MEMBERS PRESENT: ☒Glenn Adams, ☒Cynthia Binanay, Chair, ☒Christopher Bostock, ☒Heidi Carter, ☐George Corvin, MD, Vice-Chair, ☒James Edgerton, ☒Lodies Gloston, ☒Phillip Golden, ☒Duane Holder, ☒Curtis Massey, ☒George Quick, ☒William Stanford, Jr. (entered at 4:15 pm), ☒Lascel Webley, Jr., and ☒McKinley Wooten, Jr.

GUEST(S) PRESENT: Denise Foreman, Wake County Manager’s Office; Yvonne French, DMH (NC Department of Health and Human Services/Division of Mental Health); Mary Hutchins, Wake County Finance Department; and Israel Pattison, CFAC Chair

ALLIANCE STAFF PRESENT: Damali Alston, Director of Network Evaluation; Michael Bollini, Executive Vice-President/Chief Operating Officer; Hank Debnam, Cumberland Site Director/Veterans Point of Contact; Denise Dirks, Administrative Assistant II; Diane Fening, Administrative Assistant III; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Veronica Ingram, Executive Assistant II; Katherine Hobbs-Knutson, MD, Chief Medical Officer; David Jones, Appeals Coordinator; Ken Marsh, Medicaid Program Manager; Beth Melcher, Executive Vice-President/Care Management; Ann Oshel, Senior Vice-President/Community Relations; Sara Pacholke, Senior Vice-President/Financial Operations; Brian Perkins, Senior Vice-President/Strategy and Government Relations; Laura Pollock, Administrative Assistant II (via phone); Monica Portugal, Chief Compliance Officer; Roosevelt Richards, Criminal Justice Specialist; Robert Robinson, Chief Executive Officer; Laylon Williams, Criminal Justice Specialist; Sara Wilson, Government Relations Director; Carol Wolff, General Counsel; Doug Wright, Director of Individual and Family Affairs; Jeff Wright, Finance Manager; and Carla Young, Administrative Assistant I

1. CALL TO ORDER: Chair Cynthia Binanay called the meeting to order at 4:05 pm.

AGENDA ITEMS:  

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<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
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<tr>
<td>2. Oath of Office</td>
<td>Veronica Ingram, notary public, administered the oath of office to Duane Holder.</td>
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</table>
| 3. Announcements | A. Outgoing Board Members: Chair Binanay expressed gratitude to outgoing Board members; she presented commemorative plaques to Phillip Golden, George Quick, and William Stanford, Jr. Their terms end March 31, 2018.  
| | B. Budget Retreat: Chair Binanay reminded Board members of this annual meeting on March 27, 2018. Kelly Goodfellow, CFO, will forward additional information.  
| | C. Mental Health Awareness: Chair Binanay reminded Board members of an upcoming event: May 22 Children’s Mental Health Awareness Dinner. Mr. Robinson shared that notice of additional Mental Health Month events is forthcoming.  
| | D. EQR (External Quality Review) Report: Mr. Robinson and Ken Marsh, Medicaid Program Manager, presented an overview of this report and next steps. |
| 4. Agenda Adjustments | There were no adjustments to the agenda. |
| 5. Public Comment | There were no public comments. |
| 6. Committee Reports | A. Consumer and Family Advisory Committee – page 6  
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. |
AGENDA ITEMS:  

This month’s report included minutes from the February Steering, Durham, and Wake committees and minutes from the Cumberland January meeting.

Israel Pattison, CFAC Chair, presented the report. Mr. Pattison mentioned that each subcommittee meets monthly in their respective counties; the joint steering committee also meets monthly and alternates between in-person and telephonic meetings. He thanked Chair Binanay and Mr. Robinson for attending the last steering committee meeting. Additionally, Mr. Pattison provided an overview of upcoming subcommittee meetings and new CFAC members. The CFAC report is attached to and made part of these minutes.

BOARD ACTION  
The Board received the report.

B. Finance Committee – page 26  
The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Board. This month’s report included draft minutes from the February 1, 2018, meeting, the Statement of Revenue and Expenses (Budget to Actual) report, and ratios for the period ending January 31, 2018. James Edgerton, Committee Chair, presented the report. Mr. Edgerton mentioned that all State mandated ratios were met; expenditures exceeded revenue due to a reduction in State funding. Additionally, he mentioned that the Finance Committee recommends that the Board approve Jeff Wright, Finance Manager, as Deputy Finance Officer. He also mentioned that the Finance Committee recommends approval of agenda item 9: Grant to Vermilion Homestead, LLC.

BOARD ACTION  
A motion was made by Mr. James Edgerton to approve Jeff Wright as Deputy Finance Officer; motion seconded by Mr. Lascel Webley. Motion passed unanimously.

C. Policy Committee – page 32  
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 November meeting, policies for continued use and policies with recommended changes.

The following policies were included in the agenda packet for approval without revisions: CC1: Coordination of Care for Special Health Care Population Policy Management of Service Delivery; CR1: Client’s Rights to Dignity Privacy and Humane Care; CR2: Client’s Right to Confidentiality; CR3: Consumer Choice; CR4: Advanced Directives Advanced Instructions; CS1: Customer Services; PN1: Selection and Retention of Providers; PN2: Letters of Support; PN3: Provision of Services by Relatives-Legal Guardians; PN5: Rule Waiver Requests; QM1: Consumer, Provider and Stakeholder Satisfaction; QM2: Management and Investigation of Grievances; QM3:
AGENDA ITEMS:  

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<th>DISCUSSION:</th>
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Mr. Massey reviewed recommended changes for the following policy: G10: Delegation of Authority to the Chief Executive Officer.

**BOARD ACTION**

A motion was made by Mr. Phillip Golden to approve revised policy G10: Delegation of Authority to the Chief Executive Officer, and those policies which were presented by the Policy Committee for approval without modification, same being CC-1, CR-1-4, CS-1, PN-1, 2, & 5, QM1-3, and QM-1-5; motion seconded by Mr. McKinley Wooten. Motion passed unanimously.

7. **Consent Agenda**

A. Draft Minutes from February 1, 2018, Board Meeting – page 64
B. Audit and Compliance Committee Report – page 70
C. Executive Committee Report – page 72
D. Network Development and Services Committee Report – page 75
E. Quality Management Committee Report – page 105

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 Mr. William Stanford to adopt the consent agenda; motion seconded by Mr. Christopher Bostock. Motion passed unanimously.

8. **Appointment Recommendations**

In accordance with NC General Statute 122C-118.1.d and the By-Laws of the Alliance Board, the initial terms of Alliance Board members were staggered with each initial term being considered a full term. A seat representing Durham County is currently vacant. Chair Binanay shared that the Board Executive Committee is recommending David Curro for this seat, with a term ending March 31, 2020. His application was sent previously to Board members.

**BOARD ACTION**

A motion was made by Mr. Curtis Massey to recommend that the Durham Board of County Commissioners appoint David Curro to Alliance’s Board; motion seconded by Mr. Christopher Bostock. Motion passed unanimously.

9. **Grant to Vermilion Homestead, LLC**

The developer, Vermilion Homestead, LLC, is seeking a grant from Alliance in the amount of $300,000.00 in consideration for 12 townhome type units for 20 years located at 1311 Cooke Road in Durham. These funds are included in the 2017-2018 Alliance Budget for housing initiatives. The grant is contingent upon NCHFA (NC Housing Finance Agency) approving Vermilion Homestead, LLC’s Integrated Supportive Housing Program (ISHP) loan application.
### AGENDA ITEMS:

### DISCUSSION:

**Carol Wolff, General Counsel,** reviewed the proposed grant; details of the proposal were sent as part of the board packet. Ms. Wolff mentioned the benefits of this proposal which is also in the current fiscal year’s budget.

