision no later than seven (7) days following the panel meeting. The Compliance Department will issue a final written decision to the Network Provider no later than seven (7) days following the panel decision. This decision is final and there is no right to appeal beyond the reconsideration panel.

4. If the Network Provider challenges the final Alliance decision in any administrative, State or federal court, Legal Counsel will contract with outside counsel or begin preparing a defense of the case. In the event of an appeal, the Compliance Department will be required to prepare a case summary and gather relevant documents, and Alliance staff involved in the audit, review, investigation or sanction determination will participate at all levels of the appeal process as deemed necessary by Legal Counsel.

H. Reconsideration Process for Claims Denials or Other Provider Disputes

Requests for reconsideration of a claim denial must be submitted as set forth in Section D., above, within twenty-one (21) days of the date the Remittance Advice was posted in the AlphaMCS Provider Portal, and shall be considered by the Alliance Chief Financial Officer or designee. The CFO or designee will notify the Network Provider of the final decision within thirty (30) days of receipt of the request for reconsideration. Alliance will consider requests for reconsideration submitted by Network Providers concerning other disputes on a case-by-
basis. If the request for reconsideration is accepted, the review will be conducted in accordance with Section G., Reconsideration Process for Administrative Actions.

I. Approval of these procedures

The Alliance Behavioral Healthcare Human Rights Committee shall approve these procedures and any subsequent revisions which alter the content related to the reconsideration review panels. The approval shall be documented in the Human Rights Committee minutes. All operational procedures are approved by the Alliance Behavioral Healthcare Area Director/CEO per the Alliance Policy on Development of Policies and Procedures.
Q2 Incident Statistics

- There were 895 incidents (791 incident reports) occurring for 559 consumers. 531 incident reports involved children, and 260 incident reports involved adults.
- The highest number of incidents for one consumer was 18 (out of county consumer).
- Of the consumers with the highest number of incidents (over 5) all 7 are children.
  - The adolescent consumer with the most incidents (18) is an out of county consumer residing at a PRTF. All of the reports have been consumer behaviors – aggressive/destructive or suicide attempts. 77% of the incidents involving the other 6 consumers with 5 or more incidents are restrictive interventions from Day Treatment facilities and 16% are consumer behaviors.
**Q2 FY 14 Level 2 Incidents by Population**

**Background:** Level 2 incidents are monitored to ensure consumer and community safety.

**Trend and Analysis:** The lower trend line indicates those types of incidents that occurred in more than .2% of that county’s population served. The upper trend line is only for Consumer Behavior incidents. Those typically occur at a higher rate than all others. The percentage used is .4% of that county’s population served. The majority of the Wake County restrictive interventions (72%) are from one day treatment provider. This same provider accounts for 27% of the total consumer behaviors and 22% of “other” incidents in Wake County. 80% of incidents categorized as “Allegations of Abuse” occurring in Johnston County were from one ICF MR/DD provider. There were 8 reports involving 7 consumers. 6 of these incident reports were due to an anonymous call reporting allegations of abuse, therefore a report was done for each consumer in the home – the allegations were unsubstantiated. 26% of incidents categorized as “other” in Durham County were from one substance abuse provider and 19% of incidents categorized as “consumer behavior” were from one agency providing IIH and OPT services.

**Next Steps:** Review incident trends to determine if referral to Provider Account specialists is needed.
**Background:** Level 2 incidents are monitored to ensure consumer and community safety.

**Trend and Analysis:** Data is presented without outlier information.

**Next Steps:** Review incident trends to determine if referral to Provider Account specialists is needed.
**Q2 FY 14 Level 3 Incidents by Population**

**Background:** Level 3 incidents are monitored to ensure consumer and community safety. Information is shared with necessary members of management to ensure a comprehensive clinical and administrative response.

**Trend and Analysis:** The trend line indicates those types of incidents that occurred in more than 0.25% of that county’s population served. 44% of the incidents categorized as “Abuse/Neglect/Exploitation” in Wake County were from 1 provider. No trends related to the “consumer behavior” category or “other” category were noted for Wake or Durham counties.

