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

**MEMBERS PRESENT:** ☒Cynthia Binanay, Chair, ☒Christopher Bostock ☒Heidi Carter (exited at 6:26 p.m.), ☒George Corvin, MD, Vice-Chair, ☒James Edgerton, ☐Greg Ford, ☒Lodies Gloston, ☒Phillip Golden, ☒Curtis Massey, ☒George Quick (exited at 6:20 pm), ☒William Stanford, Jr., ☐Amelia Thorpe, ☒Lascel Webley, Jr. (exited at 5:25 p.m.), and ☒McKinley Wooten, Jr. (via phone)

**GUEST(S) PRESENT:** Gary Bass, CEO of Pride NC; Mary Hutchings, Wake County Finance Department; and Yvonne French, NC Department of Health and Human Services, Division of Mental Health/Developmental Disabilities/Substance Abuse Services

**ALLIANCE STAFF PRESENT:** Damali Alston, Director of Network Evaluation; Michael Bollini, Executive Vice-President/Chief Operating Officer; Courtney Cantrell, Senior Vice-President/Clinical Operations; Joey Dorsett, Senior Vice-President/Chief Information Officer; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Cheala Garland-Downey, Director of HR; Anita Foreman, Healthcare Network Project Manager; Amanda Graham, Senior Vice-President/Operational Effectiveness; Carol Hammett, General Counsel; Veronica Ingram, Executive Assistant; Wes Knepper, Director of Quality Management; Katherine Hobbs-Knutson, MD, Chief Medical Officer; Ken Marsh, Medicaid Program Director; Beth Melcher, Executive Vice-President/Clinical Operations; Sara Pacholke, Senior Vice-President/Financial Operations; Brian Perkins, Senior Vice-President/Strategy and Government Relations; Monica Portugal, Chief Compliance Officer; Robert Robinson, Chief Executive Officer; Matthew Ruppel, Director of Program Integrity; Tammy Thomas, Director of Project Portfolio Management; Sara Wilson, Government Relations Director; and Doug Wright, Director of Individual and Family Affairs

1. **CALL TO ORDER:** Chair Cynthia Binanay called the meeting to order at 4:04 p.m.

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<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
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| 2. Announcements | A. Applicant Interviews: Chair Binanay invited Board members to attend interviews with applicants for vacant Board seats on October 17 and November 21. Interviews will be part of the regular Executive Committee meetings.  
B. November Board Meeting: Chair Binanay shared that the location for the November Board meeting has changed; it will be at the home office. The meeting was originally scheduled to be in Johnston County, but due to limited space will be rescheduled for 2018.  
C. HUD Monitoring Report: Mr. Robinson shared that Alliance had an onsite monitoring of its Continuum of Care Program on August 22-25, 2017. Alliance received results from the monitoring which included no findings or concerns. He thanked Community Relations staff for their hard work, especially Tracy Stone-Dino, Director of Housing. |
### AGENDA ITEMS:

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<tr>
<th>D. Upcoming NC Council Conference: Mr. Robinson shared that the NC Council Conference is December 6-8 and that Alliance will register any Board members who wish to attend. Board members may contact Ms. Ingram for additional information and to register.</th>
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<tr>
<td>3. Agenda Adjustments</td>
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<td>4. Public Comment</td>
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<tr>
<td>5. Lease Agreement for 5200 W. Paramount Parkway – page 6</td>
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### BOARD ACTION

A motion was made by Vice-Chair George Corvin to approve the lease terms and authorize the CEO to enter into a lease agreement; motion seconded by Mr. Christopher Bostock. Motion passed unanimously.

| A. Consumer and Family Advisory Committee – page 10 | 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 included draft minutes from the September Durham and Wake subcommittee meetings and a training on suicide awareness. |
### AGENDA ITEMS:

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<td>The committee reports were sent as part of the Board packet. Israel Pattison, CFAC Chair, presented the CFAC report. Mr. Pattison reviewed recent CFAC meetings including the local/county CFAC subcommittee meetings. He mentioned a recent meeting with a quality improvement update by Tina Howard, Quality Review Manager. He mentioned some changes in CFAC membership and provided an update on the structural changes in CFAC meetings; this includes monthly meetings for each subcommittee/county meeting. The full CFAC meeting now includes officers and the chair of CFAC subcommittees. The CFAC report is attached to and made part of these minutes.</td>
</tr>
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**B. Policy Committee/By-Laws Revision – page 34**

The Board Policy Committee, in coordination and consultation with members of the Board Executive Committee, presented the attached amendments to the By-Laws for consideration and approval. The proposed amendments were provided to Board members on August 31, 2017, for review. Pursuant to the By-Laws of the Board of Directors, this action requires a super-majority vote.

Curtis Massey, Committee Chair, reminded Board members that the revisions were reviewed at the August Board meeting and require a 75% approval. There were no questions or discussion about the proposed revisions.

**BOARD ACTION**

A motion was made by Ms. Lodies Gloston to approve the revisions to the By-Laws; motion seconded by Mr. Lascel Webley. Motion passed unanimously.

**C. Finance Committee – page 46**

The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Area Board. This month’s report included draft minutes from the September 7, 2017, meeting, the budget to actual report and ratios for the period ending August 31, 2017.

James Edgerton, Committee Chair, presented the Finance Committee report. Mr. Edgerton noted that revenues exceeded expenditures and all State mandated ratios were met or exceeded. He mentioned an additional request to commit funds. Board members clarified the background for this request and its potential impact.

**BOARD ACTION**
**AGENDA ITEMS:**

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<td><strong>7. Consent Agenda</strong></td>
<td>A motion was made by Mr. James Edgerton to commit $41,569,791 related to the legislative reductions and required governmental transfers; motion seconded by Mr. George Quick. Motion passed unanimously.</td>
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<tr>
<td><strong>8. Trainings/ Presentations</strong></td>
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<tr>
<td>A. Draft Minutes from September 7, 2017, Board Meeting – page 53</td>
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<td>B. County Commissioner Advisory Committee Report – page 58</td>
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<td>C. Executive Committee Report – page 61</td>
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<tr>
<td>D. Network Development and Services Committee Report – page 64</td>
<td></td>
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<tr>
<td>E. Quality Management Committee Report – page 90</td>
<td>The consent agenda was sent as part of the Board packet. There were no comments or discussion about the consent agenda.</td>
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**BOARD ACTION**

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

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

**8. Trainings/ Presentations**

A. Key Performance Indicators – page 251

Alliance leadership reviews monthly key performance indicators (KPIs) to ensure organizational performance is on track and where needed, course corrections are identified and implemented. Michael Bollini, Ph.D., Executive Vice-President/Chief Operating Officer, reviewed key performance indicators with Board members. Dr. Bollini noted metrics for the first quarter of this fiscal year including: numbers served within the Medicaid population, emergency department admissions, call center volume, medical loss ratio, reinvestment plan expenditures, budget margins, average time to fill positions, turnover rate, tenancy retention, etc.

Board members requested additional information about how many people that need services and are not being served. Also, Board members requested additional information in the upcoming KPI reports: benchmarks and metrics related to the people we serve (i.e. life outcome). Mr. Robinson reminded Board members that this topic is a quarterly agenda item as requested by Board members.

B. Walkthrough of Consumer Experience – page 252

Board members requested an overview of the various ways people can access services through Alliance. Sara Wilson, Director of Government Relations, provided an overview of a person’s experience accessing services. She noted that services could be accessed through the following methods: Alliance’s Access and Information Center, providers, crisis centers, care coordinators or community relations staff. Additionally, Ms. Wilson reviewed the number of calls received and made through Access and
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| 9. Updates   | Information staff, and the number of people utilizing an Alliance Care Coordinator. This presentation is attached to and made part of these minutes. **BOARD ACTION**  
The Board accepted the trainings/presentations; no additional action required. |
| 10. Chair’s Report | Brian Perkins, Senior Vice-President/Strategy and Government Relations, provided an update on current events with North Carolina’s General Assembly. He mentioned that the NC House of Representatives has recessed until 7:00 pm tonight. He mentioned upcoming Joint Legislative Oversight Committee meetings: Health and Human Services and Medicaid Oversight Committee meetings are Tuesday, October 10. Also, Mr. Perkins shared that the NC Department of Health and Human Services whitepaper on Medicaid Reform received over 210 official responses from stakeholders. DHHS will disseminate a summary of the feedback later this month. Also the request for proposals for PHP (prepaid health plans) is still expected to be released in the Spring of 2018. **BOARD ACTION**  
The Board accepted the update; no additional action required. |
| 11. Closed Sessions | There was no report. **BOARD ACTION**  
A motion was made by Vice-Chair George Corvin to enter closed session pursuant to NC General Statute 143-318.11 (a) (1) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1; motion seconded by Ms. Lodies Gloston. Motion passed unanimously. The Board returned to open session. |
| 12. Adjournment | With all business being completed the meeting adjourned at 6:31 p.m. |

**Next Board Meeting**  
Thursday, September 07, 2017  
4:00 – 6:00 pm

Robert Robinson, Chief Executive Officer  
Date Approved
ITEM: Lease Agreement for 5200 W. Paramount Parkway

DATE OF BOARD MEETING: October 5, 2017

BACKGROUND: Alliance currently leases office space at 5 locations throughout its catchment area. Its main office is located at 4600 Emperor Blvd in Research Triangle Park. This lease expires at the end of 2018 and due to Alliance’s growth over the past few years does not provide enough office space to the employees housed at the main office. In anticipation of the expiration of the lease term, and the need for additional space, we have undertaken to gather employee input on future space needs as well as explore alternative work options and consolidating sites. As a result, it was decided that the Durham site and Call Center would be consolidated with the Main office and a larger space would be sought. After a thorough search for the right location and adequate space, a property was located at 5200 W. Paramount Parkway, which is approximately 3 miles from here, in Perimeter Park. The lease will be based on the attached term sheet.

The Board is requested to authorize the CEO to enter into a lease agreement for suites 100 and 200 at 5200 W. Paramount Parkway pursuant to the terms and conditions set forth herein, subject to non-substantive changes approved by General Counsel and the CEO.

Pursuant to the By-laws of the Board of Directors, this action requires a super-majority vote.

REQUEST FOR AREA BOARD ACTION: Consider the proposed lease terms for a 128 month lease for suites 100 and 200 at 5200 W. Paramount Parkway.

CEO RECOMMENDATION: The CEO recommends that the Board approve the proposed lease terms and authorize the CEO to enter into a lease agreement for suites 100 and 200 at 5200 W. Paramount Parkway pursuant to the terms and conditions set forth herein, subject to non-substantive changes approved by General Counsel and the CEO.

RESOURCE PERSON(S): Robert Robinson, CEO; Michael Bollini, Executive Vice-President/COO
Building: 5200 Paramount Pkwy, Morrisville, NC

Leased Space: Suite 100 and Suite 200 containing approximately 125,226 SF

Commencement Date: Target Occupancy of December, 2018.

Lease Term: Initial Lease Term of 128 Months

Rental Rate: $23.25/sq.ft. + 2.5% annual escalation

One Time Termination Right: Tenant shall have a one-time option to either terminate the entire Lease OR downsize by reducing out of the 1st Floor portion of the Premises, after the 5th year of full rent payments (i.e. effective July 31, 2024). Tenant shall provide Landlord not less than twelve (12) months prior written notice of its intent to terminate or downsize, and shall pay an early termination or downsize fee equal to all unamortized leasing costs and half of the rent abatement associated with the space subject to such termination or downsizing, amortized at 8%, plus 4 months of rent equivalent for the terminated or downsized space.

Tenant shall have a one-time option to downsize by reducing out of the 1st floor portion of the Premises, after the 7th year of full rent payments (i.e. effective July 31, 2026). Tenant shall provide Landlord not less than twelve (12) months prior written notice of its intent to downsize, and shall pay an early downsize fee equal to all unamortized leasing costs and two months of rent abatement associated with the space subject to such downsizing, amortized at 8%.

Security Deposit: An amount equal to the last month’s rent.

Option to Renew: 2 options to renew the entirety of the Premises for an additional period of five (5) years, with at least twelve (12) months prior notice. Should tenant exercise its options to downsize, Tenant shall have one (1) five (5) year option to renew on the downsize space.

Assignment and Subletting: Tenant may sublet or assign all or a part of the premises to affiliates, subsidiaries or any existing company controlled by the parent corporation, subject to Landlord’s standard lease language for permitted and non-permitted transfers.
Building Hours and Holiday: 8:00am – 6:00pm Monday through Friday and 9:00am – 1:00pm on Saturdays, upon prior request. (Landlord does not automatically run buildings on Saturdays due to infrequent use and energy conservation measures). The building will be closed on federal holidays.

Tenant Improvements/Building Allowances: $31/SF Tenant Improvement Allowance. Tenant shall be able to use up to $6/SF for soft costs, FFE, relocation costs. Common Area Improvements shall be outside the scope of the allowance and wholly paid for by the landlord.

Leasing Incentive: Tenant shall have the first eight (8) months of rent fully abated.

Tenant Signage: A. A sign with the full name of the company (the size, materials, and location to be selected by Tenant with Landlord’s reasonable approval) at its entrance on each full floor on which Tenant occupies space.
B. Building standard signage on the main directory and at Tenant’s suite.
C. A non-exclusive top of building lighted signage.

Access to Space: Tenant to have access 24 hours per day, 7 days per week access.

Security: The park is currently patrolled by a contracted roving security service nightly, Monday through Friday, between 6:00 p.m. and 6:00 a.m. and on weekends. The Building will be equipped with a cardkey access system for after-hours entry and Tenant may also install supplemental security measures if need be.

Parking: The building parking ratio is 4.29 spaces per 1,000 SF leased, available to Tenant on a free and unassigned basis.

ADA Compliance: The Building and Premises will be delivered to Tenant ADA compliant.
ITEM: Consumer and Family Advisory Committee (CFAC) Report

DATE OF BOARD MEETING: October 5, 2017

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

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

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

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

REQUEST FOR AREA BOARD ACTION: Receive draft minutes from the September Durham and Wake subcommittees and a copy of a training on Suicide Awareness.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Israel Pattison, CFAC Chair; Doug Wright, Director of Consumer Affairs
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES

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<td>Wake Network of Care</td>
<td>At the last meeting, the Chair asked for Dave Mullen to come back with the answers to the last CFAC meeting questions.</td>
<td>Dave unable to attend</td>
<td>30 minutes</td>
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<td>CFAC meeting change</td>
<td>Discuss having monthly subcommittee meetings. Approving new CFAC members in the subcommittee meeting instead of waiting for the full CFAC.</td>
<td>Both proposals are adopted.</td>
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<td>New CFAC Member</td>
<td>Appointing Carol to CFAC membership</td>
<td>Carol Johnson is appointed to CFAC.</td>
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<td>Nominations for subcommittee officers</td>
<td>We need to request nominations for Wake subcommittee officers</td>
<td>Israel &amp; Eric nominate Kurtis (where is Kurtis tonight?) If Kurtis is available, Election to follow in October.</td>
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<td>Wake CFAC goals</td>
<td>Review the Wake CFAC subcommittee goals.</td>
<td>- Mental Health First Aid needed for Israel, Gregory and Carol</td>
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<td>- Champion for Mental Health First Aid in the community</td>
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<td>- Resource Events for 2017-18? Everyone bring three suggestions for next month</td>
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<td>State Updates</td>
<td>State CFAC meeting was cancelled.</td>
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<td>MCO Updates</td>
<td>Doug reminded the group that the comment period has ended for the Medicaid plan, that Alliance has submitted our suggestions. We now will wait to see what other information the state will come out with for review.</td>
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The legislature will come back in October, don’t expect them to take up Medicaid reform then, expect that in the short session.

| Suicide Awareness month training | Stacy presented a Suicide Awareness Training. | Utilize the knowledge. |

5. **ADJOURNMENT**
**MEMBERS PRESENT:**  ✔ Steve Hill, ✔ Tammy Harrington, ☐ Joe Kilsheimer, ☐ James Henry, ✔ Latasha Jordan, ✔ Dave Curro, Amelia Thorpe, ☐ Kyle Reece ✔ Mark Scruggs  
**GUEST(S) PRESENT:**  ☐ Wes Rider, Div. MH/IDD/SAS  
**ALLIANCE STAFF:**  ✔ Doug Wright, Director of Consumer Affairs; ✔ Ramona Branch, Individual and Family Engagement Specialist

Dial-In Number: (605) 472-5464  
Access Code: 289674

1. WELCOME AND INTRODUCTIONS – Ramona Branch and others  
2. REVIEW OF THE MINUTES – Minutes reviewed, approved and accepted as is.

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| Public Comment | • Dave shared his insight and concerns on a recent crisis situation with his son and his provider (Monarch) not being able to assist him in a crisis situation. Dave praised Alliance for linking him with Carolina Outreach and also gave kudos to Carolina Outreach for being able to assist him in a timely manner during his son’s crisis.  
• Dave shared his feelings on a current situation with Durham Parks and Recreation on starting up a support group in Durham for families of IDD (NextStep). He reports that this group is currently available in Holly Springs and Raleigh in Wake County, and it would be beneficial in Durham.  
• Doug shared information on Carolina Outreach and their Mental Health Urgent Care clinic, which offers Mental Health care without having to wait for a formal appointment. Carolina Outreach offers this clinic on a walk-in basis on Wednesday’s. |

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<td>Members to continue to follow-up with Dave on the progression of the Durham County Support Group for IDD (NextStep).</td>
<td>Ongoing</td>
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| New Members          | • Members voted in Mark Scruggs to the CFAC subcommittee. Ramona went over orientation information and gave Mark her contact information for questions and follow-up.  
• Doug announced that the stipend had been increased to $50.  
• Dave shared that his stipend is going to the wrong address and needs to be sent to his new address in Durham.                                                                 | Ramona will follow up with Shelly to ensure Dave’s new address is corrected. Members will continue to reach out to the community to further recruitment efforts.                                          | September 2017 |
| CFAC restructure     | • Steve announced that the CFAC restructure will consist of steering committee that house smaller groups instead of (1) large group. These meetings will take place on the 1st Monday of the month, with one meeting face to face alternating with a phone meeting. |                                                                                                                                                                                                          |              |
| Event Planning       | • Recovery Event is scheduled for September 30, 2017 at the Durham Farmers Market from 2-6pm. Volunteers are needed for the table.  
• Recovery Summit is scheduled for November 28, 2017 for 8-5 pm and will include panels, small group discussions, and more. Additional information will be given as the event draws closer.  
• Brainstorming for future events: Consider a drive-in movie night for the showing of Anonymous People. Resource/ Health fair possibly partnering with Lincoln to include vendors from the community (Carolina Outreach, B&D, etc.) Training classes- 3 per year (1) for Ramona will follow up with Tammy, Latasha, Dave, Steve and Mark to schedule times for table rotation for the Recovery event on 09.30.2017.  
Steve will check on availability of space for movie (Wellness City, Trosa parking lot, library). | September 2017 |
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<td>LME/MCO Updates</td>
<td>• Ramona shared information on the following topics: General Assembly Adjournment, Veto Override Votes in the General Assembly, Legislative Maps Updates, Single Stream Funding Cuts to LME’s/MCO’s, Behavioral Health in Jail Reform, and a Hospital Deal.</td>
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<td>Announcements/Opportunities</td>
<td>• Doug shared information on Alliance Recovery University and how to access through the website, and trainings that are currently available.</td>
<td>Continue to check out Alliance Recovery University and enroll in trainings as needed.</td>
<td>Ongoing</td>
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5. ADJOURNMENT:
7:10pm
Suicide Risk Factors

- Mental disorders, in particular:
  - Depression or bipolar (manic-depressive) disorder
  - Alcohol or substance abuse or dependence
  - Schizophrenia
  - 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 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
  o A highly stressful life event
  o Prolonged stress due to adversities
  o Exposure to another person’s suicide, or to graphic or sensationalized accounts of suicide
  o 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
  
  o 14.3 of every 100,000 people ages 65 and older died by suicide in 2007 compared to 11.3 in the general population

  o 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 commit suicide

• Moderate: Suicidal thoughts, vague plan not very lethal; says he or she won't commit suicide

• High: Suicidal thoughts, specific lethal plan; says he or she won't commit suicide

• Severe: Suicidal thoughts, specific lethal plan; says he or she will commit suicide
Level of Suicide Risk

• Low: Some suicidal thoughts, no plan; says he or she won't commit suicide

• Moderate: Suicidal thoughts, vague plan not very lethal; says he or she won't commit suicide

• High: Suicidal thoughts, specific lethal plan; says he or she won't commit suicide

• Severe: Suicidal thoughts, specific lethal plan; says he or she will commit 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 commit suicide must be “crazy”

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

• People who commit suicide were unwilling to seek help
• Talking about suicide may give someone the idea to act on it
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
ITEM: Amendment to Board By-Laws

DATE OF BOARD MEETING: October 5, 2017

BACKGROUND: The Board Policy Committee, in coordination and consultation with members of the Board Executive Committee present the attached amendments to the By-Laws for consideration and approval. The proposed amendments were provided to Board members on August 31, 2017, for review. Pursuant to the By-Laws of the Board of Directors, this action requires a super-majority vote.

REQUEST FOR AREA BOARD ACTION: Consider and approve the proposed amendments to the By-Laws.

CEO RECOMMENDATION: The CEO recommends that the Board approve the proposed amendments to the By-Laws.

RESOURCE PERSON(S): Curtis Massey, Committee Chair; Monica Portugal, Chief Compliance Officer
AREA BOARD BY-LAWS

ARTICLE I
PURPOSE

The Alliance Behavioral Healthcare Board of Directors, also known as the Area Board, by virtue of powers contained in Chapter 122C of the North Carolina General Statutes is responsible for comprehensive planning, budgeting, implementing and monitoring of community based mental health, developmental disabilities and substance abuse services to meet the needs of individuals in the Durham, Wake and Cumberland County Alliance’s Catchment Area as that term is defined in the contract between NC Department of Health and Human Services (NCDHHS) and Alliance for Medicaid waiver management services. These responsibilities shall be carried out in partnership with the Durham, Wake and Cumberland County Boards of County Commissioners hereinafter referred to as County Commissioners. Any use of the term Board of Directors Area Board or CEO in these bylaws shall be deemed to include the Area Board, Area Authority, LME, Area Director and other such terms used in North Carolina General Statutes.

MISSION STATEMENT
To improve the health and well-being of the people we serve by ensuring highly effective, community-based support and care. The mission of the Area Board is to support and enhance the quality of life of those citizens affected by mental illness, intellectual/developmental disabilities and substance abuse.

VISION STATEMENT
To be a leader in transforming the delivery of whole person care in the public sector. The Area Board seeks to develop and maintain a network of quality providers whose services are evidence based or best practice and who embrace people with disabilities as equal partners and valued citizens. The entire community benefits when citizens with disabilities reach their full potential.

VALUES STATEMENT
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.

The Area Board, its administration and employees value the following:

1. Discovering ways to nurture community strengths in order to accomplish what none of us can do alone.
2. Involving stakeholders for the advancement of all citizens in our diverse community.
3. Partnerships with community agencies that assure that best practices are applied through person-centered planning.
4. Community resources that offer enduring ways to support people with disabilities.
5. Community partnerships that leverage resources to respond to the mental health, intellectual/developmental disabilities and substance abuse services (MH/IDD/SA) needs of all citizens.
6. Advocacy efforts that challenge the MH/IDD/SA delivery system to improve continuously.
7. Accountability of all parties in the system.
8. Exemplary practices that lead to meaningful outcomes and are cost effective.
9. High level of satisfaction among consumers, families, and funders.
10. Collaboration with our community partners and stakeholders.
11. Building community capacity that includes the identification of existing community resources and gaps.
12. Services and supports that are consumer and family-friendly, age appropriate and culturally competent.
13. The flexibility of the MH/IDD/SA system to provide programs and supports when needed, at the level needed, and in the amount necessary. This is important so that people may enter and exit components of the system as their needs change and without fear of re-entry complications.
14. Ongoing community education that assists in the elimination of stigma and discrimination.

ARTICLE II

STRUCTURE

A. AUTHORITY

1. The Area Alliance Board of Directors is accountable to the citizens of Durham, Wake and Cumberland Counties, the Alliance Catchment Area.
2. The authority, powers and duties of the Area Board derive from General Statute 122C-115.5 and 122C-117.
3. In addition to exercising those powers, duties, and functions set forth in 122C-115.5 and 122C-117, the Board of Director’s primary responsibilities include:
   a. Defining services to meet the needs of citizens (within the parameters of the law) through an annual needs assessment.
b. Adoption of operational policies to meet all requirements. Governing the organization by adopting broad governance necessary and proper policies to carry out the obligations under its contract as a Pre-paid Inpatient Health Plan (PIHP).

c. Evaluation. Evaluating quality and availability of services in meeting the needs of the population.

d. Providing Fiscal oversight.

e. Hearing complaints and appeals from consumers, providers and the general public.

f. Community education and advocacy. Performing public relations and community advocacy functions.

g. Appointing a CEO by an area director in accordance with General Statute 122C-121 (d). The CEO Area Director is an employee of the Area Board of Directors and shall serve at the pleasure of the Area Board Board of Directors.

h. Evaluating annually the area director for performance based on criteria established by the Secretary of NCDHHS and the Board of Directors area board.

i. Delegating responsibility to the Area Director who shall be responsible for the appointment of employees, the implementation of the policies and programs of the Area Board, for compliance with the rules of the North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services, and NCDHHS, supervision of all employees and management of all contract providers.

j. Empower Delegating to the Area Director to sign official authority to execute contracts and agreements, where appropriate.

k. Developing plans and budgets for the area authority subject to the approval of the Secretary of NCDHHS. The area authority shall submit the approved budget to the boards of county commissioners and the county managers.

l. Providing quarterly and annual reports to the Wake, Durham and Cumberland County Commissioners.

m. Maintaining open communication with the Consumer and Family Advisory Committee (CFAC).

n. Participate in strategic planning, including consideration of local priorities as determined by the County Commissioner Advisory Board;

o. Government affairs and advocacy.

B. COMPOSITION

1. The Board of Directors shall consist of nineteen (19) members.

2. The Board of Directors shall work in conjunction with the Durham, Wake and Cumberland County Commissioners.

3. The Durham and Wake County Commissioners shall appoint seven (7) members respectively and the Cumberland County Board of Commissioners will appoint four (4) members. During the effective period of the Interlocal Agreement between the Board of Directors and the Johnston County Area Authority, the Alliance Board of Directors will appoint one - member from Johnston County. All seats will be appointed at large.

4. The appointment process shall be consistent with the process outlined in the Joint Resolution between Cumberland, Durham and Wake Counties effective July 8, 2013. The Board of Directors will advertise, accept applications, interview and recommend appointments to the respective boards of commissioners.

5. Board of Directors membership may consist of the following:

   a. Consumer or family member representing the interest of individuals with mental illness, intellectual or other developmental disabilities or substance abuse.
b. CFAC member
c. An individual with health care expertise and experience in the fields of mental health, intellectual or other developmental disabilities or substance abuse services.
d. Individual with financial expertise
e. Individual with provider experience in a managed care environment.

6. The Board of Directors shall assure that there is at least one representative of each of the three disability categories, i.e., mental illness, intellectual/developmental disabilities and substance abuse, on the board.

7. No individual who contracts with the Board of Directors for the delivery of mental health, intellectual/developmental disabilities, or substance abuse services may serve on the Board of Directors during the period in which the contract for services is in effect.