**BOARD ACTION**

A motion was made by Commissioner Heidi Carter to approve issuing a grant of $300,000 to Vermilion Homestead with 12 units reserved for use by Alliance, and subject to approval of the ISHP (integrated supportive housing program w/ NCHFA); motion seconded by Mr. Phillip Golden. Motion passed unanimously.

10. **Training(s)/Presentations**

   **A. Overview of Jail Mental Health Initiatives – page 193**
   
   Ann Oshel, Senior Vice-President of Community Relations, presented an overview of Alliance’s jail mental health and criminal justice initiatives. Ms. Oshel reviewed current criminal justice efforts, CIT (Crisis Intervention Teams) training for law enforcement officials to interact with persons in a mental health crisis; she also included current numbers of officers trained in each county in Alliance’s catchment area.

   Additionally, Ms. Oshel mentioned the Stepping Up Initiative; this is a national initiative to reduce the number of people with mental illness in jails. Ms. Oshel mentioned the significance of data to develop targeted intervention; this is done through the CJ LEADS report which is compiled daily in each county in Alliance’s catchment area. Board members clarified current post-release programs, continued behavioral health services and lapse of Medicaid coverage for people who are incarcerated in jails. This presentation is attached to and made part of these minutes.

   **B. Key Performance Indicators (KPIs) – page 210**
   
   Alliance leadership reviews monthly key performance indicators to ensure organizational performance is on track and where needed course corrections are identified and implemented. Michael Bollini, Executive Vice-President/Chief Operating Officer, presented internal and external key performance indicators including a highlight of Staying Well Initiatives.

   **BOARD ACTION**
   
   The Board received the trainings/presentations.

11. **Legislative Update/Priorities – page 211**

   Brian Perkins, Senior Vice-President/Strategy and Government Relations, and Sara Wilson, Government Relations Director, presented a legislative update and Alliance’s legislative priorities for NC General Assembly’s legislative short session, which is scheduled to commence in May 2018.

   Mr. Perkins mentioned information sent previously to Board members including recent activity of the NC General Assembly. Ms. Wilson provided an update on the State’s MCAC (Medical Care Advisory Committee) subcommittees; she shared that Alliance staff are participating on these subcommittees.
**AGENDA ITEMS:**

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<td>Mr. Perkins and Ms. Wilson provided an overview of the 2018 legislative priorities. Priorities may be added and adjusted on an as-needed basis to account for developments. Board members discussed potential advocacy partners; the legislative priorities are attached to and made part of these minutes.</td>
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</table>

**BOARD ACTION**

A motion was made by Mr. James Edgerton to accept the 2018 legislative priorities as outlined by the government relations team; motion seconded by Mr. McKinley Wooten. Motion passed unanimously.

12. Chairman’s Report

Chair Binanay mentioned that next month’s meeting will be at Alliance’s community site in downtown Durham.

13. Closed Sessions

**BOARD ACTION**

A motion was made by Ms. Lodies Gloston to enter closed session pursuant to NCGS 143-318.11 (a) (1) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1.; motion seconded by Mr. William Stanford. Motion passed unanimously.

The Board returned to open session.

**BOARD ACTION**

A motion was made by Mr. Phillip Golden to approve the Johnston County deal points as presented and authorize the CEO to complete negotiations as directed; motion seconded by Mr. McKinley Wooten. Motion passed unanimously.

14. Adjournment

With all business being completed the meeting adjourned at 6:53 p.m.

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Next Board Meeting
Thursday, April 05, 2018
4:00 – 6:00 pm

Robert Robinson, Chief Executive Officer

4/5/2018 Date Approved
ITEM: Consumer and Family Advisory Committee (CFAC) Report

DATE OF BOARD MEETING: March 1, 2018

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 Steering Committee meets at 5:30pm on the first Monday each month, rotating face-to-face meetings at the Alliance Home Office, 4600 Emperor Boulevard, Durham, with telephonic meetings every other month. Local committee meetings are held in individual counties monthly, 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 February for the Steering, Durham, and Wake committees and the Cumberland January minutes along with supporting documents.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Israel Pattison, CFAC Chair; Doug Wright, Director of Individual and Family Affairs
MEMBERS PRESENT: Dr. Michael McGuire, Tracey-Glenn Thomas, Jackie Blue, Ellen Gibson, Dorothy Johnson, Carrie Morrisey, and Shirley Francis.

GUEST(S) PRESENT: Starlett Davis (Alliance), Doug Wright (Alliance), Briana Harris, Sharon Harris, Dorothy Bell, Tekeyyon Lloyd, Carson Lloyd Jr., Renee Loyd, Yvonne Linn, Jamille Blue, Angela Bayley, Nicole Caaldwell, Sharalyn Shelton, Vincent Francis, and Jason Francis.

1. WELCOME AND INTRODUCTIONS made by Dr. Michael McGuire.

2. REVIEW OF THE MINUTES – Minutes from November 2017 were approved.

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<th>AGENDA ITEMS:</th>
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<tr>
<td>Public Comment-Consumer/Family challenges and solutions</td>
<td>Starlett Davis has provided community events and resources. We went over the different events together as a group. Doug explained what CFAC was to our guest. Ms. Linn asked what the requirements to join were. Doug started out explaining what Alliance does and expectations. Doug explained the requirements in being a member of CFAC and also that guest can participate in all our open meetings. Dorothy, Michael, and Star gave input on the committee and how impactful it can be. He spoke about the importance of CFAC and their voices being impactful in assisting with concerns in the community. He explained what the Steering Committee is as well. He also went over a bit of the Medicaid Transformation and the State Funded services. Dorothy spoke about an experience she had with her daughter with the Johnston County Hospital system and how pleased she was with it. Tracey expressed her concerns about the next steps in the opioid crisis. Several members and visitors expressed their concerns on this and we discussed how this affects the community.</td>
<td>Follow up with Starlett Davis and Doug with any questions.</td>
<td>Ongoing</td>
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<td>AGENDA ITEMS:</td>
<td>DISCUSSION:</td>
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<td>Accessing Services</td>
<td>Starlett Davis gave a training on Accessing Services. No additional questions were asked.</td>
<td>Follow up with Starlett Davis with any questions.</td>
<td>Ongoing</td>
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<td>Project Update by Briana Harris</td>
<td>Brianna updated us on her project and extended the invitation to participation again to the committee.</td>
<td>Follow up with Starlett Davis with any questions.</td>
<td>March 2018</td>
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<td>Budget Retreat</td>
<td>Doug Wright explained what the retreat was. Jackie and Michael gave accounts of their experiences there and was very pleased. Jackie’s daughter accompanied her and is now interested in becoming a part of CFAC.</td>
<td>See Star and Doug for any additional information.</td>
<td>Ongoing</td>
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<tr>
<td>State Update</td>
<td>Doug Wright explained the state to local call to the committee. He went over the State CFAC meeting. They are planning a rally in Raleigh on April 12th at the Halifax Mall. There is a lot of discussion about Cardinal Innovations and the take-over by the state for fund misappropriations. That is coming to an end soon as new leadership has been put into place. There was concern about the new secretary values CFAC. A concern about our voices and continuation of them being heard in the new Medicaid system. She is new to the state and maybe having a different vision and lack of participation in the State CFAC meeting. She did show up at the last meeting. She has always expressed desires to have our opinions but CFAC is wanting to know how we are our voices going to impact.</td>
<td>Please see State Website for updates Follow up with Doug with any questions.</td>
<td>Ongoing</td>
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<td>MCO Updates</td>
<td>Doug Wright explained that the Legislature is back in session. Judicial redistricting is high on their agenda. They will shift focus in April and see how things go with the transformation. Our Alliance website has been changing. Doug encouraged the members to try to navigate it and give feedback at the next meeting. We are also coming out with a bi monthly newsletter. It will be electronic and on a hard copy. It is an internal communication for employees and people we serve, friends, and individuals in the system.</td>
<td>Please follow up with Starlett or Doug for any questions.</td>
<td>Ongoing</td>
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In the first part of January, we had an External Quality Review. When you are a Medicaid vendor, there is a requirement for an outside company to come in and make sure that your policy, procedures, and practices are up to par and you are doing what you say you are doing. They report back out and you get a corrective action plan and a best practices recommendation. The two areas for Doug were enrolling rights and appeals. Alliance did well and have scored the highest of any MCO in the state. Ms. Linn asked if the process included interview individuals we serve Doug explained that this was just internal. However, we do Consumer and family satisfaction surveys that go out annually through the state. The same is done with the provider agencies as well.