**Next Steps:** Review incident trends to determine if referral to Provider Account specialists is needed.
Q2 FY14 Incidents by Service Type – MH/SA

Incidents involving MH/SA consumers increased from 556 in the 1st quarter of FY14 to 664 in the 2nd quarter of FY14. IIH services remained the service with the highest percentage of incidents reported with 23% (156 incidents) compared to 20% (140 incidents) last quarter. Child Day Treatment was the next highest with 111 incidents reported (up from 66 incidents last quarter, followed by BH Outpatient with 95 incidents reported in the 2nd quarter.

N = 664
Q2 FY14 Incidents by Service Type – IDD

Incidents involving IDD consumers decreased from 134 to 127 in Q2 FY14. ICF MR/DD’s had the most incidents in the 2nd quarter with 27 incidents reported, the same number as last quarter. In-Home Skill Building was the next highest with 25 incidents reported. There was a large decrease in incidents involving Day Supports services – from 19 incidents in the 1st quarter FY14 to 4 incidents in the 2nd quarter FY14.

N = 127
Level 2 & 3 Incident Definitions

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

- **Level 3 incident categories and behaviors** — all are categorized as any that results in permanent physical or psychological impairment or if there is perceived to be a significant danger to the community
  - Death – Suicide, Accident, Homicide, Unknown
  - Restrictive Intervention
  - Consumer Injury
  - Abuse/Neglect/Exploitation – includes all sexual assaults
  - Medication Error
  - Behavior
  - Other
ITEM: Consumer and Family Advisory Committee (CFAC) Report

DATE OF BOARD MEETING: April 3, 2014

BACKGROUND:
The Alliance Consumer and Family Advisory Committee, or CFAC, is made up of consumers and/or family members that live in Durham, Wake, or Cumberland Counties who receive mental health, intellectual/developmental disabilities and substance use/addiction services. CFAC is a self-governing committee that serves as an advisor to Alliance administration and Board of Directors.

State statutes charge CFAC with the following responsibilities:

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

The Alliance CFAC meets at 5:30pm on the first Monday in the months of February, April, June, August, October and December at the Alliance Corporate Office, 4600 Emperor Boulevard, Durham. 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.

The Alliance CFAC is currently chaired by Dan Shaw while Maribel Rivera-Elias serves as vice-chair.
REQUEST FOR AREA BOARD ACTION:
Accept the draft minutes of March 11, 2014, meeting of the Wake Subcommittee of the Alliance Consumer and Family Advisory Committee. Durham subcommittee meeting was canceled due to weather and Cumberland happens the last week of the month.

CEO RECOMMENDATION:
Accept the draft minutes.

RESOURCE PERSON(S):
Doug Wright, Dan Shaw, Maribel Rivera-Elias
MEMBERS PRESENT: Caroline Ambrose, Dave Curro, and Maribel Rivera-Elias, Faye Griffin, and Denise Wood
STAFF PRESENT: Roanna Newton, Roosevelt Richards, and Doug Wright
GUEST(S) PRESENT: Israel Pattison, Vivian Peebles

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES: minutes were approved as written, motion made by Elias and Dave Curro seconded the motion.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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<tbody>
<tr>
<td>Public Comment</td>
<td></td>
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<tr>
<td>State Update</td>
<td>Newton distributed and reviewed March 2014 Consumer Empowerment Team Update</td>
<td>Look for the April 2014 State Update</td>
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<td>Training and Education – Intellectual and Developmental Disabilities</td>
<td>Wright reviewed I/DD PowerPoint Had a Question and Answer period</td>
<td>Look for the May Training and Education</td>
<td>N/A</td>
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<td>Wake Community Forum</td>
<td>AD-HOC committee needed for Wake Community Forum to assist in planning the forum AD-HOC committee members from last night are Ambrose, Elias, Griffin, and Pattison. Cunningham showed interest but did not attend last night’s meeting. Time frame is late summer and early fall for the actual event.</td>
<td>Confirmed membership of AD-HOC committee Confirm date and location of AD-HOC committee</td>
<td>May 13, 2014 at 4:30-5:30pm</td>
</tr>
<tr>
<td>MCO Updates</td>
<td>CIT Training 538 CIT officers for all municipals 177 of those are Raleigh Police Department and the rest of 538 are sheriffs 35% are law enforcement officers Wright went over important dates in March pertaining to ABHC Provider news and updates are on found at <a href="http://www.alliancebhc.org/">http://www.alliancebhc.org/</a> under providers</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### AGENDA ITEMS:

<table>
<thead>
<tr>
<th>Announcements</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mental Health Training for youth educators starting in June – 8 hour training also Mental Health First Aid is currently offered by Alliance and it is community wide. Information can be found on <a href="http://www.alliancebhc.org/">http://www.alliancebhc.org/</a>. Independent Living Initiative accepting applications, cross agency training, second Friday of each month, topics varies, located at 2000 Noble Road Raleigh, NC 27608 Beyond Silos- registration closed integrative care together, 6-8:30pm on 3/12/2014 ILI can be used for Oxford Houses</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

5. **ADJOURNMENT**
ITEM: Executive Committee Report

DATE OF BOARD MEETING: April 3, 2014

BACKGROUND:
The Executive Committee sets the agenda for Area Board meetings and acts in lieu of the Area Board between meetings. Actions by the Executive Committee are reported to the full Area Board at the next scheduled meeting. Attached are the minutes from the February 11, 2014, Executive Committee meeting.

REQUEST FOR AREA BOARD ACTION:
Accept the report as presented.

CEO RECOMMENDATION:
Accept the report as presented.

RESOURCE PERSON(S):
Rob Robinson
1. WELCOME AND INTRODUCTIONS – Chairman Webley

2. REVIEW OF THE MINUTES – The minutes for the December 10, 2013 and January 14, 2014 Executive Committee and the January 14, 2014 Joint Executive Committee/County Commissioner Advisory Committee meetings were reviewed and approved. Mr. Stanford made the motion to approve. Second was given by Mr. Taylor. 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. Meetings with Wake, Durham and Cumberland County Commissioners, County Managers to discuss Load deferment. | As discussed on January 8th, meetings were held with members of the County Commissioners, County Managers and County Management Staff for both Cumberland and Wake Counties to discuss the possibility of deferring our loan payments for two years. Ms. Holliman and Mr. Robinson met with Wake County Commissioner Ms. Sullivan and Wake County Management Staff Joe Durham, Johnna Rogers, and Denise Foremen on January 29th. Ms. Holliman and Mr. Robinson met with Cumberland County on Feb. 5th. Participants included Chairperson Council, Commissioner Edge, James Martin, Amy Cannon, and Cumberland County Finance Director. The group heard our request for load deferment for 2 years and all Commissioner’s in attendance indicated they understood the need for our request and appeared supportive. Wake suggested deferring the loan to include deferring the interest. The Durham meeting has not been scheduled at this time. | 1. Ms. Holliman to schedule meeting with Durham County to discuss Load deferment.  
2. Ms. Holliman to get on BOCC agenda for Cumberland, Durham and Wake to make formal request for loan deferment for 2 years. | |
| 5. CEO contract | Mr. Webley stated that a draft contract has been developed and sent to Mr. Robinson’s attorney for review. Members of the EC will discuss with Mr. Robinson at the next Board meeting. | 1. Mr. Webley and members of the EC to review contract with Mr. Robinson in closed session of the Board meeting. | |
| 6. March Board agenda | The following items were approved for the March agenda: Board Retreat, Community Relations and Criminal Justice systems, | 1. No action required | |
### AGENDA ITEMS:

<table>
<thead>
<tr>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Innovations programs, MCO consolidation update, Mercer Review update, and Committee reports. We will also schedule a closed session to discuss a personnel matter.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. ADJOURNMENT
ITEM: Policy Committee Minutes

DATE OF BOARD MEETING: April 3, 2014

BACKGROUND:
The Committee’s functions include:
1. Developing, reviewing and revising Area Board By-Laws and Policies that Govern the LME/MCO.
2. Recommending policies to the full Area Board to include all functions and lines of business of the LME/MCO.
3. Reviewing Area Board Policies at least annually, within 12 months of policies’ approval. The Committee reviews a number of Policies each quarter in order to meet the annual review requirement.
4. Revising Policies to ensure compliance with applicable law, federal and state statutes, administrative rules, state policies, contractual agreements and accreditation standards.
5. Ensure that a master Policy Index is kept current indicating policy names, original approval dates, all revision dates, all review dates, accreditation standards, and references to applicable law, federal and state rules and regulations and state policies.

REQUEST FOR AREA BOARD ACTION:
Accept Board Policy Committee minutes: 2/19/2014

CEO RECOMMENDATION:
Accept minutes as submitted for review.

