
GUEST(S) PRESENT: Carolyn Ambrose, CFAC Chair

ALLIANCE STAFF PRESENT: Michael Bollini, Chief Strategy Officer; Margaret Brunson, Hospital Relations Director; Hank Debnam, Cumberland Site Director/Veterans Point of Contact; Joey Dorsett, Chief Information Officer; Doug Fuller, Director of Communications; Kelly Goodfellow, CFO; Amanda Graham, Chief of Staff; Veronica Ingram, Executive Assistant; Carlyle Johnson, Director of Network Strategic Initiatives; Wes Knepper, Project Manager; Geyer Longenecker, Quality Management Director; Ken Marsh, Medicaid Program Director; Beth Melcher, Chief of Network Development and Evaluation; Janis Nutt, Johnston Site Director; Ann Oshel, Chief Community Relations Officer; Kate Peterson, Healthcare Network Project Manager; Monica Portugal, Chief Compliance Officer; Al Ragland, Chief HR Officer; Rob Robinson, CEO; Sean Schreiber, Chief Clinical Officer; Stephanie Williams, Community Relations Supervisor; and Doug Wright, Director of Consumer Affairs

1. CALL TO ORDER: Chairman Christopher Bostock called the meeting to order at 4:03 p.m.

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<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
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| 2. Announcements | A. New Board Committees: Chairman Bostock reminded Board members that, starting with this fiscal year, Alliance has two additional Board Committees: Audit and Compliance Committee and Network Development and Services Committee. Chairman Bostock thanked Board members for their service and staff for their support with these committees.  
B. NC Council Conference: Mr. Robinson reminded Board members of the December conference. Board members may contact Ms. Ingram for assistance registering for the conference.  
C. Mercer Review: Mr. Ken Marsh mentioned results from the May 2015 review and expectations for the next review. |
| 3. Agenda Adjustments | Chairman Bostock noted that two closed sessions were added; there were no additional adjustments to the agenda. |
| 4. Public Comment | There were no public comments. |
| 5. Committee Reports | A. Consumer and Family Advisory Committee (5 minutes) – page 5  
The Alliance Consumer and Family Advisory Committee (CFAC) is composed of consumers and/or family members from Durham, Wake, or Cumberland counties who receive mental health, intellectual/developmental disabilities or |
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<td>substance use/addiction services. This month’s report included draft minutes from the Wake, Durham and Cumberland subcommittee meetings.</td>
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<td>The committee reports were sent as part of the Board packet; Carolyn Ambrose, CFAC Chair, presented the CFAC report. Ms. Ambrose stated that the CFAC annual report was recently sent; she also reminded Board members that September is recovery and suicide awareness month. Ms. Ambrose mentioned a continued concern regarding transportation issues for consumers and noted an upcoming CFAC resource fair.</td>
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<td>B. Finance Committee (10 minutes) – page 39</td>
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<td>The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Area Board. This month’s report included draft minutes from the August meeting.</td>
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<td>James Edgerton, Finance Committee Chair, presented the Finance Committee report. Mr. Edgerton mentioned that for the period ending August 31, 2015, revenues exceed expenditures and Alliance met State mandated ratios. He also mentioned a request to restrict funds.</td>
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<td>BOARD ACTION</td>
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<td>A Motion was made by Mr. James Edgerton to restrict $79,023,183; seconded by Mr. McKinley Wooten. Motion passed unanimously.</td>
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<td>6. Consent Agenda</td>
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<td>A. Draft Minutes from September 3, 2015, Regular Board Meeting – page 42</td>
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<td>B. Human Rights Committee Report – page 48</td>
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<td>C. Quality Management Committee Report – page 98</td>
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<td>D. Area Board Conflict of Interest – page 164</td>
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<td>BOARD ACTION</td>
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<td>A Motion was made by Mr. William Stanford to approve the consent agenda; seconded by Mr. Phillip Golden. Motion passed unanimously.</td>
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<td>7. FY16 Organizational Initiatives – page 166</td>
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<td>At the May Board meeting there was a presentation on “Organizational Goals: FY16 Strategic Plan Initiatives”. Amanda Graham, Chief of Staff, presented an update on the FY16 initiatives. She provided background related to the creation of the mission, vision, values and six strategic plan goals. Ms. Graham provided an update on the current initiatives for these goals, noting which are complete, underway or pending. She also shared highlights from some</td>
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AGENDA ITEMS: | DISCUSSION:
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strategic plan initiatives, and a high level review of outcome measures for the strategic plan goals. The presentation of FY16 organizational initiatives are attached to and made part of these minutes.

**BOARD ACTION**  
The Board received the update; no additional action required.

8. Training: Housing – page 185  
Ann Oshel, Chief Community Relations Officer, presented an overview of the Independent Living Initiative, a program that provides rental and financial assistance to adults and families as well as supports landlords to increase housing success. Ms. Oshel described elements of supportive housing, fair market rental rates, targeted housing program, restoring hope initiative, independent living initiative overview, HUD funded programs, building strong relationships with landlords, and housing as a healthcare strategy. Board members discussed housing opportunities relative to specific counties. The housing presentation is attached to and made part of these minutes.

**BOARD ACTION**  
The Board received the training; no additional action required.

9. Updates  
NC Legislation/Medicaid Reform: Ms. Hammett provided an update from recent legislation noting the State budget and its impact to LME/MCOs. She additionally mentioned how Medicaid reform impacts MCOs.

**BOARD ACTION**  
The Board received the update; no additional action required.

10. Chairman’s Report  
Chairman Bostock thanked Board members Ann Akland, Lodies Gloston, and Cynthia Binanay for assisting with a recent RFP selection process. He stated that Dr. George Corvin will assist with an upcoming RFP selection process.

11. Closed Sessions  
The Area Board held a closed session pursuant to § 143-318.11(a)(1) to prevent the disclosure of information that is privileged or confidential, and pursuant to § 143-318.11(a)(3) to consult with legal counsel employed or retained by the public body in order to preserve the attorney-client privilege between the attorney and the public body.

**BOARD ACTION**  
A Motion was made by Dr. George Corvin to enter closed session pursuant to § 143-318.11(a)(1) to prevent the disclosure of information that is privileged or confidential; seconded by Mr. James Edgerton. Motion passed unanimously.
**AGENDA ITEMS:**

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<td>A Motion was made by Dr. George Corvin to enter closed session pursuant § 143-318.11(a)(3) to consult with legal counsel employed or retained by the public body in order to preserve the attorney-client privilege between the attorney and the public body; seconded by Mr. James Edgerton. Motion passed unanimously.</td>
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<td>The Board returned to open session. No action was taken during closed session.</td>
<td>12. Adjournment With all business being completed the meeting adjourned at 6:46 p.m.</td>
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**Next Board Meeting**

**Thursday, November 05, 2015**

4:00 – 6:00

Robert Robinson, Chief Executive Officer

Date Approved 11/5/2015
ITEM: Consumer and Family Advisory Committee (CFAC) Report

DATE OF BOARD MEETING: 10/1/2015

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

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

The Alliance CFAC meets at 5:30pm on the first Monday in the months of February, April, June, August, October and December at the Alliance Corporate Office, 4600 Emperor Boulevard, Durham. Subcommittee meetings are held in individual counties, the schedules for those meetings are available on our website.

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

The Alliance CFAC is currently chaired by Caroline Ambrose while Israel Pattison serves as vice-chair.

REQUEST FOR AREA BOARD ACTION:
Receive draft minutes from the Alliance CFAC’s Wake and Durham Subcommittee September meetings and from the Cumberland August meeting.

CEO RECOMMENDATION:
Receive the draft minutes and additional information for consideration.

RESOURCE PERSON(S):
Caroline Ambrose, CFAC Chair; Doug Wright, Director of Consumer Affairs
Alliance Behavioral Healthcare Consumer and Family Advisory Committee

Durham County Subcommittee Charter

Purpose:
The county subcommittees are responsible for gathering information, disseminating information, and reporting to the full CFAC its findings and concerns specific to their county and overall system concerns regarding the following statutory requirements:

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

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

- Hosting at least one community wide forum to receive input about the Mental Health/Intellectual and Developmental Disability/Substance Use Disorder service system.
- Participate in community events with the Alliance Community Relations Department at least three times per year.
- Participate on at least one other Alliance CFAC Subcommittee (Rules, Services, or Communications).
- Recruit new members for CFAC.
- Receive training and/or presentations from Alliance staff or provider agencies around relevant information and services.
Composition:

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

Meetings:

- Meetings will be held on the first Monday of July, September, November, January, March, and May at 1820 James Street (TROSA).
- The chair will construct an agenda with assistance from Alliance staff.
- The chair will designate someone to take minutes.
- A Quorum will consist of 50% of membership or more.
- The chair or designee will facilitate the meeting.
**Monday, September 14, 2015 | CFAC Durham Subcommittee**

**MEMBERS PRESENT:** J. Dan Shaw, Tammy Harrington, Amelia Thorpe, James Henry, Steve Hill, Colleen Kilsheimer, Joe Kilsheimer, Sharon O’Brien, Jean Royster-Hill, Brynda Saunders, Latasha Jordan, Doug Wright, Yancee Perez, Debra Duncan

**GUEST(S) PRESENT:**

1. **WELCOME AND INTRODUCTIONS** – WELCOME to Steve Hill – the New Durham Subcommittee chairperson.
2. **Welcome New Members** – Steve welcomed all of the new members.
3. **REVIEW OF THE MINUTES** – Minutes approved as submitted.

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<td>Public Comment</td>
<td>None voiced.</td>
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<td>Consumer/Family Concerns</td>
<td>• Sharon O’Brien has rejoined the group. WELCOME BACK Sharon! We are glad you are doing/feeling better.</td>
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**ELT Review**

- The Executive Leadership Team met to discuss involvement of CFAC members in regards to subcommittees as defined/determined by the large CFAC group. CFAC members discussed this at length.
- Subcommittees and Durham members mentioned:
  - Rules: Steve Hill, Jim Henry
  - Services/Needs and Gaps: Sharon O’Brian, Brynda Saunders
  - QM: Joe Kilsheimer, Amelia Thorpe
  - Communications: Jean Royster-Hill, Colleen Kilsheimer

- Doug Wright provided an example draft of a charter. This prompted a discussion on why a Charter was needed. A charter per county is required. A Charter is the plan for what each CFAC subcommittee would like to focus their energies on. The group had a great discussion on the many issues they would like to discuss.
- The discussion included:
  - Host a Resource Fair
  - Assist Alliance staff at already existing/scheduled fairs
  - PTA presentations – all levels

Debra will share the EC PTA information.
Debra and Yancee will begin to collect school PTA presidents (2015/16) and their contact information.
Debra will share information on upcoming resource fairs Alliance is already committed to attend/participate in.
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| Wellness City Concerns (Doug) | o Compile a Post-Secondary school resource list  
                               o CFAC presentations at groups members are already a part of (develop, schedule and provide)  
                               o Increase membership and attendance  
                               • CFAC members were tasked with determining a couple of ideas they are willing to work on and share with group at next meeting (they may also email them to Doug and Steve):  
                                 o What is the idea;  
                                 o How would it be implemented;  
                                 o Where will it be implemented;  
                                 o Member’s willingness and availability to help implement.  
                               • Wellness City responded to the concerns expressed by CFAC members. The group did not feel like the response addressed or attempt to solve the concerns expressed. Doug offered to discuss with individual members their concerns in greater detail and facilitate more closure on the situation. He did however remind the group the premise behind Wellness City: It is a Community/“City” (within Durham) striving to meet Durham Community members where they are and support them as they work to achieve and/or maintain recovery. Tasha will have further discussion with Doug concerning this issue. |            |            |
| MCO Updates                | • Alliance has begun to host Recovery and Self Determination Training with staff. Thank you to those who attended and assisted at the first training. Please let Doug know if you can assist at future trainings.  
                               • The Legislature will be announcing the budget soon. Medicaid Reform has not been decided on at this time.  
                               • Durham is hosting the Recovery Celebration on Saturday, September 19th, 3:00pm-7:00pm. |            |            |
<p>| Suicide Prevention (Doug)  | • This was tabled until a later date due to time constraints. |            |            |</p>
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| State Updates     | • DWAC meets on the third Wednesday of each month in the Brown Building on the Dix Campus.  
|                   | • The Peer Support conference in being held on September 25th at the Camp New Hope facility. Please let Glenda know if you are interested in attending.  
|                   | • A candidate for Roanna’s Newton’s position has been chosen. If hired, they will begin to attend CFAC meetings as early as next month. Glenda will continue to attend to provide support and training to the new staff member. |             |             |
| Announcements     | No announcements.                                                          |             |             |

5. ADJOURNMENT
**Members Present:** Lotta Fisher (Co-Chair), Dorothy Johnson, Jackie Blue, Marcia Hall (phone), Tracey Glenn-Thomas, **Guest(S) Present:** Doug Wright (Alliance), Nathania Headley (Alliance), Chris Bostock (Alliance BHC Board), Carrie Morrissey, Olando Morrissey, Susan Baggett (Alliance), and, Wes Rider (division)

1. **Welcome and Introductions:** The meeting was called to order by Co-Chair, Lotta Fisher. Carrie and her son, Orlando, were introduced and welcomed. Members expressed appreciation for the efforts Chris Bostock and the Alliance BHC Board are doing. Wes Rider was warmly welcomed back.

2. **Review of the Minutes:** The minutes from the May 28, 2015; June 25, 2015; and July 23, 2015 meetings were reviewed and unanimously accepted following a motion by Tracey and a second by Jackie.

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<td>Public Comment-Consumer/Family</td>
<td>Jackie Blue and Marcia Hall shared encouraging news that the Girl Scouts have a mental health badge to increase their awareness and understanding of mental health symptoms and issues. Marcia explained that local Girl Scouts leaders may be interested in having speakers as part of this program.</td>
<td>The subcommittee is supportive of the Girl Scouts mental health badge program and will provide a speaker if requested.</td>
<td>Ongoing</td>
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<td>challenges and solutions</td>
<td>Dorothy reported that the local NAMI chapter continues to plan for the NAMI Walk on Oct 4, 2015.</td>
<td>The subcommittee remains supportive of NAMI for their advocacy role.</td>
<td>Ongoing</td>
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<td>State Updates</td>
<td>Wes Rider reported that the state is now studying the idea of Peer Respite.</td>
<td>Members will listen to the next State CFAC meeting.</td>
<td>9/9/15</td>
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<td>Wes continued to urge members to stay involved and aware of policy, issues, challenges, and needs by listening to the State CFAC meetings. He also recommended ARC, NAMI, and The NC Council of Community Programs websites for updated information and comments on legislation.</td>
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<td>Wes shared that the division has selected Ken Schuesselin, Jr as the new Consumer Policy Advisor. He has a strong</td>
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<td>MCO Updates</td>
<td>background in MH, SA, recovery, case management, and stigma. Wes reminded everyone of several upcoming events including the NAMI Conference October 23-24 and the “One Community in Recovery” conference November 11-13, 2015.</td>
<td>Subcommittee will continue to identify service needs and gaps.</td>
<td>Ongoing</td>
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<td>Doug Wright shared that Alliance Behavioral Healthcare has begun a pilot project in Cumberland County to address the need for temporary therapeutic care out of home. Dorothy stated her awareness that there was a great need for this service in our community. Doug will further discuss the pilot projects at the September 24, 2015 meeting.</td>
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<td>Doug shared that the Senate proposed budget removes single stream funding for state funded services and suggest that MCOs use their fund balance instead. Alliance does not have a fund balance and would have to look at other ways such as utilizing the cost savings from good management of current funding in order to continue to cover those services. This could significantly limit Alliance’s ability to invest in additional programs and services to meet identified needs and gaps. Dorothy expressed concern which prompted Lotta to encourage subcommittee members to contact legislative officials about this issue.</td>
<td>Subcommittee members continue to monitor legislation for possible effect on the LME/MCO system.</td>
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<td>Doug reported that it appears the current LME/MCO model for MH/SA/IDD is being considered favorably at this time. CFAC has completed the Annual Report. The Executive Leadership Committee has developed three committees and every CFAC member is expected to serve on a committee. The committees are: Services, Rules, and Communications. Cumberland subcommittee members either chose a committee or have been assigned as follows:</td>
<td>Subcommittee members will serve on designated CFAC committees.</td>
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| Lotta Fisher- Rules  
Dr. Michael McGuire- Rules  
Marcia Hall- Communications  
Jackie Blue- Communications  
Dr. Mike Martin - Communications  
Dorothy Johnson- Services  
Tracey Glenn-Thomas - Services  
Carrie Morrisey requested to serve on the Services Committee if accepted by the Alliance CFAC as a full member at their next meeting October 5, 2015.  
Doug also revealed that the Executive Leadership Committee is working on a charter. He will provide more details about this the chapter develops and is completed. | | | |
<p>| Trainings on Recovery and Self-Determination | Doug Wright reported that there will be training on Recovery and Self-Determination at all Alliance sites. The training is mandatory for all Alliance staff. Cumberland CFAC subcommittee members are encouraged to sign-up for either the September 23, 2015 or the November 3, 2015 training. Consumers, families, providers, and stakeholders are welcome to attend, however each class size will be limited. | Subcommittee members will attend training on Recovery and Self-Determination. | November 3, 2015 |
| Outreach – CFAC’s role | Lotta reported that she and Co-Chair, Dr. Michael McGuire, have been attending meetings with the newly formed Critical Time Intervention (CTI) Program. This is a pilot program for 2 years in Cumberland County. Participants in the program will receive intensive case management for 9 months. Nathania Headley requested that a training on the CTI program be presented at the September 24, 2015 Cumberland CFAC Subcommittee meeting in order to increase member’s knowledge of the program. | Nathania Headley will follow-up with Wayne Cannon, Critical Time Intervention Team Program Coordinator with the Cumberland County Sheriff’s Office, to coordinate CTI and Jail Diversion presentation for the Cumberland CFAC Subcommittee. | September 24, 2015 |</p>
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<td>Alliance CFAC Meeting Schedule</td>
<td>Nay revealed that Alliance Behavioral Healthcare T-shirts are being made available to Cumberland CFAC Subcommittee members for wearing during outreach.</td>
<td>N/A</td>
<td>N/A</td>
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<td>Nathania Headley stressed the need for notifying Cumberland site Alliance staff when they plan to attend the full Alliance CFAC meetings via teleconference at the Cumberland office. Having a count will help local staff better prepare for handouts, refreshments, and staff support needs. Carrie, Dorothy, Jackie, and Tracey indicated that they will be attending by teleconference. Lotta reported that she and Dr. Michael McGuire will normally physically attend the meeting in Durham.</td>
<td>Subcommittee members will inform Cumberland staff when they plan to attend CFAC meeting via teleconference.</td>
<td>Ongoing</td>
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<td>Appreciation</td>
<td>Members briefly expressed appreciation for one another. Lotta announced that subcommittee member, Kiamesha White, has resigned due to a medical issue.</td>
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5. ADJOURNMENT:
Lotta adjourned the meeting at 7:19 p.m. following a motion by Jackie and second by Tracey.
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<td>Johnetta Aiston</td>
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<td>Caroline Ambrose</td>
<td>Carol A.</td>
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<td>Anna Cunningham</td>
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<td>Dave Curro</td>
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<td>Maribel Rivera-Elias</td>
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<td>Faye Griffin</td>
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<td>Cynthia Daniels-Hall</td>
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<td>Tammy Harrington</td>
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<td>Vivian Harris</td>
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<td>Sharon O'Brien</td>
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<td>Israel J. Pattison</td>
<td>Mark J. Pattison</td>
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<td>James Daniel Shaw</td>
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<td>David Smith</td>
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<td>Kurtis Taylor</td>
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<td>Amelia Thorpe</td>
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<td>Denise Wood</td>
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Approved By: [Signature]  Date: 9-9-14

Revised 11-1-11

Francine Spruill
Suicide Prevention
Suicide Risk Factors

- Mental Health disorders, in particular:
  - Depression or bipolar (manic-depressive) disorder
  - Alcohol or substance abuse or dependence
  - Schizophrenia
  - Post Traumatic Stress Disorder
  - Borderline or antisocial personality disorder
  - Conduct disorder (in youth)
  - Psychotic disorders and/or symptoms
  - Anxiety disorders
  - Impulsivity and aggression
Suicide Risk Factors

- Previous suicide attempt
- Family history of attempted or completed suicide
- Serious medical condition and/or pain
- The large majority of people with mental health disorders or other suicide risk factors do not engage in suicidal behavior
Environmental Factors

- Some people with major risk factors can be at increased risk due to environmental factors
  - A highly stressful life event
  - Prolonged stress due to adversities
  - Exposure to another person’s suicide, or to graphic or sensationalized accounts of suicide
  - Access to lethal methods of suicide
Factors that Lower Risk