Our transition to community living program was discussed as well. It is a program where people are who have been inappropriately housed in adult care homes are transitioned to independent living in the community. We have government overseers in that program that will go out and interview to see how their experience is going. Doug explained that it is for individuals with severe and persistent mental illness that have been inappropriately housed in adult care homes. Their persistent and severe mental illness is what deems them inappropriately placed unless they have dementia or a medical issue that keeps them from living independently. The federal government came to NC and required that the issue be fixed via suit. The implementation is the program to correct this. The individuals will be surrounded with supports. It is a transition process to get them to the independent living. There is a new position called a Post Transition Engagement Specialist. They will check in on a monthly basis and do a quality of life survey to see if they are getting their needs met,
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<tr>
<td>Membership Discussion</td>
<td>seeing provider, basic needs are met, and if there are any challenges. They will connect the individual to what is needed. They will follow them for the time needed for them to feel supported. They will have an ACT team or Transition to Management Services. They both have peer supports involved.</td>
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| Prep for the next meeting | Event Planning  
Membership Recruitment  
Doug thanked everyone for coming out. He explained that he hoped that the meeting sparked an interest. He also explained that he hoped the visitors would come back out to gain more knowledge on the committee and all they do and to get a better understanding of it each time as it is a bit confusing initially as far as all the terms and changes in the mental health community. It can be overwhelming for all of us. He really appreciated the participations. Michael extended the invitation of membership and explained the process. Participation in community Meetings; Barriers and needs  
Planning for the next meeting in the community  
Obtaining new members efforts and outreach planning  
What can be done to reach the community in the upcoming meeting | Encourage membership. | Ongoing |
| | Discuss the next meeting agenda items. Go over expectations, reminders, etc for the next meeting.  
Star asked everyone to remember to look at the website and feedback. She reminded them of the importance of staying in the community and doing outreaches. The committee is to bring suggestions to the next meeting. She explained the | | |
success of the outreach effort at the Homeless and Hunger Stand Down at the end of last year.

Star also stressed the importance of membership and taking up office positions. Jackie suggested going to other organizations and presenting about CFAC. The Next meeting will be February 22nd.

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<td>Appreciation</td>
<td>Everyone gave their appreciation for the visitors and members for being there.</td>
<td>N/A</td>
<td>February 5, 2018</td>
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5. ADJOURNMENT

The meeting was adjourned at 7:15pm.
1. WELCOME AND INTRODUCTIONS
2. REVIEW OF THE MINUTES – 12.04.2017: Minutes reviewed, approved, and accepted as is.

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<tr>
<td>Public Comment</td>
<td>Dave Curro stated that his son had been seen at Carolina Outreach’ Urgent Care center and that he was very pleased with the services that he received there. He stated that his only complaint was that the meeting hours designated for a State Funding recipient were limited to 4, and he would like to have more with the therapist.</td>
<td>Ongoing</td>
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<td>Individual/Family</td>
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<td>Challenges and Solutions</td>
<td>The floor was then open to our guests: Rob Robinson, Alliance CEO, and Cynthia Binanay, Alliance Chair.</td>
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<td>Public Comment</td>
<td>Rob Robinson, Alliance CEO gave an update on the coalition with Alliance, Vaya and Trillium Healthcare. The main purpose the coalition was formed is to enhance our ability to respond to the challenges and opportunities of Medicaid reform, demonstrating to NC DHHS, the General Assembly, and potential commercial healthcare partners that MCOs are able to work together and plan for the future.</td>
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<td>Individual/Family</td>
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<td>then opened up for any questions or concerns about the coalition. Rob then stated that the main goal for this year is to try and restore the state funding cuts, and that the voice of the people will help out greatly at the general assembly. He urged CFAC members to reach out to their local representatives and tell their stories to support this goal.</td>
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<td>Cynthia Binanay, Alliance Chair, stated that there was a “lot of uncertainty in the system” at this time and asked CFAC’s how they felt about all of the negative publicity in the news. She also urged them to get out and share their stories about their experiences.</td>
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<td>A link was given for those to access the North Carolina General Assembly. Individuals can access this website and navigate to find their representative. <a href="https://www.ncleg.net/">https://www.ncleg.net/</a></td>
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<td>Doug Wright stated that he would be glad to assist anyone in writing a letter to their representative.</td>
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<td>Alliance State Plan</td>
<td>Doug Wright gave an update on the Alliance State Plan. He stated that the information that was received from the State Funds priority survey has been compiled and submitted, but reiterated that continued feedback is welcomed and still being accepted.</td>
<td>Ongoing</td>
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<td>Budget Retreat</td>
<td>Doug Wright went over presentation (ppt) on CFAC Board budget Retreat (March 2018).</td>
<td>Local CFAC’S will discuss at their regular monthly meeting.</td>
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**AGENDA ITEMS:**

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<th>Access Training</th>
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<tr>
<td>Access Training</td>
<td>Handout was given to CFAC members on Accessing the Services of the Alliance Health Plan.</td>
<td>N/A</td>
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<tr>
<th>Subcommittees</th>
<th>DISCUSSION:</th>
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<tr>
<td>Wake</td>
<td>Local CFAC’S gave their updates. Wake, Durham, and Cumberland are all striving to increase CFAC membership. Durham is working on their Recovery Event that will be taking place on April 19, 2018. Once details are finalized, all CFAC’S will receive an invitation.</td>
<td>Ongoing</td>
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<tr>
<td>Durham</td>
<td>Doug gave an update on the Human Rights Committee and Quality Management. There is room available on both of these committees and he urged local CFAC’s to have representation on them.</td>
<td>Ongoing</td>
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<td>Cumberland</td>
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<td>Area Board</td>
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<td>Human Rights</td>
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<td>Quality Management</td>
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<th>State Updates</th>
<th>DISCUSSION:</th>
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<tr>
<td>State Updates</td>
<td>None given at this time.</td>
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<thead>
<tr>
<th>Legislative/MCO Updates</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
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<tr>
<td>Legislative/MCO Updates</td>
<td>Doug Wright gave an update on the External Quality Review that took place the 2nd week of January. The complete results not in yet, but preliminary results were very well.</td>
<td>Ongoing</td>
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<th>Announcements</th>
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<tr>
<td>Announcements</td>
<td>None given at this time.</td>
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5. **ADJOURNMENT:**
7:20pm
### AGENDA ITEMS:

| Guest Speaker | Discussion: Walter Linney, Assistant Director of II Care Coordination with Alliance Behavioral Healthcare gave a presentation on the Remote Monitoring Home. He went over the following key points:  
- What is Remote Monitoring?  
- Who can access Remote Monitoring?  
- How is it effective?  
- Background  
- Q &A  