RESOURCE PERSON(S):
Jim Edgerton, Policy Committee Chair
Monica Portugal, Corporate Compliance Officer
# Alliance Behavioral Healthcare
## Area Board Policy Committee
### Meeting Minutes

<table>
<thead>
<tr>
<th>Committee name:</th>
<th>Board Policy Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting date:</td>
<td>2/19/14</td>
</tr>
<tr>
<td>Report submitted by:</td>
<td>Jim Edgerton, Chair</td>
</tr>
<tr>
<td>Members:</td>
<td>Lascel Webley Jr., Area Board Chairman</td>
</tr>
<tr>
<td>Members Present:</td>
<td>Cynthia Binanay, Jim Edgerton, Lodies Gloston</td>
</tr>
<tr>
<td>Members Absent:</td>
<td>Lascel Webley Jr.</td>
</tr>
<tr>
<td>Staff:</td>
<td>Ellen Holliman (Area Director/CEO), Monica Portugal (Corporate Compliance Officer, Staff Support to the Board Policy Committee)</td>
</tr>
<tr>
<td>Minutes from (Date)</td>
<td>11/14/2013 minutes reviewed and unanimously approved.</td>
</tr>
<tr>
<td>Follow up Items</td>
<td>N/A</td>
</tr>
<tr>
<td>Announcements</td>
<td>None</td>
</tr>
<tr>
<td>Documents Provided</td>
<td>Agenda; draft revision of By-Laws; Policies</td>
</tr>
</tbody>
</table>

## Non-Report Topic: By-Laws

<table>
<thead>
<tr>
<th>Brief description of Topic</th>
<th>Ms. Holliman presented suggested revisions to the By-Laws.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suggestions/Comments</td>
<td>Ms. Holliman reviewed different resources to consider when making revisions to the By-Laws. Among others, the following were referenced: the joint resolution between Cumberland, Durham and Wake Counties, Senate Bill 191 and 208, and NC G.S. 122C-117. Committee reviewed revisions and made few suggested changes. A question was raised regarding the make up of the QM Committee and whether URAC requires Alliance QM Staff to serve as members. After the meeting, it was noted that URAC requires the person with the responsibility for the overall operation of the QM Program to serve on the QM Committee and that this should be included in the By-Laws.</td>
</tr>
<tr>
<td>Next steps:</td>
<td>The revised draft will be submitted to the Board for review at the next Board meeting.</td>
</tr>
</tbody>
</table>
### Annual Review: Care Coordination, Client Rights, Customer Service, Provider Network, Quality Management, Utilization Management

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Brief description of Topic</strong></td>
<td>The Committee reviewed all Care Coordination, Client Rights, Customer Service, Provider Network, Quality Management and Utilization Management Policies.</td>
</tr>
<tr>
<td><strong>Suggestions/Comments</strong></td>
<td>A. The following Policies were reviewed without revisions:</td>
</tr>
<tr>
<td></td>
<td>- Coordination of Care for Special Health Care Population</td>
</tr>
<tr>
<td></td>
<td>- Advanced Directives, Advanced Instructions</td>
</tr>
<tr>
<td></td>
<td>B. The following Policies were reviewed and suggested revisions were made:</td>
</tr>
<tr>
<td></td>
<td>- None</td>
</tr>
<tr>
<td><strong>Next steps:</strong></td>
<td>Several questions were clarified regarding some of the policies:</td>
</tr>
</tbody>
</table>

- Accessibility of UR-UM: question whether UM staff are on call in order to manage urgent/emergent requests. Most after-hours urgent requests do not require pre-service/prior authorization. However licensed clinicians are available in the Access and Information Center 24/7/365 should an emergency authorization be required after primary office hours.
- Advanced Directives: question whether Advanced Directives are only for mental health treatment, or also for SA and IDD. It is only for mental health treatment per state statutes.
Consumer, Provider and Stakeholder Satisfaction: question whether Alliance should work with other committees such as CFAC, Human Rights, and County Commissioners Advisory Committee in addition to the QM Committee. This is an option and the Board’s decision to make. Alliance does not develop or evaluate the results of the annual consumer and provider satisfaction surveys. These surveys are managed by DHHS. Results are shared with Alliance Area Board, CFAC, Human Rights Committee and Quality Management Committee.