- Receiving effective mental health care
- Positive connections to family, peers, community, and social institutions such as marriage and religion that foster resilience
- Skills and ability to solve problems
Suicide Risk by Gender

- In 2007, seventh leading cause of death for males and fifteenth leading cause for females
- Four times as many males as females died by suicide
- Firearms, suffocation and poison were the most common methods of suicide
  - Males were more likely to use firearms
  - Females were more likely to use poison
Suicide Risk by Gender

- Five times as many males as females ages 15 to 19 died by suicide
- Six times as many males as females ages 20 to 24 died by suicide
Suicide Risk by Age

- Older Americans are disproportionately likely to die by suicide
  - 14.3 of every 100,000 people ages 65 and older died by suicide in 2007 compared to 11.3 in the general population
  - 47 of every 100,000 non-Hispanic white men 85 or older died by suicide
Level of Suicide Risk

- Low: Some suicidal thoughts, no plan; says he or she won't complete suicide
- Moderate: Suicidal thoughts, vague plan not very lethal; says he or she won't complete suicide
- High: Suicidal thoughts, specific lethal plan; says he or she won't complete suicide
- Severe: Suicidal thoughts, specific lethal plan; says he or she will complete suicide
Warning Signs

• Talking about wanting to kill themselves or saying they wish they were dead
• Looking for a way to kill themselves, such as hoarding medicine or buying a gun
• Talking about a specific suicide plan
• Feeling hopeless or having no reason to live
• Feeling trapped or desperate, or needing to escape from an intolerable situation
Warning Signs

- Having the feeling of being a burden to others
- Feeling humiliated
- Having intense anxiety and/or panic attacks
- Losing interest in things, or losing the ability to experience pleasure
- Insomnia
- Acting irritable or agitated
Warning Signs

• Becoming socially isolated and withdrawn from friends, family and others

• Showing rage, or talking about seeking revenge for being victimized or rejected
Common Misconceptions

• People who talk about suicide won't really do it

• Anyone who tries to complete suicide must be “crazy”

• If a person is determined to complete suicide nothing is going to stop them

• People who complete suicide were unwilling to seek help
Common Misconceptions

- Talking about suicide may give someone the idea to act on it
Helping a Suicidal Person

Mental Health First Aid

- Assess for risk of suicide or harm
- Listen nonjudgmentally
- Give reassurance and information
- Encourage appropriate professional help
- Encourage self-help and other support strategies

ALGEE
Helping a Suicidal Person

- Get professional help
- Follow-up on treatment
- Be proactive
- Encourage positive lifestyle changes
- Make a safety plan
- Remove potential means of suicide
- Continue your support over the long haul
When Talking to a Suicidal Person

DO:

• Be yourself
• Listen
• Be sympathetic, non-judgmental, patient, calm and accepting
• Offer hope
• Ask if the person is having thoughts of suicide
When Talking to a Suicidal Person

DO NOT:

• Argue with the suicidal person
• Act shocked, lecture on the value of life, or say that suicide is wrong
• Promise confidentiality
• Offer ways to fix their problems, give advice, or make them justify their suicidal feelings
• Blame yourself
Telephone Numbers

Need help? In the U.S., call 1-800-273-8255
National Suicide Prevention Lifeline

1-800-799-4TTY
1-800-799-4889
TTY - Hearing & Speech Impaired

Alliance Behavioral Healthcare
1-800-510-9132
Wellness City Response to concerns expressed:

Thank you again for providing us with the opportunity to educate and inform the community about Wellness City. As you know, Wellness City is a recovery education center providing recovery-based learning, wellness, and community activities. Wellness City is not a clinical service. All of our classes and one-on-one support are provided by NC Certified Peer Support Specialists. These PSS bring the power of lived experience to their work, enabling them to be a living example that Recovery is Real. By sharing their recovery stories, these PSS offer hope to everyone who walks in the door and provide proof that recovery is possible for persons living with mental health and/or substance use challenges.

Wellness City is founded on the recovery principles of hope, personal choice, empowerment, development of an environment of wellness and independence, and the encouragement of spirituality and community enriched by contribution. It is a community made up of individuals embarking on or expanding their recovery journey. Services offered through Wellness City are tailored toward the experiences of individuals with significant mental health and substance use challenges. Individuals will self-identify as having this experience and seek the classes and activities they believe will best support their recovery. The Wellness City model embraces and welcomes all, as well as their family members and supporters. Wellness City services are free and open to any adults in the community who are interested in learning tools to increase their wellness.

While the openness and accessibility of our program is one of its great strengths, it can also be a challenge as individuals can walk in (or be brought in by their supporters or group home staff) in various states of wellness. At any given time we may have 45 people in the building utilizing our services. There is a clear expectation at Wellness City that if a person is in the building they are there to participate in our services (classes, organized activities, or one-on-one peer support) and not simply to hang out in the facility. On every shift, we are funded for three PSS staff, one administrative assistant (who is also a NC Certified PSS), and myself. This allows for one or two PSS to facilitate classes and leaves 3-4 additional staff to provide one-on-one peer support and address any situations that may arise.

The vast majority of attendees spend the day actively participating in the classes and other wellness activities. However, at times an individual may come in who is struggling. All Recovery Innovations staff are trained to recognize when an individual is experiencing challenges and to reach out and offer support – whether it be a listening ear, connection to resources, outreach to the person’s provider or other supporters, or even a call to Mobile Crisis or CIT (via 911). To prepare staff for these situations, all new hires go through a 40 hour new hire training and attend CPI’s Nonviolent Crisis Intervention Training. Ongoing training is also provided throughout their tenure. We also work closely with the local MH/SA providers (especially the ACT Teams and group
homes), Mobile Crisis, and first responders (CIT, EMS, 911, etc.) so that we have solid relationships to utilize when we encounter someone who is struggling. In the event that we do have an incident at Wellness City, it is Recovery Innovations policy that an Incident/Event Report be completed and, depending on the significance of the event, entered into IRIS.

As you know, mutuality and the relationship are powerful tools in the world of Recovery and Peer Support and are cornerstones of the Wellness City model. These principles apply not just to the Peer-Citizen relationships but also underlie the fabric of community that we have built at Wellness City. Every time I hear citizens speak about what they value about Wellness City, they bring up the relationships they have not just with the staff but with each other – I always hear “we’re like a family here”. It is that intentional community, those relationships, that build the energy that people rely on to help them on their recovery journey. And it is that community energy that empowers the citizens to support each other and to offer each other loving feedback when they see another citizen who is struggling with behavioral choices that might disrupt the Wellness City community. In fact, two of the four tenants of the Recovery Partnership Agreement (which is signed by all of our citizens and posted in the entry way at Wellness City) state that each citizen will:

- Support the wellness of other citizens by maintaining a safe environment and surroundings.
- Cooperatively work together with other citizens to feel a sense of respect, mutuality, trust.

In addition to the Recovery Partnership Agreement, all citizens sign that they have been informed of their Citizen Rights (which are also posted), including:

- The right to be treated with respect and dignity at all times.
- The right to have appropriate privacy/confidentiality and staff will protect and not inflict physical (including corporal punishment) and verbal abuse, neglect, exploitation, coercion, manipulation, retaliation for submitting a complaint, discharge, expulsion, suspension or transfer (or threat of) for reasons unrelated to the individual’s recovery needs, unwarranted invasion of privacy (search and seizure), denial of food, sleep or toilet.

In addition, RI also has personnel policies that speak to the importance of maintaining a violence free workplace.

These rights and policies underlie how we all come together as a community and are the cornerstones of any conversations we have with citizens and their support team whenever anyone is exhibiting behaviors that may threaten the feeling of safety in our community. The vast majority of the time, the staff are able to identify when someone is
struggling and intervene long before any conflict occurs. However, as with any community service, there is always the possibility of someone coming in who is not doing well and this could possibly lead to an argument, or fight with another citizen, or to some damage to property. When you put together a large number of people who may be struggling and are at various stages in recovery and are still learning about boundaries, healthy relationships, how to communicate their needs, how to manage intense feelings, and how to un-learn the survival skills they have had to rely on while growing up in dysfunctional families and dangerous communities, and when you add into that mix psychiatric symptoms or substance abuse challenges, then the likelihood of a conflict occurring does increase. On the few occasions when there has been a conflict at Wellness City, the staff have immediately stepped in to deescalate the situation and have connected the individual with the necessary supports, whether that be their support team or even Mobile Crisis or CIT. Following any such event, the citizen and his/her support team meet with the Wellness City staff to discuss what interventions need to be in place so that the individual can utilize the Wellness City services in a safe and productive manner. If an individual is not able or willing to utilize the Wellness City services in a safe and constructive manner, then the staff assist the person and their support team in finding other resources in the community that better meet the needs of that individual.

Lastly, I wanted to address your questions about the neighborhood. The Wellness City location was a strategic choice. We are located on a bus line, near designated low income housing, and in walking distance to downtown, the Health and Human Services building, CJRC, the Urban Ministries shelter, two public libraries, Lincoln Community Health center, food banks, and many other community resources. We are also in a historic neighborhood, with a mural in the parking lot representing Durham history and the Hayti Heritage center on the corner. These resources make our facility easily accessible to many in our target demographic and also make community resources easily available to our participants. Additionally, the other shops in their shopping center include affordable and ethnically diverse food choices, Family Dollar, a thrift store, and other affordable services that are well suited to the financial reality of the majority of our participants. These elements help our participants to feel comfortable coming into Wellness City and enhance their experience of mutuality and peer-ness. However, like many of the other community resources, we find that when we bring the services to the people who need them, we also share in a certain level of risk – the same risk that many of our participants live with on a daily basis. For example: one of our citizens was a few blocks away, making the choice to spend time with individuals who were not necessarily supportive of her recovery. While engaging in those activities, she was ‘shot’ in the wrist with a bb gun and the bb lodged in her wrist. Immediately she walked over the Wellness City because she knew that she would find safety and help here. The staff were able to support her physically and emotionally until an ambulance and her group home provider could arrive. She was able to receive the medical care she needed and expressed how grateful she was to Wellness City for being in a location where she could easily get to us for help and support.
I hope this has addressed the concerns that were brought to you. If you can think of any other questions that I have not answered, please let me know and I will be happy to get back to you with more information.
ITEM: Finance Committee Report

DATE OF BOARD MEETING: October 1, 2015

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 p.m. prior to the regular Area Board Meeting.

REQUEST FOR AREA BOARD ACTION:
Accept the report.

CEO RECOMMENDATION:
Accept the report.

RESOURCE PERSON(S):
James Edgerton, Committee Chair; Robert Robinson, CEO; Kelly Goodfellow, CFO

(Back to agenda)
Thursday, August 06, 2015  BOARD FINANCE COMMITTEE

APPOINTED MEMBERS PRESENT: □ James Edgerton, Chair; ☐ George Quick, MBA, ☑ John Griffin; ☐ Vicki Shore ☐ Chris Bostock
BOARD MEMBERS PRESENT: Amelia Thorpe, Kenneth Edge
GUEST(S) PRESENT: Vicki Evens, Cumberland County
STAFF PRESENT: Rob Robinson, CEO; Kelly Goodfellow, CFO; Sara Pacholke, Controller

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the 6/4/2015 meeting and 8/6/2015 meeting reviewed; a motion was made by Vicki Shore and seconded by Chris Bostock.

<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>3.</td>
<td>Sam Pacholke reviewed the compliance check by the IRS related to our payroll records. It was reported that board members should be issued forms W-2 and payroll tax should be withheld. It was discussed that an alternative of reimbursing mileage would still require board members to be treated as employees. The mileage to board meetings would be considered a commute and therefore would be taxable. It was suggested that the change will go into effect January 1, 2016. It was suggested that the amount be increased, however it is limited to $50 per day by general statute.</td>
<td>Discuss with full board. Board members will all have to complete the required forms.</td>
<td>12/1/15</td>
</tr>
<tr>
<td>4.</td>
<td>Kelly Goodfellow discussed the budget transfer policy. More research will be done on the general statutes relating to budget transfers and who has the authority to make transfers.</td>
<td>Research will be presented at the next meeting.</td>
<td></td>
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<tr>
<td>5.</td>
<td>Sam Pacholke gave an update on the year end and audit process. We received the last claims allowable for FY15 and are preparing for the auditors. They will be out starting September 14th. The Finance Committee will be presented with restricted balances at the October meeting for approval. The auditors will present the financial statements to the Finance Committee and then the full board at the December meeting.</td>
<td></td>
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4. ADJOURNMENT

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
<table>
<thead>
<tr>
<th>Restricted</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Investment in Capital Assets</td>
<td>$ 726,913</td>
</tr>
<tr>
<td>Risk Reserve</td>
<td>17,837,513</td>
</tr>
<tr>
<td>Medicaid Services</td>
<td>23,085,276</td>
</tr>
<tr>
<td>Medicaid Services - Crisis Site</td>
<td>3,000,000</td>
</tr>
<tr>
<td>Cumberland County</td>
<td>5,186,805</td>
</tr>
<tr>
<td>Wake County - General</td>
<td>9,701,024</td>
</tr>
<tr>
<td>Wake County - Holly Hill</td>
<td>735,283</td>
</tr>
<tr>
<td>Reserved for State Statute</td>
<td>16,414,780</td>
</tr>
<tr>
<td>State - TBI Services</td>
<td>62,500</td>
</tr>
<tr>
<td>Administration - Future Operations</td>
<td>2,000,000</td>
</tr>
<tr>
<td>Administration - Administrative Costs</td>
<td>1,000,000</td>
</tr>
<tr>
<td>Total Restricted</td>
<td>79,023,183</td>
</tr>
<tr>
<td>Unrestricted</td>
<td></td>
</tr>
<tr>
<td>Administration - Medicaid Funding</td>
<td>3,465,192</td>
</tr>
<tr>
<td>Total Net Position at 6/30/15</td>
<td>$ 83,215,288</td>
</tr>
</tbody>
</table>
ITEM: Draft Minutes from the September 3, 2015, Board Meeting

DATE OF BOARD MEETING: October 1, 2015

REQUEST FOR BOARD ACTION:
Approve the draft minutes from the September 3, 2015, Board meeting.

CEO RECOMMENDATION:
Approve the minutes.

RESOURCE PERSON(S):
Robert Robinson, CEO
**Thursday, September 03, 2015**

**AREA BOARD REGULAR MEETING**
4600 Emperor Boulevard, Durham, NC, 27703
4:00-6:00 p.m.

**MEMBERS PRESENT:** Ann Akland, Cynthia Binanay, Vice-Chairwoman (via phone), Christopher Bostock, Chairman, George Corvin, MD, Kenneth Edge, James Edgerton (joined meeting via phone at 4:13 pm), Ladies Gloston, Phillip Golden, John Griffin, Ed.D (exited at 4:30 pm), Curtis Massey, Rev. Michael Page (arrived at 4:40 pm), George Quick, Vicki Shore, William Stanford, Jr., Caroline Sullivan, Scott Taylor, Amelia Thorpe, Lascel Webley, Jr., and McKinley Wooten, Jr.

**GUEST(S) PRESENT:** Carolyn Ambrose, Alliance CFAC Chair; Denise Foreman, Wake County; Tony Braswell, Johnston Board of County Commissioners Chairman

**ALLIANCE STAFF PRESENT:** Joey Dorsett, Chief Information Officer; Doug Fuller, Director of Communications; Kelly Goodfellow, CFO; Amanda Graham, Chief of Staff; Carol Hammett, General Counsel; Veronica Ingram, Executive Assistant; Jessica King, MH/SA Care Coordination Supervisor; Carlyle Johnson, Director of Network Strategic Initiatives; Geyer Longenecker, Director of Quality Management; Ken Marsh, Medicaid Program Director; Janis Nutt, Johnston Site Director; Ann Oshel, Chief Community Relations Officer; Sara Pacholke, Controller; Monica Portugal, Chief Compliance Officer; Al Ragland, Chief HR Officer; Rob Robinson, CEO; Sean Schreiber, Chief Clinical Officer; Dr. Khalil Tanas, Medical Director; and Doug Wright, Director of Consumer Affairs

1. **CALL TO ORDER:** Chairman Christopher Bostock called the meeting to order at 4:03 p.m.

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
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| 2. Announcements | A. Board Meeting at Cumberland Site  
Mr. Robinson reported that the Board holds some of its monthly meetings at its community locations; the Board will meet at the Cumberland site in November 2015. |
|               | B. The NC Council Conference in Pinehurst  
Mr. Robinson reminded Board members of this conference scheduled for December 2-4, 2015, and that Alliance will assist Board members interested in attending. Board members may contact Ms. Ingram if they are interested in attending. |
|               | C. Recovery and Self Determination Training:  
Doug Wright provided an overview of the upcoming Recovery and Self-Determination training/workshop; there are multiple sessions and each is open to staff, providers, community stake holders and Board members. |
|               | D. IT Update:  
Mr. Robinson noted that staff are investigating alternatives for Board members’ interested in a different mobile device solution. An update will be provided at the next meeting. |
| 3. Agenda Adjustments | There were no adjustments to the agenda. |
| 4. Public Comment | There were no public comments. |
AREA BOARD REGULAR MEETING
4600 Emperor Boulevard, Durham, NC, 27703
4:00-6:00 p.m.

AGENDA ITEMS:  DISCUSSION:
5. Committee Reports

A. Consumer and Family Advisory Committee (5 minutes) – page 3
The Alliance Consumer and Family Advisory Committee (CFAC) is composed of consumers and/or family members from Durham, Wake, or Cumberland counties who receive mental health, intellectual/developmental disabilities or substance use/addiction services. This month’s report includes draft minutes from the Alliance CFAC’s June meeting, a recap of snap shot surveys, a copy of alcohol awareness training, and the CFAC monthly board report summary.

Carolyn Ambrose, CFAC Chair, presented the CFAC report, names of the newly elected CFAC officers, and an update from a recent CFAC meeting. This report was also sent as part of the Board packet and is attached to the minutes.

B. Finance Committee (10 minutes) – page 8
The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Area Board. This month’s report includes draft minutes from the June meeting, the Statement of Revenues and Expenditures and ratios for the period ending May 31, 2015.

George Quick presented the Finance Committee report on behalf of Committee Chair, Jim Edgerton, who participated remotely. Mr. Quick noted that per IRS guidelines the Board compensation will need to be taxed and Board members will receive a W-2 form at the end of the calendar year as the compensation is considered a wage. Board members will need to complete additional forms for this process which will be effective January 1, 2016.

BOARD ACTION
A Motion was made by Mr. George Quick to increase the compensation paid to Board members to $75.00 per meeting; seconded by Mr. McKinley Wooten. Mr. Curtis Massey made a point of order as the amount of compensation is dictated by statute.

A Motion was made by Mr. George Quick to table this motion until General Counsel can provide input regarding statute requirements; seconded by Mr. Curtis Massey. Motion passed.

Ms. Hammett, General Counsel, noted that per NCGS 122C-120 Board member compensation may not exceed $50.00 per meeting per day. Commissioner Kenneth Edge requested that we revise the verbiage on the policy to reflect the similar terminology in the statute: use compensation instead of stipend.

Mr. Quick requested to withdraw this motion.
Thursday, September 03, 2015

AREA BOARD REGULAR MEETING
4600 Emperor Boulevard, Durham, NC, 27703
4:00-6:00 p.m.

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<th>AGENDA ITEMS:</th>
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<tr>
<td>C. Policy Committee – page 11</td>
<td>Per Alliance Behavioral Healthcare Area Board Policy “Development of Policies and Procedures”, the Board reviews all policies annually. The Board Policy Committee reviews a number of Policies each quarter in order to meet this requirement. This month’s report includes draft minutes from the August meeting, policies recommended for continued use and policies with recommended changes.</td>
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Committee Chair, Curtis Massey, presented the Policy Committee report and reviewed the policies submitted for review without revision and those submitted with revisions. He noted that per URAC guidelines policies must be reviewed annually and that some of these policies may come before the Board at a later date for further revision. Mr. Massey stated that the by-laws were submitted for review only as change to the by-laws require thirty days’ notice.

**BOARD ACTION**
A Motion was made by Mr. Curtis Massey that the following policies be approved without revision: Area Board Member Compensation; Development of Policies and Procedures; Delegation of Authority to the Area Director; Guidelines for Public Comment at Area Board Meetings; Reporting of Abuse, Neglect, Dependency and Exploitation; Area Authority Relations with Catchment Area County Boards of Commissioners; Area Director Compensation; Evaluation of Area Director; Strategic Planning; Health and Safety; Internal Control; Business Continuity Plan; and Area Board by-laws; seconded by Mr. Lascel Webley. Motion passed unanimously.