A handout was given and there is a YouTube link: [https://www.youtube.com/watch?v=u0ztsShwE8](https://www.youtube.com/watch?v=u0ztsShwE8)  
For more information please email any questions or concerns to Walter Linney: wlinney@alliancebhc.org | Next Steps: N/A | Time Frame: N/A |
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Interest in Membership/Outreach</td>
<td>Steve Hill gave an overview of CFAC and membership. Doug gave additional information on the responsibilities of CFAC members: § 2-1. Responsibilities.</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>AGENDA ITEMS:</td>
<td>DISCUSSION:</td>
<td>NEXT STEPS:</td>
<td>TIME FRAME:</td>
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<td>-------------</td>
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</tbody>
</table>
| CFAC Steering Committee | Pursuant to N.C.G.S. § 122C-170(d), the area board and the LME/MCO director shall:  
1. Establish a committee made up of consumers and family members to a Local Consumer and Family Advisory Committee (CFAC).  
2. Provide sufficient staff to assist the CFAC in implementing its duties pursuant to N.C.G.S. § 122C-170(c), including:  
   1. Data for the identification of service gaps and underserved populations;  
   2. Training to review and comment on business plans and budgets;  
   3. Procedures to allow participation in quality monitoring; and  
   4. Technical advice on rules of procedure and applicable laws |  |  |
| Budget Retreat | Dave Curro gave an overview of the Steering committee meeting from 02.05.2018. Meeting recap included updates from Alliance CEO Rob Robinson, and Board Chair, Cynthia Binany who were both in attendance, Carolina Outreach Urgent Care, Budget Retreat, and advocacy from CFAC's. | N/A |  |
| Event Planning | Doug briefly went over the Budget retreat presentation that is in its beginning (PowerPoint) and urged CFAC members to take time and gather their thoughts and feedback to Israel Patterson for the upcoming retreat that will take place on March 27, 2018. | Ongoing |  |
| | We are in the finalization stages of the Recovery Event that is to take place on 04.19.2018 530-830. The group decided that the movie Next Generation is the first choice. In the event this movie viewing cannot be secured, the second choice in | Ongoing |  |
## AGENDA ITEMS:

<table>
<thead>
<tr>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
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</thead>
<tbody>
<tr>
<td>Anonymous People. Ramona will follow up with Doug to see options for acquiring Next Generation. Steve Hill/TROSA is responsible for the tents, chairs (75), and tables (8) for the resource portion of the event. He has also volunteered for trash and recycle. The menu for the event: Hotdogs (2 per person), popcorn, and sodas. Condiments: Mustard, Ketchup, Relish, and Chili. Ramona and Alliance staff volunteers will prepare the hotdogs, and have the popcorn bagged for individuals. A flier will be made in the next 2 weeks and it will be distributed throughout the community as well as invitations to community school board members, Board of Directors, and County commissioners.</td>
<td></td>
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</tbody>
</table>

Ramona announced a job opening in the Community Relations Department. Family Navigator This job description can be accessed and applied for via the Alliance website, under the careers tab. [www.alliancebhc.org](http://www.alliancebhc.org) | Open until filled |  |

### Announcements/Opportunities

5. **ADJOURNMENT:**

6:45pm
MEMBERS PRESENT: Carole Johnson, Eric Hall, Cynthia Hall,
GUEST(S) PRESENT: Annette Smith, Ben Smith

Dial +1 (605) 472-5464
Access Code: 289674
Pin: 8803

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
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</thead>
<tbody>
<tr>
<td>New Members</td>
<td>Ben Smith, Annette Smith&lt;br&gt;Eric Hall waive the quorum and Cynthia Hall second the motion to vote Ben Smith and Annette Smith to the Wake CFAC 5:42.</td>
<td>Annette and Ben to send in stipend paperwork.</td>
<td>2/16/2018</td>
</tr>
<tr>
<td>Budget Retreat March 27</td>
<td>Discuss what CFAC members would like to discuss to Alliance Behavioral Healthcare Board and Executive management. Annette asked if the Board and Staff listens to the CFAC suggestions. Doug explained how CFAC reports out to the board and gave as an example, items that had been accomplished and were items CFAC had recommended. Certainly CFAC wasn’t the only driving force yet their voice had an impact. Doug reassured everyone that they had the board and staff’s ear with their concerns. Doug advised how Harrington Place was created for chronically homeless individual. Annette explained what co-housing is.</td>
<td>Members to review and send additional information via email to Israel and Doug.</td>
<td>2/28/2018</td>
</tr>
<tr>
<td>Event planning and membership recruitment</td>
<td>Town of Cary Special Event is hosting an event to educate citizens what your community has to offer. This would be an excellent opportunity to share about Alliance CFAC. Stacy Guse is going to this event representing ABH and would welcome a CFAC member at the table. Please visit: <a href="http://townofcary.org/recreation-enjoyment/events/special-events/share-care.">http://townofcary.org/recreation-enjoyment/events/special-events/share-care.</a></td>
<td>Attend and participate if you can.</td>
<td>2/16/2018</td>
</tr>
</tbody>
</table>
Who from Wake CFAC will attend the Steering Committee?

| Should be the chair and someone else. Israel will be attending because he is the overall chair, so if Carole is voted in as Wake Chair, she would also be a designee. Anyone is always welcome to attend. |
| Carole Johnson to start attending with Israel. |
| March 5, 2018 via conference call. |

Wake Chair open position as well as possibly voting in/welcoming new members

| It was presented to vote Carole Johnson as Wake Chairperson. Annette made a motion to vote Carole Johnson as Wake Chair and Cynthia Hall second. All said Aye 6:39. |
| Congratulations! |

MCO Updates

| Legislature adjourned without any legislation around Medicaid transformation. |
| None. |

Training: Remote Monitoring House

| Doug presented the Remote Monitoring power point and answered questions. The power point was to be emailed to all members so they could access the u-tube video. |
| Email the presentation. Utilize the service. |
| 2/14/2018 |

CFAC

| Board budget Retreat March 2018 Doug explained the importance of CFAC and its impact at 6:19. |
| Give feedback. |
| 2/28/2018 |

Church participation

| Annette suggested to reach out to the church communities for support. Carole talked about some of her connections. The two of them and Stacy are to get together and discuss how they may collaborate with churches to get information out about CFAC and the system as a whole. |
| Set up conference call to discuss opportunities. |
| 3/13/2018 |

5. ADJOURNMENT

Carole recommended adjournment and Cynthia second at 6:56
Remote Monitoring Home

Wake CFAC
February 13, 2018
What is Remote Monitoring?

• Use of wireless censors and live remote staff to monitor and respond to individuals with special needs during nighttime hours.

• Components include:
  • Technology
  • Live Monitoring
  • Response
Who Can Access Remote Monitoring?

• Anyone receiving Innovations waiver benefits (service code: Assistive Technology Equipment & Supplies).

• Beneficial to individuals who want to live more independently in their family’s home or in a home they rent/own.

• Individuals receiving Supported Living Level 2 can use RM in lieu of awake overnight staff (if appropriate).
How Is It Effective?

• Reduces reliance on live staff during nighttime hours.
• Promotes increased independence.
• Lowers total cost of care.
RM Home - Background

• Initiative supported through the Alliance reinvestment fund.

• Funded through September 2018.

• Goals:
  
  • To determine if remote monitoring can support individuals to live more independently (i.e. can technology be effective at alleviating the need for live staff during nighttime hours?)
  
  • To create an opportunity for individuals to experience what it’s like to live independently.
Need More Info?

• Youtube video link: https://www.youtube.com/watch?v=u0zts5hwteE8

• Contact your assigned Alliance IDD Care Coordinator to make a referral.

• Contact Walter Linney, Assistant Director of IDD Care Coordination at wlinney@alliancebhc.org
ITEM: Finance Committee Report

DATE OF BOARD MEETING: March 1, 2018

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 February 1, 2018 meeting, the Statement of Revenue and Expenses (Budget to Actual) report and ratios for the period ending January 31, 2018.

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
APPOINTED MEMBERS PRESENT: ☒Chris Bostock, BSIM, ☒James Edgerton, B.S. (Committee Chair), ☒George Quick, M.B.A. ☒Cynthia Binanay; and ☒Lascel Webley, Jr.