Financial Eligibility: question regarding the following statement “Residents of the Alliance counties are eligible for crisis assessment and crisis services through the Alliance Provider Network when no other payer source is available. Under this policy, acute inpatient psychiatric services that require prior authorization are not considered crisis services.” The purpose is to highlight that walk-in or involuntary crisis assessments can be completed on any individual who presents at an assessment center regardless of their county of residence, ability to pay, insurance, etc. and that the crisis assessment does not require an authorization from Alliance. The reason is to ensure that no one who could be a potential danger to themselves or others is not adequately assessed when in need. Consumers without Medicaid in each of the Alliance counties can receive inpatient services under a Three-way contract agreement at Johnston Memorial Hospital, Cape Fear, UNC WakeBrook and Duke University Hospital. Additionally, Wake County consumers without Medicaid can receive inpatient services at Holly Hill Hospital and UNC WakeBrook.

Reviewed Policies will go as a consent agenda item for approval at the March Board meeting.

**Next meeting will be April 24, 2014 at 4:00 pm to 5:30 pm in room 208.**
ITEM: Consent Agenda

DATE OF BOARD MEETING: April 3, 2014

REQUEST FOR BOARD ACTION:
Approve the draft minutes from the March 6, 2014, Board meeting.

CEO RECOMMENDATION:
Approve the minutes as presented.

RESOURCE PERSON(S):
Rob Robinson, Veronica Ingram
1. CALL TO ORDER:
Chairman Lascel Webley, Jr. called the meeting to order at 4:06 p.m.

2. ANNOUNCEMENTS
A. Board Retreat
Chairman Webley, Jr. reminded the Board of the annual Board Budget Retreat on Wednesday, March 26, 2014, from 11:30 a.m. – 3:30 p.m. and advised Board members to RSVP to Veronica Ingram, Executive Assistant by March 18, 2014.

2. B. Introduction of Board Applicants
Chairman Webley, Jr. announced the receipt of applications for the Durham and Wake County Board seats. No applicants were in attendance.

C. New General Counsel
Ellen Holliman, Chief Executive Officer, announced that effective March 24, 2014, Alliance’s General Counsel will be Carol Hammett. Ms. Hammett previously served as Durham County’s Deputy County Attorney and has worked with Durham County for thirteen years. Ms. Hammett will be introduced to the Board at a later date.
D. Board Interviews Schedule
Chairman Webley, Jr. mentioned that Board applicant interviews will be Tuesday, March 11, 2014, as part of the Executive Committee meeting. Chairman Webley, Jr. invited all Board members to attend the Executive Committee meeting which starts at 4:00 p.m.

E. Board Emails
Ms. Holliman advised the Board of the current email policy; per HIPAA security guidelines Alliance will encrypt all outgoing emails. Emails received at personal email accounts will still be accessible and require an initial registration and then password to access. Board members can register for access or use their IPads to view emails. Chief Information Officer, Lloyd Merithew, advised Board members of recent HIPAA changes and described how this new implementation will reduce risk to individuals and Alliance.

F. NC Council Community News Update
Chairman Webley, Jr. advised Board members of articles in the current NC Council Community News Update. The articles on pages eight and nine feature Chief Executive Officer, Ellen Holliman, and Chief Operating Officer, Rob Robinson.

Chairman Webley, Jr. congratulated staff on the recent innovation of using a web based platform for sharing news.

3. AGENDA ADJUSTMENTS
Chairman Webley, Jr. moved the Chairman’s Report from item eleven to item four.

4. CHAIRMAN’S REPORT
Chairman Webley, Jr. quoted passages from President Roosevelt’s speech for the dedication of the presidential library, announced the Board’s decision to rename the Board Room as the Ellen S. Holliman Board Room and presented Ms. Holliman with the new sign for the Board Room.

BOARD ACTION
The Board accepted the report as presented. No further action needed.

5. PUBLIC COMMENT
None

6. FINANCE COMMITTEE REPORT
The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Board. The Finance Committee meets monthly at 3:00 p.m. prior to the regular Board meeting. Draft minutes and financial information from the February 6, 2014, meeting were included in the Board packet.

Finance Committee Chairman, George Quick, presented an update to the Board. Mr. Quick referred to information included in the Board packet and presented the committee’s recommendation to issue Board stipends via electronic funds transfer instead of paper check.
**BOARD ACTION**
A Motion was made by Commissioner Kenneth Edge to approve issuing Board stipends via electronic funds transfer; seconded by Dr. George Corvin. Motion passed.