C. TERMS AND CONDITIONS OF OFFICE
1. Terms of membership shall be for three years except any member of the Area Board of Directors who is a county commissioner serves on the Board in an ex officio capacity at the pleasure of the initial appointing authority, for a term not to exceed the earlier of three years or the member's service as a County Commissioner. The terms of the County Commissioner members on the Area Board shall be concurrent with their terms of office. The initial terms of office will be staggered in accordance with General Statute 122C-118.1.d. Each of the initial staggered terms of office shall be considered a full term.

2. Members other than County Commissioners shall not be appointed for more than three consecutive terms.

3. Members may be removed with or without cause by the appointing authority, upon recommendation by the Executive Committee.

4. Area Board members may resign at any time, upon written notification to the Chairperson or the Executive Secretary of the Area Board.

5. Vacancies on the Area Board shall be filled by the County Commissioners before the end of the term of the vacated seat or within 90 days of the vacancy, whichever comes first. Appointments shall be for the remainder of the unexpired term.

6. Area Board members are responsible for disclosing and may not vote on any issue in which they have a direct or indirect financial interest or personal gain. All Board members are expected to exhibit high standards of ethical conduct, avoiding both actual conflict of interest and the appearance of a conflict of interest.

7. Neither Area Board members nor members of their families will receive preferential treatment through the Area Authority’s services or operations.

8. Area Board members must be current with all property taxes in their respective counties.

9. Membership is based on the rules and regulations of the Area Board policies and all applicable North Carolina General Statutes.

10. Area Board members are required to comply with the Area Board Code of Ethics, policies and all applicable North Carolina General Statutes.

11. While Board members may be appointed because they represent a certain community, once on the Board, their responsibility is to all individuals served by Alliance.

D. OFFICERS

1. At each final regular Board meeting of the fiscal year, the Officers of the Area Board shall be chosen elected for a one-year term to begin July 1, at the final meeting of the fiscal year in which the Area Board is serving. The Officers of the Board of Directors include and shall be as follows:
a. Chairperson, and  
b. Vice-Chairperson.

2. With the exception of the position of Executive Secretary (which shall be filled by the Area Director/CEO), no officer shall serve in a particular office for more than two consecutive terms.

3. Each Area Board members other than County Commissioners, shall be eligible to serve as an officer.

4. Duties of officers shall be as follows:
   a. Chairperson – this officer shall preside at all meetings and generally perform the duties of a presiding officer. The Chairperson shall appoint all Area Board committees.
   b. Vice Chairperson – this officer shall be familiar with the duties of the Chairperson and be prepared to serve or preside at any meeting on any occasion where the Chairperson is unable to perform his/her duties.
   c. Executive Secretary – The Area Director/CEO (or his/her designee) shall serve as the Executive Secretary. The Area Director/CEO shall not be an official member of the Area Board nor have a vote. As Executive Secretary, the Area Director/CEO shall:
      i. Send Area Board packets of information.
      ii. Maintain a true and accurate account of all proceedings at Area Board meetings.
      iii. Maintain custody of Area Board minutes and other records.
      iv. Notify the County Commissioners of any vacancies on the Area Board or attendance compliance issues.

E. COMMITTEES

1. STANDING COMMITTEES - Annually, the Area Board Chairperson shall appoint the membership and the Chairperson of each of the Standing committees that are required by law, regulation, accrediting bodies or contract as well as other committees set forth below, at the discretion of the Area Board. These committees shall have the responsibility of making policy recommendations to the Area Board regarding matters within each committee’s designated area of concern. The composition of each committee shall comply with the relevant applicable statute, regulation or contract requirements. The chair of any standing committee must be a member of the Board of Directors. These standing committees shall be as follows:

a. Finance Committee (NCGS 122C-119 (d))
   i. This committee shall be composed in a manner consistent with NCGS 122C-119, having at least 3 members, two of whom have expertise in budgeting and fiscal control. The Finance member designees of the Area Board plus three other Area Board members. (The Finance Officers of Durham, Cumberland and Wake Counties or designee may serve as ex-officio members)
   ii. The Committee’s functions include:
      1) Recommending policies/practices on fiscal matters to the full Area Board.
      2) Reviewing and recommending budgets to the entire Area Board.
      3) Reviewing and recommending approval of audit reports (following a meeting by a designee of this committee with the auditor and receipt of the management letter) and assure corrective actions are taken as needed.
      4) Reviewing and recommending policies and procedures for managing contracts and other purchase of service arrangements.
5) Reviewing financial statements at least quarterly.
6) Reviewing the financial strength of the Area Authority

b. **Client Rights/Human Rights Committee (contract with DMH/DD/SAS contract and NCGS 122C-64, 10A NCAC 27G.0504)**

   i. The Client Rights/Human Rights Committee shall consist of at least 5 members, a majority of whom shall be non-Board Members and include at least 3 board members. Other members should include consumers and family members representing mental health, developmental disabilities and substance abuse. The membership of the Client Rights/Human Rights Committee shall include a representative from each of the counties in the Catchment Area.

   ii. The Client Rights/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 of Directors.

       2) Overseeing the protection of client rights and identifying and reporting to the Area Board issues which negatively impact the rights of persons served.

       3) Reporting to the full Area Board at least quarterly.

       4) Submitting an annual report to the Area Board of Directors which includes, among other things, a review of the Area Authority’s compliance with NCGS 122C, Article 3, DMHDDSAS Client Rights Rules (APSM 95-2) and Confidentiality Rules (APSM 45-1).

   iii. The Client Rights/Human Rights Committee shall meet at least quarterly.

c. **Quality Management Committee (Contract with DMH/DD/SASURAC)**

   i. The Quality Management (QM) Committee shall consist of at least 57 members to include consumers or their family members, 3 board members, two members from CFAC, and 2 non-voting provider representatives. The Board-QM Committee will meet at least 6 times a year.

   ii. The QM Committee shall review statistical data and provider monitoring reports and make recommendations to the full Area Board of Directors or other Area Board committees.

   iii. 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 QM Committee is to ensure quality and effectiveness of services and to identify and address opportunities to improve LME/MCO Alliance operations and local service system with input from consumers, providers, family members, and other stakeholders.

d. **Executive Committee** - The Area Board shall have an Executive Committee. All actions taken by the Executive Committee will be reported to the full Area Board at the next scheduled meeting.

   i. The Executive Committee shall be composed of the current Officers of the Area Board, Chairpersons of standing committees (who are Area Board members), the immediate past Board chairperson or an at-large member in the event the immediate past Board Chairperson is not available.

   ii. The Area Board Chairperson shall serve as the Chairperson of the Executive Committee.
iii. The Chairperson shall call the meetings of the Executive Committee. Any member of the Area Board may request that the Chairperson call an Executive Committee meeting.

iv. The Executive Committee shall be responsible for the following:
1) Function as the grievance committee to hear complaints regarding board member conduct and make recommendations to the full Area Board.
2) Establish agendas for full Area Board meetings.
3) Act on matters that are time-sensitive between regularly scheduled board meetings.
4) Provide feedback to the Area Director/CEO concerning current issues related to services, providers, staff, etc.
5) Fulfill other duties as set forth in these By-laws or as otherwise directed by the Area Board.
6) Notice of the time and place of every Executive Committee meeting shall be given to the members of the Executive Committee in the same manner that notice is given of Area Board meetings.

e. Policy/By-Law Committee
i. The Policy/By-law Committee shall consist of at least 3 Board members and shall meet at least 3 times a year.

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

f. County Commissioner Advisory Board
Consistent with NCGS 122c-118.2, the Area Authority shall have a county commissioner Advisory Board consisting of one commissioner from Cumberland, Durham and Wake Counties. The Commissioner appointed to the Alliance Area Authority will serve on the County Commissioner Advisory Board (CCAB). The duties of the CCAB include serving as the chief advisory board to the area authority and to the director of the area authority on matters pertaining to the delivery of services for individuals with mental illness, intellectual or other developmental disabilities and substance abuse disorders in the catchment area. Meetings will be scheduled quarterly.

f. Audit and Compliance Committee
i. The Audit and Compliance Committee will consist of at least three members of the Board of Directors. At least one member shall have financial expertise. The Chairperson
of the Audit and Compliance Committee may not also be the Chairperson of the Finance Committee.

ii. The Chief Compliance Officer will serve as staff liaison to the Committee.

iii. The Committee shall meet at least three times a year, with authority to convene additional meetings, to adequately fulfill all the obligations outlined in this charter.

iv. The purpose of the Audit and Compliance Committee is to put forth a meaningful effort to review the adequacy of existing compliance systems and functions. To assist the Board of Directors in fulfilling its oversight responsibilities for:

1) The integrity of the organization’s annual financial statements;
2) The system of risk assessment and internal controls
3) The organization’s compliance with legal and regulatory requirements;
4) The independent auditor's qualifications and independence;
5) The performance of the organization’s internal audit function; and
6) To provide an avenue of communication between management, the independent auditors, and the Board of Directors.

g. Network Development & Services Committee

i. The Network Development and Services Committee shall consist of at least three members, a majority of whom shall be members of the Board of Directors and shall meet at least quarterly.

ii. The Senior Vice President of Network Development & Evaluation, or her designee will serve as staff liaison to the Committee.

iii. The Committee’s functions include:

1) To review service network development activities.
2) Reviews progress on the network development plan and progress on fund balance spending on service development.
3) Provides guidance and feedback on development of the needs and gaps assessment to meet state and agency requirements.
4) Areas of focus may include:
   - Emerging needs and Challenges
   - Data related to the Needs and Gaps Analysis
   - Network Development Plan and Status
   - State and Federal Initiatives

2. AD HOC COMMITTEES

a. Ad hoc committees, may be appointed by the Area Board Chair of the Board of Directors with the approval of a majority of the Area Board members who are present at the meeting during which approval is given.

b. These committees shall carry out their duties as designated by the Area Board of Directors and shall report their findings to the Area Board or its committees.

3. CONSUMER AND FAMILY ADVISORY COMMITTEE – Consistent with NCGS 122C-170, the Area Authority shall have a committee made up of consumers and family members to be known as the Consumer and Family Advisory Committee (CFAC). The Consumer and Family Advisory Committee shall be self-governing and self-directed. The CFAC shall advise the Area Board on
the planning and management of the local mental health, intellectual/developmental disabilities and substance abuse services system.

4. COUNTY COMMISSIONER ADVISORY BOARD

Per 122C-118.2, there is a County Commissioner Advisory Board. The County Commissioner Advisory Board is not a board or committee appointed by the Board of Directors. The CEO or designee will assist in facilitation of the County Commissioner Advisory Board meetings.

ARTICLE III
MEETINGS

A. REGULAR MEETINGS

Regular meetings shall be held at least six times each year at a location and time designated by the Area Board of Directors. The annual meeting for the election of Officers shall be the final meeting of each fiscal year. All meetings of the Area Board shall be conducted in accordance with provisions set forth in Article 33C of NCGS 143 (the Open Meetings Act).

B. SPECIAL MEETINGS

Special meetings may be called by the Area Board Chair or by three or more members of the Area Board after notifying the Area Board Chair in writing. Notice of special meetings shall be provided in a manner consistent with those utilized to notify Area Board members (and others) of regularly scheduled meetings.

C. EMERGENCY MEETINGS

Emergency meetings may be called for unexpected circumstances that require immediate consideration by the Area Board. Due to the urgent need to assemble a meeting as soon as possible, any requirements regarding advanced notice for regularly scheduled meetings may be waived and emergency meetings shall be held as soon as a quorum of the Area Board can be convened.

D. NOTICE OF MEETINGS

Notification of Area Board meetings shall be sent out no later than 48 hours before the regular meeting and in accordance with requirements set forth in the Open Meetings Statute, Article 33C. The Area Board is scheduled to meet on the first Thursday of each month at the Area Authority facility. Notice of the date, time and place shall be sent to each board member in the form of an Area Board agenda. Information concerning Board meetings shall also be made available to the local news media in accordance with Article 33C. Notice for all board meetings including the board packet will be posted on the Alliance website.

E. CONDUCT OF MEETINGS

Area Board meetings shall be conducted under parliamentary procedures. Significant actions by the Area Board require fifteen (15) affirmative votes, or a 75% majority in the event the number of board members changes or there are vacant seats on the Board. Significant actions shall include: (1) policy decisions which affect consumer benefit plans, admit or exclude
providers, or set provider rates, (2) any action or decisions concerning the annual budget and amendments according to the Local Government Budget and Fiscal Control Act (NCGS 159), (3) personnel policies, (4) employee benefit plans, (5) the selection and dismissal of the Chief Executive Officer, (6) changes to the Area Board structure, (7) execution of contracts or leases for real or personal property including accepting any assignment thereof, (8) acceptance of grants, (9) settlement of liability claims against the Area Authority or its officers or employees, (10) approval or amendment of the Area Authority’s by-laws, and, (11) any other matter so designated by the Area Authority Board.

It is the policy of this Board that all deliberations and actions be conducted fairly, openly, and consistent with the applicable Statutes of North Carolina. Participation in Area Board meetings via electronic means, e.g. telephone, video conferencing, is permissible to the extent allowed by law. Such participation includes the right to vote on issues that arise during the course of the meeting.

The following guidelines should be followed at all Board and committee meetings:

1. The Board/Committee must act as a body in the best interests of the consumers in the Alliance catchment area
2. The Board/Committee should proceed in the most efficient manner possible
3. The Board/Committee must act by at least a majority vote
4. Every member must have an equal opportunity to participate in decision-making
5. The Board/Committee must apply the rules of procedure consistently

F. QUORUM

A majority of the actual membership of the Area Board, excluding vacant seats, shall constitute a quorum and shall be required for the transaction of business at all regular, special and emergency meetings. A majority is more than half.

G. APPROVAL OF CERTAIN ITEMS BY A SUPER MAJORITY

Significant actions by the Area Board require fifteen (15) affirmative votes, or a 75% majority in the event the number of board members changes or there are vacant seats on the Board. Significant actions shall include: (1) policy decisions which affect consumer benefit plans, admit or exclude providers, or set provider rates, (2) any action or decisions concerning the annual budget and amendments according to the Local Government Budget and Fiscal Control Act (NCGS 159), (3) personnel policies, (4) employee benefit plans, (5) the selection and dismissal of the Chief Executive Officer, (6) changes to the Area Board structure, (7) execution of contracts or leases for real or personal property including accepting any assignment thereof, (8) acceptance of grants, (9) settlement of liability claims against the Area Authority or its officers or employees, (10) approval or amendment of the Area Authority’s by-laws, and, (11) any other matter so designated by the Area Authority Board.

G. H. ABSENCES

1. Absence from three (3) consecutive meetings without notification to the Executive Secretary shall constitute resignation from the Area Board.
2. Absence from 4 or more than twenty-five percent (25%) of the regularly scheduled meetings during a 12 month period may also constitute resignation from the Area Board within the discretion of the Executive Committee.
3. In computing absences, absence from two Area Board Committee meetings may constitute one absence from a regularly scheduled Area Board meeting.
ARTICLE IV
GENERAL PROVISIONS

A. AMENDMENTS

1. These By-Laws may be amended or repealed as necessary.

2. New or amended By-Laws may be adopted by the affirmative vote of fifteen (15) Board members, or a corresponding majority of Board members in the event the number of Board members changes or there are vacant seats on the Board, during any regular (or other) meeting of the Area Board.

3. Notice of proposed changes must be given to the Area Board members at least thirty (30) days prior to the change.

B. SUSPENSION OF BY-LAWS

The Area Board has the authority to suspend the By-Laws by an affirmative vote of a majority fifteen (15) of Board members, or a corresponding majority of Board members in the event the number of Board members changes or there are vacant seats on the Board, with the exception of those items requiring a Super Majority set forth in Article III (G).

C. REVIEW OF BY-LAWS AND AREA BOARD GOVERNANCE POLICIES

These By-Laws and all Area Board governance policies shall be reviewed at least annually.
ITEM: Finance Committee Report

DATE OF BOARD MEETING: October 5, 2017

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 2:30/3:00 p.m. prior to the regular Area Board Meeting. This month’s report includes the draft minutes from the September 7, 2017 meeting, the budget to actual report and ratios for the period ending August 31, 2017.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): James Edgerton, Committee Chair; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the August 3, 2017, meeting were reviewed; a motion was made by Mr. Bostock and seconded by Mr. Quick to approve the minutes. Motion passed.

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<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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| 3. Monthly Financial Reports | The monthly financial reports were discussed which includes the Statement of Revenue and Expenses, Senate Bill 208 Required Ratios, and DMA Contract Ratios as of 7/31/17.  
   a) It is early in the year so there is not a lot of activity; however, we are currently meeting all required ratios. Sara Pacholke explained how the MLR had two changes as of 7/1/17. First, the 2% risk reserve amount that we set aside can no longer be excluded from the denominator (i.e. total revenue is considered, not revenue less the 2% risk reserve). Second, the ratio used to be evaluated monthly for compliance. Now the 85% requirement is an annual requirement. Alliance will still monitor the ratio monthly to ensure we are meeting it and to make changes if necessary.  
   b) We discussed the 6/30/17 net position. The final savings for fiscal year 2017 is $14,737,375 (however, this could change depending on any audit adjustments). Sara Pacholke discussed the current net position as of 6/30/17. The net position is as follows: | Recommend the Board commit $15,773,126 for the FY18 and FY19 reinvestment plan. | 3:00-4:00 p.m. |
**AGENDA ITEMS:**

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<tr>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
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<tr>
<td><strong>Investment in Capital Assets</strong></td>
<td><strong>6/30/2017</strong></td>
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<td>Restricted:</td>
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<td>State - TBI Services</td>
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<td>Legislative Reductions</td>
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<td>Intergovernmental Transfers</td>
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<td><strong>Total Restricted</strong></td>
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<td>Unrestricted:</td>
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<tr>
<td>General</td>
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<tr>
<td>Committed</td>
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<tr>
<td><strong>Total Unrestricted</strong></td>
<td><strong>37,830,785</strong></td>
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<tr>
<td><strong>Total Net Position</strong></td>
<td><strong>119,434,695</strong></td>
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Per discussions with our auditors, we are able to restrict the legislative reduction amount and the intergovernmental transfer amount. We also discussed the Board committing the FY18 and FY19 reinvestment plan. Chris Bostock made a motion to recommend committing $15,773,126 for future reinvestment. George Quick seconded the motion.

4. **FY18 State Report Template**
   a) Kelly Goodfellow went over the proposed format for the non-Medicaid revenue and expense reporting. We will be reporting the information on a quarterly basis.

5. **Schedule for Finance Committee Meetings**
   a) The proposed Finance meeting schedule was discussed at the 8/3/17 meeting; however, we need a motion to approve. Chris Bostock motioned to approve the schedule and George Quick seconded it.

   Sara Pacholke will add times to the approved schedule and share with the committee and guests.

6. **Policies**
   a) The Committee did not have any changes to the finance policies. George Quick made a motion to approve with no changes. Chris Bostock seconded the motion.

   Recommend the Board accept the policies with no changes.

6. **Closed Session in accordance with G.S. 143.318-11(a)(5)**
   A motion was made by Chris Bostock to enter closed session pursuant to NC General Statute 143.318-11(a)(5) to instruct the public body’s staff concerning the position to be taken by or on behalf of the public body in

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

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<th>DISCUSSION:</th>
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<th>TIME FRAME:</th>
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<tr>
<td>negotiating the price and other material terms of a contract or proposed contract for the acquisition of real property by purchase, option, exchange, or lease; seconded by George Quick. Motion passed unanimously.</td>
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</tbody>
</table>

4. **ADJOURNMENT:** next meeting will be October 5, 2017, from 3:00 p.m. to 4:00 p.m.
# Statement of Revenue and Expenses (Budget and Actual) - As of August 31, 2017

<table>
<thead>
<tr>
<th>Original Budget</th>
<th>Current Period</th>
<th>Year to Date</th>
<th>Balance</th>
<th>% Received/ Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Grants</td>
<td>$36,857,390.00</td>
<td>$6,682,601.45</td>
<td>$9,661,274.09</td>
<td>$27,196,115.91</td>
</tr>
<tr>
<td>State &amp; Federal Grants</td>
<td>47,781,186.00</td>
<td>2,388,689.36</td>
<td>5,889,307.58</td>
<td>41,891,878.42</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>359,425,264.00</td>
<td>32,880,693.25</td>
<td>62,086,441.09</td>
<td>297,338,822.91</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>$444,063,840.00</td>
<td>41,951,984.06</td>
<td>77,637,022.76</td>
<td>366,426,817.24</td>
</tr>
<tr>
<td>Administrative</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Administration</td>
<td>369,054.00</td>
<td>30,754.50</td>
<td>61,629.15</td>
<td>307,424.85</td>
</tr>
<tr>
<td>LME Administrative Grant</td>
<td>4,359,385.00</td>
<td>363,283.92</td>
<td>726,566.00</td>
<td>3,632,819.00</td>
</tr>
<tr>
<td>Medicaid Waiver Administration</td>
<td>46,704,978.00</td>
<td>4,271,116.54</td>
<td>8,067,348.38</td>
<td>38,637,629.62</td>
</tr>
<tr>
<td>Miscellaneous Revenue</td>
<td>250,000.00</td>
<td>56,708.97</td>
<td>108,508.45</td>
<td>141,491.55</td>
</tr>
<tr>
<td><strong>Total Administrative Revenue</strong></td>
<td>51,683,417.00</td>
<td>4,721,863.93</td>
<td>8,964,051.98</td>
<td>42,719,365.02</td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td>$495,747,257.00</td>
<td>46,673,847.99</td>
<td>86,601,074.74</td>
<td>409,146,182.26</td>
</tr>
<tr>
<td><strong>EXPENSES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Services</td>
<td>36,857,390.00</td>
<td>2,527,929.72</td>
<td>2,614,289.45</td>
<td>34,243,100.55</td>
</tr>
<tr>
<td>State &amp; Federal Services</td>
<td>47,781,186.00</td>
<td>4,829,528.98</td>
<td>8,680,912.60</td>
<td>39,100,273.40</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>359,425,264.00</td>
<td>32,051,625.07</td>
<td>61,829,691.91</td>
<td>297,595,572.09</td>
</tr>
<tr>
<td><strong>Total Service Expenses</strong></td>
<td>444,063,840.00</td>
<td>39,409,083.77</td>
<td>73,124,893.96</td>
<td>370,938,946.04</td>
</tr>
<tr>
<td>Administrative</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operational</td>
<td>6,657,386.00</td>
<td>514,459.22</td>
<td>833,435.14</td>
<td>5,823,950.86</td>
</tr>
<tr>
<td>Salaries, Benefits, and Fringe</td>
<td>38,175,919.00</td>
<td>3,310,237.52</td>
<td>6,596,023.94</td>
<td>31,579,895.06</td>
</tr>
<tr>
<td>Professional Services</td>
<td>6,600,112.00</td>
<td>365,993.60</td>
<td>556,897.09</td>
<td>6,043,214.91</td>
</tr>
<tr>
<td>Miscellaneous Expense</td>
<td>250,000.00</td>
<td>-</td>
<td>-</td>
<td>250,000.00</td>
</tr>
<tr>
<td><strong>Total Administrative Expenses</strong></td>
<td>51,683,417.00</td>
<td>4,190,690.34</td>
<td>7,966,356.17</td>
<td>43,447,060.83</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>$495,747,257.00</td>
<td>43,599,774.11</td>
<td>81,111,250.13</td>
<td>414,386,006.87</td>
</tr>
</tbody>
</table>

**CHANGE IN NET POSITION**

$3,074,073.88 $5,489,824.61
Senate Bill 208 Ratios - As of August 31, 2017

**CURRENT RATIO**

- **Bench Mark**
- **Alliance**

<table>
<thead>
<tr>
<th>Month</th>
<th>Bench Mark</th>
<th>Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAR-17</td>
<td>3.95</td>
<td>4.16</td>
</tr>
<tr>
<td>APR-17</td>
<td>3.95</td>
<td>4.16</td>
</tr>
<tr>
<td>MAY-17</td>
<td>3.95</td>
<td>4.16</td>
</tr>
<tr>
<td>JUN-17</td>
<td>3.22</td>
<td>3.26</td>
</tr>
<tr>
<td>JUL-17</td>
<td>3.22</td>
<td>3.26</td>
</tr>
<tr>
<td>AUG-17</td>
<td>3.22</td>
<td>3.26</td>
</tr>
</tbody>
</table>

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

**PERCENT PAID**

<table>
<thead>
<tr>
<th>Month</th>
<th>Bench Mark</th>
<th>Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAR-17</td>
<td>99.6%</td>
<td>99.7%</td>
</tr>
<tr>
<td>APR-17</td>
<td>99.6%</td>
<td>99.7%</td>
</tr>
<tr>
<td>MAY-17</td>
<td>99.6%</td>
<td>99.7%</td>
</tr>
<tr>
<td>JUN-17</td>
<td>99.7%</td>
<td>99.7%</td>
</tr>
<tr>
<td>JUL-17</td>
<td>99.7%</td>
<td>99.7%</td>
</tr>
<tr>
<td>AUG-17</td>
<td>99.7%</td>
<td>99.7%</td>
</tr>
</tbody>
</table>

**Percent Paid** = Percent of clean claims paid within 30 days of receiving. The requirement is 90% or greater.
**DEFENSIVE INTERVAL**

- **DEFENSIVE INTERVAL** = Current assets divided by average daily operating expenses. This ratio shows how many days the organization can continue to pay expenses if no additional cash comes in. The requirement is 30 days or greater.

**MEDICAL LOSS RATIO**

- **MEDICAL LOSS RATIO** (MLR) = Total Services Expenses plus Administrative Expenses that go towards directly improving health outcomes divided by Total Medicaid Revenue. The requirement is 85% or greater for the rating period (7/1/17-6/30/18). Beginning July 2017 Risk Reserve Revenue will be included in revenue, previously it was excluded.
ITEM: Draft Minutes from the September 7, 2017, Board Meeting

DATE OF BOARD MEETING: October 5, 2017

REQUEST FOR BOARD ACTION: Approve the draft minutes from the September 7, 2017, meeting.

CEO RECOMMENDATION: Approve the minutes.

RESOURCE PERSON(S): Robert Robinson, CEO; Veronica Ingram, Executive Assistant
Thursday, September 07, 2017

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

MEMBERS PRESENT: ☒Cynthia Binanay, Chair, ☒Christopher Bostock ☒Heidi Carter, ☒George Corvin, MD, Vice-Chair (exited at 6:15 pm) ☐James Edgerton, ☐Greg Ford, ☒Lodies Gloston (via phone), ☒Phillip Golden, ☒Curtis Massey (via phone), ☒George Quick (exited at 6:27 pm), ☒William Stanford, Jr. (exited at 5:35 pm), ☐Amelia Thorpe, ☐Lascel Webley, Jr., and ☐McKinley Wooten, Jr.