BOARD MEMBERS PRESENT: N/A
GUEST(S) PRESENT: Mary Hutchings, Wake County Internal Audit, Vicki Evans, Cumberland County Finance Officer
STAFF PRESENT: Rob Robinson, CEO (LCAS); Kelly Goodfellow, EVP/CFO; Sara Pacholke, SVP-Financial Operations (CPA)

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the December 7, 2017, meeting were reviewed; a motion was made by Mr. Edgerton and seconded by Ms. Binanay to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
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<th>TIME FRAME:</th>
</tr>
</thead>
</table>
| 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 December 31, 2017.  
  a) Alliance has savings of $565,881 through December 31, 2017. Alliance is meeting all required Senate Bill 208 and DMA contract ratios.  
  b) A request was made to show the fund balance amount to help clarify the reports. | Sara Pacholke will propose a change and share with Cynthia Binanay and Jim Edgerton for feedback. |                   |
<p>| 5. Budget Retreat Discussion | The budget retreat will have a recommendation regarding IPRS services.                                                                 |                                                  |                   |
| 6. IPRS Review        | Rob Robinson discussed that there will be a presentation in the Board meeting going over an IPRS overview and a survey for Board members to complete to give feedback. Kelly Goodfellow discussed that the contract caps related to UCR contracts have been lifted. These caps were set to help budget and not overspend, however it has resulted in providers not spending and limiting the number of patients. |                                                  |                   |</p>
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<tbody>
<tr>
<td>7. Deputy Finance Officer and Budget Amendment</td>
<td>A recommendation to appoint a deputy finance officer and a budget amendment will be presented at the March board meeting.</td>
<td></td>
<td></td>
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</tbody>
</table>

8. **ADJOURNMENT:** The next meeting will be March 1, 2018, from 3:00 p.m. to 4:00 p.m.
<table>
<thead>
<tr>
<th></th>
<th>Original Budget</th>
<th>Current Period</th>
<th>Q1</th>
<th>Q2</th>
<th>Year to Date</th>
<th>Balance</th>
<th>% Received/Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Grants</td>
<td>$36,857,390.00</td>
<td>$3,163,698.22</td>
<td>$3,871,095.36</td>
<td>$6,961,134.11</td>
<td>$13,995,927.69</td>
<td>$22,861,462.31</td>
<td>37.97%</td>
</tr>
<tr>
<td>State &amp; Federal Grants</td>
<td>47,781,186.00</td>
<td>3,700,881.61</td>
<td>8,500,889.73</td>
<td>11,406,120.48</td>
<td>23,607,891.82</td>
<td>24,173,294.18</td>
<td>49.41%</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>359,425,264.00</td>
<td>28,947,333.21</td>
<td>90,576,459.90</td>
<td>96,278,191.66</td>
<td>215,801,984.77</td>
<td>143,623,279.23</td>
<td>60.04%</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$444,063,840.00</td>
<td>35,811,913.04</td>
<td>102,948,444.99</td>
<td>114,645,446.25</td>
<td>253,405,804.28</td>
<td>190,658,035.72</td>
<td>57.07%</td>
</tr>
<tr>
<td><strong>EXPENSES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>96,278,191.66</td>
<td>215,801,984.77</td>
<td>143,623,279.23</td>
<td>60.04%</td>
</tr>
<tr>
<td>Total Service Expenses</td>
<td>$444,063,840.00</td>
<td>35,811,913.04</td>
<td>102,948,444.99</td>
<td>114,645,446.25</td>
<td>253,405,804.28</td>
<td>190,658,035.72</td>
<td>57.07%</td>
</tr>
<tr>
<td><strong>CHANGE IN NET POSITION</strong></td>
<td>($4,844,085.87)</td>
<td>($2,255,757.77)</td>
<td>$2,821,639.21</td>
<td>($4,278,204.43)</td>
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</tr>
</tbody>
</table>
**Senate Bill 208 Ratios - As of January 31, 2018**

**CURRENT RATIO**

- 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.

<table>
<thead>
<tr>
<th>Month</th>
<th>Benchmark</th>
<th>Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>3.28</td>
<td></td>
</tr>
<tr>
<td>Sep-17</td>
<td>2.93</td>
<td></td>
</tr>
<tr>
<td>Oct-17</td>
<td>3.11</td>
<td></td>
</tr>
<tr>
<td>Nov-17</td>
<td>2.89</td>
<td></td>
</tr>
<tr>
<td>Dec-17</td>
<td>2.63</td>
<td></td>
</tr>
<tr>
<td>Jan-18</td>
<td>2.68</td>
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</table>

**PERCENT PAID**

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

<table>
<thead>
<tr>
<th>Month</th>
<th>Benchmark</th>
<th>Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>99.94%</td>
<td></td>
</tr>
<tr>
<td>Sep-17</td>
<td>99.93%</td>
<td></td>
</tr>
<tr>
<td>Oct-17</td>
<td>99.82%</td>
<td></td>
</tr>
<tr>
<td>Nov-17</td>
<td>99.96%</td>
<td></td>
</tr>
<tr>
<td>Dec-17</td>
<td>99.96%</td>
<td></td>
</tr>
<tr>
<td>Jan-18</td>
<td>99.96%</td>
<td></td>
</tr>
</tbody>
</table>
**DMA Ratios - As of January 31, 2018**

**Defensive Interval**

$\text{Defensive Interval} = \frac{\text{Cash} + \text{Current Investments}}{\text{Average daily operating expenses}}$. This ratio shows how many days the organization can continue to pay expenses if no additional cash comes in. The requirement is 30 days or greater.

**Medical Loss Ratio (MLR)**

$\text{Medical Loss Ratio (MLR)} = \frac{\text{Total Services Expenses} + \text{Administrative Expenses}}{\text{Total Medicaid Revenue}}$. The requirement is 85% or greater cumulative 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. Each percentage above is the cumulative MLR for the respective fiscal year.
ITEM: Policy Committee Report

DATE OF BOARD MEETING: March 1, 2018

BACKGROUND: Per Alliance Behavioral Healthcare Area Board Policy “Development of Policies and Procedures”, the Board is to review all policies annually. The Board Policy Committee reviews a number of Policies each quarter in order to meet this requirement.

Policies reviewed at the November 9, 2017, Policy Committee meeting and ready for Board approval without revisions:
CC1: Coordination of Care for Special Health Care Population Policy Management of Service Delivery
CR1: Client’s Rights to Dignity Privacy and Humane Care; CR2: Client’s Right to Confidentiality;
CR3: Consumer Choice; CR4: Advanced Directives Advanced Instructions
CS1: Customer Services
PN1: Selection and Retention of Providers; PN2: Letters of Support; PN3: Provision of Services by Relatives-Legal Guardians; PN5: Rule Waiver Requests
QM1: Consumer, Provider and Stakeholder Satisfaction; QM2: Management and Investigation of Grievances; QM3: Management of Incidents

Policies reviewed with suggested revisions:
UM6: Eligibility for Services
G10: Delegation of Authority to the Chief Executive Officer. Note that this policy was reviewed at the February 8, 2018, meeting of the Policy Committee.

REQUEST FOR AREA BOARD ACTION: Accept the report. Accept Board Policy Committee minutes from the November meeting as submitted. As part of the annual review process approve the above listed policies for continued use. Approve the recommended changes to the above listed policies.

CEO RECOMMENDATION: Accept the report. Approve the reviewed policies for continued use and approve the proposed revised policies.

RESOURCE PERSON(S): Curtis Massey, Committee Chair; Monica Portugal, Chief Compliance Officer
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES: The minutes from the September 21, 2017, meetings were reviewed; a motion was made by Mr. Golden and seconded by Mr. Massey to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Documents Provided</td>
<td>Agenda, Minutes from the September 21, 2017 meeting, Care Coordination Policies, Client Rights Policies, Customer Services Policies, Provider Network Policies, Quality Management Policies and Utilization Management Policies</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
| Annual Review of Policies | Care Coordination Policies reviewed and considered for continued use without revisions requiring Board approval:  
CC1: Coordination of Care for Special Health Care Population Policy  
A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.  