A Motion was made by Mr. Curtis Massey that the following revised policies be approved: Area Board Conflict of Interest; Area Board Code of Ethics; Area Board Media Policy; Consumer/Family Advisory Committee; Management of Service Delivery; Fund Balance; Area Board Processes; Dispute Resolution; and Emergency Management Plan; seconded by Ms. Lodies Gloston. Motion passed unanimously.

A Motion was made by Mr. Curtis Massey that the new policy: Investments be approved; seconded by Mr. William Stanford. Motion passed unanimously.

Mr. Massey made a point of order regarding moving the Board meeting in Cumberland County originally scheduled for October 2015. He requested a vote by the Board to move the meeting to November.

**BOARD ACTION**
A Motion was made by Mr. Scott Taylor to move the October 2015 Board meeting in Cumberland County to November 2015; seconded by Ms. Lodies Gloston. Motion passed unanimously.
<table>
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<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
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</table>
| 6. Consent Agenda                                | A. Draft Minutes from August 6, 2015, Board Meeting – page 63  
B. Executive Committee Report – page 68  
C. Quality Management Committee Report – page 71  
Chairman Bostock mentioned that the consent agenda was sent as part of the Board packet; Board members noted the QM report on ER admissions and that an update will be provided to the Board at a later date. There were no other questions or discussion about the consent agenda. |
| 7. Area Board Conflict of Interest Disclosures  | It is the policy of Alliance to ensure that none of its Board Members have conflicts of interest with any of the provider agencies with which Alliance has a contractual or a consumer referral relationship. Board Members must disclose a conflict or the appearance of a conflict. The Area Board shall make the final decision regarding the disposition of all conflict of interest issues. Monica Portugal, Chief Compliance Officer, presented an overview of the conflict of interest policy. Board members discussed revising how disclosures are presented. This process will be discussed at the September Executive Committee meeting. |
| 8. Annual Compliance Training and Review of      | Alliance is required to have a compliance program per Federal Regulations and contractual agreement with the Division of Medical Assistance. The Area Board approved Corporate Compliance Plan states that a report of compliance efforts will be presented annually to the Alliance Behavioral Healthcare Area Board. Monica Portugal, Chief Compliance Officer, will present the compliance report.  
Monica Portugal, Chief Compliance Officer, provided annual training to the Board of Directors on the Compliance program and presented a detailed annual compliance report for the previous fiscal year. Ms. Portugal noted the Board’s legal obligations of oversight responsibility and how this is implemented in the compliance plan and the seven elements of the compliance program. She noted that the Board Audit and Compliance Committee will receive more detailed information quarterly. |
| Compliance Program FY15 – page 134               | **BOARD ACTION**  
The Board did not take action on this item at this time.                                                                                                                                                                                                                                                                 |
|                                                  | **BOARD ACTION**  
The Board received the report; no further action required.                                                                                                                                                                                                             |
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<tr>
<th>AGENDA ITEMS:</th>
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<tr>
<td>9. Training: DOJ/Transitions to Community Living</td>
<td>Jessica King, MH/SA Care Coordination Supervisor, presented an overview of the Alliance Transition to Community Living (TCL) Initiative Program. She included background information and the purpose of this program as well as current data, barriers, strategies and interventions. Board members discussed the age range that this program applies to, the number of consumers at varying stages of securing housing, and how the need varies throughout Alliance's catchment area. Board members discussed disparities in available housing throughout Alliance's catchment area and how to incentivize landlords to increase housing opportunities for consumers. The Transitions to Community Living presentation is attached to and made part of these minutes. <strong>BOARD ACTION</strong> The Board received the training; no further action required.</td>
</tr>
<tr>
<td>10. Updates</td>
<td>Legislation: Mr. Robinson stated that at 11:00 am on September 4, 2015, the new secretary of the NC Department of Health and Human Services (DHHS) will visit Alliance. Mr. Robinson invited Board members to attend this meeting. Also, he stated that the General Assembly continues to debate Medicaid Reform and the potential reduction of Single Stream funding. Mr. Robinson will continue to provide updates as more information becomes available.</td>
</tr>
<tr>
<td>11. Chairman's Report</td>
<td>None stated.</td>
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<tr>
<td>12. Adjournment</td>
<td>With all business being completed the meeting adjourned at 5:32 p.m.</td>
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**Next Board Meeting**  
**Thursday, October 01, 2015**  
**4:00 – 6:00**
ITEM: Human Rights Committee Report

DATE OF BOARD MEETING: October 1, 2015

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

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

The Human Rights Committee shall meet at least quarterly.

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

The Human Rights Committee is a Board Committee with at least 50% of its membership being either consumers or family members that are not Board Members. All members and the chair are appointed by the Chair of the Alliance Board of Directors. The Committee is currently chaired by Lodies Gloston. Draft minutes for the September 17, 2015 meeting are attached.

REQUEST FOR AREA BOARD ACTION:
Accept the report.

CEO RECOMMENDATION:
Accept the report.

RESOURCE PERSON(S):
Lodies Gloston, Committee Chair; Doug Wright, Director of Consumer Affairs; May Alexander, QM Data Manager

(Back to agenda)
Human Rights Committee Training

Serving Durham, Wake, Cumberland and Johnston Counties
Human Rights Committee

• Like other LME-MCOs, Alliance is responsible for protection of consumer rights

• HR Committee implemented in accordance with NC General Statute and Administrative Code and Alliance Board by-laws

• Alliance provides staff support to the Committee
Committee Responsibilities

• Assuring that consumer rights protections reviewed through routine provider monitoring

• Compliance with consumer rights and advance instruction

• Compliance with the protection of consumer in the community

• Assuring confidentiality

• Review of complaint and appeal data

Serving Durham, Wake, Cumberland and Johnston Counties
Committee Responsibilities

• Report system issues which negatively impact the rights of persons served to the Board

• Work with state and local agencies to protect consumer rights

• Report to the Board at least quarterly
  o Submission of annual report no longer required

Serving Durham, Wake, Cumberland and Johnston Counties
Makeup of the Committee

• Members appointed by the Alliance Board
  o Committee chaired by a Board member

• Majority of members must not be Board members

• At least 50% of members must be consumers or family members of consumers

• Representation from each county

• Staff members do not vote
Conflict of Interest & Confidentiality

- Members required to sign conflict of interest disclosure forms and Alliance confidentiality agreements
- A conflict may prohibit a member from serving or restrict them from some votes
- Members may not represent themselves as independent representatives of or act independently on behalf of the Committee
Meeting Structure

- Committee meets at least quarterly at the Alliance corporate office
- Emergency meetings may be called for unexpected circumstances
- Quorum (chair plus 50% of members) required to conduct a meeting
  - If quorum not met, informal discussion may be held with unanimous consent of members present
Meeting Structure

- Minutes recorded at each meeting
- Consumers are not identified in minutes or in written or oral reports
- Any discussion of provider-specific information must adhere to Alliance Provider Confidentiality procedure

Serving Durham, Wake, Cumberland and Johnston Counties
Meeting Structure

• Meeting called to order
• Meeting agenda review and approval
• Ensure a recorder present to take minutes
• Review and approval of previous minutes
• Consideration of agenda items
• Call for motions and voting as appropriate
• Adjournment
Attendance

- Absence from three consecutive meetings without notification to the Chair or from 25% of meetings during a 12-month period are grounds for dismissal
Required Training

• New member training
  o NC Statutes and Administrative Rules
  o Conflict of interest and confidentiality
  o Duties of the State and Alliance CFACs
  o Principles of advocacy, self-determination and recovery
  o Customer service strategies and the organization of the public MH/SA/DD

• All members trained annually on client rights issues
• LME-MCO board has ultimate responsibility for the assurance of consumer rights

• Each board shall establish at least one HR Committee

• The governing body of contract agencies also required to establish an HR Committee
NC Statutes & Administrative Rules

• Board must implement policy on:
  o Composition, size and method of appointment of committee members
  o Training and orientation of members
  o Frequency of meetings (at least quarterly)
  o Rules of conduct for meetings and voting procedures
  o Procedures for monitoring the effectiveness of existing and proposed methods and procedures for protecting consumer rights
NC Statutes & Administrative Rules

• Board must implement policy on:
  o Requirements for routine reports to the Board regarding seclusion, restraint and isolation time out
  o Other operating procedures
Committee oversees the following client rights protections for contracted services:

- Compliance with G.S. 122C, Article 3
- Compliance with provisions of 10A NCAC 27C, 27D, 27E, and 27F governing the protection of client rights, and 10A NCAC 26B governing confidentiality
Committee oversees the following client rights protections for contracted services:

- Establishment of review procedure for any of the following which may be brought by a client, client advocate, parent, legally responsible person, staff or others:
  - Client grievances
  - Alleged violations of the rights of individuals or groups, including cases of alleged abuse, neglect or exploitation
Committee oversees the following client rights protections for contracted services:

- Establishment of review procedure for any of the following which may be brought by a client, client advocate, parent, legally responsible person, staff or others:
  - Concerns regarding the use of restrictive procedures
  - Failure to provide needed services that are available
• Nothing herein precludes authority of:
  o A county DSS to investigate abuse, neglect, or exploitation
  o Disability Rights of North Carolina to conduct investigations regarding alleged violations of consumer rights

• Human Right Committees established by contract agencies shall carry out the provisions of this Rule
• Each Committee shall be composed of a majority of non-board members, with a reasonable effort made to have all applicable disabilities represented, with consumer and family member representation

• Staff serving on the Committee shall not be voting members
NC Statutes & Administrative Rules

• Committee shall maintain minutes of its meetings.

• Clients shall not be identified by name in minutes or in written or oral reports.

Serving Durham, Wake, Cumberland and Johnston Counties
Committee shall review grievances regarding incidents which occur within a contract agency after the governing body of the agency has reviewed the incident and had opportunity to take action.

- Incidents of actual or alleged violations, the facts of the incident, and the action, if any, made by the contract agency shall be reported to the area director within 30 days of the initial report of the incident, and to the board within 90 days.
Conflict of Interest & Confidentiality

• Committee members must disclose a conflict or the appearance of a conflict of interest depending on the circumstances
  o May be prohibited from serving or restricted in voting based on the disclosure

• Members may not represent themselves as independent representatives of or acting independently on behalf of the Committee
  o Noncompliance may result in removal

Serving Durham, Wake, Cumberland and Johnston Counties
Conflict of Interest & Confidentiality

• If the Committee cannot resolve the conflict of interest, the Committee Chair shall notify the Board Chair, who shall make the final decision regarding the disposition of all conflict of interest issues.
Duties of Alliance CFAC

• Review, comment on and monitor the implementation of the local business plan to Alliance, stakeholders, and DMH

• Identify service gaps and underserved populations and make recommendations on areas of service eligibility and service array to Alliance and the Board

• Make recommendations regarding the service array and monitor development of services

Serving Durham, Wake, Cumberland and Johnston Counties
Duties of Alliance CFAC

• Review and comment on the Alliance program budget

• Participate in all quality improvement measures and performance indicators

• Submit to the State CFAC findings and recommendations regarding ways to improve the delivery of MH/DD/SA services

Serving Durham, Wake, Cumberland and Johnston Counties
State CFAC

- 21-member self-governing and self-directed advisory organization, composed entirely of consumers and family members of consumers
- Provides input and conduct oversight of the Division’s operations and efforts to accomplish the strategic outcomes of the State Plan
- Advises DHHS and the General Assembly on the planning and management of the State’s public MH/DD/SA services system

Serving Durham, Wake, Cumberland and Johnston Counties
Five Components of Self-Advocacy

- Personal responsibility
- Knowledge of the law and other rules
- Fact finding and documentation
- Negotiating
- Believing in oneself
Tips for the Self-Advocate

• Realize you have rights and are entitled to equality under the law

• Keep informed and ask questions

• Take advantage of resources
  o Peer-run, family and community support programs, referral/crisis hotlines, advocacy groups, informative classes, assertiveness training groups

• When contacting a resource insist that explanations are clear and understandable

Serving Durham, Wake, Cumberland and Johnston Counties
Responsibilities of the Self-Advocate

- Be clear about what one needs and wants
- Always go to meetings
- Ask who is at one’s meetings and why
- Keeping all one’s papers
- Never signing blank copies of forms
- Document what happens; taking notes or have someone else do it
Responsibilities of the Self-Advocate

• If one needs help, taking someone along
• Know the laws that regulate one’s services
State and Federal Laws

• Most services provided because of state or federal laws

• Laws have regulations that provide guidance about how that law should be implemented

• There are always rules about how to spend money, sometimes in regulation or policy

• Laws include definitions for eligibility and services

Serving Durham, Wake, Cumberland and Johnston Counties
Working With Providers

• Many professionals have standards which must be met to be licensed or certified

• Find out if one’s provider has the needed specialized training (CPR, CFT, etc.)

• Best practices help to justify requests for services

• Request clear written information on one’s grievances/appeal rights within an agency and outside an agency

Serving Durham, Wake, Cumberland and Johnston Counties
Fact Finding and Documentation

• Keep good records and document what happens – this will become one’s proof
• Keep notes about times, dates and who one talked to and what one was told
• If required services are not being provided when promised, write it down
Figure Out if it’s Working

• Ask questions about when where and how often the service is going to happen

• Keep a log – write down when services happen

• If services don’t happen, know whom to call

• Evaluate happiness with services provided

• Always ask for any decision or change to be put in writing and wait for it

Serving Durham, Wake, Cumberland and Johnston Counties
Figure Out if it’s Working

- Use communication skills

- Use the telephone to gather information, to keep track of progress and to let people know what one wants
Expressing Dissatisfaction

• Before expressing dissatisfaction, write down the essential points

• Stay calm

• Make the conversation brief and clear

• Be willing to listen

• Ask for the name and position of the person one is talking with

Serving Durham, Wake, Cumberland and Johnston Counties
Expressing Dissatisfaction

• Ask when to expect action
• If this person can’t help, ask who can
• If necessary ask to speak to a supervisor
• Thank the person for being helpful
• Keep a record of the call and follow-up
Tips for Negotiating

• Pay attention, do not frown
• Use good listening skills
• Ask for what one wants and say why
• If the other person agrees, thank them; if not, suggest a compromise
• If they agree with the compromise, thank them
• Believe in oneself and do not give up
Self-Determination

• Principle of self-determination based on the recognition of the right and need of consumers and their families to have the freedom to make their own choices and decisions

• Alliance supports its consumers and families in those decisions and works to help them attain their goals and independence

• Everyone deserves to live happily and usefully whole
Recovery

• Recovery is holistic and is defined by individuals who have reclaimed their lives and are productive and active members of society.

• Alliance supports and encourages them as they embark upon their personal journeys.

Serving Durham, Wake, Cumberland and Johnston Counties
The Alliance Service System

• Alliance is a managed care organization for public MH/DD/SA services
  o Allows greater flexibility to shape the service delivery system to ensure access to quality care that results in better consumer outcomes

• Services delivered by a network of private providers who contract with Alliance

• Serving the citizens of Durham, Wake, Cumberland and Johnston counties
The Alliance Service System

• Goal to ensure that individuals who seek help receive the quality services and supports they are eligible for to help them achieve their goals and live as independently as possible

Serving Durham, Wake, Cumberland and Johnston Counties
The Alliance Service System

- Services that respect and support consumers
  - Build on strengths, promote recovery
  - Flexible to respond to unique and changing needs

- Services that respond to real life needs
  - Array of services provided by choice of provider
  - Connections to housing, social support, etc.

- Services that are effective
  - Based in research about what works and measured by best-practice quality standards

Serving Durham, Wake, Cumberland and Johnston Counties
The Alliance Service System

• Based on a System of Care philosophy
  o A continuum of effective, community-based services and supports for individuals, children and families who have mental health issues and other life challenges
  o Organized into a coordinated network and built on partnerships and collaboration

Serving Durham, Wake, Cumberland and Johnston Counties
SOC Core Values

• Culturally-competent, with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations they serve

• Community-based, with the focus of services, as well as the management and decision making responsibility, resting at the community level

Serving Durham, Wake, Cumberland and Johnston Counties
SOC Core Values

• Person-centered and family-focused, with the strengths and needs of the individual, child and family determining the types and mix of services

• Evidence-based to help ensure positive treatment outcomes

Serving Durham, Wake, Cumberland and Johnston Counties
Provider HR Committees

• Providers required to establish committees as well

• Multiple providers may agree in writing to form joint committees

• Responsibilities mirror those of LME-MCO committees

• Submission of annual report to the LME-MCO no longer required
Thursday, September 17, 2015

BOARD HUMAN RIGHTS COMMITTEE - SPECIAL MEETING
4600 Emperor Boulevard, Durham, NC 27703
4:00-5:30 p.m.

APPOINTED MEMBERS PRESENT: ☒ Marie Dodson, ☒ Lodies Gloston, Board member/Committee Chair, B.A., M.A., □ Marc Jacques, CFAC Chair, □ Maribel Rivera-Elias, □ Dan Shaw, □ William Stanford, Board member, B.A., J.D., □ Scott Taylor, Board member, A.A., B.A., ☒ Dr. Michael Teague, ☒ Amelia Thorpe, Board member, B.A., and ☒ McKinley Wooten, Jr., Board member, B.A., J.D.

APPOINTED, NON-VOTING MEMBERS PRESENT: N/A
BOARD MEMBERS PRESENT:
GUEST(S) PRESENT:
STAFF PRESENT: Doug Wright, Director of Consumer Affairs, Teri Kachur, Consumer Affairs Specialist, Yancee Perez, Consumer Affairs Specialist

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES - The minutes from the May 26, 2015, meeting were reviewed; a motion was made by Dr. Michael Teague and seconded by Amelia Thorpe to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership</td>
<td>Marc Jacques and Maribel Rivera-Elias are members who no longer attend meetings and have not for at least the last three meetings. Marc Jacques has moved out of town and Maribel Rivera-Elias has been unable to participate. Considering the committee’s charter and expectations, the committee accepts the resignations of these individuals due to non-attendance.</td>
<td>Doug will send out the application to members of the committee and to the Consumer and Family Advisory Committee to gauge interest in participation. Interested people will be ask to return the application for review, the committee will then consider applications and make recommendation to the board chair for appointment.</td>
<td>9/18/2015 – send application out. 1/14/2016 – make recommendations to the board chair</td>
</tr>
<tr>
<td>Annual Training</td>
<td>Members received their required annual training; training attached.</td>
<td>Receive annual training next year.</td>
<td>Next fiscal year at a special meeting.</td>
</tr>
<tr>
<td>Charter</td>
<td>Committee members received and reviewed their charter. The charter was put together on a template being used by</td>
<td>Doug will send Monica Portugal the question about the charter and how</td>
<td>October 8, 2015</td>
</tr>
</tbody>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>all board committees and was derived from the former procedure used for this committee. Discussion was had about how to change the charter if needed and that there was no provision about how to do that. Doug will follow up with compliance to see if that is something that is needed or if the charter is considered guidance only and can be changed or adjusted as needed.</td>
<td>changes are made, then report back at the next meeting.</td>
<td>9/18/2015</td>
<td></td>
</tr>
</tbody>
</table>

Schedule Verification

The committee confirmed that they would meet quarterly on the 2nd Thursday from 4:00pm until 5:30pm with the first meeting being on October 8, 2015. A special meeting will be scheduled each year to do annual training.

Doug to send out a calendar invite to all committee members for future meetings.

5. **ADJOURNMENT**: next meeting will be October 8, 2015 from 4:00 p.m. to 5:30 p.m.
ITEM: Quality Management Committee Report

DATE OF BOARD MEETING: October 1, 2015

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 15, members of the committee are: George Corvin, MD, Committee Chair (Area Board Member); Lascel Wleby, Jr. (Area Board Member); Joe Kilsheimer (CFAC-Durham member), vacant (CFAC member); Phil Golden (Area Board Member); and Ann Akland (Area Board Member). The positions of provider representatives (2) are filled by Tim Ferriera (representing I/DD services) and Nicole Novello Olsen (representing MH/SA services). The Global QMC meets at least quarterly each fiscal year and provides ongoing reporting to the Alliance Board. The Global QMC approves the MCO’s annual Quality Improvement Projects, monitors progress in meeting Quality Improvement goals, and provides guidance to staff on QM priorities and projects. Further, the Committee evaluates the effectiveness of the QM Program and reviews and updates the QM Plan annually. The draft minutes for the September meeting are attached. At the September meeting, the committee reviewed a revised report from the surveys distributed to the Area Board. The Committee requested that data be re-analyzed with the “Neutral” option removed and reported at this meeting. The areas with most dissatisfaction included provider monitoring and a long term financial plan. The Board is creating a Provider Networks Committee to improve communication...
about provider performance. The Committee also received updates on the results from the Quality Improvement Projects. Committee approved the Quality Improvement Plan for Alliance and Evaluation of the Quality Management Department. The committee also received an analysis of consumer satisfaction survey (called the ECHO survey) results. The results will be discussed with Alliance’s internal CQI committee to develop a plan to address concerns.