GUEST(S) PRESENT: Gary Bass, CEO of Pride, NC; Mary Hutchings, Wake County Finance Department; and Israel Pattison, CFAC Chair

ALLIANCE STAFF PRESENT: Courtney Cantrell, Senior Vice-President/Clinical Operations; Vaughn Crawford, Director of System Engagement; Hank Debnam, Cumberland Site Director/Veterans’ Point of Contact; Joey Dorsett, Senior Vice-President/Chief Information Officer; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Amanda Graham, Senior Vice-President/Operational Effectiveness; Carol Hammett, General Counsel; Veronica Ingram, Executive Assistant; Wes Knepper, Director of Quality Management; Ken Marsh, Medicaid Program Manager; Beth Melcher, Executive Vice-President/Clinical Operations; Ann Oshel, Senior Vice-President/Community Relations; Sara Pacholke, Senior Vice-President/Financial Operations; Brian Perkins, Senior Vice-President/Strategy and Government Relations; Monica Portugal, Chief Compliance Officer; Robert Robinson, Chief Executive Officer; and Doug Wright, Director of Individual and Family Affairs

1. CALL TO ORDER: Chair Cynthia Binanay called the meeting to order at 4:03 p.m.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Announcements</td>
<td>A. Chair Binanay mentioned the one-year anniversary of Hurricane Matthew and the potential impact of multiple hurricanes on our communities. Vaughn Crawford, Director of System Engagement/Alliance Disaster Coordinator, provided an update on disaster planning efforts and what Alliance is doing to prepare staff and provide assistance in our communities (with a goal of ensuring that the people Alliance serves are prepared). She mentioned partnerships with Red Cross and county governments and information to staff about emergency preparedness. Communication to Alliance’s provider network is forthcoming.</td>
</tr>
<tr>
<td></td>
<td>B. Chair Binanay mentioned an upcoming Board meeting at the downtown Durham site. The Board meets each quarter at a community location. The meeting at the Durham site will be postponed until 2018.</td>
</tr>
<tr>
<td></td>
<td>C. All-Staff Training: Mr. Robinson mentioned the upcoming training on Thursday, September 14 at Laurel Hills Park in Raleigh. Board members are invited to attend.</td>
</tr>
<tr>
<td>3. Agenda Adjustments</td>
<td>There were no adjustments to the agenda.</td>
</tr>
<tr>
<td>4. Public Comment</td>
<td>There were no public comments.</td>
</tr>
<tr>
<td>5. Committee Reports</td>
<td>A. Consumer and Family Advisory Committee – 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 included draft minutes from the August 7, 2017, full CFAC meeting and the 2017 annual report.</td>
</tr>
</tbody>
</table>
**AGENDA ITEMS:**

<table>
<thead>
<tr>
<th>DISCUSSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Israel Pattison, CFAC Chair, presented the CFAC report. Mr. Pattison reviewed the schedule for upcoming CFAC meetings and subcommittee meetings. He mentioned that CFAC is emphasizing local meetings; the subcommittee meetings (in each county) will start meeting monthly. He expressed gratitude for sharing Alliance’s disaster plan and the benefit it will provide to the people Alliance serves. Additionally, he shared that CFAC continues to review/revise its by-laws. Doug Wright, Director of Individual and Family Affairs, provided a detailed schedule of local CFAC meetings. Additional information about CFAC meetings can be found on Alliance’s website at <a href="https://www.alliancebhc.org/consumers-families/alliance-cfac/">https://www.alliancebhc.org/consumers-families/alliance-cfac/</a>.</td>
</tr>
</tbody>
</table>

**B. Finance Committee – page 18**

The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Area Board. This month’s report included the draft minutes from the August 3, 2017, meeting, the budget to actual report and ratios for the period ending July 31, 2017.

George Quick, presented the Finance Committee report. Mr. Quick mentioned that State mandated ratios were met. He mentioned one item will be part of closed session. Also, Mr. Quick shared that finance policies were reviewed with no recommended changes; the committee recommends their approval. Mr. Quick mentioned a request to commit $15 million for the previously approved reinvestment plan. Board members clarified the request; this would be for fiscal year 2017 and for the reinvestment plan that the Board previously approved.

**BOARD ACTION**

A motion was made by Mr. George Quick to approve the finance policies; motion seconded by Mr. Chris Bostock. Motion passed unanimously.

A motion was made by Mr. George Quick to designate $15,773,126 as committed funds for Alliance’s reinvestment plan; motion seconded by Mr. Chris Bostock. Motion passed unanimously.

**C. Policy Committee – page 25**

Per Alliance Behavioral Healthcare Area Board Policy “Development of Policies and Procedures”, the Board reviews all policies annually. The Policy Committee reviews a number of policies each quarter in order to meet this requirement. This month’s report included minutes from the August Committee meeting and policies for approval including the by-laws which were submitted last month for consideration.

Curtis Massey, Committee Chair, presented the Policy Committee report. Mr. Massey reviewed the following policies recommended for continued use: **Area Board Conflict of Interest; Management of Service Delivery; Area Board Member Meeting Compensation; Strategic Planning; Evaluation of Area Director; Reporting of Abuse, Neglect, Dependency and Exploitation; Area Board Code of Ethics; Delegation of Authority to the Area Director; Health and Safety; Guidelines for Public Comment at Area Board Meetings; Emergency Management Plan; Internal Control; Area Authority Relations with Catchment Area County Board of Commissioners; Business Continuity Plan; Corporate Communications; Area Board Media Policy and Dispute Resolution.**
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The following policies were submitted with recommended changes: Area Board Processes; Area Director Compensation; Development of Policies and Procedures; Consumer/Family Advisory Committee; and By-Laws. Approval of the proposed revision of the by-laws revision was deferred to the next Board meeting as a super majority was not present.</td>
</tr>
</tbody>
</table>

**BOARD ACTION**

A motion was made by Ms. Lodies Gloston to approve the recommended policies and adopt the new policies submitted as part of the Policy Committee report (with the exclusion of the by-laws); motion seconded by Mr. William Stanford. Motion passed unanimously.

6. Consent Agenda

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Draft Minutes from August 3, 2017, Board Meeting – page 78</td>
<td></td>
</tr>
<tr>
<td>B. Audit and Compliance Committee Report – page 84</td>
<td></td>
</tr>
<tr>
<td>C. Executive Committee Report – page 87</td>
<td></td>
</tr>
<tr>
<td>D. Quality Management Committee Report – page 90</td>
<td></td>
</tr>
</tbody>
</table>

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

**BOARD ACTION**

A motion was made by Vice-Chair George Corvin to adopt the consent agenda; motion seconded by Mr. Christopher Bostock. Motion passed unanimously.

7. Trainings & Presentation(s)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Review of Internal Controls – page 128</td>
<td></td>
</tr>
<tr>
<td>B. FY18 Organizational Goals/Strategic Plan – page 129</td>
<td></td>
</tr>
</tbody>
</table>

**DISCUSSION:**

It is Alliance’s policy to establish internal controls to provide reasonable assurance regarding the achievement of objectives in the following categories: effectiveness and efficiency of operations; reliability of financial reporting; and compliance with applicable laws and regulations. Carol Wolff Hammett, General Counsel, and Monica Portugal, Chief Compliance Officer, presented an overview of internal controls.

Mr. Robinson provided background on why this topic was added to the agenda. Ms. Portugal reviewed external oversight, components of our internal control measures, and corporate integrity responsibilities. Ms. Hammett reviewed the contracting process and how consultant contracts are developing including budget accountability, purchasing process, training, and cross-departmental oversight.

Board members discussed having the Board approve contracts over a specified amount. Mr. Bostock mentioned reviewing this aspect at the next Finance Committee and/or Executive committee meeting. Mr. Quick requested that staff bring a recommendation to the October Finance Committee and then the Finance Committee will bring a recommendation to an upcoming Board meeting.

Alliance has a multi-year strategic plan which supports the Mission and Vision of the organization. Each year key initiatives are identified as priorities. Robert Robinson, CEO, introduced Amanda Graham, SVP/Organizational Effectiveness. Ms. Graham reviewed...
Thursday, September 07, 2017

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

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>four fiscal year 2017 organizational goals, objectives and key initiatives for each goal. Dr. Melcher reviewed current pilots and think tanks under the health outcomes goal. Dr. Hobbs-Knutson reviewed the national trend of value-based contracts with providers.</td>
</tr>
<tr>
<td><strong>BOARD ACTION</strong></td>
<td>The Board accepted the training/presentations; no additional action required.</td>
</tr>
<tr>
<td>8. Updates</td>
<td>Brian Perkins, Senior Vice-President of Strategy and Government Relations, provided a legislative update. Mr. Perkins shared an update summarizing recent actions by the North Carolina Legislature and NC Department of Health and Human Services. He provided an overview of Alliance’s feedback on the DHHS Secretary’s whitepaper and proposal.</td>
</tr>
<tr>
<td><strong>BOARD ACTION</strong></td>
<td>The Board accepted the update; no additional action required.</td>
</tr>
<tr>
<td>9. Chair’s Report</td>
<td>Chair Binanay mentioned additional press with the Wake crisis center and a recent meeting with Wake County Commissioners; she mentioned a commitment from staff and community stakeholders to address concerns, provide additional education and advocate for the people Alliance serves.</td>
</tr>
<tr>
<td>10. Closed Sessions</td>
<td><strong>BOARD ACTION</strong> A motion was made by Mr. Christopher Bostock to enter closed session pursuant to NC General Statute 143-318.11 (a)(5) and 143-318.11 (1) to instruct the public body's staff concerning the position to be taken by or on behalf of the public body in negotiating the price and other material terms of a contract or proposed contract for the acquisition of real property by purchase, option, exchange, or lease and to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1; motion seconded by Commissioner Heidi Carter. Motion passed unanimously.</td>
</tr>
<tr>
<td></td>
<td>The Board returned to open session.</td>
</tr>
<tr>
<td>11. Adjournment</td>
<td>With all business being completed the meeting adjourned at 6:35 p.m.</td>
</tr>
</tbody>
</table>

**Next Board Meeting**
Thursday, October 05, 2017
4:00 – 6:00 pm

Robert Robinson, Chief Executive Officer

Date Approved
ITEM:  County Commissioners Advisory Committee Report

DATE OF BOARD MEETING:  October 5, 2017

BACKGROUND:  As stated in Alliance’s by-laws, the County Commissioner Advisory Committee’s duties include serving as the chief advisory board to the area authority and to the director of the area authority on matters pertaining to the delivery of services for individuals with mental illness, intellectual or other developmental disabilities and substance abuse disorders in the catchment area. The draft minutes from the September 7, 2017 meeting are attached.

REQUEST FOR AREA BOARD ACTION:  Accept the report.

CEO RECOMMENDATION:  Accept the report.

RESOURCE PERSON(S):  Robert Robinson, CEO; Denise Dirks, Administrative Assistant
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – Due to lack of quorum, the Committee did not approve the minutes from the September 1, 2016, meeting. Approval of the minutes has been postponed until the December 7, 2017, meeting.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
</table>
| 3. Board Member Orientation 2.0 | Commissioners need to select a date to complete Board Member Orientation. The training will be about 2 hours long and includes time for questions. The orientation will include:  
  - Governance policies  
  - Statutes (NCGS 122C) and Open Meetings Law  
  - Budget Process  
  - Accessing/Navigating Documents on Board Drive | Veronica Ingram, Executive Assistant, will coordinate orientation date with Commissioners and staff. | None specified. |
| 4. Purpose / Structure of Future CCAC Meetings | The Committee discussed what the Commissioners would most like to accomplish in Committee meetings going forward, and whether the Committee should expand or consider items from other Commissioners. The suggestion was made to extend an invitation to other Commissioners for an annual meeting by Commissioner Carter. Additional feedback will be sought from Commissioner Ford and the Cumberland Commissioner when appointed. Commissioner Carter will solicit feedback from other Commissioners to see if a larger meeting would be feasible, or if other Commissioners might actively participate in creating agenda items in the future. | Mr. Perkins will develop a presentation concerning the process of consumer use of Alliance resources for a future training or meeting; the presentation will include information about Alliance’s relationship with the Durham County CJRC. | None specified. |
**AGENDA ITEMS:**

<table>
<thead>
<tr>
<th>DISCUSSION</th>
<th>NEXT STEPS</th>
<th>TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioner Carter requested information about how consumers access</td>
<td></td>
<td></td>
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<tr>
<td>Alliance’s services, and also about Alliance’s involvement with the Durham</td>
<td></td>
<td></td>
</tr>
<tr>
<td>County Criminal Justice Resource Center.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. **ADJOURNMENT:** the next Committee meeting will be December 7, 2017, at 3:00 p.m.

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

DATE OF BOARD MEETING: September 7, 2017

BACKGROUND: The Executive Committee sets the agenda for Area Board meetings and acts in lieu of the Area Board between meetings. Actions by the Executive Committee are reported to the full Area Board at the next scheduled meeting. Attached are the draft minutes from the September 19, 2017, meeting.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Cynthia Binanay, Area Board Chair; Robert Robinson, CEO
Tuesday, September 19, 2017

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

APPOINTED MEMBERS PRESENT: ☒Cynthia Binanay, M.A., Board Chair; ☒Christopher Bostock, B.S.I.M., Previous Board Chair (via phone), ☒George Corvin, M.D., Board Vice-Chair/Quality Management Committee Chair, ☐James Edgerton, B.S., Finance Committee Chair, ☒Lodies Gloston, M.A., Human Rights Committee Chair, ☒Curtis Massey, J.D., Policy Committee Chair (via phone), ☒Lascel Webley, Jr. (via phone), M.B.A., M.H.A, Audit and Compliance Committee Chair, and ☒McKinley Wooten, Jr., J.D., Network Development and Services Committee Chair (via phone)

BOARD MEMBERS PRESENT: None
GUEST(S): None
STAFF PRESENT: Damali Alston, Director of Network Evaluation (via phone); Denise Dirks, Administrative Assistant; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Carol Hammett, General Counsel; Wes Knepper, Director of Quality Management; and Robert Robinson, CEO

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the August 15, 2017, Executive Committee meeting were reviewed; a motion was made by Ms. Gloston and seconded by Vice-Chair Corvin to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
<th>NEXT STEPS</th>
<th>TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Updates</td>
<td>A. CONTRACT PERFORMANCE MEASURES: Wes Knepper, Quality Management Director, and Damali Alston, Director of Network Evaluation, provided an update on the performance measures.</td>
<td>A. The Committee will review these measures again at next month’s Committee meeting.</td>
<td>A. 10/17/17</td>
</tr>
<tr>
<td></td>
<td>B. MEDICAID REFORM/NC LEGISLATION: Robert Robinson, CEO, shared a legislative update, including an additional item for closed session.</td>
<td>B. None specified.</td>
<td>B. N/A</td>
</tr>
<tr>
<td></td>
<td>C. APPROVAL PROCESS FOR EXPENDITURES OVER A SPECIFIED AMOUNT: Chair Binanay reviewed a topic from the September Board meeting on the Board’s responsibility for reviewing/approving administrative contracts. Additional information was provided by Kelly Goodfellow, Executive Vice-President/Chief Financial Officer. The Committee discussed the approval process, including potential changes to policy, and gave feedback and recommendations to be presented to the Finance Committee at their next meeting. A potential training for Board members regarding this process and potential changes will be considered at a later date.</td>
<td>C. This topic will be presented at the October Finance Committee meeting, with recommendations from the Executive Committee.</td>
<td>C. 10/5/17</td>
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COMMITTEE ACTION:
The Committee received the updates; no additional action required.

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

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<th>Time Frame</th>
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<td>4. Review of Board Applications</td>
<td>Chair Binanay reviewed the current process for reviewing Board applications; she also shared revisions to this process for processing future applications. In the future, Board applications will be distributed first to Compliance and General Counsel for review, then to Chair and Vice-Chair for further review of resumes prior to distribution to the Executive Committee. The Committee reviewed two applications - one for the vacant seat representing Cumberland County and one for a vacant seat representing Wake County. There were no actual or perceived conflicts of interest. <strong>COMMITTEE ACTION:</strong> The Committee decided to contact both applicants to schedule interviews for the next Committee meeting.</td>
<td>Veronica Ingram, Executive Assistant, will contact both applicants to schedule interviews.</td>
<td>Prior to 10/5/17 Board meeting.</td>
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<td>5. August 6, 2015, Area Board Draft Agenda</td>
<td>Committee members reviewed the draft agenda and provided input.</td>
<td>Ms. Dirks will forward the agenda to staff.</td>
<td>9/20/17</td>
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<td>6. Closed Session</td>
<td><strong>COMMITTEE ACTION:</strong> A motion was made by Chair Binanay to enter closed session pursuant to NCGS 143-318.11 (a) (1) and (3) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1 and to consult with and give instructions to an attorney to preserve attorney-client privilege. Motion passed unanimously. Committee returned to open session.</td>
<td>None specified.</td>
<td>N/A</td>
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7. **ADJOURNMENT:** the next Committee meeting will be October 17, 2017, at 4:00 p.m.

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

DATE OF BOARD MEETING: October 5, 2017

BACKGROUND: The committee reviews progress on the agency’s network development plan and progress on service development. The committee reports to the Area Board and provides guidance and feedback on development of the needs and gaps assessment to meet state and agency requirements. This month’s report includes draft minutes and materials from the September 13, 2017, meeting.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): McKinley Wooten, Committee Chair; Beth Melcher, Senior Vice-President/Provider Network and Evaluation
APPOINTED MEMBERS PRESENT: ☒ Heidi Carter, M.P.H., M.S., ☒ George Corvin, M.D., ☐ William Stanford, Jr., J.D., ☒ McKinley Wooten, Jr., J.D. (Committee Chair)
BOARD MEMBERS PRESENT: Cynthia Binanay, M.A.
GUEST(S) PRESENT: Marilyn Avila
STAFF PRESENT: Kate Peterson, Healthcare Network Project Manager; Carlyle Johnson, Director Provider Network Strategic Initiatives

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the July 12, 2017, meeting were reviewed; a motion was made by Dr. Corvin and seconded by Commissioner Carter to approve the minutes. Motion passed unanimously.

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<td>3. Review of Board Policies</td>
<td>The committee reviewed the following current Board Policies associated with the Provider Network: PN-1: Selection and Retention of Providers PN-2: Letters of Support PN-3: Provision of Services by Relatives/Legal Guardians PN-5: Rule Waiver Requests There is currently no policy numbered PN-4, so this list represents all current policies in the ‘Provider Network’ category. Discussion raised several questions for further clarification about Alliance procedures relating to these policies, and suggested follow-up topics for the committee include overviews of Relative as Provider and 1915C/Innovations services. After review and discussion of each policy, the committee voted separately on each and unanimously approved each policy.</td>
<td>Recommendation for approval. Will be considered by Board Policy Committee</td>
<td>Next meeting of Board Policy Committee</td>
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Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
### AGENDA ITEMS:

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**Tiered Case Management**  
Kate Peterson presented information about the Tiered Case Management pilot for high risk youth. This project was initiated in response to a State settlement with the US Department of Justice and is funded through December 2018. The Alliance pilot is being implemented in Durham through a contract with Youth Villages as well as partnerships with juvenile justice and Durham DSS, training through the Center for Child and Family Health, and evaluation by staff at UNC-Greensboro. The pilot is expected to serve approximately 40 youth per year.

Ms. Peterson provided an overview of the care model, which includes three tiers that range from “light touch” to High Intensity Wrap-around services. An important component of the model is the use of a family-driven team approach, by which families are taught how to guide service planning.

The committee discussed sustainability planning, which includes development of a Medicaid ‘in lieu of’ service definition and may require additional advocacy at state and local levels. Committee input included multiple ideas for advocacy at both state and local levels.

- Request additional updates in the future as pilot progresses, and consider additional options for advocacy as needed.

**Topics for November meeting**  
Committee appreciated the update from Ms. Peterson and expressed an interest in additional updates from population workgroups. Request for November is for Dr. Kate Hobbs-Knudson to provide a presentation on the predictive analytics project.

- Request presentation from Dr. Hobbs-Knudson

4. **ADJOURNMENT**: next meeting will be November 8, 2017, from 4:00 p.m. to 5:00 p.m.
I. PURPOSE

The purpose of this policy is to ensure that Alliance Behavioral Healthcare (“Alliance”) complies with Federal and State laws, rules and regulations, contract requirements and national accreditation standards regarding the selection and retention of providers.

II. POLICY STATEMENT

It is the policy of Alliance to select and retain providers based on quality of care, quality of service, the service needs of the catchment area population and business needs of the organization. The goal of Alliance is to develop and maintain a sufficient network of high quality service providers that meets consumer and community needs within available resources and promotes efficiency and the economic viability of network providers. Selected providers must also meet the credentialing and re-credentialing requirements established by Alliance and the North Carolina Department of Health and Human Services.

The North Carolina Medicaid 1915 b/c Waiver permits Alliance to operate a closed network by waiving the provider “freedom of choice” provision in the Social Security Act. The closed network is balanced by Alliance’s responsibility to ensure accessibility of services.

In accordance with 42 CFR 438.214 and the terms and conditions of the Alliance contract with NCDHHS to operate a Prepaid Inpatient Health Plan, Alliance is required to implement provider selection and retention criteria that do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. Criteria may include provider performance and other factors. Alliance shall not employ or contract with providers who are excluded from participation in Federal healthcare programs under either section 1128 or section 1128A of the Social Security Act or who have been terminated by the NC State Medicaid program for any reason.

Alliance will establish a fair, impartial and consistent process for the enrollment and re-enrollment of mental health, intellectual/developmental disability and/or substance abuse (“MH/I-DD/SA”) service providers in the Alliance Closed Network that complies with 42 CFR §438.207 and §438.214.
III. PROCEDURES

The Area Director shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to provide guidance on the issuance of letters of support/acknowledgment for community based projects for persons with mental illness, intellectual/developmental disabilities and substance abuse disorders.

II. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to support the development of community based MH/IDD/SA services. Pursuant to the development of these services, the Area Authority may, from time to time, be asked for a letter of support or acknowledgment for a specific project. Some of these requests may be precipitated by law or regulation which requires Area Authority involvement or knowledge of the project. Irrespective of the reason for the request, the decision to submit a letter of support/acknowledgement shall be based on the service needs of the residents of the catchment area as identified in the Area Authority’s comprehensive planning process.

III. PROCEDURES

The Area Director shall develop procedures for the issuance of letters of support for the various types of projects that might arise. The guiding principle for these procedures shall be the identification of need as reflected in the Area Authority’s comprehensive plan.
I. PURPOSE

The purpose of this policy is to ensure that Alliance Behavioral Healthcare complies with the provisions of the NC Medicaid 1915(c) Innovations Waiver as Alliance reviews and processes requests to employ relatives as providers.

II. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to process requests:

1. from Network Providers to employ relatives/legal guardians (who live in the home of the Innovations Waiver participant) to provide Innovations Waiver services to adult family members; and,

2. from individuals who wish to participate in Individual and Family Directed Supports.

The process for handling such requests shall comply with the policy and regulatory provisions of the Innovations Waiver.

III. PROCEDURES

The Area Director shall develop procedures to implement this policy.
I. PURPOSE

The purpose of this policy is to ensure that Alliance Behavioral Healthcare processes waiver of licensure rule requests made by contracted licensed facilities in a consistent manner. When recommending approval to waive a rule, Alliance must ensure the existence of safeguards to protect the consumers’ health and safety.

II. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to process all rule waiver requests submitted by licensed facilities in the Alliance Provider Network consistently and in compliance with the North Carolina Administrative Code. The Administrative Rule outlines that the decision to grant or deny the waiver request shall be based on the following:

a. The nature and extent of the request;
b. The existence of safeguards to ensure that the health, safety, or welfare of the clients residing in the facility will not be threatened;
c. The determination that the waiver will not affect the health, safety, or welfare of clients residing in the facility;
d. The existence of good cause; and
e. Documentation of LME-MCO governing body approval when requests are from an LME-MCO contract agency.

The Alliance Area Board has delegated authority to the Area Director to approve and deny requests to waive a rule as authorized by Department of Health of Human Services.

III. PROCEDURES

The Area Director shall develop procedures to ensure a consistent approval process of rule waiver requests.
Background Information

• Settlement agreement between North Carolina Department of Health and Human Services (DHHS) and Disability Rights North Carolina (DRNC) on Oct. 2016 to outline a plan to assist children with complex needs and Juvenile Justice or DSS involvement.

• NC Division of MH/DD/SAS posted an RFA for LME/MCO could apply for the Tiered Case Management pilot.
Alliance applied for the grant and was awarded the Tiered Case Management grant for the Wraparound pilot in Durham County in November 2016.
Projects Within Pilot

- Secure Provider, Develop Referral Flow with DSS and JJ.
- Hire Alliance Staff Positions, Family Navigator and Systems Navigator
- Develop workflows with Care Coordination
- Develop Trauma Informed Clinical Assessments
- Create Pilot Evaluation and Data Collection Methods
Tier I

- Light touch Casemanagement
- Connect to provider, services or other needs
- Family Navigator (Family Peer) or Systems Navigator
Tier II

- Moderate touch Casemanagement
- Connect to provider, services or other needs
- Provide Clinical Assessment
- Family Navigator (Family Peer), Systems Navigator or TCM/Assessor from Youth Villages
Tier III

- High Fidelity Wraparound
- Evidence Based Model
- Provider selected through RFA-Youth Villages
The **most important goal** in Wraparound is to prepare the youth and/or family to be able to meet their own needs after Wraparound ends.
Principles for High Fidelity Wraparound

**Family Specific**
- Family Voice & Choice
- Culturally Competent
- Individualized
- Strengths Based
- Unconditional Care

**Team Effort**
- Natural Supports
- Community Based
- Team Based
- Collaboration & Integration
- Outcome Based & Cost Responsible
Team Meeting Based vs. Team Supported

- Natural Support Input
- Family Input
- Professional Input

Team Based Decision

- Family Makes Decision
- Team Supported
- Professional Input
- Family Input

Natural Support Input
Phases of High Fidelity Wraparound

Phase 1 – Engagement & Team Preparation

Phase 2 – Planning

Phase 3 – Implementation

Phase 4 - Transition
Transition Readiness Indicators

1. Identify a Vision, prioritize Needs, establish Goals, and develop Short Term Objectives to reach those goals
2. Effectively advocate for their Needs
3. Navigate the system and access the resources they need as they need them
4. Use their support network to manage their Needs
5. Develop and follow through with a Plan
6. Manage their own crises and behavioral challenges
7. Communicate with and nurture team members
8. Develop and maintain natural supports
High Fidelity Wraparound

Family and Youth Support Partners

- Modeling effective personal interactions and behavior
- Advocating for & supporting families to identify & get met their own needs & vision
- Sharing their own experiences to build relationships & help parents and youth succeed
- Mentoring families and youth to improve their ability to advocate for & manage their own services & supports
- Supporting development, reconnecting & strengthening natural supports systems for families
- Partnering with the Wraparound staff to provide a High Fidelity Wraparound process.
- Supporting the development of Family to Family and Youth to Youth supports.
Milestones

- Partnerships with DJJ, DSS, Easter Seals, Youth Villages, and UNCG
- Implemented Wraparound in Durham Co. with Youth Villages
- Youth Villages received three referrals and enrolled one consumer
- Youth Villages hired and trained one full team by July 1
- Team earned Wraparound certification as required by the State of NC’s grant
- Developed work group to draft service definition
- Developed evaluation team to identify tools to measure success
- Received allocation letter from the State for two positions (Family and System Navigator) currently posted

Upcoming milestones:
- UNCG will hire a project manager and an implementation specialist in September
- Youth Villages to hire second Wraparound team
- Evaluation team identify measuring tool in order to measure outcomes
- New service definition draft in process
Sustainability after the pilot

- Draft Medicaid service definition for HFW in order to use Medicaid
- Develop Family Peer Medicaid Definition
- Develop Scope and Rate for Trauma Informed Assessments
- Collaboration with Dept. of Public Safety, DSS, DJJ in Durham Co. to allocate funds from their budgets towards Wraparound.
Alliance Expected Outcomes

Alliance is expected to help achieve the following definable outcomes:

Child Outcomes
1. Improved clinical outcomes
2. Engaged in school
3. No new legal involvement
4. Living at home/community
5. Reduced use of crisis services
6. Improved caregiver engagement in services (Local monitoring across agencies)

System Outcomes
1. Shorter times from screening to assessment
2. Shorter times from assessment to start of services
3. Shorter time from start of service to first Child and Family Team
4. Improved rates of completion of services
5. Improved connection to community resources
Questions
ITEM: Global Quality Management Committee Report

DATE OF BOARD MEETING: October 5, 2017

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

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

The Global QMC meets at least quarterly each fiscal year and provides ongoing reporting to the Alliance Board. The Global QMC approves the MCO’s annual Quality Improvement Projects, monitors progress in meeting Quality Improvement goals, and provides guidance to staff on QM priorities and projects. Further, the Committee evaluates the effectiveness of the QM Program and reviews and updates the QM Plan annually.