Care Coordination Policies reviewed with suggested revisions:  
None  

Client Rights Policies reviewed and considered for continued use without revisions requiring Board approval:  
CR1: Client’s Rights to Dignity Privacy and Humane Care  
A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy with non-substantive change. Motion carried. | Draft minutes, reviewed policies and Agenda Action Form will be provided to the Board Clerk for inclusion in the Board Packet |
<table>
<thead>
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</thead>
<tbody>
<tr>
<td>CR2: Client’s Right to Confidentiality Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
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</tr>
<tr>
<td>CR3: Consumer Choice Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
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<tr>
<td>CR4: Advanced Directives Advanced Instructions Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
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<tr>
<td><strong>Client Rights Policies reviewed with suggested revisions</strong></td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Customer Services Policies reviewed and considered for continued use without revisions requiring Board approval:</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>CS1: Customer Services Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
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<tr>
<td><strong>Customer Services Policies reviewed with suggested revisions:</strong></td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Provider Network Policies reviewed and considered for continued use without revisions requiring Board approval:</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>PNI1: Selection and Retention of Providers Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
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</tbody>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>PN2: Letters of Support Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PN3: Provision of Services by Relatives-Legal Guardians Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PN5: Rule Waiver Requests Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
<td></td>
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<tr>
<td>Provider Network Policies reviewed with suggested revisions:</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Management Policies reviewed and considered for continued use without revisions requiring Board approval:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QM1: Consumer, Provider and Stakeholder Satisfaction Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QM2: Management and Investigation of Grievances Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QM3: Management of Incidents Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
<td></td>
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</tr>
</tbody>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
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</thead>
<tbody>
<tr>
<td>Quality Management Policies reviewed with suggested revisions:</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilization Management Policies reviewed and considered for continued use without revisions requiring Board approval:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UM1: Accessibility of UR-UM Process Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
<td></td>
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<tr>
<td>UM2: Pre-Review Screening for Certification Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
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<tr>
<td>UM3: Utilization Review Criteria Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
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<td>UM4: Utilization Review Process Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
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<tr>
<td>UM5: Appealing Clinical Utilization Management Decisions Policy</td>
<td>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as presented. Motion carried.</td>
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<td>Utilization Management Policies reviewed with suggested revisions:</td>
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<tr>
<td>UM6: Eligibility for Services</td>
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<td>AGENDA ITEMS:</td>
<td>DISCUSSION:</td>
<td>NEXT STEPS:</td>
<td>TIME FRAME:</td>
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<td>Board Finance Committee submitted proposed changes to move UM6 to Business Operations and proposed changes to the purpose and policy statements.</td>
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<td>Data and proposed revisions will be presented to Executive Committee 11/21/17, to Board of Directors in December.</td>
</tr>
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<td><em>A motion was made by Mr. Golden and seconded by Mr. Massey to accept the policy as amended. Motion carried.</em></td>
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<td>Proposed Amendment to By-laws</td>
<td>Committee discussed a proposed change related to quorum and suggested to review one year of data to assist in evaluating how often lack of quorum impacts committee meetings.</td>
<td>Executive Assistant will be asked to provide one year of data on how often lack of quorum impacts meetings.</td>
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<td>Committee decided to present the proposed revision to the by-laws to the Board Executive Committee before presenting it to the Board of Directors.</td>
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<td>The committee also added a provision stating that a non-Board member having a conflict of interest appointed to a committee shall be a non-voting member and shall not count towards establishing quorum.</td>
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<td><em>A motion was made by Mr. Golden and seconded by Mr. Massey to move forward with this proposal. Motion carried.</em></td>
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<tr>
<td>Proposed Amendment to By-Laws: QM Committee Composition</td>
<td>Ms. Binanay asked whether additional QM committee members – non-voting provider reps – are permitted. Ms. Wolff explained that more voting members than non-voting members still would be required.</td>
<td>The committee will move forward with recommendation to present this revision of the by-laws to the Board of Directors. The committee will present the revision to the Executive Committee before presenting it to the Board of Directors.</td>
<td>Data to be presented to Executive Committee 11/21/17, to Board of Directors in December.</td>
</tr>
<tr>
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<td>The committee added a provision increasing the number of provider reps to <em>plus at least 2.</em></td>
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<td><em>A motion was made by Mr. Golden and seconded by Mr. Massey to move forward with this proposal. Motion carried.</em></td>
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</tbody>
</table>
3. ADJOURNMENT: @ 5:30 pm
I. PURPOSE

The purpose of this policy is to define the relationship between the Alliance Behavioral Healthcare Board of Directors (Board of Directors) and the Chief Executive Officer.

II. DEFINITIONS

Chief Executive Officer: The Chief Executive Officer is the Area Authority’s chief executive officer. The Chief Executive Officer is hired and evaluated by the Board of Directors and is responsible for leading and managing the Area Authority’s business and affairs.

III. POLICY STATEMENT

The Board of Directors shall maintain an ongoing relationship with the Chief Executive Officer that will ensure the effective and efficient operation of the Area Authority’s programs and services.

IV. PROCEDURES

A. Delegation of Authority and Responsibility to the Chief Executive Officer

The Chief Executive Officer shall be employed by the Alliance Behavioral Healthcare Board of Directors (Board of Directors) to administer the affairs of the Area Authority within the policies and procedures adopted by the Board of Directors and applicable Federal, State and local laws and regulations. The duties of the Chief Executive Officer shall include but are not limited to:

1. Hire, suspend and dismiss employees as necessary.
2. Provide the Board of Directors with required reports, data and information regarding programs, services, finances and any other business areas as identified by the Board of Directors.
3. Assume overall responsibility for implementing programs and services, including the execution of Provider contracts pursuant thereto.
4. Develop procedures to implement the policies of the Board of Directors.
5. Administer and monitor the Area Authority budget and recommend changes.
6. Define duties and establish the compensation of the Area Authority employees.
7. Evaluate the Area Authority employees.
8. Serve as the primary liaison between the Board of Directors and the NC Department of Health and Human Services.
9. Assist the Board of Directors in understanding their legal responsibilities in performance of their assigned duties.
10. Meet with the Board of Directors or specific Board of Directors members, during regularly established, or impromptu, meetings as required.
11. Negotiate, approve and execute settlement agreements of provider and consumer appeals deemed necessary and in consultation with General Counsel.
12. Enter into all necessary non-Provider contracts (including but not limited to consultant, service contracts, and purchase of goods) and extensions and amendments thereto costing $250,000 or less cumulatively within one fiscal year. Requests for non-Provider contracts estimated to cost over $250,000 greater than this amount shall be presented to the Board Finance Committee for consideration and authorization for approval by the Board. Nothing herein delegates authority to the CEO for those matters set forth in the Board By-laws requiring approval by a super majority of the Board. The CEO may delegate his authority for non-Provider contracts costing $250,000 or less, as deemed necessary for the efficient operation of the organization. Further delegation of contract approval to the CEO as deemed appropriate by the Board and the CEO may delegate his authority hereunder as deemed necessary for the efficient operation of the organization.

B. Board of Directors Access to Area Authority Management and Employees

From time to time Board of Directors members may need to interact with staff of the Area Authority in order for the Board to fulfill its mission. The Chief Executive Officer shall develop the framework and procedures to facilitate Board/staff interaction.
I. PURPOSE

The purpose of this policy is to acknowledge the enrollment and coverage of Medicaid eligible consumers enrolled in the Prepaid Inpatient Health Plan (PIHP) of Alliance as well as to establish financial eligibility criteria for individuals not eligible for Medicaid and who are seeking treatment in the Alliance Provider Network. Eligibility for non-Medicaid funded services is not an entitlement and is contingent upon availability of funding/coverage.

II. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to comply with the DHHS Division of Medical Assistance contract in that all Medicaid categories listed as eligible in the contract are covered by Alliance as part of the 1915 (b)(c) Waiver operations.