REQUEST FOR AREA BOARD ACTION:
Accept the report.

CEO RECOMMENDATION:
Accept the report.

RESOURCE PERSON(S):
Geyer Longenecker, JD, Director of Quality Management and Analytics
FY 2016 Quality Management
Program Description and Plan - DRAFT

Revised August 27, 2015
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1. INTRODUCTION

Description of Alliance

Alliance Behavioral Healthcare manages behavioral health services for Cumberland, Durham, Johnston and Wake counties in a catchment area that includes a mix of urban and rural areas.

Alliance supports self-direction and recovery and believes the best outcomes are reached when individuals receive the right level of service in the right amounts at the right time. Alliance efficiently manages resources to ensure system-wide quality for its members. Services are delivered through a network of community providers and licensed practitioners, and are closely monitored for quality.

Alliance Behavioral Healthcare was created on July 1, 2012 with the merger of the Durham Center and the Wake County LME. On February 1, 2013, Alliance began managed care operations under the Medicaid 1915 (b)/(c) waivers in Durham, Wake, Cumberland and Johnston counties. The network now includes over 2,000 credentialed providers.

Alliance has the second largest Medicaid population among the eight MCOs in North Carolina:

<table>
<thead>
<tr>
<th>Alliance</th>
<th>357,275</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance</td>
<td>216,036</td>
</tr>
<tr>
<td>Eastpointe</td>
<td>189,143</td>
</tr>
<tr>
<td>Sandhills</td>
<td>171,934</td>
</tr>
<tr>
<td>Trillium</td>
<td>170,430</td>
</tr>
<tr>
<td>Smoky Mountain</td>
<td>164,743</td>
</tr>
<tr>
<td>Partners</td>
<td>139,837</td>
</tr>
<tr>
<td>Centerpointe</td>
<td>80,809</td>
</tr>
</tbody>
</table>

For Alliance, 2014 marked a year of continued evolution and a new Strategic Plan that positions Alliance to be a strong, vibrant and successful behavioral health managed care organization no matter what the future of Medicaid reform holds. The Plan includes several major goals and multiple objectives and concrete initiatives. Read more about our new mission, vision and values on the opposite page.

Critical new positions and functional units were created in response to targeted needs identified by organizational analysis and business lessons learned. These included a Chief of Staff, an expanded legal department, a Hospital Relations Director and additional care coordination liaisons to regional hospitals and crisis facilities, as well as an I/DD Clinical Director. Two additional directors in Business Operations were added to oversee budget, finance and reimbursement, as well as a Registered Nurse to review hospital claims.
A restructuring of leadership enhanced cross-collaboration across Alliance’s administrative and business and clinical operations components with a focus on improving business processes. To that end a new Director of Strategic Project Management and two new Strategic Project Architects joined the Strategic Operations Unit tasked with reviewing key organizational projects with an eye toward streamlining and reengineering processes to improve efficiency and ensure quality outcomes.

**Alliance’s Mission**

To improve the health and well-being of the people we serve by ensuring highly effective, community-based support and care.

**Alliance’s Vision**

To be a leader in transforming the delivery of whole person care in the public sector.

**Alliance’s Values**

**Accountability and Integrity**: We keep the commitments we make to our stakeholders and to each other. We ensure high-quality services at a sustainable cost.

**Collaboration**: We actively seek meaningful and diverse partnerships to improve services and systems for the people we serve. We value communication and cooperation between team members and departments to ensure that people receive needed services and supports.

**Compassion**: Our work is driven by dedication to the people we serve and an understanding of the importance of community in each of our lives.

**Dignity and Respect**: We value differences and seek diverse input. We strive to be inclusive and honor the culture and history of our communities and the people we serve.

**Innovation**: We challenge the way it’s always been done. We learn from experience to shape a better future.

**Alliance Customers**

Alliance’s catchment area is experiencing higher than average population growth and is challenged to meet the needs of a diverse population with important needs such as those who do not speak English, homeless individuals with mental illness and substance use disorders, and members of the military, veterans and their families.

The total population for the Alliance catchment area as of July 2013 was estimated to be 1,766,717 (US Census Bureau QuickFacts, [http://quickfacts.census.gov](http://quickfacts.census.gov)). The four counties that
make up Alliance Behavioral HealthCare are racially and ethnically diverse. The chart below shows the major demographic groups in each of the four Alliance counties:

<table>
<thead>
<tr>
<th></th>
<th>Wake</th>
<th>Durham</th>
<th>Cumberland</th>
<th>Johnston</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>974,289</td>
<td>288,133</td>
<td>326,328</td>
<td>177,967</td>
</tr>
<tr>
<td>White</td>
<td>61.3%</td>
<td>42.1%</td>
<td>45.8%</td>
<td>69.2%</td>
</tr>
<tr>
<td>Black</td>
<td>21.4%</td>
<td>38.7%</td>
<td>37.4%</td>
<td>15.9%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>10.0%</td>
<td>13.5%</td>
<td>10.7%</td>
<td>13.2%</td>
</tr>
<tr>
<td>Asian</td>
<td>6.1%</td>
<td>4.8%</td>
<td>2.6%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Native American</td>
<td>0.8%</td>
<td>1.0%</td>
<td>1.7%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

The chart below shows the number of Medicaid-eligible population and the percent of the total population:

<table>
<thead>
<tr>
<th></th>
<th>Population</th>
<th>Medicaid Eligibles</th>
<th>Pct Eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland</td>
<td>326,328</td>
<td>59,324</td>
<td>18.2%</td>
</tr>
<tr>
<td>Durham</td>
<td>288,133</td>
<td>43,740</td>
<td>15.2%</td>
</tr>
<tr>
<td>Johnston</td>
<td>177,967</td>
<td>30,606</td>
<td>17.2%</td>
</tr>
<tr>
<td>Wake</td>
<td>974,289</td>
<td>90,256</td>
<td>9.3%</td>
</tr>
</tbody>
</table>

**Alliance Staff**

During its first year of operations, Alliance grew from a professional staff of 142 to nearly 350. Staff making the transition to Alliance from The Durham Center and the LMEs in Wake, Cumberland and Johnston counties formed the nucleus and brought with them invaluable expertise and experience. From that point, staffing more than doubled to accommodate MCO operations. Alliance current employs more than 400 staff members at its corporate site in Durham and four county offices.

**Alliance Providers**

Alliance depends on a strong and diverse network of agencies and group practices, licensed independent practitioners and hospitals to provide the range of high-quality services and supports required by the densely-populated Alliance region. To meet that goal, Alliance considered over 2,000 provider applications in a credentialing, enrollment and contracting process that can take up to 20 hours per provider.

Alliance assembled a vibrant, engaged Consumer and Family Advisory Committee (CFAC) and Provider Advisory Council representing the four counties in its region. Existing CFACs and PACs in each county continue to meet locally and offer feedback to the corporate advisory groups.
Members of the Alliance CFAC collaborated in the choosing of providers to assume the services previously provided by Wake County and participated in Alliance’s Board Budget Retreat. They carried their concerns to local legislators about the needs of our communities and served as respected voices at the State CFAC level.

The Alliance Consumer and Family Advisory Committee, or CFAC, is made up of consumers and family members 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 the Board of Directors.

2. PURPOSE OF THE ALLIANCE QM PROGRAM

The purpose of this Quality Management Operations Plan is to provide a systematic method for continuously improving the quality, efficiency and effectiveness of the services managed by Alliance Behavioral Healthcare for enrollees served. This plan also encompasses internal quality and effectiveness of all MCO processes.

Quality Management plays a major role in ensuring the MCO has well-established and evaluated processes for the timely identification, response, reporting, and follow-up to consumer incidents and stakeholder complaints about service access and quality. Alliance must ensure that its employees and the provider staff of its Provider Network are fully compliant with critical incident and death reporting laws, regulations, and policies, as well as event reporting requirements of national accreditation organizations. QM, along with the MCO Medical Director and/or designees, shall review, investigate, and analyze trends in critical incidents, deaths, and take preventive action to minimize their occurrence with the goals of improving the behavioral healthcare system, behavioral healthcare access, and consumer and provider outcomes.

3. PURPOSE OF QUALITY MANAGEMENT PLAN

The Quality Management (QM) Plan outlines the quality management structure and activities throughout the organization. The plan describes the process by which the organization monitors, evaluates and improves organizational performance, to ensure quality and efficient outcomes for enrollees served. The Quality Management Plan describes how administrative and clinical functions are integrated into the overall scope and purpose of the Quality Management Department. The Quality Management Program Description is updated and reviewed annually thereafter. Progress toward performance improvement goals are evaluated yearly.

4. GOALS AND OBJECTIVES OF THE QM PROGRAM

The Quality Management Department’s ongoing goals mirror many of the goals of the Medicaid Waiver. While Quality Management will play a major role in ensuring Alliance is successful at
meeting performance outcomes and contract requirements, the goals listed below are of particular focus due to direct involvement of QM staff and organization-wide QM activities.

1. To ensure individual consumers receive services that are appropriate and timely;
2. To transition local systems toward treatment with effective practices that result in real life recovery outcomes for people with disabilities, as possible;
3. To promote community acceptance and inclusion of individuals with disabilities; to provide outreach to people in need of services; to promote and ensure accommodation of cultural values in services and supports; and to serve people in their local communities wherever possible;
4. To provide for easy access to the System of Care;
5. To ensure quality management that focuses on health and safety, protection of rights, achievement of outcomes, accountability, and that strives to both monitor and continually improve the System of Care;
6. To empower consumers and families to set their own priorities, take reasonable risks, participate in system management, and to shape the system through their choices of services and providers;
7. To empower Alliance Behavioral Healthcare – to build local partnerships with individuals who depend on the system for services and supports, with community stakeholders, and with the providers of service; and
8. To demonstrate an interactive, mutually supportive, and collaborative partnership between the State agencies and Alliance – in the implementation of public policy at the local level and realization of the State’s goals of healthcare change.

5. PRINCIPLES AND STRATEGIES OF THE QM PROGRAM

Continuous Quality Improvement

There are four main assumptions that the MCO should embrace to encourage a quality culture within the value chain:

- To understand that it is better to prevent errors than to fix them
- To detect defects for early prevention
- To reduce testing and audit processes to reduce costs
- To determine root causes of errors and problems as they occur

Continuous Quality Improvement demands that staff and providers answer three basic questions:
1. Are we doing the right things?
2. Are we doing things right?
3. How can we be certain that we do things right the first time, every time?

Experts in the quality management field agree that one of the most complex challenges related to quality management and improvement is how to maximize quality and outcomes given
economic constraints. One method to meet this challenge is the collaborative quality management life cycle. Questions that are continually asked in this process are: When do we delay action? How do we act early on? What are the costs to errors and barrier? Can we deliver services on time and in a quality manner?

**Accreditation**

Alliance also demonstrates its commitment to continuous quality improvement via accreditation by URAC, a national accreditation organization. The URAC accreditation process is an evaluative, rigorous, transparent and comprehensive process in which a health care organization undergoes an examination of its systems, processes, and performance by an impartial external organization (accrediting body) to ensure that it is conducting business in a manner that meets predetermined criteria and is consistent with national standards.

Alliance has achieved URAC accreditation in four areas: Utilization Management, Call Center, Health Network and Credentialing.

The Health Utilization Management is the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan. URAC’s Health Utilization Management Accreditation ensures that all types of organizations conducting utilization review follow a process that is clinically sound and respects consumers’ and providers’ rights while giving payers reasonable guidelines to follow.

The Health Call Center provides triage and health information services to the public via telephone, website, or other electronic means. URAC’s Health Call Center Accreditation ensures that registered nurses, physicians, or other validly licensed individuals perform the clinical aspects of triage and other health information services in a manner that is timely, confidential, and includes medically appropriate care and treatment advice.

The Health Network is made up of contracted physicians and other health care providers. URAC’s Health Network Accreditation standards include key quality benchmarks for network management, provider credentialing, quality management and improvement, and consumer protection.

The Credentialing Department reviews new and current providers to assure that providers meet all required standards of licensure, legal standing and performance. Alliance has initiated a recredentialing process to assure that all current providers are reviewed at least every three years.
6. OVERSIGHT OF QM PROGRAM ACTIVITIES

Oversight of Alliance's quality management activities and the Continuous Quality Improvement process is the responsibility of the Alliance Board of Directors, the Board's Global Quality Committee, and Alliance CQI Committee and its various subcommittees.

Board of Directors

Alliance is governed by a Board of Directors that is responsible for comprehensive planning, budgeting, implementing and monitoring of community-based mental health, developmental disability and substance abuse services to meet the needs of individuals in the Alliance region. The Alliance Board consists of community stakeholders from Cumberland, Durham and Wake counties that are appointed by their respective County Commissioners, as well as representation from Johnston county.

Global QM Committee

The Global QMC is the standing committee that is granted authority for Quality Management by the MCO. The QMC reports to the Alliance Board of Directors. The Alliance Board of Directors Chairperson appoints the Quality Management Committee, which consists of five voting members — three Board members and two members of the Consumer and Family Advisory Committee (CFAC). Other non-voting members include at least one MCO employee and two provider representatives.

The MCO employees typically assigned include 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; and other staff as designated. The Global QMC meets at least six times each fiscal year and provides ongoing reporting to the Alliance Board. The Global QMC approves the MCO's annual Quality Improvement Projects, monitors progress in meeting Quality Improvement goals, and provides guidance to staff on QM priorities and projects. Furthermore, the Committee evaluates the effectiveness of the QM Program and reviews and the QM Plan annually.

Alliance Committees

Quality activities at Alliance are overseen internally by the Continuous Quality Improvement Committee and its subcommittees, which focus on program/provider improvement, appropriateness and effectiveness of care and services, integration of healthcare efforts, high-risk and high-cost factors, and utilization of evidence-based practices in the care continuum. Decisions are determined by this committee based on input and feedback from committees, staff, and stakeholders.
Each committee has created a charter defining its purpose, responsibilities, relationships and membership (see Appendix A).

External Reviews

In addition to internal review by the Alliance Board and the CQI Committee, Alliance's Quality Management program is routinely assessed by external review organizations.

**DHHS Intradepartmental Monitoring Team:** The North Carolina Department of Health and Human Services' Intradepartmental Monitoring Team (DHHS IMT) is responsible for oversight of Alliance on behalf of the state of North Carolina. The DHHS IMT consists of staff members from the Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities, and Substance Abuse (DMH). The DHHS IMT conducts an annual review of Alliance in conjunction with consulting firm Mercer. The annual review includes a desk review of key documents and an on-site review of the administrative, financial, clinical and quality operations.

**Mercer:** The state has contracted with the Mercer consulting firm to conduct annual appraisals of Alliance and the other LME-MCOs. The focus of these reviews is on the state’s requirements and expectations of the evolving LME-MCOs. Mercer’s last site visit was conducted in May 2015.

**External Quality Review (EQR):** Under federal law, Alliance must undergo annual external quality review. DHHS contracts with an external quality review organization (EQRO) to conduct the annual review. Alliance completed its first EQR in November 2014.

**URAC:** Alliance is accredited by URAC in the areas of Health Network, Utilization Management, Call Center and Credentialing (recently received in August 2014). URAC required re-accreditation reviews every three years and conducts compliance checks more frequently.

7. QM DEPARTMENT ORGANIZATION

The Alliance QM Department consists of a QM Director, who oversees three teams: Quality Review, Data Management and Provider Review. In addition, the QM Director oversees a Business Analyst and a Statistical Research Assistant. The QM Director reports directly to the Chief of Program Development and Evaluation. Alliance's Medical Director provides collaboration and guidance. The Medical Director meets weekly with the QM Director to review quality-related issues.

8. QM DEPARTMENT STAFF

**QM Director:** The QM Director manages a Quality Management Department and works closely with all internal departments, sites, boards of directors, CFACs and other external entities as required. The QM Director is involved with overseeing internal and external quality
improvement activities throughout the Alliance area. The QM Director develops and designs measurement tools for meeting contractual performance criteria and accreditation requirements. The QM Director produces written and oral presentations and reports for a variety of internal and external audiences are developed. The QM Director works closely with the Alliance IT Department to develop and/or design reports for other departments and staff to streamline data collection and reporting processes. The QM Director oversees organizational and provider assessments, measurements, and research when applicable and/or necessary. The QM Director develops and implements policies and procedures to ensure compliance with regulatory requirements related to quality improvement, outcome monitoring, and evaluation of services and programs.

**Quality Review:** The QR Manager oversees the Quality Improvement Projects to ensure appropriate type and number according to URAC and contracts; monitors by accuracy of QIPs, timeliness and correct process flows to ensure the QIPs are completed on time and are accurate; and implements Performance Improvement Projects (PIPs) as identified.

The QR Manager also manages quality improvement activities required by contract including PCP reviews, quality audits, certain survey projects, and committee reviews of the data; ensures that analyses and reports are accurate, thorough, and professional; is responsible for overall supervision of all unit employees; and participates in network management, and other program, evaluation activities

The Quality Review Manager currently oversees a team of four Quality Review Coordinators.

**Data Management:** The QM Data Manager manages the daily/weekly/monthly data processes, such as Incident Reporting and Analysis (IRIS), NC-TOPPS, NC-SNAP, Utilization Management and Call Center Statistics, network monitoring, DHSR notification process and the grievance process. The Grievance Reporting requirements and staff assigned to the grievance reporting process are managed by the QM Data Manager. Data Manager ensures that analyses and reports are accurate and professional with charts/graphs to facilitate stakeholder input and decision making. The QM Data Manager works closely with the IT Department to facilitate implementation of reports to be automated. As requested, the QM Data Manager coordinates and/or assists with other data analyses/processes/reports; this may include assistance with the strategic planning and/or the provider capacity study process. The QM Data Manager ensures contract requirements for Innovations Health and Safety measures, NC-SNAP, NC-TOPPS, incidents, and complaints. The QM Data Manager responsible for overall supervision of the team.

The QM Data Manager currently oversees a team of seven Quality Assurance Analysts.

**Provider Network Evaluation:** The Provider Network Evaluator Supervisor is responsible for managing the provider monitoring activities performed by the Provider Network Evaluators. This position provides leadership, mentoring and clinical oversight to Evaluators to ensure the monitoring activities adhere to MCO rules and guidelines so that sufficient, safe, and effective
services are being provided to consumers who have been identified as having Mental Health, Intellectual/Developmental Disabilities or Substance Abuse needs. The Provider Network Evaluator Supervisor will ensure that staff has the necessary assistance, support, training, and education to perform effective monitoring and review activities so that providers can succeed and continue to serve consumers. The Provider Network Evaluator Supervisor assists the Director of Quality Management and Chief of Network Development and Evaluation to develop policies, procedures and quality indicators for the Provider Network and to ensure that all required monitoring data is maintained.

The Provider Network Evaluation Supervisor currently oversees a team of 11 Provider Evaluators.

**QM Business Analyst:** The QM Business Analyst reviews business workflows for Alliance departments and sites; develops processes and key data elements in order to develop specified reports for the MCO; works closely with IT staff to provide content and context to reports; writes specifications and develop reports independently and/or with IT assistance; develops required Business Intelligence charts, graphs, and other Report formats as required by management. The Business Analyst works with IT staff to ensure the data elements and desired outcome of the BI tools are accurate; conducts Quality Assurance testing on IT projects as they apply to reporting, data collection, and analyses; creates databases as required by the QM Director, and other management staff; develops enhancements for Alpha as staff identify data issues; and serves as liaison between departments and IT to coordinate data automation efforts.

**QM Statistical Research Assistant:** The Statistical Research Assistant develops reports, databases, spreadsheets, and surveys; develops maps specific to requests from QM and Provider Network; develops required Business Intelligence charts, graphs, and other Report formats as required by the QM Director; analyzes data for QM Department such as claims data, residential capacity and utilization, DSHR findings, and Quality of Care Concerns tracking; works with QM Director and managers to facilitate survey and other quality improvement studies/projects, such as the NCI state project, Perception of Care surveys, and provider capacity surveys across counties in the catchment area; and helps coordinate, manage survey dissemination, tracking and analysis.

9. **DATA SYSTEMS**

**AlphaMCS:** Alliance has contracted with AlphaMCS of Wilmington, NC to provide database and processing support. The AlphaMCS system's features include Patient Management; Service Provider Management; Claims Processing; Quality Management; Provider Agency Portal; Reporting; Care Coordination; and EDI. The AlphaMCS system is fully web accessible. The QM Department also is actively involved with the development of new AlphaCMS features and reports. QM staff participates in a weekly AlphaMCS user group teleconference; beta tests new features and reports; and produces AlphaMCS reports for QM and other departments.
State: QM Department staff has access to important online reporting systems run by NC DHHS. These include the NC Treatment Outcomes and Program Performance System (NC-TOPPS), which collects quality data from providers; and the Incident Response Improvement System (IRIS), which is used by providers to report Level II and Level II incidents.