The draft minutes and materials from the September meeting are attached. At the meeting, the committee heard a presentation on the final results from the Area Board surveys—a 100% response rate! Five surveys were received from non-Board members who serve on Board committees. QM staff highlighted several key findings: while there was no improvement in Board member’s perceptions of the quality of services, there was improvement in Board members feeling that they are aware of provider monitoring and are satisfied with Board involvement in organizational stability. QM is recommending that Board hear highlighted reports from Provider Services Committee on provider quality of services

The committee received an update on Alliance’s Quality Improvement Projects. Three are expected to close by the end of the year. There are concerns about two of the projects (Access to
Care and Crisis Services). The QM staff have made recommendations to the Project Advisory Teams and are moving forward with corrective actions.

The committee reviewed the three QM policies. They are recommending changes to the language in the documents from “consumer/enrollee” to “individual or member”. This recommendation will be taken to the Executive Committee.

Additionally, the committee received presentations on appeals, grievances, and incidents. The number of appeals have decreased, while the number of grievances and incidents have increased. Some of the main reasons for the increase in grievances is the change in Innovations services and complaints about the quality of services. The number of more serious (Level 3) incidents increased 13% from FY 16, primarily in Wake County.

Finally, the committee heard an update on the QM Plan and Evaluation. A member asked that the language, similar to the policies, be changed. The committee voted to approve the plan and evaluation, with the change in the language.

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

**CEO RECOMMENDATION:** Accept the report.

**RESOURCE PERSON(S):** George Corvin, Committee Chair, and Wes Knepper, Quality Management Director

(Back to agenda)
VOTING MEMBERS PRESENT: ☒ George Corvin, MD, Chair (Area Board); ☒ Phillip Golden, BA, Co-Chair (Area Board); ☐ William Stanford, Jr. (Area Board); ☐ Lascel Webley, Jr., BS, MBA, MHA (Area Board); ☒ Amelia Thorpe, BA (CFAC/Area Board); ☒ Joe Kilsheimer, MBA (CFAC)

NON-VOTING MEMBERS PRESENT: ☐ Cynthia Binanay (Area Board Chair); ☐ Tim Ferreira, BA (Provider Representative, I/DD); ☒ Jeremy Reed (Provider Representative, MH/SA)

STAFF PRESENT: ☒ May Alexander, MS, LMFT (Quality Assurance Manager); ☒ Tina Howard, MA (Quality Review Manager); ☒ Wes Knepper, LPC (Quality Management Director); ☐ Katherine Knutson (Chief Medical Officer); ☒ Doug Wright (Director Individual & Family Affairs); ☒ Linda Losiniecki, (Administrative Assistant)

GUEST(S) PRESENT: Davida Jones, Appeals Coordinator

REVIEW OF THE MINUTES: GQMC Meeting minutes from August 3, 2017 were read. Joe Kilsheimer motioned that the minutes be approved, Philip Golden seconded the motion. The motion was carried, the minutes were approved by the Committee.

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<td>1. Welcome &amp; Introductions:</td>
<td>Welcome: Chair Dr. Corvin opened the meeting and welcomed guests and committee.</td>
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<td>2. Old Business:</td>
<td>Update on Board Surveys&lt;br&gt;Received 100% responses for the surveys. Overall results of the survey:&lt;br&gt; • Slight decrease in participants reporting that they receive adequate support from Alliance staff&lt;br&gt; • High agreement with statements related to financial accountability and partnerships with community&lt;br&gt; • No change in agreement with statements related to quality of services&lt;br&gt; • Increase in agreement with statements related to provider monitoring and organizational stability&lt;br&gt;Recommendations:&lt;br&gt; • Continue to bring and highlight reports from Provider Services Committee on provider quality of services&lt;br&gt; • Refer concerns about support of Board and Board Committee members to appropriate staff persons</td>
<td>Results will be reported at next month’s Board meeting and Dr. Corvin will present results at Executive Committee&lt;br&gt;Tina to follow up with coworker staffing Board committee</td>
<td>Next month</td>
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<td><strong>QIP Updates (Tina)</strong>&lt;br&gt;There are 9 Active projects. Improving PCPs, Initiation in IDD Services, and First Responder may successfully close by end of calendar year. Of the 9 QIPs, the Crisis QIP for Wake County and Access to Care-Routine/Urgent Care QIP are most concerning. In the Crisis QIP, the intervention does not seem to be impacting results. In the Access to Care, there have been improvements in Routine care, but not enough to meet benchmark. For Urgent care, performance has decreased. Project Advisory Team is moving forward with several interventions to improve performance.</td>
<td>Dr. Corvin will make the recommendation to the Board to change the verbiage</td>
<td>October Board meeting</td>
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<td><strong>QM Policy Review (Committee)</strong>&lt;br&gt;The 3 current Area Board Policies and Procedures were reviewed:&lt;br&gt;  • Consumer, Provider and Stakeholder Satisfaction&lt;br&gt;  • Management and Investigation of Grievances&lt;br&gt;  • Management of Incidents</td>
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<td>The committee suggested to change verbiage within the policies from consumer/enrollee to member/individual.</td>
<td>Tina to provide the committee the average age of I/DD members on the Waiver waitlist.</td>
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<td><strong>Appeals Data (Davida)</strong>&lt;br&gt;Davida presented the data on Appeals for Medicaid. Slight decrease from 2013-2016 for the rate of appeals, down to 5.1%. MH/SA appeals are down, Intensive In-Home Services has the highest rate. I/DD had an increase due the changes within the Innovations Waiver. For I/DD services, Day Supports had the highest appeal rate.</td>
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<td><strong>Grievances &amp; Incidents (May)</strong>&lt;br&gt;<strong>Complaints:</strong> For FY17, of the 940 reported complaints, with 143 regarding Alliance, an increase from 76 in FY16. Most of the issues are related to quality of services. All complaints are required to be resolved within 30 days or less.</td>
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<td><strong>Incidents:</strong> For FY17, there were 2,286 reported incidents, an overall increase of 4% and a 13% increase in Level 3s (serious and permanent harm or death) from FY16. QM began issuing warning letters and Plans of Correction in FY 17 for delayed incident reports.</td>
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3. **New Business:**
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<td><strong>QM Plan and Evaluation:</strong> Wes reviewed the plan and evaluation. Doug Wright recommended that, similar to the policies, language be changed from consumer/enrollee to individual or member. The committee approved the plan and evaluation with that change.</td>
<td>Wes to make that change and resend to committee</td>
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<td><strong>Upcoming Meeting:</strong> October 5, 2017 *(Time: 2:00 – 3:30 pm <strong>Location:</strong> Home Office). November meeting is scheduled to take place at the Johnston office.</td>
<td>Clarify location of December meeting</td>
<td>By next meeting</td>
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<td><strong>Adjournment:</strong> Meeting adjourned at 3:15 p.m.</td>
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Area Board Survey Results

Global Quality Management Committee
September 2017
Methodology

• Electronic version of survey emailed to Area Board members and non-Board Committee members in April

• Deadline extended to increase response rate

• Hard copies handed out at May, June, and August 2017 Board meeting to increase response rate
Results

• 13 surveys from Board members received

• 5 surveys from non-Board members serving on Board Committees received

• Response rate: **100%** from Board members (substantial increase from last year)
1. The Board's roles [or Board Committee's roles] are clearly defined.*

2. I understand my roles and responsibilities as an Alliance Board [or Board Committee] member.*

3. Alliance staff provide sufficient training to ensure the Board members [or Board Committee members] perform their roles and responsibilities.*

4. Alliance staff provide sufficient information and support to the Board [or Board Committee] to adequately perform roles and responsibilities.*

5. Board members develop, review and adopt a Business/Strategic Plan every three years.

*Some statements that include responses from non-Board members (4 in 2016, 5 in 2017) who serve on Board Committees.
1. The Board and Alliance staff have a clear process for setting strategic goals and objectives.

2. The Board regularly monitors and evaluates progress toward strategic goals and objectives outlined in the Strategic Plan.

3. The Board has a defined process to identify major changes needed to improve organizational leadership, structures, programs, or resources.

4. I feel that Alliance's strategic goals and objectives reflect our mission, vision, and values.

% Agreement:

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<th>Year</th>
<th>85%</th>
<th>92%</th>
<th>100%</th>
<th>87%</th>
<th>54%</th>
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<th>88%</th>
<th>56%</th>
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1. NO RESPONSE / NEUTRAL  
   UNABLE TO RATE  
   STRONGLY DISAGREE  
   DISAGREE  
   AGREE  
   STRONGLY AGREE
1. Board members (or Board Committee Members) use the organization's vision, mission and values to monitor provider services.*

2. A wide range of community members participate in providing feedback and evaluating the performance of Alliance’s Board, organization and providers.

3. Our Board regularly seeks feedback from our citizens on the quality and effectiveness of the services they receive.

4. The Board reviews reports on unmet local service needs and provider capacity.
1. The Board uses standard benchmarks to assess financial performance and acts if performance standards are not met.

2. Board members review reports on Alliance's finances.

3. Our Board makes the hard choices and politically unpopular decisions when required or necessary.

4. Our Board ensures finances are closely related to performance expectations and the organization's mission.
5. Our Board makes sure adequate financial tools and resources are in place for the organization to accomplish strategic objectives.

6. Our Board has a long term financial plan.

7. I feel that I have the information and support from Alliance staff to provide fiscal oversight of the organization.
The Board oversees the quality and effectiveness of Alliance's provider network.

Board members regularly review reports that provide performance data on our provider services, using comparable performance data where available.

The Board monitors and evaluates progress toward strategic and program performance goals outlined in Alliance's Strategic Plan.

The Board reviews reports on local performance.

The Board reviews trends in service utilization.

The Board reviews reports on customer service.

Quality and Availability of Services

<table>
<thead>
<tr>
<th>% Agreement:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>NO RESPONSE / NEUTRAL</th>
<th>UNABLE TO RATE</th>
<th>STRONGLY DISAGREE</th>
<th>DISAGREE</th>
<th>AGREE</th>
<th>STRONGLY AGREE</th>
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<tbody>
<tr>
<td>2017</td>
<td>10</td>
<td>4</td>
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<td>2017</td>
<td>6</td>
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<td>2015</td>
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<td>9</td>
<td>9</td>
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<td>9</td>
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<td>2015</td>
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<td>2013</td>
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<td>11</td>
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</tbody>
</table>

1. The Board oversees the quality and effectiveness of Alliance's provider network.
2. Board members regularly review reports that provide performance data on our provider services, using comparable performance data where available.
3. The Board regularly monitors and evaluates progress toward strategic and program performance goals outlined in Alliance's Strategic Plan.
4. The Board reviews reports on local performance.
5. The Board reviews trends in service utilization.
6. The Board reviews reports on customer service.
1. Our Board members represent the community’s interests.

2. Our Board stays informed about important trends in the larger environment that are likely to affect our communities and local governments.

3. The Board listens to people with diverse views, opinions and experiences.

4. Before reaching an important decision this board seeks input from people likely to be affected by the decision.
5. The Board seeks and acquires knowledge that can be used to satisfy the needs of our citizens and communities.

6. If our Board thinks a key constituency or stakeholder group may disagree with an issue we are considering, we will make an effort to hear from them directly before taking action.

7. Our Board seeks information and advice from leaders of similar and related organizations.

8. Relationships among Board members and the public are characterized by openness, trust and mutual respect.

9. Our Board communicates effectively with the county, other community organizations, and local businesses.

Partnerships with Community and Stakeholders (2)

1. Our Board takes responsibility for issues facing the organization.

2. Our Board [or Board Committee] is proactive and addresses issues before they become urgent or critical.*

3. Our Board [or Board Committee] has a clearly defined process to identify major changes needed to improve organizational leadership, structures, programs or resources.*

4. The organization is able to respond and adapt to new opportunities and challenges.*

5. I feel that our process for evaluating the Area Director is clear, fair, and adequately measures expected performance.

*Some statements that include responses from non-Board members (4 in 2016, 5 in 2017) who serve on Board Committees.
Board Committee Processes


1. The committee(s) I serve on have clear goals and objectives.*
2. The committee(s) I serve on are organized well.*
3. The committee(s) I serve on achieve goals promoted by the agency.*
4. I feel the committee(s) I serve on adds value to the agency and community.*
5. I am well informed of committee meetings ahead of time.*
6. I receive information regarding committee topics assists me with making decisions.*

*Statements that include responses from non-Board members (4 in 2016, 5 in 2017) who serve on Board Committees.
Conclusions

• Slight decrease in participants reporting that they receive adequate support from Alliance staff

• High agreement with statements related to financial accountability and partnerships with community

• No change in agreement with statements related to quality of services

• Increase in agreement with statements related to provider monitoring and organizational stability
Recommendations

• Continue to bring and highlight reports from Provider Services Committee on provider quality of services

• Refer concerns about support of Board and Board Committee members to appropriate staff persons
Progress on Action Items from 2016 Survey

• Highest percent of disagreement with statements (in 2016):
  • (Provider Monitoring) Community members provide feedback on Board, Alliance and providers; Board regularly seeks feedback from citizens; and Board reviews reports on unmet local service needs and provider capacity (also had the lowest agreement in 2014 & 2015 surveys)
  • (Quality of services) Board regularly reviews reports on provider performance and Board reviews reports on local performance
  • (Partnerships with Community) Before reaching important decisions, Board seeks input from those impacted, Board reaches out to key stakeholders and leaders of similar organizations
  • (Organizational Stability) Board has clearly defined processes to identify major changes
Progress on Action Items from 2016 Survey

• Action Plan:

  • Bring reports from Provider Services Committee to Area Board meeting (done-created county reports)
  • Provide training to Board on data and quality management (done-March meeting)
  • Consider strategies for seeking additional input from those impact by Board decisions (done-Rob committed in January 2017 to increase outreach to additional stakeholders)
Quality Improvement Projects

Presentation to
Global Quality Management Committee
(September 2017)
Quality Improvement Projects

Executive Summary:

- Open/Active: 9 projects
  - Crisis Services, Access to Care-Routine/Urgent, First Responder, IIH, PCPs, Innovations Initiation in Services, Access to Care-Emergent, Care Coordination, TCLI-Housing
- Closed (conducted post-closure analysis in FY 17): 4
  - IRR (IDD UM), Grievances, UM Call Monitoring-MH/SUD, UM Call Monitoring-IDD
- Hoping to close by end of 2017 (calendar year): 3
  - First Responder, PCPs, Innovations Initiation in Services
Quality Improvement Projects

Successes:

- Improve PCPs – 92% of PCPs reviewed met or partially met health/safety elements
- Initiation in IDD (Innovations) Services – Continue to exceed benchmark of 85% timely care for 3 quarters (100%, 94%, 88%)
- First Responder – Overall, 75% of calls answered satisfactorily, best results since project started in 2012; only one agency referred to Compliance (9 last year)
- UM Call Monitoring – Improvement (93% met) sustained one year after closure, QM to stop monitoring, transition to operational team (UM)
Quality Improvement Projects

Red Flags:

- Crisis QIP (Wake County): Reduction in CAS closures NOT due to intervention - fewer individuals showing to Open Access clinic after regular business hours even though facility is open later every weekday, numbers did start increasing in May

- Access to Care-Routine/Urgent QIP: Continued poor show rate of individuals identified as Urgent showing for care within 2 days, even worse for individuals releasing from incarceration
Detailed Results for Active QIPs
Access to Care - Emergent

Goal:

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

Interventions:

- Revised Mobile Crisis services (start: July 2017, delayed start)
- Improve internal coding and data entry (start: January 2017)
- Conducted another barrier analysis to identify any other interventions that may improve performance (none identified within Alliance’s control)
Access to Care - *Emergent*

**Results:**

<table>
<thead>
<tr>
<th>Baseline (FY16Q4: Apr-Jun 2016)</th>
<th>FY 17, Q1: Jul-Sep 2016</th>
<th>FY 17, Q2: Oct-Dec 2016</th>
<th>FY 17, 3: Jan-Mar 2017</th>
<th>FY 17, Q4: Apr-Jun 2017</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>67%</td>
<td>70%</td>
<td>67%</td>
<td>54%</td>
<td>53%</td>
<td>77%</td>
</tr>
</tbody>
</table>

**Next Steps:**

- Project Advisory Team will meet after implementation of new Mobile Crisis contracts and first data measurement (FY18, Q1)
Access to Care – Urgent/Routine

Goals:

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

Methodology changes for FY 17

- Use only claims submitted to calculate measure due to inaccuracy of Alpha report
- Revised baselines-Routine: FY 16, Q1; Urgent: FY 16, Q4
Access to Care – Urgent/Routine

Interventions-Routine:

- Reminder calls a few days before appointment (start: January 2016)
- Feedback letters to providers (start: February 2017)
- Provider meetings – Alliance met with providers in Durham and Johnston to discuss barriers/solutions; reviewing suggestions (start: Spring 2017)
Access to Care – Urgent/Routine

Interventions-Urgent:

- Expanded hours of Open Access on Friday late afternoons in Wake County (start: April 1, 2017)
- Interventions to improve engagement of CJ population (still gathering data, will decide on interventions in Sept 2017)
- Feedback letters to providers (start: February 2017)
- Provider meetings – Alliance met with providers in Durham and Johnston to discuss barriers/solutions; reviewing suggestions (start: Spring 2017)
Access to Care – Urgent/Routine

Results:

Routine callers:

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Total # of Calls</th>
<th># show in 14</th>
<th>% show in 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 16, Q1 (Jul-Sep 2015)</td>
<td>1,051</td>
<td>424</td>
<td>40%</td>
</tr>
<tr>
<td>FY 16, Q2 (Oct-Dec 2015)</td>
<td>959</td>
<td>430</td>
<td>45%</td>
</tr>
<tr>
<td>FY 16, Q3 (Jan-Mar 2016)</td>
<td>778</td>
<td>370</td>
<td>48%</td>
</tr>
<tr>
<td>FY 16, Q4 (Apr-Jun 2016)</td>
<td>806</td>
<td>361</td>
<td>45%</td>
</tr>
<tr>
<td>FY 17, Q1 (Jul-Sep 2016)</td>
<td>753</td>
<td>370</td>
<td>49%</td>
</tr>
<tr>
<td>FY 17, Q2 (Oct-Dec 2016)</td>
<td>700</td>
<td>309</td>
<td>44%</td>
</tr>
<tr>
<td>FY 17, Q3 (Jan-Mar 2017)</td>
<td>697</td>
<td>357</td>
<td>51%</td>
</tr>
<tr>
<td>FY 17, Q4 (Apr-Jun 2017)*</td>
<td>665</td>
<td>289</td>
<td>43%</td>
</tr>
</tbody>
</table>

- Approximately 87% of appointments made within 14 days of calls (aligning with measures from other states)

*All claims for Q4 most likely not submitted, yet.
At Baseline (FY 16, Quarters 1 & 2), 42% of individuals who called Alliance’s Access & Information Center requesting services received those services within 14 days of the call. The percent increased slightly to 46% of callers in the 1st post-intervention time period (FY 16, Quarters 3 & 4) and 47% in the 2nd post-intervention time period received services in 14 days. Note: not all individuals with routine appointments are being called due to errors in the IT report.*

*Number of matched calls: FY 16 Q3 & 4=674 (of 1,527), FY 17 Q1-2 = 725 (of 1,453)
Impact of Reminder Calls to Individuals with Routine Appointments: By Type of Reminder – Direct Contact with Alliance

Of those individuals who were reminded of their appointment by an Access staff person, 55% attended the appointment within 14 days of the 2016 call. A larger percent attended their appointments in a timely manner in FY 16 (the first six months of 2016), compared to FY 17 (the last six months of 2016).
Impact of Reminder Calls to Individuals with Routine Appointments:
By Type of Reminder – Alliance Left a Message

For all of 2016, 52% of individuals who received a reminder call in their voicemail or via message to friends/family showed for the appointment in 14 days. The percent showing in a timely manner was similar for both halves of 2016.
Impact of Reminder Calls to Individuals with Routine Appointments: No Reminder*

Finally, for those individuals that received no reminder call, either because the Access staff person could not reach them or no attempt was made to make the call, 38% (199) showed for their appointment within 14 days. The percent not showing in a timely manner was slightly greater in FY 16 than FY 17.

*The data does not include the calls in which consumer rescheduled appointment or expressed refusal to attend appointment during the reminder call.
Access to Care – Urgent/Routine

Urgent Callers - Percent Met

The table below compares overall performance based on claims and attendance status:

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Total # of Calls</th>
<th># show in 2</th>
<th>% show in 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 16, Q4 (Apr-Jun 2016)</td>
<td>452</td>
<td>122</td>
<td>27%</td>
</tr>
<tr>
<td>FY 17, Q1 (Jul-Sep 2016)</td>
<td>479</td>
<td>100</td>
<td>21%</td>
</tr>
<tr>
<td>FY 17, Q2 (Oct-Dec 2016)</td>
<td>448</td>
<td>72</td>
<td>16%</td>
</tr>
<tr>
<td>FY 17, Q3 (Jan-Mar 2017)</td>
<td>422</td>
<td>87</td>
<td>21%</td>
</tr>
<tr>
<td>FY 17, Q4 (Apr-Jun 2017)*</td>
<td>439</td>
<td>57</td>
<td>13%</td>
</tr>
</tbody>
</table>

- Provider self-report of attendance is about 10% higher than claims submitted.
- Approximately 65% of Urgent callers receive appointments within 2 days, an increase from 59% at baseline.

*Data not complete, claims run less than 30 days after last call
At Baseline (4th Q of FY 16), only 17% of individuals releasing from incarceration showed for their appointments within 2 days. The performance has decreased throughout FY 17. A small project team has analyzed the quantitative data to identify the population. The vast majority of individuals are releasing from prison with an average length of stay of 1.65 years, about half are indicated as having co-occurring MH/SU disorders. Most referrals come from a few prisons in the state (about 5). The project team decided to conduct interviews with individuals recently incarcerated, prison social workers, and criminal justice partners to determine root causes of low show rate.

In comparison, an average of 21% of callers not releasing from incarceration show for care in 2 days.

*Data not complete, claims run less than 30 days after last call*
Access to Care – Urgent/Routine

Next Steps:

- Continue to conduct reminder calls to all Routine callers, making every effort to contact the consumer or guardian directly.

- Make the reminder calls at different times of the day (even after regular business hours) if it increases the likelihood of making direct contact with consumer or guardian.

- Conduct Multivariate statistical analysis of reminder calls with larger samples sizes to control for confounding variables.

- Analyze impact of expanded Open Access for Urgent callers and feedback letters for Routine & Urgent callers.

- Compile data on post-release population, select interventions.

---

Improve MH/SUD Care Coordination

Goal:
- 80% of individuals assigned to Care Coordinator, and recently discharged from inpatient, receive contact within 2 business days of discharge

Interventions:
- Training/coaching Care Coordination staff, revised desk reference

Next Steps:
- Revised measure to include contact with consumer/guardian
- Baseline data being re-run
Improve Crisis Services

Goals:

- Reduce ED admissions of youth in best practice pilot programs (FCT and Enhanced TFC) in Cumberland County
- Increase the number of consumers utilizing Same Day Access (Tier II) after 3:00 PM by 20%
- Reduce percentage of time that WakeBrook CAS in Wake County is on diversion by 2%
Improve Crisis Services

Interventions (Cumberland):
- Family Centered Treatment (FCT) and Enhanced Therapeutic Foster Care (TFC) pilots

Interventions (Wake):
- Encourage a provider offering Open Access (Tier II) to open after regular business hours

Update:
- Measure #1: Promising results from Cumberland pilots (Baseline: 19%, lower ED/Crisis/Inpatient admissions post discharge)
- Wake: Provider expanded hours of Tier II on April 1, now open until 7 PM on Mondays - Friday (Baseline: 0.24%)
1. Reduction in ED Admits for youth in FCT & ETFC (Cumberland County)

Goal: Less than 5%

- Baseline (April 2015-February 2016): 5/20 (25%)
  *Data measures the number of youth in these services who had an Emergency Department admission during the 90 days prior to their initial service authorization effective date

- Measure #1 (Sept 2015 – Aug 2016): 2/20 (10%)
  *Data measures the number of youth in these services who had an Emergency Department admission 90 days after their last claim date of service (90 days post discharge from the program)
2. Increase # of consumers using Open Access after 3 PM (Wake County)

Goal: At least 8% of total served

Intent behind measure: More individuals, not needing crisis services, are diverted to Open Access clinic instead of going to WakeBrook CAS

- Baseline (Feb - April 2016): 2/831 (.24%)
- Measure #1 (May – Jul 2016): 32/719 (4.45%)
- Measure #2 (Aug – Oct 2016): 14/757 (1.85%)
- Measure #3 (Nov 2016 – Jan 2017): 33/609 (5.42%)
- Measure #4 (Feb – April 2017): 7/189 (3.70%)
- Measure #5 (May – July 2017): 43/374 (11.49%)
## Improve Crisis Services

### 2. Increase # of consumers using Open Access after 3 PM (Wake County) Data Drill-Down:

<table>
<thead>
<tr>
<th>Consumers Presenting (but not admitted) to WakeBrook CAS</th>
<th>3-Month Breakdown</th>
<th>12:00-4:59 000-459</th>
<th>5:00-8:59 500-859</th>
<th>9:00-11:59 900-1159</th>
<th>12:00-2:59 1200-1459</th>
<th>3:00-4:59 1500-1659</th>
<th>5:00-6:59 1700-1859</th>
<th>7:00-8:59 1900-2059</th>
<th>9:00-11:59 2100-2359</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb-Apr 2016</td>
<td>11</td>
<td>28</td>
<td>76</td>
<td>91</td>
<td>42</td>
<td>30</td>
<td>26</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>May-July 2016</td>
<td>16</td>
<td>43</td>
<td>79</td>
<td>88</td>
<td>44</td>
<td>35</td>
<td>28</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Aug-Oct 2016</td>
<td>12</td>
<td>17</td>
<td>69</td>
<td>65</td>
<td>45</td>
<td>35</td>
<td>22</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Nov 2016-Jan 2017</td>
<td>7</td>
<td>19</td>
<td>43</td>
<td>64</td>
<td>47</td>
<td>19</td>
<td>21</td>
<td>19</td>
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<tr>
<td>Feb-Apr 2017</td>
<td>15</td>
<td>25</td>
<td>58</td>
<td>60</td>
<td>36</td>
<td>20</td>
<td>21</td>
<td>38</td>
<td></td>
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<tr>
<td>May-Jul 2017</td>
<td></td>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th># of Individuals presenting to Open Access clinic</th>
<th>Feb-Apr 2016 (Baseline)</th>
<th>May-July 2016 (open until 7PM 1 day/week)</th>
<th>Aug-Oct 2016 (open until 7PM 2 days/wk)</th>
<th>Nov 2016-Jan 2017 (open until 7PM 3 days/wk)</th>
<th>Feb-Apr 2017 (Feb. 1-open late 4 days/week; Apr 1-open all weekdays)</th>
<th>May-Jul 2017 (open late all weekdays)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>not open</td>
<td>not open</td>
<td>not open</td>
<td>not open</td>
<td>not open</td>
<td>not open</td>
</tr>
</tbody>
</table>
2. Increase # of consumers using Open Access after 3 PM (Wake County)

Even though Open Access has continued to expand hours, the number of individuals presenting during those hours, after the initial three months, decreased through May. This provider switched to an “Advanced Access” model in which individuals seeking services can call the clinic to be screened, then given an appointment time. This change resulted in a 69% decrease (from Nov-Jan to Feb-April) of individuals being served. The number served, though, has begun to rebound since May.
Crisis QIP Measures: 3. Reduce % of operating hours that CAS’ back door (IVC) is closed (Wake County)

Goal: 21%; Baseline (Jan-June 2014): 23%
**Crisis QIP Measures: 4. Reduce % of operating hours that CAS’ front door (“full diversion”) is closed (Wake County)**

**Goal:** 13%; Baseline (Jan-June 2014): 15%

Crisis QIP Measures 3. & 4. Reduce % of operating hours that CAS’ front and back doors are closed (Wake County)

• WakeBrook CAS closures have decreased to levels similar to baseline data in FY 14, data for back door:
  • FY16 Q1-Q4, the back door was closed 41% of the time
  • FY17 Q1-Q4 closures decreased to 22% of total operating hours
• The Front door has experienced a decrease as well; FY16: 19%
  FY17: 14%
• Several compounding variables should be considered: Addition of 12 inpatient beds, administration changes, and closer scrutiny from Wake County and Alliance
Improve Crisis Services

Next Steps:

- Network Development meets on a regular basis with provider to discuss low showing at Open Access after regular business hours, Monarch has made a leadership change at Open Access clinic.
- Network Development will schedule meeting with provider and WakeBrook to improve communication between two agencies.
Test crisis lines of providers after business hours

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

**Interventions:**

- Providers assigned to “Tiers” based on last FY’s performance (some called more frequently, others less)
- Written feedback to all providers after calls
- Refer to Compliance the providers who continue to score “unsatisfactory”, issue Plan of Correction if poor performance continues
- Compare test results with actual data of consumers, open to enhanced services, using crisis services
First Responder

Results:

- Overall results represent the highest percent in satisfactory calls since we started project in 2012
- Lowest satisfactory percent for providers offering Substance Use Disorder treatment
- Only one agency referred to Compliance (compared to 9 providers this time last year)

<table>
<thead>
<tr>
<th>Call Cycle</th>
<th>1&lt;sup&gt;st&lt;/sup&gt; Measurement</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; Measurement</th>
<th>3&lt;sup&gt;rd&lt;/sup&gt; Measurement</th>
<th>4&lt;sup&gt;th&lt;/sup&gt; Measurement</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfactory</td>
<td>65% (N=17)</td>
<td>81% (N=34)</td>
<td>78% (N=21)</td>
<td>64% (N=9)</td>
<td>75% (N=82)</td>
</tr>
<tr>
<td>Unsatisfactory</td>
<td>35% (N=9)</td>
<td>19% (N=8)</td>
<td>22% (N=6)</td>
<td>36% (N=5)</td>
<td>25% (N=28)</td>
</tr>
<tr>
<td>Total calls made</td>
<td>26</td>
<td>42</td>
<td>27</td>
<td>14</td>
<td>110</td>
</tr>
</tbody>
</table>
Goals: Reduce use of crisis services, reduce behavioral health interference with daily activities, and decrease severity of mental health symptoms.