7. **COMMITTEE REPORTS**
   A. Consumer and Family Advisory Committee Report
   B. Executive Committee Report

Chairman Webley, Jr. mentioned that Board members received the reports as part of the Board packet.

**BOARD ACTION**
A Motion was made by Mr. George Quick to accept the committee reports as presented; seconded by Mr. Christopher Bostock. Motion passed.

8. **CONSENT AGENDA**
   A. Draft Board minutes from the February 6, 2014, Board meeting
   B. Area Board Member Meeting Compensation Policy

Chairman Webley, Jr. stated that the Board received the consent agenda in the Board packet.

**BOARD ACTION**
A Motion was made by Mr. George Quick to approve the consent agenda as presented; seconded by Mr. William Stanford. Motion passed.

9. **BOARD TRAINING:**
   A. Community Relations Collaboration with the Legal System
   James Osborn, Crisis and Incarceration Manager, presented a detailed PowerPoint presentation depicting the collaboration that occurs between the legal, criminal justice system and Alliance’s Community Relations department. Additionally, Mr. Osborn announced Hank Debnam, Cumberland Site Director, who was recognized by Cumberland County and Fayetteville/Cumberland crisis teams for work related to Cumberland’s CIT program and officer training.

As Board members discussed the presentation and the impact on the criminal system and school system, Ann Oshel, Director of Community Relations, presented additional information detailing the roles of Jail Liaisons and Court Liaisons and the national concern of decriminalization of the mentally ill, release planning practices, and the impact on the community. Ms. Oshel mentioned meetings with judges and educators have occurred and are scheduled; part of the purpose of these meetings is to facilitate prompt identification and referral for individuals needing services.

B. Innovations Waiver
Andrea Kinnaugh, I/DD UM Manager, and Suzanne Goerger, I/DD Care Coordination Director, presented a detailed PowerPoint presentation which included an overview of the core components of managing the Medicaid Innovations Waiver; the components include care coordination, utilization management and ensuring a qualified provider network.
As Board members discussed the presentation Ms. Goerger and Ms. Kinnaugh clarified the history of the waiting list/Registry of Unmet Needs and the length of time some consumers are on this list. Dr. Khalil Tanas, Medical Director, stated that although consumers may not be under the Innovations Waiver they could still be eligible to receive other services.

Ms. Goerger added that consumers on the Innovations Waiver also have a Care Coordinator. Ms. Kinnaugh stated the purpose of Individual Support Plan and the Care Coordinator’s role in creating it. Also, Ms. Kinnaugh stated that the Division of Medical Assistance allocates the number of slots available on the Innovations Waiver and any potential increase or decrease in the number of slots. This amount then impacts the number of consumers on the Registry of Unmet Needs.

**BOARD ACTION**
The Board received the trainings. No further action required.

10. **BOARD BY-LAWS**
In addition to NC General Statues 122C-117, 122C-118.1 and 122C-119, the Board by-laws provide the operational basis for the area authority. Changes to the current by-laws were needed to reflect recent legislation as noted in Senate Bill 208, Senate Bill 191 and the July 8, 2013, Joint Resolution between Cumberland, Durham, and Wake Counties. The Policy Committee met on February 19, 2014, and finalized recommended changes to the by-laws. Ellen Holliman, Chief Executive Officer, provided an update of the proposed changes to the by-laws as submitted in the Board packet.

**BOARD ACTION**
A Motion was made by Mr. James Edgerton to approve the by-laws; seconded by Mr. Phillip Golden. Motion passed.

11. **UPDATES**
A. **MCO Consolidation/Medicaid Reform**
Chief Executive Officer, Ellen Holliman, provided an overview of the MCO Consolidation/Medicaid Reform plan as presented at the February, 26, 2014, meeting of the Medicaid Reform Advisory Committee. Ms. Holliman stated that as mentioned at this meeting the current plan is a compromise as it is differs from the initial plan; LME/MCOs are part of the new Medicaid reform with includes a consolidation from ten MCOs to four.

**BOARD ACTION**
The Board accepted the update. No further action required.

12. **CLOSED SESSION**
The Area Board had a closed session in accordance with NC General Statue 143-318.11(a) (6) to discuss the qualifications and conditions of appointment of a public employee.