Internal: The QM Department also uses internal database and reporting systems developed by Alliance's IT Department. These include the BI Report System, which provides access to routine reports. QM staff works directly with the IT Department to design, develop and test new BI reports.

Alliance is expanding its internal reporting capabilities via recently signed contracts with CMT and MicroStrategy. CMT will provide reports combining Alliance's encounter data with pharmaceutical and primary care data for Alliance's consumers. MicroStrategy will offer a versatile platform for developing a wide variety of reports.

10. QM PROGRAM RELATIONSHIPS

Continuous Quality Improvement must be ongoing and pervasive. The Alliance QM Program is the responsibility of all staff, and the QM Department has ongoing relationships with all Alliance departments.

Administration: Alliance's Administration Department is led by the Alliance Chief Executive office and his staff. The QM Department assists the CEO with routine reports; ad hoc reports requested by the state and external stakeholders; and special presentations to the Alliance Board of Directors and county commissioners. The QM Department is represented on Alliance's Senior Leadership team by the Chief of Network Development and Evaluation.

Medical Affairs Department: The Medical Affairs Department is headed by the Alliance Medical Director and includes Alliance's Peer Advisors. The QM Department meets regularly with the Medical Affairs team to review quality improvement activities. The Medical Affairs team and QM Department have worked together to implement IRR testing of Call Center and UM staff. The Medical Director serves as co-chair of the CQI Committee. The Medical Director and QM Director meet weekly to review quality activities.

Provider Networks: The Provider Networks Management and Development Department. The QM Department is part of the Provider Networks Department, and the QM Director reports directly to the Chief of Network Development and Evaluation. The QM Director is a member of the Provider Networks leadership team. QM staff assist Provider Networks by developing reports and data sets for Provider Networks staff, reviewing provider contracts, identifying quality issues with providers undergoing recredentialing, and conducting program evaluation studies.

Utilization Management Department: Alliance's UM Department reviews and approves Service Authorization Requests (SARs) from providers for Medicaid, IDD and IRPS services. At the
request of UM Department leadership, the QM Department's Quality Review Team reviews UM activities and documentation. The QR team also participates in the development and administration of Inter-Rater Reliability testing of UM staff to determine the accuracy and consistency of reviews. The QM Director and other QM staff are members of the UM Committee.

**Care Coordination:** Alliance provides Care Coordination services to all Innovations enrollees and to high-risk MH/SA consumers with a history of crisis care or other high-cost treatment. During FY 2014, Care Coordination and QM Department collaborated on studies focusing on the accuracy of Care Coordination documentation and the effectiveness of services. During FY 2015, the QM Department initiated a formal Quality Improvement Project (QIP) on CC services.

**Access Department:** Overseen by the Alliance Chief Clinical Officer, the Alliance Access Department is the first point of contact for consumers seeking services. The QM Department receives routine reports from the Access Department on average speed to answer, abandonment rate and service levels, and includes these reports in Alliance's monthly reporting to the state. The QR team also consults with Access on Inter-Rater Reliability testing of Access staff to determine the accuracy and consistency of communications with consumers and conducts oversight of the delegated contractor for roll-over calls.

**Finance Department:** The Finance Department manages Alliance's financial activities and claims processing. Finance Department staff assist the QM Department with the development of reports for quality reviews. The Chief Financial Officer is a member of the CQI Committee.

**Community Relations:** The Community Relations Department works with federal/state/local agencies, providers and consumer advocacy groups to improve the delivery of care. QM Department staff assist Community Relations by developing reports required by block grant programs, participating in CQI activities and evaluation with crisis services providers and jail programs, and participates on county-wide Crisis Collaboration provider groups. In particular, QM staff works directly with Community Relations’ Crisis and Incarceration Manager.

**Information Technology:** The Information Technology Department works with Alliance's IT vendor AlphaMCS to test new features, develops internal database systems, creates reports, supports the Alliance data network, and maintains Alliance's computers. The IT Department also trains Alliance's Business Analysts. The QM Department's Business Analyst is in routine contact with the IT Department to evaluate new database features and reports. The QM Director discusses IT developments as a member of the IT Committee.

**Compliance:** The Compliance Department assesses provider and Alliance staff adherence to Alliance procedures, Alliance’s contracts, and state and federal law. Compliance staff conduct program integrity investigations when necessary. The QM Department provides Compliance with the results of any analyses finding evidence of non-compliance or fraud and abuse by providers or Alliance staff. The QM Department also informs Compliance of trends in complaints, grievances and incidents involving providers.
11. QM PROGRAM ACTIVITIES

The Alliance QM Program involves a wide range of quality-related activities that are focused on all aspects of Alliance's activities.

Quality Improvement Projects: QIPs are formal, long-term initiatives that focus on one or more clinical or non-clinical area(s) with the aim of improving health outcomes and beneficiary satisfaction. Alliance is required to conduct QIPs both under its contracts with DMA and DMH, and also as part of URAC accreditation.

A QIP is launched with consultation from the CQI Committee and the Global QM committee when a problem and potential solution have been identified through ongoing data analysis. Data is initially collected to establish a statistical baseline, interventions are implemented, and post-intervention data are collected.

QIPs are typically more resource-intensive and longer-term than other quality improvement activities. Under URAC requirements, the QIP must show sustained improvement for one year after project goals are met.

FY 2016 QIPs

1. Reduction of Admissions to Emergency Departments (ongoing) [renamed Improving Crisis Services for FY 16]: Although Alliance’s overall average rate of consumers presenting to Emergency Rooms (ER) is lower than the state average, the total number presenting and the care our consumers receive are concerning. Additionally, Alliance will be responsible for paying for visits directly related to a consumers’ behavioral health disorder. This project will continue for Wake and Cumberland Counties.

Need: Reduce ED admissions and crisis facility utilization, particularly for high-risk individuals such as Medicaid recipients with unstable medical conditions and frequent utilizers of crisis services.

Goals: Reduce ED admissions for youth in pilot programs in Cumberland County, reduce percent of time crisis facility in Wake County is closed due to over-capacity, and increase number of providers offering same day access to care.

2. Access to Care: URAC-Call Center & Health Network (ongoing): Alliance’s Access & Information Center (Call Center) link members to appropriate services when requested. Facilitating a member’s access to necessary services is essential in meeting the needs of the individual. Alliance has established protocols for screening and triaging callers in order to collaborate with the network of providers to meet this need. Callers are screened by Alliance Access & Information Center (Access) staff with a risk assessment before a clinician gathers information in order to help make an initial determination about the clinical severity of the
need. Depending on the need identified callers are assigned to Emergent, Urgent or Routine call protocols and linked to appropriate services. Data indicates that Alliance providers have struggled to meet the benchmarks for the initial visit in a timely manner.

Goals: Increase in consumers showing for care within benchmarks set for Emergent, Urgent, and Routine care.

3. First Responder Evaluation of Providers (ongoing): Alliance is responsible for program integrity, monitoring activities of their providers, and routinely testing First Responder capacity and quality throughout its coverage area. First Responder is defined as specific services and agency types required to provide crisis response to their enrolled consumers 24 hours a day, 7 days a week, and 365 days per year. The QM Department tests the “first responder” crisis phone numbers of enhanced service providers on a tiered basis based upon results from previous QIP. Crisis numbers will be obtained by reviewing Crisis Plans (Basic and Comprehensive) for consumers receiving services that have first responder requirements.

Interventions include offering additional PCP/Crisis plan trainings; referring poor performers to compliance; and issuing Plans of Correction to poor performers.

Need: The First Responder QIP purposes to improve the quality and timeliness of a provider’s response to their consumer’s crisis situations. The Project is continuing because only one benchmark, out of three, was met.

Goals: Increase the number of test calls returned within one hour of voicemail and increase the number of calls successfully answered within 30 seconds.

4. Care Coordination-MH/SA (ongoing): In 2014, Alliance has served over 4,500 unduplicated consumers in care coordination providing linkage to services, supports and resources in an effort to optimize clinical outcomes, decrease recidivism to crisis facilities, and foster longer periods of community tenure. The impact of care coordination services to consumers is a concern given the high caseloads. A sample of cases involving adults receiving Medium-Level intensity Care Coordination indicated that only 56% received a contact from Care Coordination within the required 2 business days.

Goal: Increase adherence to Care Coordination procedures as measured by contact with consumers and/or providers within 2 business days.

Care Coordination-I/DD (ongoing): An estimated 1,485 I/DD consumers received Innovations services, and required Care Coordination, between Feb. – June 2013. The Alliance Care Coordinator is responsible to facilitate and develop an Individual Support Plan (ISP) to accurately reflect services and supports that meet the individuals’ needs. In QM reviews of the plans, concerns have been raised about health and safety issues. In addition to health and safety issues, an internal cross-functional team identified a concerns about the underlying issues in the development of the ISPs that result in denials and reductions of services.
Goals: Decrease the number of service authorization adverse actions due to lack of justification (information) and the number of health/safety concerns filed by QM.

Mystery Shopper - UM Call Monitoring (ongoing): Calls to Utilization Management (UM) staff were monitored for adherence to URAC standards. UM staff receive, on average, around 3,000 calls per month. Call monitoring has proven to assist in determining areas of inconsistency as well as strengths. This project has continued into FY 16 because the benchmark has not been met. New interventions have been developed and will be implemented in the Fall. Another round of monitoring will take place at the end of the year to ensure improvement has been made.

Goals: Increase the number of calls in which the UM staff greet callers following Alliance procedures.

Mystery Shopper — PCP Reviews (ongoing) [now called Improving Person-Centered Planning QIP]: This project was originally selected in FY14-15 as a portion of the Mystery Shopper QIP after specific patterns and trends emerged in relation to PCP development among MH/SA providers. Trends revealed poor quality and person-centeredness on crisis prevention and stabilization as well as consumer health and safety in the PCPs.

Goals: Improve % of quality elements met in the PCPs.

5. Improve Best Practices in Intensive In-Home (ongoing): The Intensive In-Home service is authorized more than any other enhanced Medicaid service for children in the Alliance catchment area. Numerous concerns have been raised about the quality of this service. Due to those concerns, Alliance issued RFPs in late 2013 for IIH providers offering practices that they identified as having empirical support for better outcomes. QM conducted a pre- and post-intervention analysis to determine if RFP process resulted in better outcomes for youth receiving the service. The analysis indicated that results were not statistically significant. The project has been redesigned for FY 16 to study the effectiveness of several evidence based models, with rigorous fidelity monitoring.

Goals: Improve outcomes of youth receiving the identified evidence-based practices.

6. Reduce Complaints and Grievance Error Rates (New): A complaint, also called a quality of care concern, filed by an employee, addresses those issues either identified by a consumer/family member/or provider; and/or an employee through their own work. Without complete and accurate information, the complaint may be delayed or misunderstood. Data collected on a monthly basis by QM shows that, since July 2014 to March 2015 (9 months), there has been a 70% error rate for internal staff filing concerns.

Goals: Reduce the error rate by 10%.
Other Quality Activities

**Performance Improvement Projects:** Performance Improvement Projects are short-term activities addressing a problem identified through ongoing data analysis. The PIP may involve additional data analysis to understand root causes. PIPs are typically less resource-intensive, shorter-term, or more targeted than QIPs. Like QIPs, a PIP may involve multiple interventions.

**Quality Reviews:** A Quality Review involves a review of a process or documentation against best practice standards. Quality Reviews are identified through ongoing data analysis, as a contract requirement, or upon request by a department. QM staff will create a review tool based on standards, and rate performance as met/not met/partially met against standards. Staff will then create recommendations or an action plans, and re-evaluate with additional quality review.

**Studies:** A study focuses on a concern identified through ongoing data analysis. QM staff may conduct in-depth data analysis to gain a better understanding of the problems and root causes. Studies typically are less resource-intensive, short-term and targeted. A study may evolve into PIP or QIP.

**Ongoing Analysis of Data:** QM staff develop a report to closely monitor performance data associated with a contract performance measure, HEDIS measures or program requirement. QM staff currently conduct ongoing analyses of crisis data, management reports, utilization, STR, MCO operations, financial, performance of network, and System of Care data.

**Surveys:** QM staff develop and disseminate surveys to gather and incorporate feedback. Surveyees include consumers, providers, Area Board members and stakeholders.

QM staff also review the findings of surveys conducted by the state and other external parties. These include the annual Perception of Care survey and Provider Satisfaction Survey conducted by the state, and the Provider ECHO Survey conducted as part of the federal EOR process. The QM Department works with the relevant departments and committees to develop, implement and track improvements identified in the survey results.

12. **GRIEVANCES AND COMPLAINTS**

The QM Department’s Data Management Team is responsible for processing grievances submitted from within and outside Alliance. A grievance is an expression of dissatisfaction about any matter other than decisions regarding requests for Medicaid services. Alliance's goal is to use a fair, impartial and consistent process for receiving, investigating, resolving and managing grievances filed by consumers or their legal guardians/representatives concerning Alliance staff or Network Providers. Alliance will respond to grievances received concerning providers or Alliance staff in the Alliance catchment area.
13. INCIDENTS

The QM Department’s Data Management Team is responsible for tracking incident reporting by network providers. The goal is a uniform and consistent approach for the monitoring of and response to incidents which are not consistent with the routine operations of a facility or service or the routine care of a client enrolled in the Alliance Behavioral Healthcare Closed Network.

All Category A and B Providers serving consumers in the Alliance catchment area are required to report Level II or Level III incidents to Alliance within seventy-two (72) hours of the incident. The report shall be reported in the state’s web-based Incident Response Improvement System (IRIS). All crisis providers are required to report incidents that occur during the provision of crisis services. Provider submit quarterly reports of all Level I incidents.

14. PROVIDER MONITORING

The DHHS Provider Monitoring process is designed to promote North Carolina’s commitment to ensuring high quality services for individuals with mental health, intellectual/developmental disabilities, and substance abuse issues. It is the vehicle used for entry into the provider network, for the evaluation of service providers against quantitative and qualitative measures, and for determining advanced placement status, using a series of monitoring tools. The provider monitoring process is used to monitor both Medicaid and State-funded behavioral health services.

A new process for routine provider monitoring was implemented March 1, 2014. The Provider Monitoring process is used statewide by the LME-MCOs to monitor providers of publicly-funded MH, IDD and SA services, regardless of funding source, and includes the tools and guidance for monitoring licensed independent practitioners (LIPs) and MH, IDD and SA provider agencies. Routine provider monitoring consists of two components—a routine review and a post-payment review.

15. TRAINING

Training of both internal and external stakeholders is an essential part of Alliance’s quality program. In particular, the QM Department plays a significant role in developing training to inform stakeholders and staff of quality processes in general, and processes actively subject to quality improvement activities.

During FY 2015, the QM Department developed training for Alliance staff on crisis plan development, PCP and ISP development, and complaints and grievance submissions. The QM Department also trained providers on PCP/Crisis Plan development, QM program development, Plan of Corrections, and Incident Reporting.
16. QM PROGRAM OBJECTIVES – FY 2016

The process of Continuous Quality Improvement includes the establishment of new goals by Alliance’s QM program. The Alliance QM Department has set the following goals for FY 2016:

1. **Meet 100% of performance measures:** The QM Department is committed to ensuring that Alliance meets all performance measures established in Alliance's contracts with the DMA and DMH. These measures cover the range of Alliance's activities, including performance by Alliance's Clinical, Utilization Management, Call Center and QM Departments.

2. **Review 100% of Alliance committee reports to identify new QM risk factors:** The QM Department will review all reports created by the various Alliance committees, identify areas of risk or non-performance, and facilitate the mitigation of these issues.

3. **Implement 100% of Mercer and EQR recommendations:** During FY 2015, Mercer and EQR evaluations resulted a total of 15 recommendations for the Alliance quality management program. As of July 31, Alliance had implemented four of the 15 recommendations. The QM Department will work to implement the remaining recommendations by the deadline of the next on-site visit.

4. **Revise the charters and reporting requirements for 100% of CQI committees:** Alliance has developed its CQI committee structure to identify and correct quality issues. During FY 2015, Alliance initiated a strategic planning initiative facilitated by the consulting firm Zelios. One of the initiative’s goals is to review and revise the descriptions, functions and memberships of the CQI Committee and its subcommittees. A second goal was to establish formal reporting requirements for each committee in the form of Key Performance Indicators or performance standards.

5. **Implement provider performance measurements and reporting in 100% of contracts:** As part of its Strategic Planning process, Alliance has established the goal of improved provider measurement and reporting. Provider reporting will improve consumer care and facilitate the development of a high-quality provider network via contracting, credentialing and recredentialing.
APPENDIX A – CQI Committee and Subcommittee Charters

1. Continuous Quality Improvement Committee

Purpose

The CQI Committee is the venue for the review and assessment of all performance data and quality activities for Alliance. The CQI Committee meets at least monthly to review clinical and provider network performance data and review operations.

Responsibilities

As a committee within the Alliance CQI structure, the CQI Committee is responsible for identifying and reporting:

- Key areas of risk or concern for the committee;
- Reports or data that support/identify these areas being considered a risk/concern;
- An analysis of the risk/concern, including how long has been a concern, the impact on Alliance departments, or the organization as a whole;
- Committee response to the area of risk/concern, including action steps, timeframes, and when CQI Leadership Team will receive an update;
- How issues identified in your committee are communicated to other affected committees;
- The results of any Quality Improvement activities implemented to address risk or concern.

The CQI Committee is responsible for the implementation and evaluation of the Alliance Quality Management Plan, monitoring of quality improvement goals and activities and identifying opportunities for improvement within the provider network and Alliance operations.

Data Reporting/Review

The committee examines data and information for trends, to identify areas of risk for the organization, and to areas where there has been or needs to be performance improvement.

Relationships

The committee reviews state reports, information and reports to be shared with the board of directors. Information reviewed with strategies for improvement are shared with the Global Quality Management Committee of the Board for additional review, feedback, recommendations and approval.

Membership
The committee is composed of:

- Alliance CEO
- Medical Director
- Chief of Staff
- Compliance Officer
- Chief Clinical Officer
- Chief of Network Development and Evaluation
- Chief Finance Officer
- Chief Information Officer
- Director of Analytics and Quality Management
- Chief of Community Relations
- Director of Consumer Affairs

2. Budget and Finance Committee

Purpose

The primary charge of this committee to provide an internal review of expenditures, allocations, trends, and an overall financial picture of the agency in regards to services and programs. It also ensures a fair system is in place for allocating or de-allocating dollars.

Responsibilities

As a committee within the Alliance CQI structure, the Budget and Finance Committee is responsible for identifying and reporting to the CQI Leadership Team:

- Key areas of risk or concern for the committee;
- Reports or data that support/identify these areas being considered a risk/concern;
- An analysis of the risk/concern, including how long has been a concern, the impact on Alliance departments, or the organization as a whole;
- Committee response to the area of risk/concern, including action steps, timeframes, and when CQI Leadership Team will receive an update;
- How issues identified in your committee are communicated to other affected committees;
- The results of any Quality Improvement activities implemented to address risk or concern.

The Committee acts as the recommending body to the CFO as to the manner in which funds should be distributed or de-allocated by reviewing financial/service data and reports. The Committee prevents one sole authority, namely the CFO, from having a programmatic or
service impact to the Community without input from key stakeholders such as clinical operations, provider networks, consumer affairs and local sites.

The committee's responsibilities include but are not limited to:

- Review data reports
- Provides an internal review of expenditures, allocations, trends, and an overall financial picture of the organization
- Discuss concerns about specific programs or services
- Discuss new allocations or budget reductions
- Ensure recommendations for financial adjustments adhere to policies and procedures, strategic plan, gap/needs assessment, and organizational priorities
- Discuss specific actions taken in Claims or UM that have impact to the community

**Data Reporting/Review**

- Progress on state fund drawdown
- Claim trends
- Medicaid expenses by level of care
- Per Member Per Month (PMPM) budget adherence
- Specific services compared to previous months, authorizations, or other data elements
- Financial reports:
  - Incurred But Not Reported (IBNR)
- Rate variance reports
- Month end financial statements
- Over and underutilization of budgeted funds

**Relationships**

The Chair of the B&F Committee reports to the CQI Committee and is a member of ELT as well as the Corporate Compliance Committee. The Director of Budget and Financial Analysis if a member of the UM Committee to allow for representation from a budget perspective.

**Membership**

The Budget and Finance Committee is a mandatory committee made up of representatives from Clinical, Quality Management, and local sites. There is no limit on terms as this is a management tool in the financial stability of the agency. All members are voting members. A majority of members represents a voting quorum.