Interventions:

- IIH providers to implement specific, family-focused EBP with external fidelity monitoring
- Training and technical assistance to providers
Improve Intensive In Home

Update:

- Evidence based practice models selected, Alliance offered subsidized trainings in June 2016
- Implementation plans included in FY17 contracts, implementation deadline March 2017
- Collect post-intervention data late 2017
Improve Person Centered Plans

Goals:

- at least 55% of health and safety quality elements are met or partially met

Interventions:

- Focus on service lines with fewest health/safety elements met (substance abuse services)
- Reached out to SA providers for input on improving performance, provide targeted training on integrated care, crisis planning
- Revised review tool to expand on health/safety elements
- Reviewed a larger sample of plans to generalize results
Improve Person Centered Plans

Results:

- 92% of PCPs reviewed met or partially met health/safety elements
- Feedback letters to providers on review findings sent
- Project Advisory Team to meet to discuss next steps
Improve Timeliness of Innovations Services

Improve timeliness of services for individuals who recently received Innovations slots

**Goal:**

- 85% receive services within 45 days of plan approval

**Update/Interventions:**

- Project Advisory Team, along with other subject matter experts, conducted comprehensive process map to identify bottlenecks in process
- Educated Care Coordinators on timeliness standards, consistency across sites
- Automated Medicaid C activation in NC Tracks system, updates daily
Improve Timeliness of Innovations Services

Improve Timeliness of Services for IDD Consumers

Results:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 16, Q1</td>
<td>69%</td>
</tr>
<tr>
<td>FY 16, Q2</td>
<td>75%</td>
</tr>
<tr>
<td>FY 16, Q3</td>
<td>77%</td>
</tr>
<tr>
<td>FY 16, Q4</td>
<td>79%</td>
</tr>
<tr>
<td>FY 17, Q1</td>
<td>100%</td>
</tr>
<tr>
<td>FY 17, Q2</td>
<td>94%</td>
</tr>
<tr>
<td>FY 17, Q3</td>
<td>88%</td>
</tr>
</tbody>
</table>

DMA Standard = 85%
TCLI-Increase private housing

Goals:

- Increase the # of housing units available within the private sector
- Increase the # of units that get rented to TCLI pop

Interventions:

- Standardize internal process for housing placements
- Training to property owners on Alliance, housing program, anti-stigma and recovery oriented system of care (measure change in owners’ perception and willingness to rent to our population)
- Centralize/Simplify internal data collection/analysis
- Create marketing campaign
TCLI-Increase private housing

Update:

- Internal process for housing placements standardized
- IT creating a SharePoint site to centralize internal data, new database will include additional data validation controls, allows for simplified data analysis
- Small sub-group creating brochure, landlord packet, and revamped website
- Outreach to landlords – landlords in “preferred” zip codes of Raleigh identified, will receive marketing blast and invitation to attend training (Information Faire), incentives approved for new landlords
Detailed Results for Closed QIPs
Results:

*Post-Closure Analysis Results:*

- **March 2017** – 86% agreement, improvement sustained

**Recommendation:** QM stopped monitoring, transitioned to operational team (UM)
Grievances – Reduce Errors

Post-Closure Analysis Results:

- March – May 2017 – 59% errors

Recommendation: QM stop monitoring, transition to operational team (QM-Grievances)
Part of Mystery Shopper QIP

One year post-closure results: 93% met (June 2017)

Recommendation:

- QM stop monitoring project, transition to operational team
2013 – 2016 Medicaid Appeals Analysis

There continues to be a slight decrease in the rate of appeal from 2015 through 2016. This decrease is attributed to both the decreased number of appeals received and the decreased number of denials from 2015.

There was a significant decrease in the rate of appeals since from 2015 for MH/SA service denials. As the number of denials decreased, appeals of MH/SA services. There has been a significant decrease in the overall number of MH/SA denials since 2013.
For IDD services, the number of appeals have been consistent, yet the rate of appeals to denials has increased by 7.6%. This is likely due to changes in services within the Innovations Waiver and the use of IRC.

**Analysis of Medicaid Most Appealed Services**

**2013 MostAppealed Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>I IH</td>
<td>40</td>
</tr>
<tr>
<td>Psych Testing</td>
<td>30</td>
</tr>
<tr>
<td>IHSB</td>
<td>20</td>
</tr>
<tr>
<td>PSR</td>
<td>10</td>
</tr>
<tr>
<td>Community Support Team</td>
<td>20</td>
</tr>
</tbody>
</table>

**2014 MostAppealed Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>I IH</td>
<td>45</td>
</tr>
<tr>
<td>Psych Testing</td>
<td>40</td>
</tr>
<tr>
<td>IHSB</td>
<td>30</td>
</tr>
<tr>
<td>PSR</td>
<td>20</td>
</tr>
<tr>
<td>PRPF</td>
<td>10</td>
</tr>
<tr>
<td>Community Support Team</td>
<td>25</td>
</tr>
</tbody>
</table>

**2015 MostAppealed Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>IIH</td>
<td>45</td>
</tr>
<tr>
<td>Inpatient</td>
<td>40</td>
</tr>
<tr>
<td>PSR</td>
<td>30</td>
</tr>
<tr>
<td>IHSB</td>
<td>20</td>
</tr>
<tr>
<td>Community Support Team</td>
<td>25</td>
</tr>
</tbody>
</table>

**2016 MostAppealed Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>IIH</td>
<td>25</td>
</tr>
<tr>
<td>Peer Support</td>
<td>20</td>
</tr>
<tr>
<td>PSR</td>
<td>15</td>
</tr>
<tr>
<td>Day Supports</td>
<td>10</td>
</tr>
<tr>
<td>Community Living Support</td>
<td>5</td>
</tr>
</tbody>
</table>
IIH, PSR, and Community Living Support (formerly known as a component of IHSB) continue to remain in the top 5 most appealed services since 2013. Day Supports and Peer Support appeals have most recently increased in the numbers in 2016.
IIH has remained the highest appealed MH/SA service since 2013. PSR and PRTF have also remained in the top 5. Inpatient appeals have decreased since 2015. 80% of all Inpatient appeals requested in 2016 were invalid due to being requested by the provider for billing claims, and not because of a Utilization Management Determination.

### 2016 Inpatient Appeals Resolution Rate

- **Invalid**: 0%
- **Withdrawn**: 0%
- **Upheld**: 80%
- **Partial**: 0%
- **Overturned**: 0%
- **Admin (Upheld)**: 0%

### 2013 I/DD Most Appealed Services

- IHSB: 35
- Community Networking: 10
- IHS: 5
- Day Supports: 1
- Personal Care Services: 1

### 2014 I/DD Most Appealed Services

- IHSB: 35
- Respite: 25
- Community Networking: 10
- Personal Care Services: 5
- Eligibility: 1

### 2015 I/DD Most Appealed Services

- IHSB: 16
- Community Networking: 10
- Day Supports: 5
- Respite: 4
- Eligibility: 3
Day Supports has become the most appealed I/DD service in 2016. Community Networking and In Home Skill Building/Community Living Support have remained in the top 5.
There has been an increase in the rate of outcomes for Upheld decisions during the reconsideration process.
2013 Appeals Not Clinically Reviewed

- Invalid: 22
- Withdrawn: 5
- Admin (upheld): 24

2014 Appeals Not Clinically Reviewed

- Invalid: 24
- Withdrawn: 11
- Admin (upheld): 25

2015 Appeals Not Clinically Reviewed

- Invalid: 24
- Withdrawn: 1
- Admin (upheld): 43
In 2014, the process changed for mailing eligibility letters to better ensure members received notifications and understood the appeals process. There was little change in the number of IDD Eligibility request for appeals, but a significant decrease in modifications appeals over the past year.
State Fair Hearing level appeals

The decrease in State fair hearing parallels the numbers of decreasing requests, denials, and appeals.

Mediation typically resolves 80% of the State fair hearing appeals.
2013- 2016 IPRS Data

There continues to be a significant decrease in the rate of appeal from 2013 through 2016. This decrease is attributed to both the decreased number of appeals received and the decreased number of denials from 2013.

There continues to be a consistent pattern of appeals for services in the Adult population, specifically MH/SA services over the past 4 years.

**All numbers in this report are based on Calendar Year 2016, not Fiscal year 2016.**
FY17 Complaint Analysis

QM Quality Assurance
FY16 vs FY17

- FY16 had 869 entries into the Grievance Portal while FY17 had 940 entries.
- Type of Case Breakdown:

<table>
<thead>
<tr>
<th>TYPE</th>
<th>FY16</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliment</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>External Stakeholder Concern</td>
<td>192</td>
<td>164</td>
</tr>
<tr>
<td>Grievance</td>
<td>374</td>
<td>461</td>
</tr>
<tr>
<td>Internal Employee Concern</td>
<td>294</td>
<td>300</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
Overview

- FY17 yielded 940 entries
- 143 were regarding ABH (FY16 had 76)
- Topics discussed in this report:
  - Nature of Issue
  - Source
  - Service Breakdown
  - ABH Concerns
  - Actions Taken For Confirmed Issues
  - Resolution Status
<table>
<thead>
<tr>
<th>Nature of Issue</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Services</td>
<td>366</td>
</tr>
<tr>
<td>Administrative Issues</td>
<td>102</td>
</tr>
<tr>
<td>Authorization/Payment/Billing</td>
<td>94</td>
</tr>
<tr>
<td>LME/MCO Functions</td>
<td>89</td>
</tr>
<tr>
<td>Access to Services</td>
<td>74</td>
</tr>
<tr>
<td>Abuse, Neglect, Exploitation</td>
<td>59</td>
</tr>
<tr>
<td>Authorization/Payment/Billing-LME-MCO Only</td>
<td>53</td>
</tr>
<tr>
<td>Service Coordination Between Providers</td>
<td>25</td>
</tr>
<tr>
<td>Clients Rights</td>
<td>23</td>
</tr>
<tr>
<td>Confidentiality/HIPAA</td>
<td>22</td>
</tr>
<tr>
<td>Basic Needs</td>
<td>15</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
</tr>
<tr>
<td>Provider Choice</td>
<td>4</td>
</tr>
</tbody>
</table>

**Pie Chart:**
- **Quality of Services:** 39%
- **Administrative Issues:** 11%
- **Authorization/Payment/Billing:** 10%
- **LME/MCO Functions:** 9%
- **Access to Services:** 8%
- **Abuse, Neglect, Exploitation:** 6%
- **Authorization/Payment/Billing-LME-MCO Only:** 6%
- **Service Coordination Between Providers:** 3%
- **Clients Rights:** 2%
- **Confidentiality/HIPAA:** 2%
- **Basic Needs:** 2%
- **Other:** 2%
- **Provider Choice:** 0%
Source

<table>
<thead>
<tr>
<th>Source</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCO Staff</td>
<td>309</td>
</tr>
<tr>
<td>Parent/Guardian</td>
<td>250</td>
</tr>
<tr>
<td>Consumer</td>
<td>210</td>
</tr>
<tr>
<td>Provider</td>
<td>51</td>
</tr>
<tr>
<td>Family Member</td>
<td>48</td>
</tr>
<tr>
<td>Anonymous</td>
<td>36</td>
</tr>
<tr>
<td>Consumer Advocate/Rep.</td>
<td>23</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
</tr>
<tr>
<td>DMH/DD/SAS</td>
<td>1</td>
</tr>
</tbody>
</table>

MCO Staff: 33%
Parent/Guardian: 27%
Consumer: 22%
Provider: 5%
Family Member: 5%
Anonymous: 4%
Consumer Advocate/Rep.: 3%
Other: 1%
DMH/DD/SAS: 0%
MH/SA Service Breakdown

*10% of all complaints, or 96, fell under “unknown,” “not service related,” or “other.”
I/DD Service Breakdown

*10% of all complaints, or 96, fell under “unknown,” “not service related,” or “other.”
ABH Complaints

• 143 entries involved ABH
  • 31 were confirmed issues
    (there was a problem to address)
  • 43 were nonissues
    (there was an issue but ABH followed appropriate policies or procedures in handling the issue)
  • 17 were undetermined
    (the complaint could not be validated or invalidated)
  • 48 were for tracking
  • 4 were compliments
ABH Complaint Actions

The 31 confirmed ABH issues resulted in the following actions:

<table>
<thead>
<tr>
<th>Action</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Actions</td>
<td>18</td>
</tr>
<tr>
<td>Referral and/or TA by an ABH Dept</td>
<td>12</td>
</tr>
<tr>
<td>External Referral (DSS/DHSR)</td>
<td>1</td>
</tr>
</tbody>
</table>

![Bar chart showing the number of concerns for Corrective Actions, Referral and/or TA by an ABH Dept, and External Referral (DSS/DHSR).]
Actions Taken For Confirmed Issues

308 of 940 entries were confirmed issues and resulted in the following actions:

- Provider Initiated Corrective Actions: 244
- Referral and/or TA by an ABH Dept.: 29
- Revert Claims: 13
- External Referral (DSS/DHSR): 10
- Hospital Relations: 6
- Corporate Compliance: 3
- Medical Consult: 2
- Other: 1

Number of Concerns
Resolution Status

All 940 entries were resolved in the following time frames:

<table>
<thead>
<tr>
<th># of Days</th>
<th># of Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15</td>
<td>639</td>
</tr>
<tr>
<td>16-30</td>
<td>244</td>
</tr>
<tr>
<td>&gt;30</td>
<td>57</td>
</tr>
</tbody>
</table>

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

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

• FY 17 had a total of 2826 incident reports for 1450 unique members*

• 2641 Level 2 reports and 185 Level 3 reports

• Overall a 4% increase between FY16 and FY17

• 3% increase Level 2, 13% increase Level 3

* 295 incident reports were for members that did not have Alpha ID’s
Of the 5 children who had 20-29 incident reports – all have been placed in a higher level of care 3 of the 5 are dually diagnosed
Level 2 Incidents MH/SU
FY17 Level 2 Incidents N=2197

- Community Support Team: 3%
- ACTT: 4%
- .5600A Supervised Living Adult MH: 5%
- Therapeutic Foster Care: 5%
- .4300 TROSA: 5%
- MST: 6%
- OPT: 10%
- Intensive In-Home: 19%
- PRTF: 19%
- Child and Adolescent Day Treatment: 13%
- Level 3 Group Home: 11%
Level 3 Incidents MH/SU
FY17 Level 3 Incidents N=155

- OPT 27%
- MST 3%
- Psychosocial Rehabilitation 3%
- TASC 3%
- Peer Support 4%
- ACTT 4%
- Therapeutic Foster Care 4%
- Med Management 6%
- SAIOP 6%
- Community Support Team 7%
- Opioid Treatment 9%
- .5600A Supervised Living Adult MH... 14%
- Intensive In-Home 14%
Level 2 Incidents IDD
FY17 Level 2 Incidents N=442

- Personal Care Services: 3%
- Residential Supports Level 2: 4%
- ADVP: 6%
- In Home Skill Building: 6%
- Day Supports: 11%
- Residential Supports Level 3: 11%
- Residential Supports Level 4: 16%
- ICFDD: 24%
- .5600C Supervised Living Adult IDD: 19%
Level 3 Incidents IDD
FY17 Level 3 Incidents N=30

- Community Living Supports: 3%
- Residential Supports Level 3: 17%
- In Home Skill Building: 17%
- .5600C Supervised Living Adult IDD: 17%
- ICFDD: 10%
- Day Supports: 10%
- Residential Supports Level 2: 7%
- Residential Supports Level 4: 7%
- Personal Care Services: 6%
- Community Guide: 3%
- IPRS IDD Services: 3%
Incident Compliance

During FY 17 QM implemented a plan of correction process to increase provider timely submission of incidents. Providers should submit level 2 incidents within 72 hours of discovery. Level 3 incidents should be verbally reported with in 24 and submitted within 72 hours.

Warning letters are sent if more than 50% of incidents are late within a quarter. If a provider has two quarters in a row with 50% or more late submission they are issued a plan of correction.

FY 17 issued 46 warning letters and one plan of correction.
FY Comparison by County and Level

Cumberland: 371 (Level 2 FY 16) + 23 (Level 3 FY 16)
Durham: 421 (Level 2 FY 16) + 30 (Level 3 FY 16)
Johnston: 154 (Level 2 FY 16) + 9 (Level 3 FY 16)
Wake: 1431 (Level 2 FY 16) + 97 (Level 3 FY 16)

Level 2 FY 17: 688
Level 3 FY 17: 155
Level 2 FY 16: 5
Level 3 FY 16: 5

Total: 1377
FY17 Incident Reporting Trend Analysis – Level 2 Incidents
Level 2 & 3 Incident Definitions

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

- **Level 3 incident categories and behaviors** – all are categorized as any that results in permanent physical or psychological impairment or if there is perceived to be a significant danger to the community
  - Death – Suicide, Accident, Homicide, Unknown, Opioid
  - Restrictive Intervention
  - Consumer Injury
  - Abuse/Neglect/Exploitation – includes all sexual assaults
  - Medication Error
  - Behavior
  - Other
FY 2018 Quality Management Program Description

Revised August 31, 2017
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1. Introduction

a. Description of Alliance

Alliance Behavioral Healthcare is a public-sector managed care organization administering behavioral health services for the North Carolina counties of Cumberland, Durham, Johnston and Wake. Alliance authorizes Medicaid and state funds for members in the Alliance Region who need services for mental health, intellectual/developmental disabilities and substance use/addiction.

Alliance is a multi-county area authority/Local Management Entity (LME) established and operating in accordance with Chapter 122C of the North Carolina General Statutes. Alliance is a political subdivision of the State of North Carolina and an agency of local government. Additionally, Alliance operates as a regional Prepaid Inpatient Health Plan (PIHP) on a capitated risk basis for behavioral health services as described in 42 CFR Part 438.

Alliance is responsible for authorizing, managing, coordinating, facilitating and monitoring the provision of State, Federal and Medicaid-funded MH/IDD/SUD services in Cumberland, Durham, Johnston and Wake Counties. The LME/MCO model developed by the State utilizes a funding strategy that includes single management of all public funding resources through a local public system manager. Under this model, Alliance receives funding from multiple Federal, State and County sources. The financing provides for coordination and blending of funding resources, collaboration with out-of-system resources, appropriate and accountable distribution of resources, and allocation of the most resources to the people with the greatest disabilities. Re-engineering the system away from unnecessary high-cost and institutional use to a community-based system requires that a single entity has the authority to manage the full continuum of care.

Alliance receives funding on a capitated per-member, per-month (PMPM) basis, which covers both treatment services and administrative costs, for the entire Medicaid Network population in the four Alliance counties. Alliance also receives a limited allocation from the Department for State-funded MH/IDD/SA services, and some competitive grant funding.

The North Carolina MH/DD/SAS Health Plan is a prepaid inpatient health plan (PIHP) funded by Medicaid and approved by the Centers for Medicare and Medicaid (CMS). The Health Plan combines two types of waivers: a 1915(b) waiver generally known as a Managed Care/Freedom of Choice Waiver, and a 1915(c) waiver generally known as a Home and Community-Based Waiver.

The NC Innovations Waiver is a 1915(c) Home and Community Based Services (HCBS) Waiver (formerly the Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities). This is a waiver of institutional care. Funds that are typically used to serve a person with intellectual and/or developmental disabilities in an Intermediate Care Facility through this waiver may be used to support the participant outside of the ICF setting.

Alliance manages a variety of County-funded programs, including but not limited to crisis and assessment centers and outpatient walk-in clinics.
b. History of Alliance

On July 1, 2012, The Durham Center and the Wake County LME merged to create Alliance Behavioral Healthcare. The Cumberland and Johnston County LMEs contracted with Alliance to perform a variety of managed care responsibilities in those counties and their citizens became part of the Alliance region. The corporate headquarters near the Research Triangle Park (RTP) began operations and offices were maintained in all four counties to house staff that work closely with local stakeholders.

Alliance began its managed care operations on February 1, 2013 under the Medicaid 1915 (b)/(c) waivers, with responsibility for approximately 186,000 individuals eligible for Medicaid and a total population in excess of 1.7 million. Over 900 providers were credentialed at this point and enrolled initially in the Alliance Provider Network.

In March 2013, Alliance reorganized to create a more integrated infrastructure promoting collaboration and consistency across the organization, enhancing support to the community offices, and creating a single point of accountability for each functional area.

At the end of 2013, the Cumberland County LME was in a process that was largely seamless for the citizens of that county, and its staff became employees of Alliance. At this point, more than 2,000 providers were credentialed in the network.

During the 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 four 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.

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. The management of budget, finance and reimbursement was consolidated under one 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.

Prior to July 1, 2017, the Alliance Quality Management Department was part of the Provider Networks and Evaluation Department, with the QM Director reporting to the Chief of Provider Network Evaluation and Development. Beginning July 1, 2017, Alliance implemented a broad reorganization that created
three divisions: Care Management, Organizational Performance, and Business Operations. The Alliance Quality Management Department was repositioned as part of the Organizational Performance Division, with the QM Director reporting to the newly created position of Chief Operating Officer.

In that reorganization Alliance created a Network Evaluation unit in order to partner with providers to develop, enforce, and build upon quality standards in provider contracts. These efforts will result in enhance quality of care to the individuals receiving care in Alliance’s network.

c. Alliance’s Mission

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

d. Alliance’s Vision

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

e. 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.

f. Alliance Customers

Alliance’s coverage area includes a total population of 1,800,902. By far the largest county by population is Wake, exceeding the population of the other three counties combined. Wake and Durham are the most densely populated counties, reflecting their more urbanized settings. Johnston is the least densely populated county.
Population by County in Alliance Catchment Area

<table>
<thead>
<tr>
<th>County</th>
<th>Population</th>
<th>Square Miles</th>
<th>Persons per Square Mile</th>
<th>Medicaid Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland</td>
<td>333,073</td>
<td>652</td>
<td>510.8</td>
<td>66,382</td>
</tr>
<tr>
<td>Durham</td>
<td>303,416</td>
<td>286</td>
<td>1060.9</td>
<td>43,049</td>
</tr>
<tr>
<td>Johnston</td>
<td>186,764</td>
<td>791</td>
<td>236.1</td>
<td>32,079</td>
</tr>
<tr>
<td>Wake</td>
<td>1,025,434</td>
<td>835</td>
<td>1228.1</td>
<td>101,161</td>
</tr>
<tr>
<td>Alliance Total</td>
<td>1,848,687</td>
<td>2564</td>
<td>721.0</td>
<td>242,671</td>
</tr>
</tbody>
</table>

The service area includes both urban and rural areas but the majority of the population lives in urban areas. Because of the proximity to relatively dense population areas such as Raleigh, Durham and Fayetteville, all Alliance counties are classified as ‘metropolitan/urban’ counties according to United States Office of Management and Budget criteria.

The four counties that make up Alliance Behavioral Healthcare are racially and ethnically diverse. Across the Alliance area, the primary ethnic group is Caucasian followed by Black and Hispanic/Latino. There is some variability across region, however. Johnston has a higher percentage of white population, with Black and Hispanic/Latino populations roughly the same percentage. Compared to the state average, Alliance has a higher percentage of Hispanic/Latino population with Durham and Johnston having the highest percentage in the Alliance area.

Race by County in Alliance’s Catchment Area

<table>
<thead>
<tr>
<th>County</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>American Indian</th>
<th>Native Hawaiian and Pacific Islander</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland</td>
<td>51.4%</td>
<td>36.7%</td>
<td>2.2%</td>
<td>1.6%</td>
<td>0.4%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Durham</td>
<td>46.4%</td>
<td>38.0%</td>
<td>4.6%</td>
<td>0.5%</td>
<td>0.1%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Johnston</td>
<td>74.2%</td>
<td>15.1%</td>
<td>0.6%</td>
<td>0.6%</td>
<td>0.0%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Wake</td>
<td>66.3%</td>
<td>20.7%</td>
<td>5.4%</td>
<td>0.5%</td>
<td>0.0%</td>
<td>4.5%</td>
</tr>
<tr>
<td>North Carolina</td>
<td>68.5%</td>
<td>21.5%</td>
<td>2.2%</td>
<td>1.3%</td>
<td>0.1%</td>
<td>4.3%</td>
</tr>
</tbody>
</table>

Source: 2010 Census Data

Ethnicity by County in Alliance’s Catchment Area

<table>
<thead>
<tr>
<th>County</th>
<th>Hispanic or Latino</th>
<th>Non-Hispanic or Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland</td>
<td>52.5%</td>
<td>47.5%</td>
</tr>
<tr>
<td>Durham</td>
<td>49.1%</td>
<td>50.9%</td>
</tr>
<tr>
<td>Johnston</td>
<td>32.6%</td>
<td>67.4%</td>
</tr>
<tr>
<td>Wake</td>
<td>76.3%</td>
<td>23.7%</td>
</tr>
<tr>
<td>North Carolina</td>
<td>85.6%</td>
<td>14.4%</td>
</tr>
</tbody>
</table>

Source: 2010 Census Data

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.

g. 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. Alliance has credentialed providers and most organization types available in each county, as well as prescribers and licensed practitioners. Providers by categories are as follows:

- 1,613 licensed professionals
- 249 agencies
- 285 outpatient practices
- 36 Hospitals/Residential Treatment Facilities

Services available in the network include a broad array of Medicaid and State-funded care, and providers served 45,500 Medicaid consumers and 18,767 with State funds in FY 2016.