**BOARD ACTION**
A Motion was made by Commissioner Kenneth Edge to enter into closed session; seconded by Mr. Scott Taylor. Motion passed.
A Motion was made by Dr. George Corvin to return to open session; seconded by Mr. George Quick. Motion passed.

A Motion was made by Commissioner Caroline Sullivan to approve all of the Employee Agreement except section four; seconded by Ms. Cynthia Binanay. Motion passed.

A Motion was made by Dr. George Corvin to approve section 4.5 of the Employee Agreement and exclude items 2 and 4 of the agreement; seconded by Mr. Scott Taylor. Motion passed.

13. **ADJOURNMENT**

With all business being completed the meeting adjourned at 6:37 p.m.

Next Board Meeting
Thursday, April 3, 2014
4:00 – 6:00

Respectfully submitted:

[Signature]

Ellen S. Holliman, Chief Executive Officer  Date Approved
ITEM: Intellectual/Developmental Disabilities Care Coordination Overview

DATE OF BOARD MEETING: April 3, 2014

BACKGROUND:
Alliance is charged with providing care coordination to individuals with special health care needs, including those individuals who are considered high risk or high cost based on a mix of diagnosis, services utilization and clinical complexity. The presentation will provide an overview of the Alliance I/DD care coordination model, populations served, staffing and key responsibilities.

REQUEST FOR AREA BOARD ACTION:
Accept the training as presented.

CEO RECOMMENDATION:
Accept the training as presented.

RESOURCE PERSON(S):
Suzanne Goerger, Director of I/DD Care Coordination
Alliance
BEHAVIORAL HEALTHCARE

IDD Care Coordination

April Board Meeting

A New Multi-County Area Authority Merging The Durham Center and Wake LME
Criteria for Referral

- NC Innovations enrollee
- Screened IDD Eligible
- Crisis
  - Homelessness
  - Inpatient Admission
  - Health and Safety Concerns
  - Legal charges and/or incarceration
- Standard
  - Admission to Skilled Nursing Facility
  - Expulsion from services
  - Difficulties with transition from child to adult services
  - Loss of caregiver
  - Complex unmet needs and/or extreme behavioral challenges
Responsibilities

• Support all 1,800 NC Innovations Enrollees
  • Plan development
  • Monitoring
  • Education
  • Linking
  • Problem resolution

• Special Needs Population
  • Short Term
  • Crisis
  • Regular
Staffing

Durham
• 1 Supervisor,
• 10 Care Coordinators

Wake
• 2 Supervisors
• 26 Care Coordinators

Cumberland
• 1 Supervisor
• 12 Care Coordinators

Johnston
• 1 Supervisor
• 5 Care Coordinators

Average Caseload Size = 35
Questions?

Suzanne Goerger
Director of IDD Care Coordination
919-651-8474
sgoerger@alliancebhc.org
ITEM: Mental Health/Substance Abuse Care Coordination Overview

DATE OF BOARD MEETING: April 3, 2014

BACKGROUND:
Alliance is charged with providing care coordination to individuals with special health care needs, including those individuals who are considered high risk or high cost based on a mix of diagnosis, services utilization and clinical complexity. The presentation will provide an overview of the Alliance MH/SA care coordination model, populations served, and key program metrics.

REQUEST FOR AREA BOARD ACTION:
Accept the training as presented.

CEO RECOMMENDATION:
Accept the training as presented.

RESOURCE PERSON(S):
Michael Bollini, PhD, Director of MH/SA Care Coordination
ITEM: MCO Consolidation/Medicaid Reform Update

DATE OF BOARD MEETING: April 3, 2014

BACKGROUND:
Mid-March 2014, the Department of Health and Human Services presented their Medicaid reform proposal that describes their vision for the future which includes adopting Accountable Care Organizations model on the physical health side and continuing with the MCO model on the behavioral health side. The plan was previously discussed with the five member Medicaid Advisory Committee meeting on February 26, 2014. An additional focus of the plan is developing a sustainable integrated physical and behavioral health. This plan is consistent with the work done over the past year between DHHS and MCO Directors through the NC Council. Rob Robinson, CEO, will present highlights of the plan for the board.

REQUEST FOR BOARD ACTION:
Accept the update as presented.

CEO RECOMMENDATION:
Accept the update as presented.

RESOURCE PERSON(S):
Rob Robinson, CEO