**Chair:**
Chief Financial Officer

**Members:**
Chief Clinical Officer

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Chief of Network Development and Evaluation
Chief of Community Relations
Director of Consumer Affairs
Director of Budget and Financial Analysis

Membership may also include MCO Contractors.

3. Clinical Care Management Team

Purpose

The primary charge of the CCMT is to review all adverse incidents that may affect the health and safety of consumers.

Responsibilities

As a committee within the Alliance CQI structure, the Clinical Care Management Team is responsible for identifying and reporting to the CQI Leadership Team:

- Key areas of risk or concern for the committee;
- Reports or data that support/identify these areas being considered a risk/concern;
- An analysis of the risk/concern, including how long has been a concern, the impact on Alliance departments, or the organization as a whole;
- Committee response to the area of risk/concern, including action steps, timeframes, and when CQI Leadership Team will receive an update;
- How issues identified in your committee are communicated to other affected committees;
- The results of any Quality Improvement activities implemented to address risk or concern.

The committee’s responsibilities include but are not limited to:

- Oversee the activities of the Mortality/Morbidity subcommittee by reviewing deaths and other significant adverse events.
- Conduct root cause analyses related to death and other serious incidents
- Review incident reports and incident trends to identify potential consequences to consumer health and safety.
- Identify gaps in utilization of Best Practices and make recommendation for the development or adoption of Clinical Guidelines to the Clinical Advisory Committee
- Review cases of concern referred to Alliance or elicited by Alliance staff
- Conduct case conferences for complex clinical cases identified by outside regulatory bodies
- Assist in the identification of substandard practice among the network provider and refer those to Quality Management and/or Compliance Committees for further action
Data Reporting/Review

- Mortality/morbidity (Level III Incident Reports)
- NC DHSR and other regulatory body reports and findings
- QM generated data regarding care concerns and incident trends.

Relationships

The committee reports to the CQI Committee. The committee’s membership enhances communications among the represented Alliance departments.

Membership

CCMT committee is chaired by the Medical Director. All members are voting members. A majority of members represents a voting quorum. Membership is cross-departmental and includes the following:

- Chief Clinical Officer
- Associate Medical Director
- UM Director MHSA
- UM Director IDD
- Provider Networks Staff
- Quality Management Staff
- County site directors
- Director of Customer Services
- Director of MH/SA Care Coordination

4. Community Relations Committee

Purpose

The committee reviews relations with community partners, identifies issues and concerns, and creates systemic solutions.

Responsibilities

As a committee within the Alliance CQI structure, the Community Relations Committee is responsible for identifying and reporting to the CQI Leadership Team:

- Key areas of risk or concern for the committee;
- Reports or data that support/identify these areas being considered a risk/concern;
• An analysis of the risk/concern, including how long has been a concern, the impact on Alliance departments, or the organization as a whole;
• Committee response to the area of risk/concern, including action steps, timeframes, and when CQI Leadership Team will receive an update;
• How issues identified in your committee are communicated to other affected committees;
• The results of any Quality Improvement activities implemented to address risk or concern.

Data Reporting/Review
• Care reviews
• Services received by Alliance consumers involved in the jail system
• Housing assistance received by Alliance consumers
• Child and family team activities
• SOC collaboratives activities

Relationships

The committee reports to CQI committee. It receives input from the Community Advisory Committee(s).

Membership

The Community Relations Director chairs this committee. All members are voting members. A majority of members represents a voting quorum.

Members include:
• Community Relations staff
• Director of Community Affairs
• Medical Affairs staff
• Quality Management staff

5. Corporate Compliance Committee

Purpose

The Corporate Compliance Program is designed to monitor adherence to applicable statutes, regulations and program requirements as well as to identify, prevent, reduce, and correct violations of legal and ethical conduct. The Corporate Compliance Committee assists the Chief Compliance Officer with the development of Alliance Compliance efforts and oversees the implementation in order to evaluate the effectiveness of the program.

Responsibilities
The responsibilities of the Committee include but are not limited to:

- Analyzing the organization’s regulatory obligations;
- Developing and recommending standards of conduct and policies and procedures that promote compliance;
- Developing and monitoring internal systems and controls to carry out standards, policies and procedures as part of the organization’s daily operations;
- Determine the appropriate strategy and approach to promote compliance and detection of potential risk areas through various reporting mechanisms;
- Determine methodology to conduct the annual risk assessment, overseeing the process and determine the levels of risk as part of formulating the annual Compliance Work Plan;
- Review major provider compliance violations to determine provider sanctions;
- Review and approve provider corrective actions for major out of compliance issues;
- Monitor findings of internal and external reviews for the purpose of identifying risk areas or deficiencies requiring preventive and corrective action; and
- Annually evaluate the effectiveness of compliance efforts, determine if adjustments need to be made to the Compliance Plan, and set forth the annual Compliance Report.

As a committee within the Alliance CQI structure, the Corporate Compliance Committee is responsible for identifying and reporting to the CQI Leadership Team:

- Key areas of risk or concern for the committee;
- Reports or data that support/identify these areas being considered a risk/concern;
- An analysis of the risk/concern, including how long has been a concern, the impact on Alliance departments, or the organization as a whole;
- Committee response to the area of risk/concern, including action steps, timeframes, and when CQI Leadership Team will receive an update;
- How issues identified in your committee are communicated to other affected committees;
- The results of any Compliance activities implemented to address risk or concern.

Regular Agenda Items:
1) Quarterly Reports (may include for example):
   a) Exclusions Checks
   b) Billing Audits Scores by Provider
   c) Summary of Claims Audits (by Business Ops. Claims Auditor)
   d) HIPAA Activities and Actions
   e) Internal Audits and Results
   f) Grievances Trends (by region, type, provider, etc.)
   g) POC Trends (by region, type, provider, etc.)
2) Provider Violations Review, Sanctions and Recoupment:
   a) Fraud, Waste, and Abuse
   b) Health and Safety
3) Credible Allegations of Fraud (if allowed to be reported)
   a) DMA action
   b) Alliance action

Relationships

The committee reports to the Continuous Quality Improvement Leadership Team, including matters of significant non-compliance such as fraud and abuse.

Committee Membership and Terms

The Corporate Compliance Committee is formed representative of the clinical and administrative operations of Alliance. The Chief Compliance Officer serves as the chair of the committee and does not vote on any matters, unless the vote is required to break a tie. Committee members will serve one-year terms with no limitations on the number of terms a member can serve. The make-up of the committee will be re-evaluated at the end of each fiscal year. For the sake of consistency and knowledge of responsibilities and actions of the committee, no more than 50% of committee members may resign from the committee in the same year. New members will be nominated by their department head and will be selected by majority vote by the current committee. The Chief Compliance Officer should be consulted on the selection of membership.

Meeting Structure

1) Calling the meeting to order
2) Reviewing and approving an agenda
3) Ensuring there is a recorder and having minutes taken
4) Reviewing and approving minutes from previous meeting
5) Calling for motions, a seconder and voting on items when appropriate
6) Adjournment

When quorum is present (Chair plus 50% of members present) the chair can call the meeting to order. When quorum is not met a meeting cannot be called to order nor can any decision be made, issues voted on or minutes taken. Minutes should simply reflect that the meeting was cancelled due to quorum not being met.

Meeting Time

The Committee meets Mondays at 1:30 PM as frequently as necessary. In order to meet important time frames for certain actions, the Committee may review and vote on actions by electronic means, as long as the response from the members is at least 50%. Reviewing and voting by electronic means may only be initiated by the Chief Compliance Officer. Minutes at
the next meeting must reflect any decisions made by electronic voting, the date of the voting, and the number of votes.

Confidentiality

Committee members will sign a confidentiality form agreeing to keep items discussed during meetings confidential as required and as appropriate in order to protect the integrity of the committee and the organization.

Membership

Chair:
Chief Compliance Officer

Members:
Medical Director
Senior Psychologist
Chief of Network Development and Evaluation
Quality Management Data Manager
Chief of Staff
Medicaid Program Director
Chief Financial Officer
Director of Customer Services

6. IT Committee

Purpose

This committee reviews IT projects and activities, IT systems including those developed by external vendors, data management, and internal and external reporting.

Responsibilities

As a committee within the Alliance CQI structure, the IT Committee is responsible for identifying and reporting to the CQI Leadership Team:

- Key areas of risk or concern for the committee;
- Reports or data that support/identify these areas being considered a risk/concern;
- An analysis of the risk/concern, including how long has been a concern, the impact on Alliance departments, or the organization as a whole;
- Committee response to the area of risk/concern, including action steps, timeframes, and when CQI Leadership Team will receive an update;
- How issues identified in your committee are communicated to other affected committees;
• The results of any Quality Improvement activities implemented to address risk or concern.

The responsibilities of the committee include:

• Review data reports and develop response to negative trends
• Assess data integrity issues
• Analyze progress on implementing new IT programs
• Oversee updates to IT vendor systems

Data Reporting/Review

• Report Requests – number, type, time to completion, deadlines met
• KACE system help tickets – number, time to completion

Relationships

The committee reports to CQI Leadership Committee.

Membership

The committee meets twice monthly. All members are voting members. A majority of members represents a voting quorum.

Members include:
• CIO
• Chief of Network Development and Evaluation
• CFO
• Director of Community Relations
• Director IT Applications Development
• Director IT Reporting
• Chief Clinical Officer
• Director of Quality Management

7. Provider Network Management Committee

Purpose
The primary charge of this committee is to review provider-related data, identify and address service gaps, and explore network trends.

Responsibilities

As a committee within the Alliance CQI structure, PNMC is responsible for identifying and reporting to the CQI Leadership Team:

- Key areas of risk or concern for the committee;
- Reports or data that support/identify these areas being considered a risk/concern;
- An analysis of the risk/concern, including how long has been a concern, the impact on Alliance departments, or the organization as a whole;
- Committee response to the area of risk/concern, including action steps, timeframes, and when CQI Leadership Team will receive an update;
- How issues identified in your committee are communicated to other affected committees;
- The results of any Quality Improvement activities implemented to address risk or concern.

The Provider Network Management Committee’s responsibilities include:

- Review data reports and develop response to negative’s trends
- Identify and review provider-related QIPs
- Recommend provider surveys and training
- Identify network gaps
- Review Network Development Plan status
- Examine the implications of state and federal funding changes on the services that are provided within the community
- Make recommendations on how to address service needs from a system and network perspective.
- Review credentialing program activities including number of providers credentialed and de-credentialed.

Data Reporting/Review

- Network Development Plan initiative completion rate
- Provider Departures and Additions
- Provider Monitoring Failure
- Credentialing/Re-credentialing/De-credentialing
- Number Served Per Capita by Service by County
- Penetration Rate by Service by County
- Access and choice of provider (geomapping)
- Provider surveys
• Trends in provider-related grievances and incidents
• Single Case/Out of Network Agreements

Relationships

The Committee receives data and information from the network development plan and key performance indicators. The Committee makes recommendations to the Chief of Network Development and Evaluation and the CQI Leadership Committee on actions needed to address quality issues and network performance. The committee also provides input into the annual gaps and needs assessment.

Membership

The PNMC is chaired by Director of Provider Network Strategic Initiatives. This committee meets at least quarterly. All members are voting members. A majority of members represents a voting quorum.

Member representation is from the following areas:
• Access
• Community Relations
• Utilization Management
• Care Coordination: IDD and MH/SA
• Consumer Affairs
• Quality Management
• Crisis Services
• Provider Network

8. Utilization Management Committee

Purpose

The purpose of the Utilization Management committee is to ensure that consumers have appropriate access to behavioral health services, service utilization and projected expenditures are within expected ranges, trends, issues and utilization drivers are identified, responses are implemented and effectiveness of responses are measured.

Responsibilities

As a committee within the Alliance CQI structure, the Utilization Management Committee is responsible for identifying and reporting to the CQI Leadership Team:

• Key areas of risk or concern for the committee;
• Reports or data that support/identify these areas being considered a risk/concern;
- An analysis of the risk/concern, including how long has been a concern, the impact on Alliance departments, or the organization as a whole;
- Committee response to the area of risk/concern, including action steps, timeframes, and when CQI Leadership Team will receive an update;
- How issues identified in your committee are communicated to other affected committees;
- The results of any Quality Improvement activities implemented to address risk or concern.

Roles and Functions of the UM Committee include:

- Review of the Utilization Management Plan and the Annual Evaluation
- Monitoring clinical performance metrics, related to the functions of Utilization management Departments, Access and Information Center and Care Coordination departments.
- Review utilization of crisis services and post discharge linkage.
- Review recommended state and Medicaid benefit plans that are approved by the Medical Director.
- Review and adopts Medical Necessity Criteria that is required by the NC Division of Medical Assistance Clinical Coverage Policies annually and as these criteria are updated based on the Division of Medical Assistance. This review requires final approved by the Medical Director.
- Reviews and approves of clinical action plans and initiatives that have been implemented by Clinical Operations.

Data Reporting/Review

To accomplish the roles and functions noted above, the Committee examines targeted data elements to:

- Ensure that service utilization expenditure are within expected ranges
- Identify trends and drivers of service utilization (including crisis services) to inform risk and areas of quality improvement
- Detect over and under-utilization
- Implement response(s) to areas of risk
- Measure effectiveness of responses
- Monitor for standard performance measures through the use of the Clinical Operations Dashboard
- Review of Budget to actual financial report – Medicaid and State
- Ad-hoc reports as created or requested by the committee

Data elements may evolve as the needs of the Committee change and new areas of risk are identified. At this time, the Clinical Operations Dashboard includes:
1. Quality of Care
2. SARs processing volume with percentages of those denied or partially denied for both internal as well as external Peer Reviewers
3. Number of SARs issued to Out-of-Network providers
4. Service Trends of daily census, average Length of Stay for I1H, PRTF, BH LT Residential, ICF-MR and FCB. Inpatient readmission rates both at 7 and 30 days are also reported through the dashboard.
5. Call Center Statistics
6. Appeals statistics
7. Crisis Services utilization data will be added to the dashboard and monitored.

Relationships

The committee serves as a subcommittee to communicate and coordinate quality improvement efforts to and with the CQI.

Membership

The Utilization Management committee is co-chaired by the Medical Director and the Utilization Management Director. All members are voting members. A majority of members represents a voting quorum.

Membership is inclusive of a cross-departmental representation including:

- Chief Clinical Officer
- Director of Budget and Financial Analysis
- Provider Networks representative
- I/DD Clinical Director
- Director of MH/SA Care Coordination
- Director of I/DD Care Coordination
- Associate Medical Director
- Senior Psychologist
- Utilization Review Manager
- Director of Quality Management and Research
- Quality Review Manager
- QM Data Manager
FY 2015 Quality Management Evaluation - DRAFT

Revised August 27, 2015
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1. PURPOSE

The purpose of this Quality Management Evaluation Report is to review Alliance Behavioral Healthcare’s progress at implementing quality management activities required under its contract with the North Carolina Department of Health and Human Services (DHHS) contract requirement. This report also will help Alliance identify areas needing improvement and establish future quality management goals.

2. TYPES OF EVALUATION

Alliance’s QM activities are evaluated in a variety of ways:

1. Contract-required performance measures
2. Internal reports and dashboards
3. Mercer reviews
4. EQR reviews
5. URAC accreditation
6. Strategic plan development

3. QM EVALUATION – STATE REQUIREMENTS

Alliance’s contract with the NC Department of Health and Human Services specifies certain elements in the annual QM program evaluation:

Requirement 1: Meet or exceed CMS, DMA and Alliance defined minimum standard performance levels on standardized quality measures annually.

During FY 2015, Alliance routinely submitted various monthly, quarterly and semi-annual performance measures to the state as required under contract. These performance reports are reviewed by Alliance’s CQI Committee. When a performance measure is not met, the committee approved a quality initiative designed to address the issue. These included ad hoc quality initiatives, formal Corrective Action Plans and, in one case, a formal Quality Improvement Plan.

Monthly LME-MCO Report

Requirements: Alliance reports each month whether it met the following performance measures set under its state contracts:

- Medicaid/State – less than 5% of calls abandoned
- Medicaid/State – 90% of calls answered within 30 seconds
- Medicaid - 85% of readmits assigned to Care Coordination
- Medicaid - 90% of standard authorizations processed in 14 days
- Medicaid - 90% of expedited authorizations processed in 3 days
- Medicaid - Total of 90% processed in required timeframes
- Medicaid - 90% of claims processed within 30 days
• Medicaid - 90% of complaints resolved in 30 days
• State - 90% of standard authorizations processed in 14 days
• State - 90% of expedited authorizations processed in 3 days
• State - Total of 90% processed in required timeframes
• State - 90% of claims processed within 30 days
• State - 90% of complaints resolved in 30 days

**Results:** During FY 2015, Alliance met 155 of 156 (99.4%) performance measures (see Appendix A).

Alliance’s only subpar performance was “Medicaid - 90% of Readmits Assigned to Care Coordination” for May 2015, when 84.6% of readmits were assigned. A review determined that one consumer was not assigned to care coordination because he indicated he intended to leave the state. A Corrective Action Plan was completed under which care coordination staff were instructed to assign consumers to care coordination regardless of the consumer’s intentions.

**Submission Performance Report**

**Requirements:** Alliance is required to submit the following reports in a timely and accurate fashion:

• Monthly Financial Reports
• Substance Abuse/Juvenile Justice Initiative Quarterly Report
• Work First Initiative Quarterly Reports
• Traumatic Brain Injury (TBI) Services Quarterly Report
• Quarterly Complaints Report
• System of Care Report
• SAPTBG Compliance Report
• National Core Indicators (NCI) Consents, Pre-Surveys, and Mail Surveys
• Client Data Warehouse (CDW) - Screening Records
• Client Data Warehouse (CDW) - ICD-9 Diagnosis
• Client Data Warehouse (CDW) - Unknown Data (Admissions)
• Client Data Warehouse (CDW) - Unknown Data (Discharges)
• Client Data Warehouse (CDW) - Identifying and Demographic Records
• Client Data Warehouse (CDW) - Drug of Choice
• Client Data Warehouse (CDW) - Episode Completion Record (SA Clients)
• NC Treatment Outcomes and Program Performance System (NC-TOPPS)
• NC Support Needs Assessment Profile (NC-SNAP)

**Results:** During FY 2015, the state provided Alliance with one quarterly Submission Performance Report for Q1 FY 2015. Alliance met eight of 14 (57.1%) performance measures reported by the state (see Appendix B).

Alliance subsequently determined that it was in compliance with two requirements:

1. Monthly Financial Reports
2. Quarterly Complaints Report

Alliance implemented successful Corrective Action Plans that resulted in compliance with the following requirements:

1. Traumatic Brain Injury (TBI) Services Quarterly Report
2. NC Support Needs Assessment Profile (NC-SNAP)

Alliance remains out of compliance with the following requirements:

1. Client Data Warehouse (CDW) - Screening Record
2. Client Data Warehouse (CDW) - Episode Completion Record (SA Clients)

Alliance implemented a Corrective Action Plan including IT systems improvements, new staff hiring, and coordinating efforts with the state to improve CDW file accuracy.

Access to Care Report

Requirements: Alliance is required to provide services to a consumer according to the following standards:

- Emergent – Medicaid - 97% within 2 hours
- Emergent - Non-Medicaid - 97% within 2 hours
- Emergent – Combined - 97% within 2 hours
- Urgent – Medicaid - 82% within 48 hours
- Urgent - Non-Medicaid - 82% within 48 hours
- Urgent – Combined - 82% within 48 hours
- Routine – Medicaid - 75% within 14 days
- Routine - Non-Medicaid - 75% within 14 days
- Routine – Combined - 75% within 14 days

Results: During FY 2015, Alliance met three of 36 (8.3%) of performance measures (see Appendix C).

The state has noted that the current standards are based on the historic performance of the pre-merger LMEs. The state has announced that it will be resetting the standards for FY 2016.

During FY 2015, Alliance launched a formal QIP aimed at improving its Access to Care performance.

Innovations Program report

Requirements: Alliance is required to meet the following quarterly performance measures:

- Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval - 85%
- Percent of Actions Taken to Protect the Consumer- 85%
- Proportion of Level 2/3 Incidents reported within required timeframes - 85%
- Percentage of deaths where required LME/PIHP follow-up interventions were completed as required - 85%
- Percentage of Level 2 or 3 incidents where required LME/MCO follow-up interventions were completed as required - 85%

Alliance is required to meet the following semi-annual performance measures:

- Proportion of Level of Care evaluations completed at least annually for enrolled participants - 85%
- Proportion of Level of Care evaluations completed using approved processes and instrument- 85%
- Proportion of New Level of Care evaluations completed using approved processes and instrument - 85%
- Proportion of Individual Support Plans that address identified health and safety risk factors - 85%
• Proportion of PCPs that are completed in accordance with DMA requirements - 85%

**Results:** During FY 2015, Alliance met 26 of 30 (86.6%) performance measures (see Appendix D).

Following its Q2 FY 2015 report, Alliance initiated a Corrective Action Plan to address non-compliance with three semi-annual performance measures. Alliance returned to compliance with its Q4 report. Alliance currently is conducting a quality review of one non-compliant performance measure in its Q4 report.