The following charts provides a summary of service expenditures for FY17:
Contracts between Alliance and MH/IDD/SA providers create reciprocal partnerships designed to ensure an integrated system of quality services and supports is available to Cumberland, Durham, Johnston and Wake County residents. All contracts between Alliance and providers contain requirements that promote person and family-centered treatment, sound clinical and business practices, and delivery of high quality services within Alliance’s System of Care.

As the Alliance system of care evolves, Alliance will use performance indicators, outcome measures and other factors to determine selection and retention of providers in its network; however, consumer access to care will remain the primary determining factor.

The continual self-assessment of services, operations, and implementation of Quality Improvement Plans to improve outcomes to consumers is a value and expectation that Alliance extends to its providers. Providers are required to be in compliance with all quality assurance and improvement standards outlined in North Carolina Administrative Code as well as in the Alliance Contract. These items include:

- The establishment of a formal continuous Quality Improvement Committee to evaluate services, plan for improvements, assess progress made towards goals, and implement quality improvement projects and follow through with recommendations from the projects. This does not apply to LIPs.
- The assessment of need as well as the determination of areas for improvement should be based on accurate, timely, and valid data. The provider’s improvement system, as well as systems used to assess services, will be evaluated by Alliance at the provider’s qualifying review.
- The submissions of accurate and timely data, as requested, including claims for services delivered, no later than the deadline set by Alliance. Assessment of program fidelity, effectiveness, and efficacy shall be derived from data and any data requested. Providers shall be prepared to submit any and all data, reports, and data analysis upon request.
- Meeting performance standards set by Alliance and by the NC Health and Human Services for behavioral health services.
While these items have not changed, Alliance’s efforts toward enhancing provider performance have evolved. With the creation of the Network Evaluation unit Alliance is poised to work more closely with providers to develop, enforce, and build upon quality standards in provider contracts. This focus allows Alliance and its network providers to remain focused on improving care for the individuals we serve.

2. Purpose of the Alliance Quality Program

Quality Management plays a major role in ensuring Alliance 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 meet a variety of Quality Management requirements. These are set by Alliance’s contracts with the state of North Carolina; by the federal government’s Medicaid waiver process; and by the URAC accreditation requirements.

Alliance also must ensure that its employees and providers 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 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.

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

3. Purpose of the Quality Management Plan

The Quality Management 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. It also 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 program plays a major role in ensuring Alliance is successful at meeting performance outcomes and contract requirements. The goals listed below are of particular focus to the QM staff and organization-wide QM activities.

- To ensure individual consumers receive services that are appropriate and timely;
To transition local systems toward treatment with effective practices that result in real life recovery outcomes for people with disabilities, as possible;

To provide for easy access to the System of Care;

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;

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;

To empower Alliance 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

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

Alliance’s Quality Management program is based on the principles of Continuous Quality Improvement. These principles are confirmed and improved via accreditation by URAC.

a. Continuous Quality Improvement

Alliance’s quality program begins with Quality Assurance (QA), which is a major activity of Alliance’s QM Department. QA involves ongoing activities that ensure compliance with rules, regulations, and requirements. Examples of the QA activities conducted by Alliance include internal audits or reviews, performance measurement, provider monitoring, and consumer satisfaction surveys.

QA allows Alliance to identify opportunities for Quality Improvement (QI), which involves continuously monitoring, analyzing, and improving of systems and procedures throughout the agency, i.e., “Continuous Quality Improvement” or CQI.

Alliance has implemented a Plan/Do/Study/Act model for CQI:

- Plan: how you plan to accomplish your goals
- Do: implement procedures for reaching goals
- Study: use data to determine effectiveness
- Act: modify procedures as needed to reach goals more effectively

A goal of the CQI process is ensuring quality Care for Consumers. This is achieved by:

- Evaluating evidence-based practices
- Ensuring equal/easy access to services
- Maintaining client rights
- Obtaining consumer feedback
- Aligning agency policies and procedures with Federal, State, contract and accreditation expectations

Another goal of the CQI process is contributing to Alliance’s viability as an ongoing organization. This is done via:

- Risk management
- Using data and outcomes measures to gauge success
- Constant data analysis results in higher-quality services

b. 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 the Alliance CQI Committee and its various subcommittees.

a. Board of Directors
Alliance is governed by a Board of Directors which is responsible for overseeing the operations of Alliance and its efforts to provide effective services for children and adults with psychiatric, intellectual/developmental disabilities, or substance use/addiction needs. The Alliance Board consists of community stakeholders that are appointed by their respective County Commissioners, and the Board selects one additional member from Johnston County, which has a contract with Alliance to manage services in that county. Service providers cannot serve as Board members.

b. 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 the QM Plan annually.

c. 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.

The current CQI subcommittees are:

- Budget and Finance
- Clinical Care Management
- Community Relations
- Compliance
- Information Technology
- Provider Networks Management
- Utilization Management
Each CQI committee has created a charter defining its purpose, responsibilities, relationships and membership (see Appendix A). Responsibilities include developing data and reports on the committee’s areas of responsibility; identifying risks and opportunities; reporting these risks/opportunities to the CQI Committee; and updating the CQI Committee on progress towards resolving the identified issues.

d. 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.

**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. Alliance will undergo its next EQR in January 2018.

**URAC:** Alliance is accredited by URAC in the areas of Health Network, Utilization Management, Health Call Center and Credentialing (recently received in August 2014). URAC required reaccreditation reviews every three years and conducts compliance checks more frequently. During FY 2018, Alliance will undergo reaccreditation by URAC for all modules.

7. QM Department Organization

The Alliance QM Department consists of a QM Director, who oversees two teams: Quality Review and Quality Assurance. In addition, the QM Director oversees a Statistical Research Assistant.

The QM Director reports directly to the Chief Operating Officer. 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 five Quality Review Coordinators.

**Quality Assurance:** The QM Quality Assurance 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 Quality Assurance Manager. Quality Assurance ensures that analyses and reports are accurate and professional with charts/graphs to facilitate stakeholder input and decision making. The Quality Assurance Manager works closely with the IT Department to facilitate implementation of reports to be automated. As requested, the Quality Assurance 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 Quality Assurance Manager ensures contract requirements for Innovations Health and Safety measures, NC-SNAP, NC-TOPPS, incidents, and complaints. The Quality Assurance Manager responsible for overall supervision of the team. The Quality Assurance Manager currently oversees a team of seven Quality Assurance Analysts.

**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, DHSR 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 and Reporting 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 AlphaMCS 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 III 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. During FY 2017, Alliance expanded its internal reporting capabilities via contracts with CMT and MicroStrategy. CMT provides reports combining Alliance’s encounter data with pharmaceutical and primary care data for Alliance’s consumers. MicroStrategy provides advanced analytic tools allowing a broad range of reporting.

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 and stakeholders. All Alliance stakeholders – from each staff member, to whole departments, to consumers and providers, to the Alliance Board - contribute to the CQI process.

a. Alliance Staff

During its first four years of operation, Alliance grew from a professional staff of 142 to nearly 450 working at its corporate site in Durham, a dedicated call center facility, and four county offices. The QM Department routinely informs staff of quality-related development via updates at all-staff meetings, posting on Alliance SharePoint sites, and updated policies and procedures.

b. Departments

Administration: Alliance's Administration Department is led by the Alliance Chief Executive Officer 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 Executive Leadership Team by the Chief Operating Officer.

Organizational Effectiveness: The Organizational Effectiveness department includes the Strategic Project Management Office, Communications, and Organizational Learning and Development. The QM department has regular meetings with these groups in order to collaborate on enterprise strategic initiatives from the strategic plan.

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 and QM staff meet regularly to review quality activities.

Networks Development and Evaluation Department: In FY 17 the Network Evaluation Team was created in the Provider Network and Evaluation Department. Network Evaluation team is responsible for
reviewing provider contracts, identifying quality issues with providers undergoing recredentialing, and conducting program evaluation studies. QM and the Network Evaluation team work collaboratively to ensure quality concerns are actively addressed and monitored within the Alliance provider network. The Network Evaluation team ensures that Alliance providers are meeting the performance standards and Outcome Measures as set-forth in their contracts. During FY 17 Provider Monitoring became a function of the Network Evaluation team. QM works closely with Provider Monitoring by informing provider Quality of Care issues for monitoring purposes.

**Utilization Management Department:** Alliance's UM Department reviews and approves Service Authorization Requests (SARs) from providers for Medicaid, IDD and IPRS 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.

**Business Operations:** 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 participating 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 Office of Compliance encourages ethical and sound ways to do business in compliance with federal and state law, contractual requirements, policies and accreditation standards. Compliance
provides training and manages Alliance’s policies and procedures, conducts internal audits, monitoring and investigations to prevent, detect and remediate non-compliance. The Office of Compliance Program Integrity Unit conducts fraud and abuse prevention and detection activities and reports suspected credible allegations of fraud to DMA PI. 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.

c. Consumers
Consumers are represented at Alliance via the Consumer and Family Advisory Committee, or CFAC, which 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.

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.

Quality Management Department staff routinely update all CFAC members on Alliance’s quality improvement activities. Two CFAC members also serve as voting members on the Board’s Global Quality Management Committee.

d. Providers
The Alliance Provider Advisory Council (APAC) includes representatives from each county within the Alliance catchment area and all age and disability areas. The APAC provides input to Alliance on development and implementation of its Local Business Plan, identification of needs and gaps, and other areas in which provider input is critical. The APAC also coordinates provider feedback from local Provider Advisory Councils in each county.

Quality Management Department staff routinely updates APC on Alliance’s quality improvement activities that impact providers. Two providers serve as non-voting members of the Board’s Global Quality Management Committee. In addition, the QM Department enrolls providers to participate on advisory committees for quality improvement programs that can benefit from provider input.

The QM Department also informs providers of its activities via presentations at All-Provider meetings, notices in provider communications, and postings on the Alliance web site. QM staff also provides technical assistance for providers on NC-TOPPS and IRIS submissions, and the creation of quality management plans.

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.

a. 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. Federal regulations also set requirements for QIPs:

- **URAC:** Alliance must conduct two QIPs for each module for which Alliance accredited: Core, Call Center, Health Utilization Management, and Health Network. A QIP can focus on more than one module. One QIP must focus on consumer safety.

- **State Contracts:** Alliance must conduct at least 3 QIPs, of which at least one must be clinical and at least one non-clinical. QIPs shall focus on reducing the need for inpatient at community hospitals, and reducing the use of crisis and Emergency Department services.

- **Federal regulations:** QIPs can be clinical or non-clinical, must impact health or functional status, and reflect high-volume or high-risk populations. Examples include access to care, grievances, appeals and children with special health care needs.

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.

QIPs are identified by tracking routine performance reports, conducting special quality reviews, reviewing reports from Alliance’s CQI subcommittees, and surveying Alliance staff, providers and consumers/families.

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.

Each QIP is managed by a QM Department staff member who serves as Project Lead. Decisions are made by a dedicated Project Advisory Team consisting of subject matter experts. The team includes a member of Alliance’s Medical Affairs department if the QIP addresses clinical issues.

**FY 2018 QIPs**

Alliance will have nine active QIPs during FY 2018:

- **Access to Care (Routine & Urgent)** – Improve % of consumers who show for first appointment based on need;
- **Access to Care (Emergent)** - Increase % of consumers who show for emergency services within 2:15 hours of state of call requesting services;
- **Care Coordination (MHSUD)** – Improve % of Care Coordination contacts within 2 business days of assignment to case;
- **Crisis Services QIP** – Reduce admissions to Emergency Departments for primarily behavioral health reasons in Cumberland for a high risk adolescent population and reduce closures of the crisis and assessment services in Wake Counties;
• First Responder – Improve enhanced providers’ responses to consumers in crisis; Intensive In-Home – Improve outcomes of youth receiving Intensive In-Home services;
• Improve Person-Centered Plans – Improve quality of MH/SUD person-centered plans focusing on health/safety elements;
• Initiation in Innovations Services – Increase % of new Innovations consumers who receive first service within 45 days of plan approval;
• TCLI Project – Increase number of individuals in TCLI population who move into private housing in Wake County

b. 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.

PIPs under way for FY 2018 include:

• Veterans Study – study & improvement of identification of veterans who call Access & Information Center.
• Care Reviews – streamlined application process and reporting database.
• Community Collaborative – Assessed effectiveness of Collaborative groups using Collective Impact (best practice) tools.
• School-Based Care Coordination - program involves providing Care Coordination for students attending Wake County Public Schools who are identified as needing behavioral health and academic support, created data analysis plan, pulled and analyzed data on performance, identified opportunity for improvement in timeliness of assessments, Team implemented solution, data is in process of being re-evaluated to determine if solution improved performance.
• SIS Resource Allocation process – Created process and quality assurance system to ensure new state requirement for sending SIS Resource Allocation letters to individuals and their families was accurate and complete.
• Performance Metrics for UM – Identified qualitative metrics to measure quality of UM reviews, created data analysis plan, and draft review tool. Review and improvement plan to take place in FY 18.
• Staying Well Initiative – New initiative operated by Individual and Family Affairs unit, involved contacting individuals who received Care Coordination services to determine impact. Created data tracking tool and analysis plan for unit. Trained co-workers on using data tracking tool and quality assurance system.

c. Clinical Practice Guidelines:
Alliance uses clinical guidelines that have been reviewed by the Alliance Clinical Advisory Committee and approved for use by the medical director as part of the medical necessity determination process.

The QM Department has developed process to assess provider compliance with the clinical practice guidelines adopted by Alliance. This process involves: identifying two or more milestone elements in a clinical practice guideline; determining provider compliance via data analysis or record reviews;
informing providers of any compliance issues via training and other communications; and identifying outlier providers for focused training.

In FY 2018, the QM Department will focus on provider compliance with clinical practice guidelines for opioid prescribing and will continue to follow up on the two previous best practice recommendations: (1) ADHD in children and (2) schizophrenia in adults.

d. 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.

Quality reviews to be conducted by QM staff during FY 2018 will focus on URAC accredited areas: Delegation – URAC (ProtoCall and PREST) and Call Center standards (#10, 13, 15, and 16. Also review Individual Service Plans for Innovations consumers as part of Innovations Performance Measures.

e. 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.

f. 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.

g. 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 EQR process. The QM Department works with the relevant departments and committees to develop, implement and track improvements identified in the survey results.

h. Provider Network
Alliance is required under its state contract to conduct an annual evaluation of its provider network. The evaluation must identify any gaps in coverage or choice for consumers. Alliance’s Provider Network Department then creates an annual development plan based on the evaluation’s findings.

QM staff support the evaluation process via analysis of provider locations and consumer access, and the creation of “geomaps” illustrate gaps in coverage.
Also at the request of the Provider Network Department, QM staff conducts numerous evaluations of provider programs to further assess the effectiveness of Alliance’s provider network. During FY 2018, for example, QM staff will be evaluating pilot programs for enhanced Intensive In-Home services, and the effectiveness of a new Rapid Response program for youths.

12. Grievances

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.

Examples of a grievance may include but are not limited to grievances about quality of care, failure of the provider or Alliance to follow Client Rights Rules; failure of providers to provide services in the consumer’s PCP or ISP including emergency services noted in the crisis plan and interpersonal issues such as being treated rudely. Consumers, or a network provider authorized in writing to act on behalf of a consumer, may file a grievance.

The QM Department's Data Management Team is responsible for processing grievances submitted from within and outside Alliance. Grievances first are designated as Medicaid-related or non-Medicaid-related depending on consumer eligibility.

Medicaid: QM staff will notify, in writing by U.S. mail, the complainant within five (5) working days of receiving the grievance to acknowledge receipt of the grievance and communicate whether the grievance will be initially addressed informally or by conducting an investigation. Alliance’s initial response to a grievance shall be to attempt to resolve the issue through informal dialogue and to reach agreement between the parties.

Alliance will seek to resolve grievances expeditiously and provide written notice by U.S. mail to all affected parties no later than ninety (90) calendar days of the date Alliance received the grievance. Alliance may extend the timeframe by up to fourteen (14) calendar days if the client requests extension or there is a need for additional information and the delay is in the best interest of the client.

Non-Medicaid: QM staff will notify in writing by U.S. mail the complainant within five (5) working days of receiving the grievance regarding whether the grievance will be initially addressed informally or by conducting an investigation. Alliance’s initial response to a grievance shall be to attempt to resolve the issue through informal dialogue and to reach agreement between the parties. Alliance will seek to resolve grievances expeditiously and provide written notice by U.S. mail to all affected parties no later than fifteen (15) calendar days of the date Alliance received the grievance. If the grievance is not resolved within fifteen (15) working days, then QM staff will send a letter to the complainant updating progress on the grievance resolution and the anticipated resolution date.

13. Incidents

Providers must implement procedures that ensure the review, investigation, and follow up for each incident that occurs through the Providers’ internal quality management process. This includes:

- A review of all incidents on an ongoing basis to monitor for trends and patterns.
• Strategies aimed at the reduction/elimination of trends/patterns.
• Documentation of the efforts toward improvement as well as an evaluation of ongoing progress.
• Internal root cause analyses on any deaths that occur.
• Mandatory reporting requirements are followed.
• Entering Level II and III incidents into the State’s Incident Response Improvement System (IRIS).

An incident is an event at a facility or in a service/support that is likely to lead to adverse effects upon a consumer. Incidents are classified into several categories according to the severity of the incident. 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 also must 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.

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 network.

Upon receipt, QM staff reviews all incidents for completeness, appropriateness of interventions and achievement of short and long term follow up both for the individual consumer, as well as the Provider’s service system. If questions/concerns are noted when reviewing the incident report, QM staff will work with the provider to resolve these.

If concerns are raised related to consumer’s care, services, or the provider’s response to an incident, an onsite review of the Provider may be arranged. If deficiencies are found during the review process, the provider will be required to submit and implement a plan of correction. QM staff will provide technical assistance as needed and appropriate to assist the Provider to address the areas of deficiency and implement the plan.

14. Provider Monitoring

Alliance is required under its state contract to routinely monitor its providers to assure compliance with state and federal regulations, and patient rights requirements. Prior to July 1, 2017, Alliance’s Provider Monitoring team was part of the QM Department. Under the most recent reorganization, Provider Monitoring is part of the Provider Network Department.

The QM Department continues to work closely with Provider Monitoring. Most importantly, the QM Department is responsible for recommending a special provider monitoring when QM has found a series of grievances or incidents that raise issues of provider performance or consumer safety.

15. Over/Under Utilization

Service over/under utilization may indicate poor quality and potentially inefficient care. To ensure the appropriate provision of services, Alliance implements a program that monitors a broad range of data to determine variations in the use of service across providers and levels of care. The UM Committee, a CQI subcommittee, and Clinical operations leadership are responsible for detecting over and under-utilization and analyze claims (encounter) data and authorization data on a monthly basis to determine
utilization patterns. Data analysis will identify the potential need for further review. Data reviewed includes:

- Average Length of stay in inpatient and residential facilities
- Provider treating multiple family members individually
- Consumers receiving multiple services
- High cost/high utilized service trends
- Low use of evidenced based services
- Inpatient Readmissions
- High volume of authorized units compared to billing
- Higher than average costs per treatment episodes

In the event that data analyses identify questionable patterns, Alliance may contact Providers to review their medical records in order to identify the reasons particular practice patterns are different from the norm. Although this could be a function of the Provider’s case mix severity, it could also indicate potential problems that need to be resolved.

Clinical Operations leadership may refer to the UR Manager for a record review or may refer cases to the Compliance Department for a further review. Responses to validated utilization issues include, training and technical assistance, increased monitoring or referral to the Special Investigations unit if the over-utilization appears to be driven by wasteful practice of fraudulent billing. Alliance also may initiate internal action plans to ensure more appropriate service management by the clinical operations department if utilization issues are related to poor oversight and care coordination.

16. Training

Alliance provides timely and reasonable training and technical assistance to providers on a regular basis in the areas of State mandates and initiatives, or as a result of monitoring activities related to services for which the provider has a contract with Alliance. A wide variety of links to web-based resources of potential interest to the Provider Network can be found on the Alliance website at:

https://www.alliancebhc.org/providers/provider-resources/videoswebinars/

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 2017, the QM Department provided training for Alliance staff on Microsoft Excel for basic data collection and analysis projects. Internal staff were also trained on complaints and grievance submissions. The QM Department also trained providers on PCP/Crisis Plan development, QM program development, Plan of Corrections, Cultural Competency Plan requirements, NC-TOPPS reporting, and Incident Reporting.
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 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:
- Chief Executive Officer
- Associate Medical Director
- Chief Medical Officer
- Chief Operations Officer
- Senior VP- Organizational Effectiveness

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• Chief Compliance Officer
• Senior VP Clinical Operations
• Chief of Network Development and Evaluation
• Chief Finance Officer
• Chief Information Officer
• Director of Quality Management
• Medicaid Program Director
• Senior VP- Community Relations
• Director of Individual and Family Affairs
• Director of Network Evaluation

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
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:
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:

Quarterly Reports (may include for example):

- Exclusions Checks
- Billing Audits Scores by Provider
- Summary of Claims Audits
- HIPAA Activities and Actions
- Internal Audits and Results
- Grievances Trends (by region, type, provider, etc.)
- POC Trends (by region, type, provider, etc.)

Provider Violations Review, Sanctions and Recoupment:

- Fraud, Waste, and Abuse
- Health and Safety
- Quality of Care
- Integrity of documentation and billing practices

Credible Allegations of Fraud (if allowed to be reported)

- DMA action
- 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:
Senior Psychologist
Chief of Network Development and Evaluation
Quality Management Data Manager
Medicaid Program Director
Chief Financial Officer
Director of Customer Services

6. Information Technology Strategic Prioritization Committee

Purpose

The purpose of the Information Technology Strategic Prioritization Committee shall be to discuss and develop the Alliance IT strategy, to oversee the Business Intelligence data governance structure and to assist in prioritizing all IT reporting, application development and business intelligence initiatives. The committee will develop and maintain the required corporate governance and participate in an advisory role for Alliance Behavioral Healthcare concerning its corporate IT investments, operations and strategy as it relates to technology and information systems. In this role the committee is responsible for performing its duties in accordance with this Charter and to meet the requirements of and report to the
Alliance Executive Leadership Team. In addition, this group will have a reporting obligation to the CQI (Continuous Quality Improvement) Committee on areas of risk or areas needing improvement pertaining to IT projects, initiatives or operations.

Responsibilities

The Committee’s role is to report to the Alliance Executive Leadership Committee on a monthly basis and provide discussion and recommendations on matters covered by this Charter.

The Committee will review and make recommendations to the Alliance Executive Leadership Team relative to:

- The IT strategic alignment for key initiatives of the company related to information technology, application development, business intelligence, security, data management and internal and external reporting.
- The financial, tactical and strategic benefits of all proposed major IT related projects and technology decisions.
- Alliance’s IT programs and their effectiveness in support of the Company’s business objectives and strategies.
- The utilization and management of all systems developed by external vendors, to include but not be limited to, AlphaMCS, Care Management Technologies, MicroStrategy and the State Reporting Systems.
- Future trends in technology or Information System Management that may affect the Alliance’s business initiatives and strategic plans.
- Engage internal and external advisors as required to carry out the committee’s oversight responsibilities.
- Report back monthly to the CQI committee listing areas of risk, concern or any topics requiring improvement that pertain to IT projects, strategic initiatives or day to day IT operations. These reports will provide detailed analysis, level of risk to the department or entire organization and a high level action plan to correct any deficiencies.

Relationships

The chairperson of the IT committee is the Chief Information Officer (CIO) and reports to the CEO. The CIO is also a member of the Alliance Executive Leadership Team. The various team members on this committee represent the key departments within the organization and participate on the decision making committees and groups housed at the Alliance Corporate Headquarters.

Membership

The committee is chaired by the Chief Information Officer.

Members include:

- Chief Information Officer
- Chief of Network Development and Evaluation
- Chief Financial Officer
Chief Clinical Officer
Chief Strategy Officer
Chief Community Relations Officer
Director of Information Technology Applications Development
Director of Information Technology Reporting
Director of Quality Management

Role of a committee member

The committee members are selected to leverage the experiences, expertise, and insight of key individuals throughout the organization and they are committed to supporting and sustaining the all corporate IT initiatives. The committee members are not directly responsible for managing project activities but provide support and guidance for the internal departments and individuals in those roles.

Committee members should:

- Understand the strategic implications and outcomes of initiatives being pursued through project outputs.
- Appreciate the significance of the project for some or all major stakeholders and represent their interests.
- Be an advocate for broad support for the outcomes being pursued in the project.
- Ensure the project meets the requirements of the business owners and key stakeholders.
- Advise the committee on ways to balance conflicting priorities and resources.
- Provide guidance to the project team and users of the project’s outputs.

Meetings

The committee shall meet as often as deemed appropriate to carry out its responsibilities under this charter, but no less frequently than once per month. The committee currently meets on a monthly basis at the Alliance corporate headquarters. The chairperson of the committee, in consultation with the other committee members, shall determine the frequency and length of the committee meetings and shall set meeting agendas consistent with this charter.

The committee shall maintain and make available to the CEO and Executive Leadership Team copies of the meeting minutes, along with any other reports or documents summarizing the details of each meeting. These documents shall be maintained on the corporate SharePoint site for easy access.

The chairperson of the committee may call a meeting of the IT committee at any time if requested by any member of the committee. All meetings may be conducted in person, by telephone or other form of real time electronic communication.

The committee, at its discretion, may include in its meetings members of Alliance’s Management Team, Senior Management team, corporate associates or other third parties as deemed appropriate by the committee to conduct its business.
The committee may delegate its authority to any subcommittees or to the chairperson of the committee when appropriate and deemed in the best interests of Alliance Behavioral Healthcare.

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:

• Quality of Care
• SARs processing volume with percentages of those denied or partially denied for both internal as well as external Peer Reviewers
• Number of SARs issued to Out-of-Network providers
• Service Trends of daily census, average Length of Stay for IIH, PRTF, BH LT Residential, ICF-MR and FCB. Inpatient readmission rates both at 7 and 30 days are also reported through the dashboard.
• Call Center Statistics
• Appeals statistics
• 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
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1. Purpose

Alliance is committed to providing quality and effective care to our consumers in Wake, Durham, Cumberland and Johnston Counties.

The purpose of this Quality Management Evaluation Report is to review Alliance Behavioral Healthcare’s progress at implementing the quality management activities required under its contract with the North Carolina Department of Health and Human Services (DHHS) and as a URAC-accredited organization.

This report also will identify areas needing improvement and establish future quality management program strategies.