It is the policy of Alliance Behavioral Healthcare to establish financial eligibility criteria by which consumers/individuals may be eligible for the use of state funds as payment for behavioral health services to a non-Medicaid eligible individual in the Alliance area. For an individual to receive state funded treatment services, the following basic criteria must be met:

1. There must be funding available to pay for such treatment;
2. The individual must be a resident of a county in the Alliance catchment area;
3. There must be no other payer to cover the cost of care; and
4. The individual or minor individual’s parent or legal guardian are deemed financially eligible for services, as defined below.

An individual meets financial eligibility if the household income is at or below 300% of the federal poverty level and they have no assets or third party funding or insurance available to pay for services.

Residents of the Alliance counties are eligible for crisis assessment and crisis services through the Alliance Provider Network when no other payer source is available. Under this policy, acute inpatient psychiatric services that require prior authorization are not considered crisis services.

III. PROCEDURES
The Area Director/Chief Executive Officer shall develop procedures to implement the provisions of this policy.
I. PURPOSE

The purpose of this policy is to ensure that Alliance Behavioral Healthcare carries out its responsibility for providing care coordination to eligible individuals and families within the Alliance catchment area and to define the process of identifying and referring individuals to Care Coordination.

II. DEFINITIONS

**Care Coordination:** A collaborative process that links individuals and families with special healthcare needs and high risk/high cost individuals to services and resources in an effort to optimize clinical outcomes, decrease unnecessary utilization of services, and ensure delivery of quality care.

**Special Health Care and High Risk Populations:**

- Adult enrollees who are severely and persistently mentally ill and meet Level of Care Utilization System for Psychiatric Services (LOCUS) criteria
- Child enrollees who are severely emotionally disturbed and meet Child and Adolescent Level of Care Utilization System (CALOCUS) criteria
- Children under 21 years of age with a mental health or substance use diagnosis who are currently, or have been within the past thirty (30) days, in a facility (including a Youth Development Center and Youth Detention Center) operated by the Department of Public Safety, or Division of Adult Correction and Juvenile Justice for whom Alliance has received notification of discharge.
- Enrollees with substance use diagnosis and current ASAM PPC Level of III.7 or II.2-D or higher.
- Enrollees with co-occurring diagnoses (SA/MH/I/DD)
- Opioid Dependent: Individuals with an opioid dependence diagnosis and who have reported to have used drugs by injection within the past thirty days
- CCNC/MCO (Community Care of North Carolina/Managed Care Organization) Priority List
- Consumers who meet criteria for the Transitions to Community Living Initiative
- Individuals on the NC Innovations Waiver
- Individuals with an intellectual or developmental disability diagnosis who are currently, or have been within the past thirty (30) days, in a facility operated by the Division of Adult Correction and Juvenile Justice for whom Alliance has received notification of discharge
III. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to provide Care Coordination to individuals that meet the Special Health Care and High Risk Populations criteria delineated in part II. Alliance shall develop protocols to identify individuals who are high risk or who have special health care needs and ensure that those individuals identified receive care coordination as appropriate. Alliance shall employ qualified professionals who shall be located in the geographic areas covered by Alliance Behavioral Healthcare to provide care coordination.

IV. PROCEDURES

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

The purpose of this policy is to ensure that clients’ rights are respected and protected by all providers in the Alliance Behavioral Healthcare Provider Network.

II. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare that every person served has a right to dignity, privacy and humane care that must be respected and protected. Providers in the Alliance Behavioral Healthcare Provider Network shall assure basic human rights to each client. All programs operated by providers shall comply with the clients’ rights standards set forth in G.S. 122C, Article 3.

III. PROCEDURES

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

The purpose of this policy is to protect each client’s right to privacy and to safeguard the confidentiality of identifiable health information.

II. POLICY STATEMENT

All clients of Alliance Behavioral Healthcare shall be assured that their right to privacy and the confidentiality of their identifiable health information will be safeguarded. No staff member, volunteer, student or other person associated with Alliance Behavioral Healthcare shall use or disclose any information except as provided by these policies and procedures as authorized by the General Statutes of the State of North Carolina 122C Parts 52-56, Client Right to Confidentiality, the Federal Regulations 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, and the Health Insurance Portability and Accountability Act (HIPAA) regulations in 45 CFR. Any violation of this policy shall be grounds for disciplinary action, including termination of employment or termination of other services with Alliance.

III. PROCEDURES

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

The purpose of this policy is to advocate and support an individual’s right to make informed choices about service provision.

II. POLICY STATEMENT

It is the policy of the Area Authority to promote and encourage choice when consumers seek services from Alliance Behavioral Healthcare. Alliance Behavioral Healthcare shall ensure that each consumer seeking services receives the following:

i. information necessary to make an informed choice about service;

ii. information about the range of other services available and;

iii. information about their right to receive services in a way that is non-coercive and protects their right to self-determination and;

For Medicaid funded services, consumers shall be provided with a choice of at least two provider agencies from which they may elect to receive services. (May not apply to some highly specialized services)

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 complies with regulatory requirements surrounding Advanced Directives and Advanced Instructions for Mental Health Treatment.

II. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to distribute written information regarding Advance Directives and Advanced Instructions for Mental Health Treatment policies to adult Enrollees, including a description of applicable State and Federal laws. Written information regarding Advance Directives and Advanced Instructions shall cover the following topics:

1. Enrollee rights under State law;
2. Alliance policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives and Instructions as a matter of conscience;
3. Information on the Advance Directive and Instructions policies of Alliance; and
4. The Enrollee's right to file a grievance with the State Certification and Survey Agency or the Division of MH/IDD/SA Services concerning any alleged noncompliance with the Advance Directive or Instructions laws.

In compliance with 42 CFR 438.3(j) and N C GS 122C Article 3, Part 2, the written information provided to Enrollees shall reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

III. PROCEDURES

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

The purpose of this policy is to establish the expectation that Alliance Behavioral Healthcare shall operate a comprehensive customer services program.

II. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare that its Customer Services Program will provide the following:

1. 24/7/365 access to services by providing screening, triage and referral through the Access and Information Line;
2. Crisis services authorization as needed; and
3. Information in response to questions and inquiries expressed through the Access and Information Line.

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 (“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/ID/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.
I. PURPOSE

Alliance Behavioral Healthcare endeavors to provide services to the community that are timely, high quality and effective. Alliance Behavioral Healthcare is committed to a process of continuous quality improvement and assessment of its relationships with its community partners.

II. POLICY STATEMENT

Alliance Behavioral Healthcare seeks to serve the community in a manner that is efficient, responsive, and effective. It is the policy of the Board to employ appropriate techniques to measure the extent to which the Board is meeting its objectives and the level of satisfaction among the Board’s many constituencies. The results of these measurements are to be used to promote improvement of consumers’ providers’ and other stakeholders’ satisfaction and to improve the quality of services and treatment outcomes.

III. PROCEDURES

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

The purpose of this policy is to establish a process for receiving, investigating, resolving, and managing grievances in a consistent manner.

II. DEFINITIONS

Complainant: Enrollee/consumer, legally responsible person, or Providers, authorized in writing and acting on behalf of the enrollee/consumer filing the grievance. Does not include providers, stakeholders or other individuals not acting on behalf of a consumer.

Grievance: an expression of dissatisfaction by an enrollee, their legal guardian, or Provider, authorized in writing and acting on behalf of the enrollee/consumer about any matter other than decisions regarding requests for Medicaid services.

Provider: an individual, agency or organization that provides mental health, developmental disabilities and/or substance abuse services to consumers and families.

III. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to respond to grievances received concerning the provision of publicly funded services in the Alliance Behavioral Healthcare catchment area. It is also the policy of Alliance Behavioral Healthcare to use the information gleaned from grievance proceedings as part of Alliance’s quality improvement process.