**NC-TOPPS submissions**

**Requirements:** Alliance is required to meet the following quarterly performance measures:

Percent Received - 90%
Percent Received On-Time - 90%

**Results:** During FY 2015, Alliance met four of eight (50%) of performance measures (see Appendix E).

In Q1 FY 2015, Alliance implemented a compliance action plan requiring providers to meet the state's NC-TOPPS performance standards. Alliance staff subsequently imposed a Plan of Correction on those providers that did not meet the performance measures. With the plan, Alliance was in compliance with the Percent Received standard during FY 2015, and continues to work to meet the Percent Received On-Time standard.

**Requirement 2: Develop and implement performance improvement projects using data from multiple sources that focus on clinical and non-clinical areas.**

Alliance conducts a variety of quality activities. These range from ad hoc quality reviews, to short-term Performance Improvement Projects, to formal Quality Improvement Projects. Alliance is required under its state contracts and URAC accreditation status to conduct a number of QIPs. In addition, URAC requires a QIP to demonstrate one year of sustained improvement before the QIP is closed (see Appendix F).

During FY 2015, Alliance continued five ongoing QIPs:

• Intensive In-Home
• Reduce ED Admissions
• Mystery Shopper
• First Responder
• Inter-Rater Reliability

Alliance also continued two other QIPs that were started by The Durham Center prior to its merger into Alliance:

• SA Engagement
• DCA Discharges for Youth & Adults

In addition, Alliance initiated two new QIPs:

• Access to Care
• Care Coordination – MH/SA Initiative

**Results:** During FY 2015, Alliance successfully closed all or part of two QIPs after demonstrating improvement:
- Inter-Rater Reliability – MH/SA closed and I/DD testing met benchmark for two tests, conducting final test in August
- Mystery Shopper - Access Center QA & Assessment question initiative closed

In addition, Alliance closed the two legacy QIPs from The Durham Center:

- SA Engagement
- DCA Discharges for Youth and Adults

Alliance did not meet its objectives in two QIPs, and will continue these QIPs unmodified in FY 16:

- Access to Care
- First Responder

Alliance will continue the following QIPs with modified goals and/or interventions:

- Care Coordination – MH/SA Initiative
- Intensive In-Home
- Reduce ED Admissions (Wake and Cumberland) - renamed Crisis Services Project
- Mystery Shopper – PCP reviews placed in separate QIP
- Mystery Shopper – UM call monitoring

Due to a delay in the implementation of an intervention, results from the following QIP will be received in the Fall:

- Care Coordination – I/DD initiatives

Alliance launched one new QIP for FY 16:

- Reduce Grievance Error Rate

Requirement 3: Have an effective mechanism to detect both over and under-utilization of services.

During FY 2015, Alliance developed important analytical tools to help it determine the over and under-utilization of services. This information was used to develop projects aimed at improving the level of services.

The new reports include:

- UM Dashboard: Developed for the CQI's UM Subcommittee, the UM Dashboard provides routine reporting on consumer counts, lengths of stay and admissions/readmissions for all services managed by Alliance.
- Key Cost Indicator report: Developed for the CQI's Budget and Finance Subcommittee, the report calculates the monthly PMPM expenditure for each service, allowing Alliance to determine whether spending on individual services is consistent with budget, and if overall spending is within budget.

During FY 2015, Alliance initiated a project to review the delivery of PRTF services, which historically have been overutilized. The PRTF project determined appropriate alternative services, and reduced PRTF census by 30%.
In Q2 FY 2015, Alliance initiated a project to review another overutilized service, IIH. The project’s goals are to determine the cost and effectiveness of care delivered by individual providers, inform the provider community of overall standards for services, and assist Alliance’s care reviews with better identifying inappropriate requests for IIH.

In Q4 2015, Alliance initiated three pilot projects aimed at improving services and reducing long-term overutilization by high-acuity IIH consumers. The care models launched by Kids Peace, Mentor and Youth Villages focus on extending services to improve community tenure and family placement, and reduce disruptions in care.

In Q4 2015, Alliance conducted a quality review of consumers with long lengths of stay in inpatient settings. The review is ongoing.

**Requirement 4: Have and effective mechanism to assess the quality and appropriateness of care furnished to enrollees with behavioral health care needs.**

Alliance’s QM Department also resolves any grievances or complaints submitted by consumers regarding the delivery of care by providers.

Alliance’s Medical Affairs, Clinical and Quality Management Departments also collaborate to handle Quality of Care issues that are identified by Alliance staff when reviewing the delivery of care to consumers.

Alliance tracks serious incidents among its provider network via the state’s IRIS system. QM Department staff reviews all Level 2 and 3 incidents, identified trends with specific providers, and reports these trends to Alliance’s Compliance Committee for review and action.

Alliance’s QM Department also reviews NC-TOPPS data submitted by providers. Alliance currently is evaluating the use of NC-TOPPS submissions for measuring the quality of provider care.

Alliance’s QM Department reviews Person-Centered Plans (PCP) and Individualized Service Plans (ISP) for quality. Due to concerns about the quality of care in the plans, QM provided training to over 220 professionals at 5 trainings on person-centered elements of the PCP and the new Comprehensive Crisis Plan. QM is continuing the QIP focusing on Improving PCPs. Additionally, QM staff facilitated an internal workgroup to improve the quality of the ISPs created by Alliance IDD Care Coordinators.

**Requirement 5: Include all demographic groups, care settings and types of services over multiple review periods.**

Alliance has developed reports to assess consumer demographics within its catchment area. These reports are informing Alliance’s efforts to improve access for these consumers.

**Needs Assessment Report:**

As part of its March 2015 Community Needs Assessment and Gaps Analysis, Alliance analyzed access to care for various demographic groups. The report noted that the Alliance catchment area is experiencing higher than average population growth and is challenged to meet the needs of a diverse population with important needs such as those who do not speak English, homeless individuals with mental illness and substance use disorders, and members of the military, veterans and their families.
The report noted that Alliance exceeds the state average with respect to non-English languages, and stressed the importance of continuing to prioritize adequate access to Spanish language services throughout the catchment area. In particular, the report identified the need to expand services to the child and adult IDD populations.

Based on the findings of the Community Needs Assessment report, Alliance has initiated a provider network development plan that includes the specific goal of improving access to services for non-English speaking consumers. In particular, Alliance will:

- Conduct a survey of providers with identified services for non-English speaking consumers;
- Clarify service availability and the capacity for more robust bilingual/bicultural programs;
- Identify barriers for providers to offer bilingual/bicultural services and develop recommendations;
- Integrate network development initiatives with Alliance’s Cultural Competence Plan.

Cultural Competency Plan:

In FY 2015, Alliance reiterated as part of its strategic plan its commitment to cultural competency. In Q4, Alliance issued an updated Cultural Competency plan.

The purpose of the Alliance Cultural Competency Plan is two-fold: first, to foster cultural competency within the Alliance organization and second, to nurture and guide cultural competency in the Alliance provider network. The plan’s activities include a three-year plan for promoting cultural linguistic competency by both Alliance internal staff and Alliance providers.

Veterans Plan:

In FY 2015, Alliance launched the development of a veterans plan with the goals of better identifying former members of the armed forces and their families, and extending the delivery of services.

During Q4 2015, Alliance’s QM Department completed an assessment of Alliance’s procedures for identifying veterans who contact our Call Center. The analysis recommended changes in the interview process and IT systems. The veterans plan currently is developing outreach programs for veterans and identifying needed services.

Requirement 6: Measure the performance of the Network Providers and conduct peer review activities such as: identification of practices that do not meet Plan standards; recommendation of appropriate action to correct deficiencies; and monitoring of corrective action by Providers.

Provider Monitoring: Alliance assesses the performance of its providers via the Routine Provider Monitoring process required by the state. Alliance is required to conduct post payment reviews at least every two years for all providers except those providing only in-patient, therapeutic foster care or ICF-MR services. Currently there are 510 providers with sufficient billing in services requiring routine provider monitoring to allow the review to be completed.

In FY 2015, Alliance conducted 128 routine monitorings of provider agencies. Of these, 79 reviews were post payment only. Alliance also initiated reviews of LIPs, conducting 41 reviews. Some 39% of agency reviews resulted in a plan of correction. By comparison, 90% of LIP reviews resulted in a plan of correction.

During the same period, Alliance completed reviews of 134 unlicensed AFLs, six investigative reviews and one health and safety check of consumer’s safety.
**IRIS:** During Q4 FY 2015, Alliance developed a new database for IRIS data. The new system allows Alliance to better track and trend provider incidents, and to place the incidents in the context of consumer diagnoses and services.

**NC-TOPPS:** During Q4 FY 2015, the state launched new analytic tools that allow Alliance to assess the performance of individual providers using NC-TOPPS data. An Alliance work group is assessing this data now to determine its usefulness for provider quality management.

**Quality Improvement Projects:** Alliance is currently operating two QIPs focused on Provider Network performance—Access to Care and First Responder. Access to Care focuses on improving the percent of individuals who show for their initial assessment appointment within a specified time period. The goal of First Responder QIP is to improve the crisis response of Network providers who offer enhanced services.

**Requirement 7: Measure provider performance through medical record audits.**

Alliance’s Utilization Management staff routinely reviews provider performance during the review of authorization requests. Staff can report any issues regarding provider performance by submitting a formal grievance to the QM Department, or by raising a Quality of Care issue with Alliance’s medical staff.

As part of its ongoing quality activities, Alliance’s Quality Management Department reviews samplings of Person Centered Plans submitted by providers.

**Requirement 8: Provide performance feedback to providers, including detailed discussion of clinical standards and the expectations of Alliance Behavioral Healthcare.**

Alliance’s Utilization Review staff currently discusses service definitions and clinical practice guidelines with providers as part of the authorization review process.

As part of its Strategic Planning process, Alliance is developing an initiative to develop comprehensive provider performance measures and reporting.

As part of the First Responder QIP, providers receive feedback on their performance following a test. Additionally, providers receive letters detailing the quality elements met and not met following a review of selected Person Centered Plans.

**Requirement 9: Develop and adopt clinically appropriate practice parameters and protocols/guidelines and provide Alliance's providers enough information about the protocols/guidelines to enable them to meet the established standards.**

Alliance has approved more than 20 clinical practice guidelines to guide providers in the delivery of care. These practice guidelines are reviewed and approved by Alliance’s Clinical Practice Committee, and posted on the Alliance web site. During the authorization process, Alliance’s Utilization Review staff assist providers with following these clinical practice guidelines.

Alliance currently is launching a program to assess provider compliance with clinical practice guidelines. Working with medical and clinical staff, the QM Department will identify clinical practice guidelines that providers are not following, identify critical measures within the guidelines, and assess provider compliance via data analysis and consumer record reviews.
Requirement 10: Evaluate access to care for Enrollees, and implement a process for ensuring that Network Providers achieve and maintain contract standards.

Alliance evaluates access to care as part of its annual Needs and Gaps Assessment report. Alliance determines whether each consumer of site-based services has access to a provider within 30 minutes or 30 miles. Alliance also determines whether consumers have a choice of providers. Any gaps in access are addressed by Alliance’s Network Development Plan.

While the gaps analysis report is required by the state only annually, Alliance is updating the report each quarter to determine if the gaps are being closed by the Network Development plan. This routine assessment also will help Alliance identify any new gaps arising from changes in the provider network or consumer population.

4. OTHER EVALUATIONS OF ALLIANCE QM ACTIVITIES

In addition the state, Alliance’s quality management program is assessed by other third parties. These organizations also provide Alliance with standards and recommendations for improve quality management.

Mercer: The state has contracted with Mercer to conduct annual reviews of Alliance’s performance. During FY 2015, Alliance implemented the findings of Mercer’s May 2014 site visit. During FY 2015, the QM Department completed the two recommendations arising from the May 2014 visit (see Appendix G).

Mercer conducted its most recent site visit in May 2015. Alliance is awaiting the results of that evaluation.

EQR: During FY 2015, the state contracted with the Carolina Center for Medical Excellence to conduct external quality reviews required under federal law. CCME conducted its site visit of Alliance in December 2014. To date, Alliance has implemented three of the nine best practices recommendations made by CCME (see Appendix H). The next EQR is scheduled for November 2015.

URAC: Alliance is accredited by URAC in the areas of Health Network, Utilization Management, Call Center and Credentialing. During FY 2015, the QM Department assisted the Compliance Department with the development of a semi-annual self-assessment process for assuring continued compliance with URAC standards. The first self-assessment was completed in Q4 FY 2015.

Strategic Planning: During FY 2015, Alliance initiated a strategic planning process under a contract with Zelios. The process has identified a number of initiatives to improve Alliance processes and systems. Zelios currently is developing with Alliance leadership a plan to improve Alliance’s Continuous Quality Improvement process by documenting process details such as committee structures and reporting requirements.

5. FY 2015 GOALS REVIEW

As part of its FY 2014 assessment, Alliance established seven goals for FY 2015 aimed at improving Alliance’s QM structure and activities. During FY 2015, Alliance met five of those goals:

- Establish QM reporting in 100% of Alliance committees: Alliance is committed to a QM program that is data-driven. The QM Department reviewed the activities and data requirements of the Global QM Committee, CQI Committee, and various Alliance subcommittee. The QM Department facilitated the development of relevant reporting, including the creation of “dashboards” to assess fundamental performance, and the development of reports required by contract or accreditation.
• **Create a rapid QM response program and train 100% of department heads on its use:** The QM Department identified the need for a quick and user-friendly way for Alliance departments to request QM assistance. QM staff developed a request form for QM assistance and associated training materials. QM staff informed 100% of department heads on how to submit a request for QM review.

• **Review HEDIS standards and implement relevant performance measures:** Developed by the NCQA, the HEDIS program is a set of performance measures that allow MCOs to better evaluate their performance against national standards. The QM Department conducted a review of the HEDIS measures, identified the measures that are relevant to Alliance’s behavioral health activities, and identified reports that use HEDIS measures.

• **Develop provider QM education and inform 100% of providers:** Continuous quality improvement is the responsibility of all stakeholders in Alliance, including providers. The QM Department created training materials to help providers create effective QM programs. The QM Department informed providers about the availability of these materials via the Alliance web site, and conducted a training at an All-Provider meeting.

• **Evaluate the establishment of provider outcomes:** The establishment of provider outcomes is the next great step in improving the effectiveness and efficiency of patient care. The QM Department developed a process for assessing outcomes, and provided guidance on outcomes in three new pilot projects and in provider contracts.

Alliance did not meet two goals:

• **Meet 100% of performance measures:** The QM Department is committed to ensuring that Alliance meets all performance measures established in Alliance’s contracts with the DMA and DMH. These measures cover the range of Alliance’s activities, including performance by Alliance’s Clinical, Utilization Management, Call Center and QM Departments. During FY 2015, Alliance met 196 of 244 (80.3%) of performance measures.

• **Review 100% of Alliance committee reports to identify new QM risk factors:** The QM Department will review all reports created by the various Alliance committees, identify areas of risk or non-performance, and facilitate the mitigation of these issues. During FY 2015, the QM Department reviewed 50% of committee reports as the committees worked to develop and better distribute reports.

6. **FY 2016 GOALS**

• **Meet 100% of performance measures (continued from FY 2015):** The QM Department is committed to ensuring that Alliance meets all performance measures established in Alliance’s contracts with the DMA and DMH. These measures cover the range of Alliance’s activities, including performance by Alliance’s Clinical, Utilization Management, Call Center and QM Departments.

• **Review 100% of Alliance committee reports to identify new QM risk factors (continued from FY 2015):** The QM Department will review all reports created by the various Alliance committees, identify areas of risk or non-performance, and facilitate the mitigation of these issues.

• **Implement 100% of Mercer and EQR Recommendations:** During FY 2015, Mercer and EQR evaluations resulted a total of 15 recommendations for the Alliance quality management program. As of July 31, Alliance had implemented four of the 15 recommendations. The QM Department will work to implement the remaining recommendations by the deadline of the next on-site visit.
• **Revise the charters and reporting requirements for 100% of CQI committees:** Alliance has developed its CQI committee structure to identify and correct quality issues. During FY 2015, Alliance initiated a strategic planning initiative facilitated by the consulting firm Zelios. One of the initiative’s goals is to review and revise the descriptions, functions and memberships of the CQI Committee and its subcommittees. A second goal was to establish formal reporting requirements for each committee in the form of Key Performance Indicators or performance standards.

• **Implement performance measurements and reporting in 100% of provider contracts:** As part of its Strategic Planning process, Alliance has established the goal of improved provider measurement and reporting. Provider reporting will improve consumer care and facilitate the development of a high-quality provider network via contracting, credentialing and recredentialing.
<table>
<thead>
<tr>
<th>Measure</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
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<td>1.1%</td>
<td>1.3%</td>
<td>1.6%</td>
<td>1.5%</td>
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<tr>
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<td>98.8%</td>
<td>98.7%</td>
<td>98.8%</td>
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<td>99.0%</td>
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<tr>
<td>State - Total - 95% Processed in Required Timeframes</td>
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<td>98.6%</td>
<td>98.6%</td>
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<td>State - 90% Claims Processed within 30 Days</td>
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<td>100%</td>
<td>100%</td>
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<td>100%</td>
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<tr>
<td>State - 90% Complaints Resolved in 30 days</td>
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<td>90.9%</td>
<td>94.1%</td>
<td>100%</td>
<td>100%</td>
<td>93.3%</td>
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Page 16
# APPENDIX B – Performance Submission Reports

<table>
<thead>
<tr>
<th>Report</th>
<th>Standard</th>
<th>FY15 Q1</th>
<th>FY15 Q2</th>
<th>FY15 Q3</th>
<th>FY15 Q4</th>
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<tr>
<td>Monthly Financial Reports</td>
<td>Timely/Complete</td>
<td>Not Met</td>
<td>NR</td>
<td>NR</td>
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<td>Substance Abuse/Juvenile Justice Initiative Quarterly Report</td>
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<td>Work First Initiative Quarterly Reports</td>
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<td>Traumatic Brain Injury (TBI) Services Quarterly Report</td>
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<td>Quarterly Complaints Report</td>
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<td>NR</td>
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<td>NR</td>
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<tr>
<td>System of Care Report</td>
<td>Timely/Complete</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<tr>
<td>SAPTBG Compliance Report</td>
<td>Timely/Complete</td>
<td>NR</td>
<td>NR</td>
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<tr>
<td>National Core Indicators (NCI) Consents, Pre-Surveys, and Mail Surveys</td>
<td>Timely/Complete</td>
<td>NR</td>
<td>NR</td>
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<tr>
<td>Client Data Warehouse (CDW) - Screening Record</td>
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<td>NR</td>
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<tr>
<td>Client Data Warehouse (CDW) - Unknown Data (Admissions)</td>
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<td>Met</td>
<td>NR</td>
<td>NR</td>
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<tr>
<td>Client Data Warehouse (CDW) - Unknown Data (Discharges)</td>
<td>Timely/Complete</td>
<td>Met</td>
<td>NR</td>
<td>NR</td>
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<tr>
<td>Client Data Warehouse (CDW) - Identifying and Demographic Records</td>
<td>Timely/Complete</td>
<td>Met</td>
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<td>NR</td>
<td>NR</td>
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<td>Client Data Warehouse (CDW) - Drug of Choice</td>
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<td>Met</td>
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<td>Client Data Warehouse (CDW) - Episode Completion Record (SA Clients)</td>
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<td>NC Treatment Outcomes and Program Performance System (NC-TOPPS)</td>
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# APPENDIX C – Access to Care Report

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<th>Standard</th>
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<th>FY15 Q2</th>
<th>FY15 Q3</th>
<th>FY15 Q4</th>
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<tr>
<td>Emergent - Medicaid (2 hours)</td>
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<td>94%</td>
<td>77%</td>
<td>95%</td>
<td>78%</td>
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<tr>
<td>Emergent - Non-Medicaid</td>
<td>97%</td>
<td>94%</td>
<td>77%</td>
<td>100%</td>
<td>78%</td>
</tr>
<tr>
<td>Emergent - Combined</td>
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<td>94%</td>
<td>77%</td>
<td>98%</td>
<td>78%</td>
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<tr>
<td>Urgent - Medicaid (48 hours)</td>
<td>82%</td>
<td>67%</td>
<td>68%</td>
<td>55%</td>
<td>53%</td>
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<tr>
<td>Urgent - Non-Medicaid (48 hours)</td>
<td>82%</td>
<td>58%</td>
<td>63%</td>
<td>50%</td>
<td>46%</td>
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<td>Urgent - Combined (48 hours)</td>
<td>82%</td>
<td>61%</td>
<td>64%</td>
<td>52%</td>
<td>49%</td>
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<tr>
<td>Routine - Medicaid (14 days)</td>
<td>75%</td>
<td>66%</td>
<td>79%</td>
<td>53%</td>
<td>52%</td>
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<tr>
<td>Routine - Non-Medicaid (14 days)</td>
<td>75%</td>
<td>54%</td>
<td>62%</td>
<td>53%</td>
<td>43%</td>
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<td>Routine - Combined (14 days)</td>
<td>75%</td>
<td>58%</td>
<td>69%</td>
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APPENDIX D – Innovations Program Reports