2. Alliance Quality Program

The Alliance quality program involves all of the agency’s stakeholders. Leadership is provided by the Alliance Board of Directors and its Global Quality Management Committee. Within Alliance, the CQI Committee and its seven subcommittees are responsible for quality. Provider and consumer representatives participate at both the board, agency, and project level. Finally, all Alliance staff are responsible for continuous quality improvement.

FY 2017 Performance:
The Alliance quality program’s accomplishments in FY 2017 include:

- Ensured that network providers are adhering to key elements in clinical guidelines for ADHD and Schizophrenia
- Improved the timeliness of assessments and treatment of the School-Based Care Coordination Team
- Improved provider after-hours crisis line performance
- Using data and reporting to better identify new QIPs
- Developed a Provider Network Evaluation unit to focus on the performance of network providers
- Included performance targets in provider contracts
- Started on-going efforts to improve internal performance of Alliance departments
- Developed web-based quality improvement training series for internal staff

FY 2018 Strategy:
Alliance will create a provider led CQI subcommittee in order to more formally incorporate provider voices into the CQI process. Additionally, the Quality Management department will expand our focus on improving our internal performance via business process mapping and education around lean principals.

3. QM Department

As of June 30, 2017, the Alliance QM Department consisted of a QM Director who oversaw two teams and one additional research staff person:

Quality Assurance: This team promotes quality assurance within Alliance and the Alliance provider network; develops reports for Alliance management, committees and the state; investigates and resolves incidents and complaints reported by consumers, providers, Alliance staff and others; and analyzes data from NC-TOPPS, IRIS and other sources. Staffing consisted of a Data Manager and seven Quality Assurance Analysts.

Quality Review: This team oversees QIPs and other quality improvement related activities; performs quality reviews to identify opportunities for improvement; conducts in-depth analyses of internal processes and
programs; conducts research studies; conducts performance improvement projects and develops quality management standards and training for our providers. Staffing includes the Quality Review Manager, two Quality Review Coordinator II positions and two Quality Review Coordinator I positions.

Research Staff: This includes one Statistical Research Analyst responsible for report completion, geomapping and survey management.

FY 2017 Performance:
During FY 2017, the Alliance QM Department broadened its focus by partnering with internal stakeholders to identify efficiencies and developing methods to measure improvement of departmental process improvement initiatives.

The QM Department successfully partnered with Power Analysts and Provider Networks to identify and address quality issues quickly and directly.

FY 2018 Strategy:
Alliance will continue to assess new and ongoing quality activities and staffing levels. QM also will continue to coordinate responsibilities with the newly created department of Provider Evaluation.

4. Quality Committees

Alliance’s continuous quality improvement program is reviewed and approved by the Global Quality Management Committee, a subcommittee of Alliance’s Board of Directors. The internal CQI Leadership Committee oversees quality improvement activities through seven subcommittees:

- Budget and Finance
- Clinical Care Management
- Community Relations
- Compliance
- Information Technology
- Provider Networks
- Utilization Management

FY 2017 Performance:
During FY 2017, Alliance piloted a new and more transparent method of tracking quality issues at the CQI level. This new method provided more visibility of issues and potential issues to executive leaders.

The Global QMC met a total of nine times, satisfying its mandate to meet at least quarterly. Alliance expanded its use of teleconferencing to improve committee attendance and the meeting of quorum requirements. The CQI Committee and its subcommittees also met routinely.

FY 2018 Strategy:
Alliance will create a provider led CQI subcommittee in order to more formally incorporate provider voices into the CQI process.

5. Provider Participation in the QM Program

The Global Quality Management Committee is required to include two non-voting provider representatives. In addition, the QM Department is required to update the Alliance Provider Advisory Committee on QM activities.
FY 2017 Performance:
During FY 2017, Alliance expanded the participation of providers in the QM program. Provider representatives serve as two non-voting members of the Global Quality Management Committee. In addition, providers now sit on four QIP advisory teams and a variety other work groups related to provider issues. Alliance continues to solicit providers for involvement in other quality activities such as including performance metrics in provider contracts, developing best practice guidelines, and a variety of other ad hoc issues through existing committees.

FY 2018 Strategy:
Alliance will create a provider led CQI subcommittee in order to more formally incorporate provider voices into the CQI process.

6. Consumer Participation in the QM Program

The Global Quality Management Committee is required to include two voting consumer/family representatives. In addition, the QM Department is required to update the Alliance Consumer and Family Advisory Committee on QM activities annually.

FY 2017 Performance:
During FY 2017, Alliance met the requirement for individual/family participation in the QM program by maintaining two voting CFAC members on the Global Quality Management Committee. The QM Department provided CFAC with an update on QIPs in August 2017.

FY 2018 Strategy:
Alliance will continue to identify opportunities to expand consumer/family representative participation in quality improvement activities.

7. Call Center

Alliance is required to meet URAC and contractual standards for the performance of its Call Center. Performance is measured monthly and reported to the state as part of the monthly LME-MCO Report. Alliance’s advanced Mitel phone system provides sophisticated real-time reporting.

**Standard: Less Than 5% of Calls Are Abandoned**

*Definition:* Abandonment occurs when the caller dials directly into the organization’s Member Services Call Center or selects the Member Services option, is placed in the call queue and hangs up the phone, disconnecting from the call center before being answered by a Member Services representative.

**FY 2017 Performance:**

<table>
<thead>
<tr>
<th></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>
</tr>
</thead>
<tbody>
<tr>
<td>Standard</td>
<td>5%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>4%</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

*Source: FY 2017 LME-MCO Monthly Reports*

*Analysis:* Alliance met the standard of <5% abandoned calls for all of FY 2017.

**FY 2018 Strategy:**
Alliance will continue to maintain an abandonment rate of <5%.
**Standard: 95% of calls are answered within 30 seconds**

The number of calls answered by a live voice within 30 seconds/Telephone contact initiated by an external caller that connects to the organization’s Member Services call center. For calls transferred from other parts of the organization’s telephone system, measure time from after the call is transferred into the call center and the member chooses the option to speak to a Member services representative and is placed in the call queue.

**FY 2017 Performance:**

<table>
<thead>
<tr>
<th></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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</thead>
<tbody>
<tr>
<td>95%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>96%</td>
<td>98%</td>
<td>99%</td>
<td>99%</td>
<td>98%</td>
<td>98%</td>
<td>99%</td>
<td></td>
</tr>
</tbody>
</table>

*Source: FY 2018 LME-MCO Monthly Reports*

**Analysis:**

Alliance met the standard of answering 95% of call within 30 seconds.

**FY 2018 Strategy:**

Alliance will continue to maintain an answer rate of 95%.

---

**Standard: Less than 5% of Calls are Blocked**

Blockage rate is the frequency with which a consumer calling the Alliance Call Center experiences of busy signal.

**FY 2017 Performance:**

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent Calls Blocked</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>(Standard = 5%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calls Blocked</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Calls</td>
<td>15,918</td>
<td>14,964</td>
<td>17,205</td>
<td>14,814</td>
</tr>
</tbody>
</table>

*Source: Alliance Mitel System Reports*

**Analysis:**

Alliance contracts with ProtoCall to handle all roll-over calls when Alliance Call Center staff is not available. During FY 2017, no call that were answered by Alliance or by Proto-Call were met with a busy signal.

**FY 2018 Strategy:**

Alliance will continue to maintain a blockage rate of <5% of calls.

---

**Standard: All calls are answered “live”**

Alliance is expected to “live answer” 100% of calls.

**FY 2017 Performance:**

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent Calls Answered Live</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>(Standard = 100%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calls Answered by Alliance</td>
<td>15,918</td>
<td>14,964</td>
<td>17,205</td>
<td>14,814</td>
</tr>
<tr>
<td>or Proto-Call</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Calls</td>
<td>15,918</td>
<td>14,964</td>
<td>17,205</td>
<td>14,814</td>
</tr>
</tbody>
</table>

*Source: Alliance Mitel System Reports*
Analysis:
Alliance contracts with Proto-Call to handle all roll-over calls when Alliance Call Center staff is not available within 30 seconds. During FY 2017, Proto-Call provided routine reporting showing that no roll-over calls were answered by a voicemail or recorded message. This measure is based on the Health Call Center URAC module.

FY 2018 Strategy:
Alliance will continue to live answer 100% of calls according to the URAC Health Call Center accreditation module.

8. Access to Care
Alliance is required to provide consumers with access to services at all times. Alliance’s Call Center is staffed 24/7/365, and Alliance maintains a network of crisis and emergency services to quickly provide services. Performance is reported to the state on a quarterly basis.

NOTE: The state’s standards require the delivery of services, and are different from URAC and HEDIS standards requiring the scheduling of services.

NOTE: Fourth-quarter results are preliminary and currently are under review.

Standard: Emergent Services

Alliance’s contract requires that 95% of Emergent cases receive care in less than 2 hours, 15 minutes.

FY 2017 Performance:

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent Calls Receiving Timely Services (Standard = 95%)</td>
<td>84%</td>
<td>67%</td>
<td>54%</td>
<td>53%</td>
</tr>
<tr>
<td>Calls Needing Emergent Care</td>
<td>136</td>
<td>168</td>
<td>186</td>
<td>227</td>
</tr>
<tr>
<td>Calls Referred To 911</td>
<td>36</td>
<td>18</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Calls For Which Care Was Provided Within 2 Hours 15 Minutes</td>
<td>78</td>
<td>95</td>
<td>85</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: FY 2018 Alliance Access to Care Call Center Quarterly Reports

Analysis:
Alliance did not meet the Emergent Call standard of 95% in any of the four quarters of FY 2017.

FY 2018 Strategy:
Alliance has adapted the ongoing QIP to improve the response rate with updated interventions. Alliance will continue the QIP during FY 2018.

Standard: Urgent Services

Alliance’s contract requires that 82% of Urgent cases receive care in less than 48 hours.

FY 2017 Performance:

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Calls Receiving Services in 48 Hours (Standard = 82%)</td>
<td>21%</td>
<td>16%</td>
<td>21%</td>
<td>13%</td>
</tr>
<tr>
<td>Calls Needing Urgent Care</td>
<td>479</td>
<td>448</td>
<td>422</td>
<td>439</td>
</tr>
<tr>
<td>Calls For Which Care Was Provided Within 48 Hours</td>
<td>100</td>
<td>72</td>
<td>87</td>
<td>57</td>
</tr>
</tbody>
</table>
Analysis:
Alliance did not meet the Urgent Call standard in any of the four quarters of FY 2017.

FY 2018 Strategy:
Alliance has an ongoing QIP to improve the response rate. Alliance will continue the QIP during FY 2018. One area of focus in particular is the post incarceration population which has historically been a very difficult group to meet within 48 hours.

**Standard: Routine Services**

Alliance’s contract requires that 75% of Routine cases receive care in less than 14 days.

**FY 2017 Performance:**

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Calls Receiving Timely Services (Standard = 75%)</td>
<td>49%</td>
<td>44%</td>
<td>51%</td>
<td>43%</td>
</tr>
<tr>
<td>Calls Needing Routine Care</td>
<td>753</td>
<td>700</td>
<td>697</td>
<td>665</td>
</tr>
<tr>
<td>Calls For Which Care Was Provided Within 14 Days</td>
<td>370</td>
<td>309</td>
<td>357</td>
<td>289</td>
</tr>
</tbody>
</table>

Analysis:
Alliance did not meet the Routine Call standard in any of the four quarters of FY 2017.

FY 2018 Strategy:
Alliance has adapted the ongoing QIP to improve the response rate with updated interventions. Alliance will continue the QIP during FY 2018.

9. Transition to Community Living Staffing

Beginning with FY 2016 Q3, the state set standards for the filling of initiative-funded in-reach staff and transition coordinators.

**Standard: In-reach staffing**

**FY 2017 Performance:**

<table>
<thead>
<tr>
<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>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>89</td>
<td>89</td>
<td>89</td>
<td>100</td>
<td>100</td>
<td>89</td>
<td>89</td>
<td>78</td>
<td>89</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Analysis:
Alliance has successfully filled all In-reach staffing positions. March of 2017 showed the only month in which the metric was not met.

FY 2018 Strategy:
Alliance will continue to staff all In-reach positions.
**Standard: Transition Coordinator staffing**

**FY 2017 Performance:**

<table>
<thead>
<tr>
<th></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>
</tr>
</thead>
<tbody>
<tr>
<td>Percent</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>108%</td>
<td></td>
</tr>
</tbody>
</table>

Source: FY 2017 LME-MCO Monthly Reports

**Analysis:**

Alliance has staffed TCLI Transition Coordinator positions above the level funded by the state. However, the reporting does not reflect these changes until June of 2017 when the number was changed to reflect guidance issued by the state in Joint Communication Bulletin #J214.

**FY 2018 Strategy:**

Alliance will continue to staff all transition coordinators positions.

10. **Care Coordination Assignment**

Alliance is required to assign a Care Coordinator to at least 85% of Medicaid consumers who are readmitted to inpatient care.

**FY 2017 Performance:**

<table>
<thead>
<tr>
<th>Percent of Patients Assigned to Care Coordination after Hospital Readmission</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>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>91%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
<td>86%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: FY 2017 LME-MCO Monthly Reports

**Analysis:**

Alliance met the standard for eleven months in FY 2017. A review of February data determined that Care Coordination staff did not conduct timely assignment in two cases. Both cases were subsequently assigned.

**FY 2018 Strategy:**

Alliance will continue to meet the standard in FY 2018.

11. **Authorization Requests - Medicaid**

The state requires Alliance to process 95% of standard authorization requests within 14 days and 90% of expedited authorization requests with three days.

**FY 2017 Performance:**

<table>
<thead>
<tr>
<th>% Requests Processed in Required Timeframes (Standard = 95%)</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>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>99.9%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.9%</td>
<td>99.6%</td>
<td>99.7%</td>
<td>99.7%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.8%</td>
<td>99.9%</td>
<td>99.8%</td>
</tr>
</tbody>
</table>

Source: FY 2017 LME-MCO Monthly Reports

**Analysis:**

Alliance met the standard for FY 2017.
FY 2018 Strategy:
Alliance will continue to meet the standard in FY 2018.

12. Authorization Requests – State/Block Grant

The state requires Alliance to process 95% of standard authorization requests within 14 days and 90% of expedited authorization requests with three days.

FY 2017 Performance:

<table>
<thead>
<tr>
<th>% Requests Processed in Required Timeframes (Standard = 95%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>100%</td>
</tr>
</tbody>
</table>

Source: FY 2017 LME-MCO Monthly Reports

Analysis:
Alliance met the standard for FY 2017.

FY 2018 Strategy:
Alliance will continue to meet the standard in FY 2018.

13. Claims - Medicaid

The state requires Alliance to process 90% of claims within 30 days.

FY 2017 Performance:

<table>
<thead>
<tr>
<th>Percent Proceed within 30 Days (Standard = 90%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>98.2%</td>
</tr>
</tbody>
</table>

Source: FY 2017 LME-MCO Monthly Reports

Analysis:
Alliance met the standard for FY 2017.

FY 2018 Strategy:
Alliance will continue to meet the standard in FY 2018.

14. Claims - State/Block Grant

The state requires Alliance to process 90% of claims within 30 days.

FY 2017 Performance:

<table>
<thead>
<tr>
<th>Percent Proceed within 30 Days (Standard = 90%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>97.8%</td>
</tr>
</tbody>
</table>

Source: FY 2017 LME-MCO Monthly Reports

Analysis:
Alliance met the standard for FY 2017.
FY 2018 Strategy:
Alliance will continue to meet the standard in FY 2018.

15. Innovations

The state has established a variety of measures for consumers in the Innovations waiver program. These include the following safety-related measures:

NOTE: The fourth quarter metrics for Innovations have not been reported yet and therefore are not included.

<table>
<thead>
<tr>
<th>Quality Item</th>
<th>Standard</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of new waiver beneficiaries receiving services within 45 days of ISP approval.</td>
<td>85%</td>
<td>100.0%</td>
<td>93.8%</td>
<td>86.7%</td>
</tr>
<tr>
<td>Percent of Actions Taken to Protect the Beneficiary</td>
<td>85%</td>
<td>91.4%</td>
<td>92.9%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Percentage of level 2 and 3 incidents reported within required timeframes</td>
<td>85%</td>
<td>86.5%</td>
<td>91.1%</td>
<td>87.9%</td>
</tr>
<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>
</tr>
<tr>
<td>Percentage of medication errors resulting in medical treatment.</td>
<td>&lt;15%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Percentage of beneficiaries who received appropriate medication</td>
<td>85%</td>
<td>100.0%</td>
<td>99.9%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Percentage of level 2 or 3 incidents where required LME/PIHP follow-up interventions were completed</td>
<td>85%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Percentage of incidents referred to the DSS or DHSR</td>
<td>85%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Percentage of restrictive interventions resulting in medical treatment.</td>
<td>&lt;15%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Analysis:
Alliance met the standard for all of the above standards in FY 2017. Note that this data is only reported for the first three quarters of the year. The final quarter’s data is not reported until November.

FY 2018 Strategy:
Alliance will continue to meet the standards in FY 2018.

16. Network Gaps Analysis

Alliance is required to produce an annual Community Needs Assessment and Gaps Analysis to identify community service needs and gaps. The report informs and guides provider network development activities via a formal Network Development Plan.

FY 2017 Performance:
Alliance made progress on a number of significant needs and gaps that were identified as priorities for the FY16 Network Development Plan:

- Expanded access to Medication Assisted Treatment, Psychosocial Rehabilitation,
- Improved crisis capacity and access through expansion of access to Behavioral Health Urgent Care Centers, purchase of building for new crisis facility, and expansion of rapid response crisis diversion services for children and adolescents
- Implemented Intensive Wrap-Around for children and transition age youth, and Enhanced Therapeutic Foster Care service, which provides extra support and staffing for children with high needs who are
living in therapeutic foster homes.

- Expanded access to evidence-based services for autism by adding Applied Behavior Analysis / Adaptive Behavior Treatment services.
- Developed short-term comprehensive functional assessment program for Autism Spectrum Disorders.
- Conducted comprehensive evaluation of SUD continuum of care and prepared plans for improving accessibility and effectiveness of care.
- Expanded evidence-based treatment within Intensive In-Home, Psychosocial Rehabilitation, and Therapeutic Foster Care services.

**Analysis:**
Alliance submitted its most recent Needs Assessment Report to the state on May 31, 2017. The report found the following:

- Need for continued development of crisis services and alternatives to inpatient treatment
- Limited array of recovery-oriented, individualized and person-centered services
- Limited service adequacy for individuals with complex needs
- Barriers to receiving appropriate care associated with factors such as housing, transportation and social and economic disparities
- Inconsistent service accessibility, especially for uninsured and for certain underserved populations
- Lack of a comprehensive, robust system of care for individuals with substance use disorders

**FY 2018 Strategy:**
Alliance has submitted to the state its proposal for addressing the gaps identified in the 2017 Needs Assessment report. However, all of the following potential interventions are contingent upon funding being available for their implementation.

Alliance also has identified the following priorities for network development that will be included in the FY17 Network Development Plan:

**Expand Capacity for Crisis and Hospital Diversion**
- Assure the availability of high quality, accessible, and effective Mobile Crisis services in all counties
- Expand access to Behavioral Health Urgent Care Centers (Tier II Same Day Access)
- Expand capacity for facility based crisis services in Wake County
- Develop Facility Based Crisis capacity for children

**Use of engagement and self-management approaches**
- Support technology assisted homes
- Implement self-management pilot initiatives
- Evaluate options for expanding peer respite capacity

**Youth and Adults with Complex Needs**
- Expand Trauma Informed Therapeutic Foster Care
- Implement Intensive Wrap-Around for children and transition age youth
- Implement EBPs in Therapeutic Foster Care programs
- Expand implementation of integrated physical/behavioral healthcare programs
- Implement Tiered Case Management, Develop plans for addressing gaps for individuals in need of long-term services and supports
Address Social Determinants of Health
- Housing initiatives, including Supportive Housing and Group Living Step Down projects
- Social Determinants pilot initiatives
- Mobility on Demand

Continuum of Care for Individuals with Substance Use Disorders
- Enhance the service array for SUD for adolescents
- Evaluate options and make recommendations for expanding withdrawal management continuum
- Improve service quality and continuity of care through training, consultation, technical assistance and other efforts as identified in the 2017 analysis of the Alliance SUD continuum
- Expand opioid treatment availability

17. Grievances

Any consumer, legally responsible person and/or network provider authorized in writing to act on behalf of a consumer, is encouraged to contact Alliance if they feel that services being provided to a consumer are unsatisfactory or if the consumer’s emotional or physical well-being is being endangered by such services. Alliance staff will assist any consumer, legally responsible person and/or network provider authorized in writing to act on behalf of a consumer in filing a grievance as needed.

FY 2017 Performance:

<table>
<thead>
<tr>
<th>Primary Nature of Complaint</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
<th>Pct.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse, Neglect, Exploitation</td>
<td>10</td>
<td>6</td>
<td>12</td>
<td>24</td>
<td>52</td>
<td>6%</td>
</tr>
<tr>
<td>Access to Services - Difficulty or Inability to obtain services</td>
<td>18</td>
<td>21</td>
<td>14</td>
<td>14</td>
<td>67</td>
<td>8%</td>
</tr>
<tr>
<td>Administrative Issues by Provider</td>
<td>24</td>
<td>21</td>
<td>26</td>
<td>18</td>
<td>89</td>
<td>11%</td>
</tr>
<tr>
<td>Basic Needs</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>6</td>
<td>15</td>
<td>2%</td>
</tr>
<tr>
<td>Authorization/ Payment/ Billing - Provider ONLY</td>
<td>10</td>
<td>19</td>
<td>27</td>
<td>21</td>
<td>77</td>
<td>10%</td>
</tr>
<tr>
<td>Authorization/ Payment/ Billing - LME-MCO ONLY</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>18</td>
<td>2%</td>
</tr>
<tr>
<td>Confidentiality/ HIPAA</td>
<td>5</td>
<td>7</td>
<td>3</td>
<td>5</td>
<td>20</td>
<td>2%</td>
</tr>
<tr>
<td>Client Rights</td>
<td>5</td>
<td>11</td>
<td>5</td>
<td>2</td>
<td>23</td>
<td>3%</td>
</tr>
<tr>
<td>LME-MCO Functions (excluding Authorization/Payment/Billing)</td>
<td>24</td>
<td>12</td>
<td>18</td>
<td>15</td>
<td>69</td>
<td>9%</td>
</tr>
<tr>
<td>Provider Choice</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>Quality of Care by Providers</td>
<td>91</td>
<td>56</td>
<td>84</td>
<td>106</td>
<td>337</td>
<td>42%</td>
</tr>
<tr>
<td>Service Coordination Between Providers</td>
<td>5</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>23</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>3</td>
<td>10</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: FY 2017 Alliance Quarterly Complaints Reports

<table>
<thead>
<tr>
<th>Investigations</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints that Resulted in an Investigation</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Complaints that Did Not Result in an Investigation</td>
<td>200</td>
<td>174</td>
<td>203</td>
<td>223</td>
<td>800</td>
</tr>
</tbody>
</table>

Source: FY 2017 Alliance Quarterly Complaints Reports
<table>
<thead>
<tr>
<th>Total Number of Complaints Not Investigated that Were:</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
<th>Pct.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resolved By Working with Provider</td>
<td>50</td>
<td>49</td>
<td>55</td>
<td>195</td>
<td>349</td>
<td>44%</td>
</tr>
<tr>
<td>Resolved By Referral to Community Resource and/ or Advocacy Group</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>Resolved by Providing Information or Technical Assistance to Complainant</td>
<td>136</td>
<td>123</td>
<td>141</td>
<td>26</td>
<td>426</td>
<td>54%</td>
</tr>
<tr>
<td>Resolved By Referring to an External Licensing or State Agency</td>
<td>13</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>16</td>
<td>2%</td>
</tr>
<tr>
<td>Referred to Another LME/ MCO for resolution</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>Resolved By Mediating With Parties</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0%</td>
</tr>
</tbody>
</table>

Source: FY 2017 Alliance Quarterly Complaints Reports

- During FY 2017, Alliance received a total of 800 grievances.
- The largest number of these (337 or 42%) were related to the Quality of Care of provider services.
- Only 2.3% of grievances were serious enough to require a formal investigation by Alliance or a state agency.
- Most (98%) of grievances that did not require investigation were resolved by working with the provider or providing information or technical assistance to the complainant.

**Standard: Resolution of Grievances**

The state requires that 90% of grievances be resolved within 30 days.

**FY 2017 Performance**

<table>
<thead>
<tr>
<th>Working Days from Receipt by LME-MCO to Completion:</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
<th>Pct.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-30 Days</td>
<td>197</td>
<td>165</td>
<td>177</td>
<td>216</td>
<td>755</td>
<td>95%</td>
</tr>
<tr>
<td>31-60 Days</td>
<td>2</td>
<td>8</td>
<td>22</td>
<td>7</td>
<td>39</td>
<td>5%</td>
</tr>
<tr>
<td>61-90 Days</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: FY 2017 Alliance Quarterly Complaints Reports

Analysis:
Alliance resolved 95.0% of grievances within 30 days. Alliance had a spike in complaints that were resolved in more than 30 days in the third quarter due to staffing issues. These issues were resolved and performance in the fourth quarter returned to expected levels.

**FY 2018 Strategy:**
Alliance will continue the changes adopted in the third quarter and will meet the standards in FY 2018.

18. **Adverse Incident Reports**

The state requires Alliance to track the submission of Level 2 and 3 critical incidents reported by providers.

**FY 2017 Performance:**

<table>
<thead>
<tr>
<th>Level 2 Critical Incident Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>239</td>
</tr>
</tbody>
</table>

Source: FY 2017 Alliance LME-MCO Monthly Reports
## Level 3 Critical Incident Reports

<table>
<thead>
<tr>
<th></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>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>13</td>
<td>15</td>
<td>10</td>
<td>9</td>
<td>18</td>
<td>15</td>
<td>16</td>
<td>21</td>
<td>23</td>
<td>18</td>
<td>11</td>
<td></td>
</tr>
</tbody>
</table>

*Source: FY 2017 Alliance LME-MCO Monthly Reports*

### 19. Surveys

#### a. Provider Satisfaction Survey

The **2016 DHHS Provider Satisfaction Survey** was conducted by the Carolina Centers for Medical Excellence (CCME) under contract with DHHS. Survey results were released in October 2015.

**FY 2017 Performance:**

<table>
<thead>
<tr>
<th>Area/ Survey Question</th>
<th>2014 Score</th>
<th>2015 Score</th>
<th>2016 Score</th>
<th>Change 15 - 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access LME/MCO staff is easily accessible</td>
<td>73.1</td>
<td>82.3</td>
<td>85.8</td>
<td>3.5</td>
</tr>
<tr>
<td>Access LME/MCO staff consumer referral match provider services</td>
<td>60.8</td>
<td>72.7</td>
<td>85.7</td>
<td>13.0</td>
</tr>
<tr>
<td>Appeals Satisfied with appeals process</td>
<td>46.8</td>
<td>59.2</td>
<td>76.1</td>
<td>16.9</td>
</tr>
<tr>
<td>Authorizations Authorizations made within required timeframes</td>
<td>88.3</td>
<td>90.4</td>
<td>95.5</td>
<td>5.1</td>
</tr>
<tr>
<td>Authorizations Denials for treatment and services are explained</td>
<td>74.3</td>
<td>79.2</td>
<td>86.8</td>
<td>7.6</td>
</tr>
<tr>
<td>Authorizations Authorizations issued are accurate</td>
<td>86.0</td>
<td>91.5</td>
<td>96.9</td>
<td>5.4</td>
</tr>
<tr>
<td>Claims Staff consistent and accurate information about claims</td>
<td>77.2</td>
<td>76.9</td>
<td>81.6</td>
<td>4.7</td>
</tr>
<tr>
<td>Claims Claims are processed in a timely and accurate manner</td>
<td>87.7</td>
<td>93.1</td>
<td>93.4</td>
<td>0.3</td>
</tr>
<tr>
<td>Communications LME/MCOs website is useful</td>
<td>74.9</td>
<td>82.7</td>
<td>84.6</td>
<td>1.9</td>
</tr>
<tr>
<td>Compliance LME/MCO staff conducts fair and thorough investigations</td>
<td>55.0</td>
<td>65.8</td>
<td>83.5</td>
<td>17.7</td>
</tr>
<tr>
<td>Compliance Corrective action plans are fair and reasonable</td>
<td>50.3</td>
<td>67.3</td>
<td>86.0</td>
<td>18.7</td>
</tr>
<tr>
<td>Overall LME/MCO staff responds quickly to provider needs</td>
<td>74.9</td>
<td>74.6</td>
<td>81.5</td>
<td>6.9</td>
</tr>
<tr>
<td>Overall Technical assistance is accurate and helpful</td>
<td>82.5</td>
<td>81.2</td>
<td>92.8</td>
<td>11.6</td>
</tr>
<tr>
<td>Overall Overall satisfaction with the LME/MCO</td>
<td>84.2</td>
<td>85.0</td>
<td>88.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Networks Provider Network meetings are informative and helpful</td>
<td>64.3</td>
<td>63.1</td>
<td>90.3</td>
<td>27.2</td>
</tr>
<tr>
<td>Networks Provider Network keeps providers informed of changes</td>
<td>77.8</td>
<td>75.8</td>
<td>93.3</td>
<td>17.5</td>
</tr>
<tr>
<td>Networks Provider Network staff are knowledgeable</td>
<td>70.2</td>
<td>74.2</td>
<td>92.2</td>
<td>18.0</td>
</tr>
<tr>
<td>Networks Overall satisfaction with Provider Networks</td>
<td>79.5</td>
<td>81.5</td>
<td>88.3</td>
<td>6.8</td>
</tr>
<tr>
<td>Stakeholders Customer Service is responsive</td>
<td>58.5</td>
<td>68.8</td>
<td>87.2</td>
<td>18.4</td>
</tr>
<tr>
<td>Stakeholders Interests are adequately addressed in local Provider Council</td>
<td>50.9</td>
<td>56.5</td>
<td>81.1</td>
<td>24.6</td>
</tr>
<tr>
<td>Training Claims trainings meet my needs.</td>
<td>71.3</td>
<td>71.6</td>
<td>88.1</td>
<td>16.5</td>
</tr>
<tr>
<td>Training Information Technology trainings are informative</td>
<td>63.2</td>
<td>64.2</td>
<td>90.4</td>
<td>26.2</td>
</tr>
<tr>
<td>Training Trainings are informative</td>
<td>71.9</td>
<td>71.5</td>
<td>89.2</td>
<td>17.7</td>
</tr>
</tbody>
</table>

*Source: 2014-2016 DHHS Provider Satisfaction Survey*
CCME also asked providers to identify areas where additional training and educational materials were needed:

<table>
<thead>
<tr>
<th></th>
<th>2014 Score</th>
<th>2015 Score</th>
<th>2016 Score</th>
<th>Change 15 - 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Coverage Policies</td>
<td>37.4</td>
<td>41.2</td>
<td>45.7</td>
<td>4.5</td>
</tr>
<tr>
<td>Quality Management/Reporting</td>
<td>40.4</td>
<td>43.1</td>
<td>30.5</td>
<td>-12.6</td>
</tr>
<tr>
<td>Audit/Reimbursement</td>
<td>36.3</td>
<td>30.8</td>
<td>30.5</td>
<td>-0.3</td>
</tr>
<tr>
<td>Provider Monitoring</td>
<td>34.5</td>
<td>35.4</td>
<td>24.4</td>
<td>-11.0</td>
</tr>
<tr>
<td>Enrollment</td>
<td>17.5</td>
<td>19.6</td>
<td>21.3</td>
<td>1.7</td>
</tr>
<tr>
<td>Claims Processing</td>
<td>26.3</td>
<td>21.9</td>
<td>20.3</td>
<td>-1.6</td>
</tr>
<tr>
<td>Information Technology</td>
<td>22.2</td>
<td>16.2</td>
<td>17.8</td>
<td>1.6</td>
</tr>
<tr>
<td>Appeals</td>
<td>17.5</td>
<td>14.6</td>
<td>17.3</td>
<td>2.7</td>
</tr>
<tr>
<td>Payment Policy</td>
<td>12.3</td>
<td>8.5</td>
<td>15.2</td>
<td>6.7</td>
</tr>
</tbody>
</table>

Source: 2014-2016 DHHS Provider Satisfaction Survey

Analysis:
Alliance demonstrated improvement in every satisfaction element that was surveyed compared to 2015, which continues improvements that were seen beginning in 2014.

Alliance’s QM staff grouped the questions together by organization function to better evaluate individual departments, and compared each department’s performance compared to the average for all LME-MCOs. It found “Above Average” satisfaction for Access, Appeals, Authorizations, Claims, Communications and Stakeholders. It found “Average” satisfaction for Compliance, Provider Networks and Training.

The results of this survey have been posted to Alliance’s website and shared with providers for discussion and analysis at the Provider Advisory Council.

Last year Alliance developed QM-related trainings and it appears that the need for trainings in Quality Management diminished as a result.

FY 2018 Strategy:
Alliance will continue to conduct trainings on Clinical Coverage policies as that appears to be the highest area of need.

b. Consumer Perception of Care Survey

The North Carolina Mental Health and Substance Abuse Consumer Perception of Care Survey is conducted annually by the NC DHHS. The survey assesses individual consumer and family perceptions of the quality of care, provider service and LME-MCO performance. Results of the survey were released in May 2017.

Alliance’s responsibilities included: identifying providers of MH and SA services to English and Spanish-speaking consumers; calculating the number adult, youth and child consumers seen by each provider; distributing survey forms in proportion to the provider’s consumer types; and following up with providers to assure that surveys were completed and returned to DHHS.
Analysis

Alliance’s performance:

<table>
<thead>
<tr>
<th></th>
<th>Adults</th>
<th>Youths</th>
<th>Family</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required</td>
<td>520</td>
<td>151</td>
<td>168</td>
<td>839</td>
</tr>
<tr>
<td>Completed</td>
<td>654</td>
<td>110</td>
<td>125</td>
<td>889</td>
</tr>
</tbody>
</table>

Source: 2017 North Carolina Mental Health and Substance Abuse Consumer Perception of Care Survey

Alliance returned 889 completed surveys, exceeding its responsibility to return 839 surveys.

Alliance returned more youth and family surveys, and fewer adult surveys, than requested. Beginning with the 2018 survey, DHHS modified its survey request numbers to better reflect the consumer types of each LME-MCO.

Domain: Adult

<table>
<thead>
<tr>
<th>Element</th>
<th>Alliance %</th>
<th>State %</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>93.10%</td>
<td>92.10%</td>
<td>1.00%</td>
</tr>
<tr>
<td>Functioning</td>
<td>76.10%</td>
<td>77.50%</td>
<td>-1.40%</td>
</tr>
<tr>
<td>General Satisfaction</td>
<td>95.20%</td>
<td>93.10%</td>
<td>2.10%</td>
</tr>
<tr>
<td>Outcomes</td>
<td>73.20%</td>
<td>76.50%</td>
<td>-3.30%</td>
</tr>
<tr>
<td>Quality and Appropriateness</td>
<td>95.70%</td>
<td>94.60%</td>
<td>1.10%</td>
</tr>
<tr>
<td>Social Connectedness</td>
<td>72.10%</td>
<td>75.00%</td>
<td>-2.90%</td>
</tr>
<tr>
<td>Treatment Planning</td>
<td>85.80%</td>
<td>85.50%</td>
<td>0.30%</td>
</tr>
</tbody>
</table>

Source: 2017 North Carolina Mental Health and Substance Abuse Consumer Perception of Care Survey

Findings:

- Alliance was consistent with the state average in the low-ranking areas of Functioning, Social Connectedness, and Outcomes.
- Alliance surpassed the state average in the low-ranking area of Access, General Satisfaction, Quality and Appropriateness of Services, and Treatment Planning.
- Efforts at improving access from last year appear to have improved the perception of care.
- Outcomes, Functioning, and Social Connectedness remain lower than expected given last year’s interventions.

Domain: Youth

<table>
<thead>
<tr>
<th>Element</th>
<th>Alliance %</th>
<th>State %</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>86.10%</td>
<td>72.90%</td>
<td>13.20%</td>
</tr>
<tr>
<td>Cultural Sensitivity</td>
<td>99.10%</td>
<td>92.10%</td>
<td>7.00%</td>
</tr>
<tr>
<td>General Satisfaction</td>
<td>92.60%</td>
<td>84.90%</td>
<td>7.70%</td>
</tr>
<tr>
<td>Outcomes</td>
<td>71.00%</td>
<td>66.90%</td>
<td>4.10%</td>
</tr>
<tr>
<td>Treatment Planning</td>
<td>78.70%</td>
<td>75.20%</td>
<td>3.50%</td>
</tr>
</tbody>
</table>

Source: 2017 North Carolina Mental Health and Substance Abuse Consumer Perception of Care Survey
Findings:

- Alliance surpassed the state average on every element.
- Alliance showed significantly higher satisfaction related to access compared to the state average.
- Interventions aimed at youth perception of care measures appear to have had the intended impact.

Domain: Family

<table>
<thead>
<tr>
<th>Element</th>
<th>Alliance %</th>
<th>State %</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>83.90%</td>
<td>90.90%</td>
<td>-7.00%</td>
</tr>
<tr>
<td>Cultural Sensitivity</td>
<td>95.00%</td>
<td>71.30%</td>
<td>-1.80%</td>
</tr>
<tr>
<td>Functioning</td>
<td>67.50%</td>
<td>70.10%</td>
<td>-3.80%</td>
</tr>
<tr>
<td>General Satisfaction</td>
<td>91.90%</td>
<td>96.80%</td>
<td>-1.50%</td>
</tr>
<tr>
<td>Outcomes</td>
<td>67.50%</td>
<td>93.40%</td>
<td>-2.60%</td>
</tr>
<tr>
<td>Social Connectedness</td>
<td>85.10%</td>
<td>87.80%</td>
<td>-2.70%</td>
</tr>
<tr>
<td>Treatment Planning</td>
<td>93.30%</td>
<td>94.90%</td>
<td>-1.60%</td>
</tr>
</tbody>
</table>

Source: 2017 North Carolina Mental Health and Substance Abuse Consumer Perception of Care Survey

Findings:

- Alliance was within 3% of the state average on all elements other than Access and Functioning.
- These findings conflict with the findings for youth in the previous section.
- Alliance’s General Satisfaction was consistent with the state average.

FY 2018 Strategy:

Adult Access:

- Initiatives to improve access to crisis services and engagement in treatment
- Ongoing improvements to walk-in clinics aimed at increasing availability
- Centralization of mobile crisis dispatch

Adult Outcomes/Function:

- Additional housing resources
- Peer Respite and Peer Transition Teams
- Renewed focus on substance use disorders service continuum
- Promotion of Evidence-Based practices and development of provider quality committee to identify and respond to quality issues within the provider network

Family Access:

- Centralization of mobile crisis dispatch
- Ongoing improvements to walk-in clinics aimed at increasing availability

C. Network Needs Assessment Community Survey

Alliance solicited feedback from the Alliance Provider Advisory Committee (APAC) as well as distributing an online community survey as part of its annual Network Needs Assessment report. The survey included separate sections for Intellectual and Developmental Disabilities (IDD), Child Mental Health/Substance Abuse (Child
MH/SA), Adult Mental Health and Substance Abuse (Adult MH/SA) and Traumatic Brain Injuries (TBI). Additional sections were included regarding needs and gaps in areas of housing, employment and transportation.

The community survey was conducted in January of 2017 and yielded a total of 512 responses. A breakdown of individual responses by county and type follows:

<table>
<thead>
<tr>
<th>County</th>
<th>Individuals &amp; Families</th>
<th>Providers</th>
<th>Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland</td>
<td>4</td>
<td>57</td>
<td>5</td>
</tr>
<tr>
<td>Durham</td>
<td>20</td>
<td>105</td>
<td>17</td>
</tr>
<tr>
<td>Johnston</td>
<td>13</td>
<td>59</td>
<td>3</td>
</tr>
<tr>
<td>Wake</td>
<td>45</td>
<td>160</td>
<td>53</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>13</td>
<td>0</td>
</tr>
</tbody>
</table>

In addition, collective input was solicited from the following community groups and collaboratives:
- Consumer and Family Advisory Committee (CFAC)
- Alliance Provider Advisory Committee (APAC), including local PAC meetings in each county
- Durham and Wake Juvenile Justice SA/MH Partnership (Durham and Wake JJSAMHP)
- Provider Collaboratives for Community Support Team (CST), Substance Use Disorders, Intensive In-Home (IIH), Therapeutic Foster Care (TFC), Peer Support and Psychosocial Rehabilitation
- Crisis Collaboratives in Cumberland, Durham and Wake
- Alliance Hospital Partners Collaborative
- Child and Family Community Collaboratives in each county
- Judges and judicial partners in Cumberland and Durham counties
- Partnership for a Healthy Durham
- Alliance Clinical Operations Staff
- Alliance Call Center Staff
- Alliance MH/SA Care Coordinators
- Alliance Cultural Competency Committee
- Johnston County DSS

The following groups were contacted to request completion of online surveys and distribution of survey materials to members:
- Wake County Domestic Violence Fatality Review Team
- Child Fatality Prevention / Community Child Protection Team (Wake)
- Early Childhood Collaborative (Wake)
- Youth Thrive Action Teams
- Alliance providers through e-mail and All-Provider Meeting
- NAMI chapters in Cumberland, Durham and Wake
- Durham Parks and Recreation
- CFT Trainers Group (Durham)
- Durham Public Schools CTAG
- My Brother’s Keeper (Durham)
- Durham TRY
- Durham Partnership for Seniors
- Cumberland County Reclaiming Futures
- Stepping Up (Durham)
- Durham CIT Collaborative
• Durham Family Partners

Results:

This effort identified the following service gaps:

1. Housing: includes need for more availability of affordable housing as well as services such as supported housing and transitional housing. There were also significant concerns about the quality of group homes, capacity of these facilities to serve individuals with complex needs, and group homes refusal to accept consumers back at their facilities after crisis or inpatient visits. Other: nutritional training for group homes; underutilization of ILI; ready to rent classes.
2. Access / availability of appointments: need for improved accessibility of current providers and/or more providers, including those willing to serve outlying areas and to accept complex cases. Increased availability of in-home treatment options, expanded hours of appointments, and for IDD, availability during summer and after school.
3. Medication access for uninsured
4. Medication Assisted Treatment: evidence-based MAT for individuals with substance use disorders, especially for the uninsured
5. Respite Services: includes respite for individuals with mental illness, peer respite and medical respite
6. Continuum for justice-involved: Expanded service continuum for justice system involved, including jail transition services, improved coordination of care and step-down services for higher needs violent Juvenile offenders. Several groups also recommended addition of a Forensic ACTT team.
7. Inpatient capacity and access: includes inpatient psychiatric beds for all ages, dual diagnosis capacity, and reduced waits for CRH beds
8. Housing for individuals with substance use disorders (SUD): includes adult recovery homes, transitional living and halfway houses
9. SUD Withdrawal Management continuum: improved capacity and access to effective withdrawal management services, improved access to ADATC on weekends, longer length of stay for transition to aftercare, and social detox for cocaine
10. System navigation and information: need for clarification of services, how to access care and navigate the system, more information about provider availability, capacity and expertise, with several respondents noting questions about NCSTART access
11. Cross-disability fluency and expertise: need for improved provider network capacity to serve individuals with co-occurring conditions
12. Case Management: including new providers of case management for complex child funding
13. Adolescent SUD continuum: includes local residential treatment and services for children younger than 16
14. Innovations waiting list

Source: 2017 Network Needs Assessment Report

Analysis:
Consistent with the findings of past network gaps analysis, service access for the uninsured and underinsured, residential treatment, housing, and transportation remain areas of concern and ongoing barriers for promoting treatment engagement and positive outcomes. Other consistently endorsed priorities are the development of an effective and accessible continuum for substance use disorders, access to services and supports for individuals with intellectual and developmental disabilities services for individuals with co-occurring conditions, service access for non-English speaking, and the adequacy of crisis, respite and hospital diversion service capacity.
**FY 2018 Strategy:**
The survey results were used in setting the goals for Alliance’s FY 2018 Network Development Plan.

d. **Experience of Care and Health Outcomes (ECHO) Survey**

Carolinas Center for Medical Excellence (CCME), was contracted to conduct a satisfaction survey of the consumers participating in the 1915(b)(c) Medicaid Waiver program. This survey utilized the CAHPS adult and child versions of the Experience of Care and Health Outcomes (ECHO®) Survey for Managed Behavioral Healthcare Organizations. The purpose of the survey was to assess consumer perceptions of the LME/MCOs in North Carolina. A sample size of 571 adults (age 18+) and 571 children (age 12-17) consumers from each LME/MCO that had received Medicaid services from an Alliance provider between September 2015 and August 2016. Surveys were completed between October and November of 2016.

**Results:**

**Adult Survey:**

<table>
<thead>
<tr>
<th>Global</th>
<th>Alliance</th>
<th>Benchmarks</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating of Counseling and Treatment</td>
<td>72.3%</td>
<td>Met</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Composite</th>
<th>Alliance</th>
<th>Benchmarks</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Treatment Quickly</td>
<td>73.8%</td>
<td>Above</td>
<td>Score significantly higher than other MCOs</td>
</tr>
<tr>
<td>How Well Clinicians Communicate</td>
<td>91.5%</td>
<td>Met</td>
<td></td>
</tr>
<tr>
<td>Getting Treatment, Information</td>
<td>52.8%</td>
<td>Met</td>
<td></td>
</tr>
<tr>
<td>Perceived Improvement</td>
<td>60.1%</td>
<td>Met</td>
<td></td>
</tr>
<tr>
<td>Information About Treatment Options</td>
<td>60.8%</td>
<td>Met</td>
<td></td>
</tr>
</tbody>
</table>

**Child Survey:**

<table>
<thead>
<tr>
<th>Global</th>
<th>Alliance</th>
<th>Benchmarks</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating of Counseling and Treatment</td>
<td>67.5%</td>
<td>Met</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Composite</th>
<th>Alliance</th>
<th>Benchmarks</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Treatment Quickly</td>
<td>70.6%</td>
<td>Met</td>
<td>Score significantly higher than other MCOs</td>
</tr>
<tr>
<td>How Well Clinicians Communicate</td>
<td>93.6%</td>
<td>Met</td>
<td>Score significantly higher than other MCOs</td>
</tr>
<tr>
<td>Getting Treatment, Information</td>
<td>55.4%</td>
<td>Met</td>
<td></td>
</tr>
<tr>
<td>Perceived Improvement</td>
<td>56.9%</td>
<td>Below</td>
<td></td>
</tr>
</tbody>
</table>

**Analysis:**

**Adult Survey**
- Alliance scored statistically significantly above the other MCOs on the:
  - “Getting Treatment Quickly” composite score.
- Alliance did not score statistically significantly below the other MCOs on any items.
- The priority matrix indicated “How well clinicians communicate” as a high priority for adults.
Child Survey

- Alliance scored statistically significantly above the other MCOs on the:
  - Composite Score:
    - Getting Treatment Quickly
    - How Well Clinicians Communicate
- Despite having the highest scores in three of four composite measures, Alliance still ranked fifth overall in satisfaction due to a low score on the Perceived Improvement composite score. This score is most highly correlated with overall satisfaction and is marked a top priority for Alliance.
- The priority matrix indicated “Perceived Improvement” as a top priority for children.
- The priority matrix indicated “How well clinicians communicate” as a high priority for children.

**FY 2018 Strategy:**

- Promotion of Evidence-Based practices and development of provider quality committee to identify and respond to quality issues within the provider network in order to address the lack of perceived improvement.
- Shared results with Alliance Provider Advisory Committee (APAC) in order to educate providers about the high priority noted by CCME for improved communication between clinicians and consumers.

**19. Quality Improvement Projects**

A QIP is an organization-wide initiative to assess and improve the processes and outcomes of health care services and delivery. Alliance must conduct various QIPs in order to meet requirements set by the state, URAC and the federal government:

- **URAC:** Alliance must conduct two QIPs for each of the three modules for which Alliance accredited: Call Center, Health Utilization Management, and Health Network. A QIP can focus on more than one module. One QIP must focus on consumer safety for each accredited module.

- **State Contracts:** Alliance must conduct at least 3 QIPs, of which at least one must be clinical and at least one non-clinical. QIPs shall focus on reducing the need for inpatient at community hospitals, and reducing the use of crisis and Emergency Department services.

- **Federal regulations:** QIPs can be clinical or non-clinical, must impact health or functional status, and reflect high-volume or high-risk populations. Examples include access to care, grievances, appeals and children with special health care needs.

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 2017 Performance:**

During FY 2017, Alliance operated nine active QIPs:

- Crisis Services: reduce ED use for high risk youth in Cumberland County and closures of Crisis and Assessment Services in Wake County
- Person-Centered Plans: improve quality of PCPs
- First Responder: test crisis lines of providers after business hours
- Intensive In-Home: improve the quality of IIH services
- MH/SUD Care Coordination: improve adherence to procedures, reduce authorization request denials
- Access to Care: improve initiation of services for Urgent and Routine callers
- Access to Care: improve initiation of services for Emergent callers
- Initiation in Innovations Services within 45 days: Increase the number of new Innovations consumers who received their first service within 45 days of plan approval
- TCLI Project: Increase number of private housing units available and rented to individuals in TCLI population

Alliance successfully closed, and maintained improvement, in four QIPs
- Grievances: Reduce staff error rate in reporting system
- UM Call Monitoring-IDD staff: improve adherence to greeting protocol
- UM Call Monitoring-MH/SUD staff: improve adherence to greeting protocol
- Inter-Rater Reliability (IDD): Improve consistency in decision making among IDD Care Management staff

NOTE: Details about each QIP and its current status are available separately on formal QIP Report Forms.

Analysis:
Alliance met the federal, state and URAC requirements for the number and types of QIPs.

QIP Successes:
- First Responder: 75% of calls answered satisfactorily, best results since project started in 2012; only one agency referred to Compliance (9 last year)
- Improve PCPs – 92% of PCPs reviewed met or partially met health/safety elements
- Initiation in IDD (Innovations) Services – Continue to exceed benchmark of 85% timely care for 3 quarters (100%, 94%, 88%)
- Continued high level of consistency in Inter-Rater Reliability (IRR) studies with UM Care Managers (IDD and MH/SA)
- Sustained adherence to Alliance procedures for greeting staff who call from providers (93% met)

Concerns:
- Crisis Services: Reduction in CAS closures not due to intervention - fewer individuals showing to Monarch after regular business hours even though facility is open later every weekday, numbers did start increasing in May
- Access to Care QIP: Continued poor show rate of individuals identified as Urgent showing for care within 2 days, even worse for individuals releasing from incarceration

FY 2018 Strategy:
Alliance will continue the following QIPs which have not yet met project goals:
- Crisis services: reduce crisis and assessment closures in Wake and ED use in Cumberland
- First Responder: improve provider response to after-hours crisis calls
- Intensive In-Home: improve IIH services via EBPs
- Care Coordination: Improve timeliness of contact for individuals discharging from inpatient services
- Access to Care-Emergent: Improve percent of individuals who show for Emergent care in timely manner
- Access to Care-Routine/Urgent: improve timeliness of services
- TCLI Project: Increase private housing options for TCLI population
Alliance will close the following QIPs in FY18, which met program goals, and conduct post-closure analysis to meet the URAC requirement of one year of sustained improvement:

- Person Centered Plans: improve PCP quality, health and safety elements
- Innovations: Improve timeliness of services for individuals who recently received Innovations slots
ITEM: Alliance Key Performance Indicators

DATE OF BOARD MEETING: October 5, 2017

BACKGROUND: Alliance leadership reviews monthly key performance indicators to ensure organizational performance is on track and where needed course corrections are identified and implemented. This training will review our current key performance indicators with the goal of providing the Board quarterly reviews.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Michael Bollini, PhD, Executive Vice-President/Chief Operating Officer
ITEM:  Board Training: Walkthrough of Consumer Experience Accessing Services

DATE OF BOARD MEETING:  October 5, 2017

BACKGROUND:  Board Members have requested training on the various ways that Alliance members are able to access services.

REQUEST FOR AREA BOARD ACTION:  Accept the report.

CEO RECOMMENDATION:  Accept the report.

RESOURCE PERSON(S):  Sara Wilson, Director of Government Relations
Walkthrough of the Consumer Experience
Accessing Services
Points of Entry – “No Wrong Door”

- Access and Information Center
- Service Providers
- Crisis Continuum
- Care Coordination
- Community Relations

Member Linked to Services
Caller places call to Alliance Access & Information Center

Is individual calling with a MH/SU/IDD need?

**NO**

Caller is provided resources on Non-Behavioral Health providers (Housing, Financial Assistance, Medical, etc.)

**YES**

Caller is screened for BH needs by Access Coordinator

Access Coordinator determines if caller is at emergent risk to self or others

**NO**

Caller has IDD/TBI Needs

Caller is referred to IDD or TBI Access Specialists for eligibility determination

**YES**

Caller transferred to Access Clinician (licensed staff)

CALLER IS LINKED TO SERVICE PROVIDER/SERVICES BASED ON BENEFIT PLAN

Caller has MH/SUD Needs

ROUTINE/URGENT CALL

Caller’s needs established financial eligibility determined (Medicaid/State)

**NO**

Caller is linked to service provider/services based on benefit plan

**YES**

EMERGENT CALL

Caller transferred to Access Clinician (licensed staff)

Crisis Services Engaged: Mobile Crisis Facility Based Crisis Inpatient 911/CIT Officer

Caller is linked to service provider/services based on benefit plan
Individual is screened for life threatening emergency

Is individual enrolled with Alliance?
- **NO**
  - Provider completes member enrollment
- **YES**
  - Updates member information as needed in portal
  - Submits relevant SAR upon enrollment confirmation from Alliance

Service Provider

Submits Service Authorization Request (SAR)

Services initiated by provider
Hospital/Crisis Liaison notified or determines Alliance member is present (Daily Census)

Researches individual’s clinical information
- Provider History
- CCNC Involvement
- Care Coordination Eligibility
*Discharge Planning

Refer to Care Coordination if individual meets criteria

Is individual already connected to a service provider?

Individual is linked to existing community provider within 7 days of discharge

Individual is linked to new community provider within 7 days of discharge

Yes

No
Access and Information Center

- Responded to 62,000+ calls in FY17
- 28,000 more outbound follow-up calls made to ensure engagement

Crisis Continuum

- 8800+ people served by Crisis and Assessment Centers in 2016
- 2,100+ diverted from EDs and jails
- Nearly 1,500 supported by Mobile Crisis
• MH/SA Care Coordinators helped 5,500 individuals in 2016
• I/DD Care Coordinators worked with another 1832

• Staff embedded throughout community
• 280+ community events last year
• 900 trained in MHFA last year