Quarterly Performance Measures

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<th>Measure</th>
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<th>FY15 Q2</th>
<th>FY15 Q3</th>
<th>FY15 Q4</th>
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</thead>
<tbody>
<tr>
<td>Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval.</td>
<td>85%</td>
<td>85.2%</td>
<td>95.2%</td>
<td>95.2%</td>
<td>78.3%</td>
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<tr>
<td>Percent of Actions Taken to Protect the Consumer</td>
<td>85%</td>
<td>95.5%</td>
<td>96.5%</td>
<td>96.5%</td>
<td>98.1%</td>
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<tr>
<td>Proportion of Level 2/3 incidents reported within required timeframes.</td>
<td>85%</td>
<td>86.6%</td>
<td>89.5%</td>
<td>93.1%</td>
<td>87.7%</td>
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<tr>
<td>Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.</td>
<td>85%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Percentage of Level 2 or 3 incidents where required LME/MCO follow-up interventions were completed as required</td>
<td>85%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
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Semi-Annual Performance Measures

<table>
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<th>FY15 Q3-Q4</th>
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</thead>
<tbody>
<tr>
<td>Proportion of Level of Care evaluations completed at least annually for enrolled participants</td>
<td>85%</td>
<td>96.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Proportion of Level of Care evaluations completed using approved processes and instrument</td>
<td>85%</td>
<td>96.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Proportion of New Level of Care evaluations completed using approved processes and instrument</td>
<td>85%</td>
<td>68.3%</td>
<td>95.2%</td>
</tr>
<tr>
<td>Proportion of Individual Support Plans that address identified health and safety risk factors</td>
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<td>67.1%</td>
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<td>Proportion of PCPs that are completed in accordance with DMA requirements.</td>
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<td>67.1%</td>
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## APPENDIX E – NC-TOPPS Submissions

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<th>FY15 Q3</th>
<th>FY15 Q4</th>
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<tr>
<td>% Received</td>
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<td>92.9%</td>
<td>95.3%</td>
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<td>93.4%</td>
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<tr>
<td>% Received On-Time</td>
<td>90%</td>
<td>85.5%</td>
<td>86.8%</td>
<td>89.8%</td>
<td>85.5%</td>
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</table>
## APPENDIX F – QIP Requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Reduce ED Admits</th>
<th>Access to Care</th>
<th>1st Responder</th>
<th>Care Coordination</th>
<th>IIH</th>
<th>Mystery Shopper</th>
<th>Complaints and Grievances</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 QIPs</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Reduce need for inpatient at community hospitals for Medicaid recipients with medical/MHDDSA</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Reduce use of crisis &amp; ED services for high-risk Medicaid recipients</td>
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<td></td>
<td>X</td>
<td></td>
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<tr>
<td>At least 1 with Clinical focus</td>
<td>X</td>
<td></td>
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<td>X</td>
<td>X</td>
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<tr>
<td>At least 1 with Non-Clinical focus</td>
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<td>X</td>
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<tr>
<td>2 QIPs per URAC program-UM</td>
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<td></td>
<td>X</td>
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<tr>
<td>2 QIPs per URAC program-Call Center</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>X</td>
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<tr>
<td>2 QIPs per URAC program-Health Network</td>
<td></td>
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<td>X</td>
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<td>At least 1 QIP addresses consumer safety</td>
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<td>X</td>
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<tr>
<td>At least 2 QIP topics measured (1 clinical and 1 non-clinical) use one or more quality indicators—changes in health status, functional status, or satisfaction</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td>At least 2 QIP topics measured (1 clinical and 1 non-clinical) use multiple data sources</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<td>Topics identified through continuous</td>
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<td>X</td>
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<tr>
<td><strong>data collection &amp; analysis</strong></td>
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<tr>
<td><em>(Suggestion)</em> At least 1 focuses on entire MCO catchment area</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td><em>(Suggestion)</em> At least 1 focuses on local communities</td>
<td>x</td>
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<td>Required in at least one of our contracts or by an auditor</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<td>x</td>
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<tr>
<td>Issue</td>
<td>Recommendation</td>
<td>Percentage Complete</td>
<td>Date Completed</td>
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<tr>
<td><strong>FINDING:</strong> The QM documentation audit tool did not include standards to assess if QOC concerns are being appropriately identified by the I/DD care coordinator team and referred for review.</td>
<td>QM's desktop procedure instructs I/DD auditors on the standards for identifying QOC concerns. Any QOC concerns found during the audit are documented on a review form and a clinical consultation is initiated. The form is sent to I/DD Care Coordination management for review and response.</td>
<td>100%</td>
<td>Alliance notified the IMT of closing out this item out on 11/19/2014. No further discussion.</td>
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<tr>
<td><strong>FINDING:</strong> There is no current process in place to validate the accuracy of the complaint data.</td>
<td>QM has completed a business process review of the complaint process and implemented improvements to procedures, staff training and IT systems aimed at improving the accuracy of complaint data. In addition, QM now produces a monthly report identifying the type and number of errors made by individual staff members in complaint submission. Staff are being trained on preventing the specific complaint data errors identified in the report.</td>
<td>100%</td>
<td>Alliance notified the IMT of closing out this item out on 11/19/2014. No further discussion.</td>
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### APPENDIX H – EQRO Recommendations Work Plan

<table>
<thead>
<tr>
<th>Category</th>
<th>Status</th>
<th>Percentage Complete</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The PIHP formulates reasonable policies and procedures for registering and responding to enrollee grievances in a manner consistent with contract requirements, including, but not limited to:</td>
<td>Updated 1/28/2013: QM's Data Management team has reviewed current grievance process and documentation; reviewed grievance requirements in federal/state law, contracts; and surveyed other LME-MCOs to learn about their processes. QM will design an improved grievance process, create necessary documentation, and develop staff training. QM will oversee implementation of the revised program and assess its effectiveness. 3/17/2015: QM, Legal and Compliance have agreed on new timeframes for grievance resolution, and submitted the proposed timeframes to the EQRO as part of the Corrective Action Plan (CAP) process. Any timeframes approved by the EQRO will be carried forward into the implementation of Best Practices. Updated 7/13/2015: New timeframes were accepted by the EQRO and implemented by Alliance staff. An internal work group has been created with representatives from QM, UM and Medical Affairs. The work group is reviewing all complaint and grievance processes, including Quality of Care issues, and developing proposed changes.</td>
<td>50%</td>
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</tr>
</tbody>
</table>

Page 24
2. The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines. Recommendation: Results of the monitoring conducted to assess provider compliance with the guidelines should be reported to each provider. Include this process in the Quality Management Plan/Program Description.

Updated 1/28/2015: QM has discussed this recommendation with Provider Networks. QM will review practice guidelines, provider contract requirements, and current practice guidelines monitoring. QM will develop improve methods for assessing provider compliance with guidelines, and develop new methods for reporting compliance to providers. QM will include process in FY 2016 QM Program Description. Updated 7/13/2015: The Alliance Clinical Affairs Committee has completed its annual review of clinical practice guidelines. QM has reviewed research on assessing compliance with practice guidelines, and examined compliance plans implemented by other MCOs. QM has proposed that UM identify those practice guidelines that are most problematic with providers. QM will develop a compliance tool based on the elements of the clinical practice guidelines, and review a random selection of patient records to assess compliance. QM will then recommend interventions such as provider training based on the findings of the reviews.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.

Recommendation: Monitoring of utilization data to detect over and under-utilization of services should be included in the Quality Management Program Description and Plan.

<table>
<thead>
<tr>
<th>Updated 02/05/2014: UM Plan updated and now includes a section on Over and Under Utilization, includes mechanism for detection and responses. 100% Completed - Sean</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
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</tbody>
</table>

| Updated 02/06/2014: QM has reviewed UM's utilization data collection and analysis process. QM will include a description of this process in the FY2016 QM Program Description. 25% Completed - Geyer. |
| 50% |

| Updated 07/13/2015: QM will include a description of this process in the FY2016 QM Program Description, which now must be submitted to the state by August 31, 2015. |
| 50% |

4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, time frame for implementation and completion, and the person(s) responsible for the project(s).

Recommendation: Include the specific quality improvement activity or task in the annual work plan. The work plan should also include all quality improvement tasks as outlined in the Quality Management Program Description and Plan and follow-up of any previous projects/activities not completed.

| Updated 02/28/2015: QM has reviewed existing work plans and identified additional documentation of quality activities for inclusion in a single master work plan. |
| 50% |

| Updated 07/13/2015: QM will include the master work plan in its FY 2016 QM Plan, now due to the state by August 31, 2015. |
| 50% |
| 2. The composition of the QI Committee reflects the membership required by the contract. Recommendation: Recruit additional network providers for the Global Quality Management Committee to ensure a quorum of voting members are present at each meeting. | Updated 1/28/2015: QM staff have recruited two provider representatives for the Global QM Committee. At the committee’s February 5, 2015 meeting, QM staff will review quorum requirements with committee members. Updated 03/17/2015: The Global QMC Committee has been expanded with the inclusion of two provider representatives. In accordance with board policy, the provider representatives are non-voting members. The committee also has reviewed attendance rules and quorum requirements. Updated 7/13/2015: A quorum was not present for the committee’s March meeting, but was present for meetings in May and June. In July, Alliance staff attended Open Meetings training, where Alliance legal counsel informed them that teleconferencing committee members can be counted towards a quorum. Alliance staff will review this rule with the Global QMC at its August meeting and review teleconferencing procedures to increase attendance. | 90% |

| 3. The QI Committee meets at regular intervals. Recommendation: Ensure that the Global Quality Management Committee is meeting at the established frequency. | Updated: 1/28/2015: QM staff will review meeting frequency requirements and future meeting scheduling at the Global Quality Management Committee’s February 5, 2015 meeting. Updated 7/13/2015: QM staff has confirmed that the Global QM Committee is required to meet six times per fiscal year. During FY 2015, the committee met a total of six times (Aug. 7, Sep. 4, Oct. 1, Dec. 4, Feb. 5 and June 4), thereby meeting Alliance’s requirement. | 100% | Alliance notified the IMT of closing out this item out on 7/29/2015. No further discussion. |
2. The annual report of the QI program is submitted to the QI Committee and to the PIHP Board of Directors.

Recommendation: Include documentation in the annual Quality Management Evaluation of when the report was approved by the Quality Management Committee and the Board of Directors.

QM staff will discuss the documentation requirement with the Global Quality Improvement Committee at its February 5, 2015 meeting. QM staff will then implement the committee's recommendations in the existing Quality Management Evaluation and present for committee approval at its March 5, 2015 meeting. QM staff will include the approval documentation in the FY 2015 QM Program Evaluation and FY 2016 QM Program Description.

Updated 03/17/2015: At its March 5 meeting, the Global QM Committee agreed to include signature sheets on upcoming QM descriptions and plans.

Updated 7/13/2015: The state has announced that the FY 2016 QM Plan must be submitted by August 31, 2015. The final version will include documentation of its approval.

| 50% |
ITEM: Conflict of Interest

DATE OF BOARD MEETING: October 1, 2015

BACKGROUND:
It is the policy of Alliance to ensure that none of its Board Members have conflicts of interest with any of the provider agencies with which Alliance has a contractual or a consumer referral relationship. Certain activities are prohibited as conflicts of interest. Board Members must disclose a conflict or the appearance of a conflict of interest and depending on the circumstances, may be prohibited from serving or restricted in voting based on the disclosure. The Area Board shall make the final decision regarding the disposition of all conflict of interest issues.

REQUEST FOR AREA BOARD ACTION:
Accept the proposal.

CEO RECOMMENDATION:
Accept the proposal.

RESOURCE PERSON(S):
Chris Bostock, Board Chair; Monica Portugal, Chief Compliance Officer; Carol Hammett, Legal Counsel

(Back to agenda)
Conflict of Interest Disclosure

On July 21, 2015, the Board Executive Committee reviewed conflict of interest disclosures.

From the Board Executive Committee:

Recommendation to the Area Board that George Quick’s conflict disclosure be accepted and that he be allowed to continue serving and recuse himself from topics related to the specified conflict.

Conflict: Family member works for Network Provider.

Recommendation to the Area Board that McKinley Wooten, Jr.’s conflict disclosure be accepted and that he be allowed to continue serving and recuse himself from topics related to the specific conflict.

Conflict: Family member owns and operates an agency in the Alliance Provider Network.
ITEM: FY16 Organizational Initiatives

DATE OF BOARD MEETING: October 1, 2015

BACKGROUND:
At the May Board meeting, there was a presentation on “Organizational Goals: FY16 Strategic Plan Initiatives”. This status update includes progress on FY16 active initiatives, highlights from a few other strategic plan initiatives, and a review of the high level outcome measures for the 6 strategic plan goals.

REQUEST FOR AREA BOARD ACTION:
Accept the training.

CEO RECOMMENDATION:
Accept the training.

RESOURCE PERSON(S):
Rob Robinson, Chief Executive Officer; Amanda Graham, Chief of Staff
Organizational Goals:
FY16 Strategic Plan Initiatives

October 1, 2015
Our organizational Vision shapes the way we conduct our business…

“To be a leader in transforming the delivery of whole person care in the public sector”
To improve the health and well-being of the people we serve by ensuring highly effective, community-based support and care

**Goals**

1. Have effective relationships with a wide variety of stakeholder groups
2. Be a data-informed organization
3. Develop and effectively manage a high quality provider network
4. Be a high-performing and financially sound organization
5. Attract and retain a talented workforce
6. Be proactive in the midst of a changing external environment

**Objectives**

- Working Towards Our Mission
Strategic Plan Progress

• 30 original initiatives
  o 7 completed
  o 15 underway
  o 8 pending

• 18% active staff participation in initiatives
(Goal 1)
Have effective relationships with a wide variety of stakeholder groups

1.1. Understand our key stakeholders
1.2. Be able to articulate and demonstrate our mission
1.2.1. Continue to implement the Community Awareness Campaign
1.2.2. Develop and implement organizational branding campaign
1.3. Understand the collective impact of our partnership work, focusing on key areas that produce results
(Goal 1)
Have effective relationships with a wide variety of stakeholder groups

Outcome measure:
Access to services as measured by an enhanced penetration rate
(Goal 2)
Be a data-informed organization

2.1. Have reliable data and systems
2.2. Have easy access to our data
2.3. Know, understand and use data
2.4. Communicate our data effectively
2.5. Create a culture of data ownership across the organization

2.1.1 Initiate a data integrity audit process
2.4.1 Develop and implement an enterprise-level BI tool
(Goal 2)
Be a data-informed organization

Outcome measure:
CQI Committee structure – charters exist and are used
(Goal 3)
Develop and effectively manage a high quality provider network

3.1. Have only quality providers in our network
3.2. Monitor provider performance
3.3. Ensure a continuum of services that matches the needs of the populations we serve
3.3.2. Implement network development plan
(Goal 3)
Develop and effectively manage a high quality provider network

3.1. Have only quality providers in our network

3.2. Monitor provider performance
- 3.2.1. Recredentialing: Clarify elements and process
- 3.2.2. Refine and share provider measures

3.3. Ensure a continuum of services that matches the needs of the populations we serve
- 3.3.2. Implement network development plan
(Goal 3)
Develop and effectively manage a high quality provider network

Outcome measure: Community tenure rate
(Goal 4)
Be a high performing and financially sound business

4.1. Continuously improve business operations

4.1.1. Measure and evaluate organizational impact of community activities

4.2. Have effective financial management

4.3. Break down internal communication barriers

4.3.3. Develop and launch company intranet
(Goal 4)
Be a high performing and financially sound business

4.1. Continuously improve business operations
4.1.1. Measure and evaluate organizational impact of community activities

4.2. Have effective financial management

4.3. Break down internal communication barriers
4.3.1. Implement and maximize video conference usage
4.3.3. Develop and launch company intranet
(Goal 4)
Be a high performing and financially sound business

Outcome measure:
Percentage of funds being invested back into services or core infrastructure
(Goal 5)
Attract and retain a talented workforce

5.1. Manage our human resources pipeline

5.2. Manage staff performance effectively

5.3. Create an attractive, desired work environment

5.2.1. Develop a reward and recognition program for staff contributions

5.3.2. Create a healthy workforce initiative (to include wellness initiatives)
(Goal 5)
Attract and retain a talented workforce

Outcome measure:
Time to fill and turnover rates
(Goal 6)
Be proactive in the midst of a changing external environment

6.1. Anticipate and participate in external environmental change conversations

6.2. Plan for possible future alternatives
  6.2.1. Develop a strategy for integrating care
  6.2.2. Prepare for potential MCO consolidation

6.3. Stop, slow or start other operational work as appropriate
(Goal 6)
Be proactive in the midst of a changing external environment

Outcome measure:
Formalized Futures Committee – charter exists and is used
ITEM: Overview of Community Housing Programs

DATE OF BOARD MEETING: October 1, 2015

BACKGROUND:
Safe and affordable housing is a healthcare strategy. We will provide an overview of the Independent Living Initiative, a program that provides rental and financial assistance to adults and families as well as supports landlords to increase housing success. We will also provide an overview of our HUD funded permanent supportive housing programs in Durham

REQUEST FOR AREA BOARD ACTION:
Accept the training.

CEO RECOMMENDATION:
Accept the training.

RESOURCE PERSON(S):
Ann Oshel, Chief Community Relations Officer
Overview of Independent Living Housing Initiative (ILI)

Presentation to Alliance Board of Directors
October 2, 2015
Housing is a Healthcare Strategy

“Access to safe, quality and affordable housing- and the supports necessary to maintain that housing- constitute one of the most basic and powerful social determinants of health. In particular, for individuals and families trapped in a cycle of crisis and housing instability due to poverty, mental illness, addictions or chronic health issues, housing can entirely dictate their health and health trajectory.” World Health Organization, 2008
What is Supportive Housing?

• Quality, permanent and affordable
  • Landlord/tenant relationship
  • Promotes housing choice

• Housing First
  • No preconditions to “housing readiness”

• Comprehensive, person centered services
• Community integration
Independent Living Initiative

• Short term, one time financial assistance
• Serves single adults, couples or families
• Have to currently be involved in services
• Rapid re-housing or eviction prevention funds
• $200,000 allocation Durham, Wake and Cumberland
• $50,000 allocation in Johnston
Fair Market Rental Rates

• Wake/Johnston
  • 1 Bedroom: $774
  • 2 Bedroom: $918

• Cumberland
  • 1 Bedroom: $605
  • 2 Bedroom: $774

• Durham
  • 1 Bedroom: $737
  • 2 Bedroom: $874
The Targeted Housing Program

• Partnership between DHHS and NC Financing Agency
  • Low Income Housing Tax Credit
• Alliance is a referral agency
• Provide housing linked to supports and services with a point of contact
• Rent does not exceed 30% of household income (puts the “affordable” in affordable housing)
Restoring Hope Initiative

• Longer term financial assistance
• Serves single adults, couples or families
• Target population:
  • Persons with high crisis usage
  • Currently incarcerated with high recidivism
  • Exiting institutional care
• Involvement or willingness to engage in enhanced services for the duration of assistance
Restoring Hope Initiative KPI’s

• Number of persons/families who sustain housing 3 months following 3 months or more of rental assistance

• Number of persons/families who improve retention in services for 3 months following 3 months or more of rental assistance

• Number of persons/families who decrease utilization of crisis services or re-arrests for 3 months following 3 months or more of rental assistance
HUD Funded Programs

• Shelter Plus Care
  • Voucher based housing

• Durham DASH
  • Serves chronically homeless adults or families
  • 12 vouchers
    • 14 people currently in housing
  • $144,016
  • 97% retention rate in housing
Ensuring Successful Housing

• Landlords are our customers!

• Providers required to attend Fair Housing training prior to submitting application

• Ready to Rent curriculum

• Landlord appreciation events

• Active participation on local CoC and other housing committees
Promoting Housing as a Healthcare Strategy

• Housing is the Best Medicine: should be central to integrated healthcare models

• Increase capacity for permanent supportive housing using evidence based models

• Cost model to show return on investment

• Advocate for leveraging federal and local dollars