IV. PROCEDURES

The Area Director shall develop procedures to implement this policy. The procedures shall comply with all relevant state and Federal statutes and requirements of all regulatory, funding or accrediting bodies.
I. PURPOSE

The purpose of this policy is to define and establish a uniform and consistent approach for handling incidents which occur in the operations of a facility or service.

II. DEFINITIONS

Incidents: Events that are inconsistent with the routine operations of a service or care of a consumer that are likely to lead to adverse effects.

Level I Incident: Event that is inconsistent with the routine operation of a service or care of a consumer that is likely to lead to adverse effects but does not meet the definition of a Level II or III incident.

Level II Incident: As described in Level I Incident above but results in a threat to a consumer’s health and safety and presents a threat to the health and safety of others due to the consumer’s behavior. This includes a client death due to natural causes or terminal illness.

Level III Incident: Event that is inconsistent with the routine operation of a service or care of a consumer that is likely to lead to adverse effects and result in:
1. A death or permanent physical or psychological impairment to a consumer;
2. A death or permanent physical or psychological impairment caused by a consumer;
3. A threat to public safety caused by a consumer;
4. An amber or silver alert, or news media involvement
5. Any allegation of rape or sexual assault of a consumer or by a consumer.

III. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to ensure consumer safety and quality of care within the Alliance Behavioral Healthcare Network. Alliance will require that Network Providers respond to all level I, II and III incidents according to 10A North Carolina Administrative Code 27G .0603 and .0604 and that Alliance Behavioral Healthcare responds to all level III incidents in accordance with 10A North Carolina Administrative Code 27G .0605.
IV. PROCEDURES

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

The purpose of this policy is to ensure timely reviews of oral or written requests for service authorization.

II. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to ensure timely access to care. Utilization management personnel shall be available during regular business hours to process requests and to communicate with providers, consumers and other stakeholders. All communications and interactions with the affected parties shall be cordial and courteous.

III. PROCEDURES

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

The purpose of this policy is to set forth policy regarding the use of licensed and non-licensed staff in the utilization management process.

II. DEFINITIONS

Certification – authorization for an individual to receive services from an Area Authority provider.

III. POLICY STATEMENT

Alliance Behavioral Healthcare shall employ licensed clinical staff as well as non-clinical, administrative personnel to perform the utilization management functions required to issue certifications. Alliance shall ensure that licensed clinical staff are available to provide oversight and follow-up of clinically related questions during initial screening activities.

IV. PROCEDURES

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

The purpose of this policy is to set forth the standards and criteria used by Alliance Behavioral Healthcare to determine the medical necessity of service requests submitted by network providers.

II. DEFINITIONS

Medical Necessity:
1. The procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient’s needs;
2. The procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
3. The procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.

III. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to implement objective clinical review criteria to govern all utilization management decisions regarding service authorization requests. These criteria have been developed by the North Carolina Division of Medical Assistance, and are documented in NC DMA Clinical Coverage Policies and the North Carolina Division of Mental Health/Developmental Disabilities/Substance Abuse Services and are documented in the MH/DD/SA Services Definition manual. The Alliance Clinical Advisory Council is authorized to approve clinical guidelines that can be used during the utilization review process. All Clinical Coverage Policies, Service Definitions and clinical guidelines that are used in the utilization management process shall be made available to providers and consumers.

IV. PROCEDURES

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

The purpose of this policy is to clearly define the standards and procedures for authorizing Medicaid and State funded services.

II. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to make timely and accurate utilization management determinations and notifications regarding requests for certification of treatment. Determinations and notifications shall be made in accordance with the requirements of the North Carolina Division of Mental Health/Intellectual and Developmental Disability/Substance Abuse Services, the North Carolina Division of Medical Assistance and the external accrediting body, URAC.

III. PROCEDURES

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

To establish a clear process to ensure that consumers’ federal and state due process rights are protected in regards to service reductions, suspensions, termination and denials.

II. POLICY STATEMENT

Alliance Behavioral Healthcare shall utilize a formal written process with concrete timeframes to govern appeals of denial, suspension, termination or reduction of service based on medical necessity determinations for all services. In accordance with applicable Federal and State laws, rules and regulations, the process shall make a distinction between appeals filed concerning Medicaid, state-funded and locally-funded services, standard appeals, i.e., cases involving non-urgent care, expedited appeals, and cases involving urgent care. The process shall clearly delineate the steps that may be taken by a consumer or the consumer’s legal representative, or a provider or facility rendering service when the appellant asserts their right to appeal, either in verbal or written form. Written directions on how to file an appeal shall be provided with the decision. The directions shall be written in a manner that meets the health, literacy and linguistic needs of the persons affected by the policy.

III. PROCEDURES

The Area Director shall develop procedures to implement this policy.
ITEM: Draft Minutes from the February 1, 2018, Board Meeting

DATE OF BOARD MEETING: March 1, 2018

REQUEST FOR BOARD ACTION: Approve the draft minutes from the February 1, 2018, meeting.

CEO RECOMMENDATION: Approve the minutes.

RESOURCE PERSON(S): Robert Robinson, CEO; Veronica Ingram, Executive Assistant
MEMBERS PRESENT: ☒Cynthia Binanay, Chair, ☒Christopher Bostock, ☒Heidi Carter (entered at 4:08 pm), ☒George Corvin, MD, ☒James Edgerton, ☒Lodies Gloston (entered at 4:20 pm), ☒Phillip Golden, ☒Curtis Massey (via phone; entered at 4:12 pm), ☒Erv Portman (exited at 5:30 pm), ☒George Quick, ☒William Stanford, Jr., ☒Lascel Webley, Jr., and ☐McKinley Wooten, Jr

GUEST(S) PRESENT: Denise Foreman, Wake County Manager’s Office; Yvonne French, NC DHHS-DMH (Department of Health and Human Services-Division of Mental Health); Mary Hutchings, Wake County Finance Department; Israel Pattison, CFAC Chair; and Sean Schreiber, Shift Consulting

ALLIANCE STAFF PRESENT: Damali Alston, Director of Network Evaluation; Michael Bollini, Executive Vice-President/Chief Operating Officer; Hank Debnam, Cumberland Site Director/Veterans’ Point of Contact; Joey Dorsett, Senior Vice-President/Chief Information Officer; Doug Fuller, Director of Communications; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Amanda Graham, Senior Vice-President/Organizational Effectiveness; Veronica Ingram, Executive Assistant II; Ken March, Medicaid Program Director; Beth Melcher, Executive Vice-President/Care Management; Sara Pacholke, Senior Vice-President/Financial Operations; Brian Perkins, Senior Vice-President/Strategy and Government Relations; Kentina White, Administrative Assistant III; Tonya Wilkerson, Administrative Assistant III; Sara Wilson, Director of Government Relations; Carol Wolff, General Counsel; and Doug Wright, Director of Individual and Family Affairs

1. CALL TO ORDER: Chair Cynthia Binanay called the meeting to order at 4:01 p.m.

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<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
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<tr>
<td>2. Oath of Office</td>
<td>Ms. Ingram, a notary public, administered the oath of office to new Board member, Erv Portman, a Commissioner from Wake County.</td>
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| 3. Announcements | A. Welcome: Chair Binanay welcomed Commissioner Portman.  
B. Current and Upcoming Vacancies: Chair Binanay mentioned the following resignations: Amelia Thorpe, Commissioner Greg Ford, and upcoming vacancies: Phillip Golden, George Quick, and William Stanford. Lucy Bode decided to not accept her appointment. Chair Binanay thanked members for their service and shared that we would recognize them at the March 1, 2018, Board meeting.  
C. Branding Book: Mr. Robinson reviewed Alliance’s branding book; Amanda Graham, Senior Vice-President of Organizational Effectiveness, reviewed the purpose of this document, potential uses and how it incorporates Alliance’s strategic plan. |
| 4. Agenda Adjustments | There were no adjustments to the agenda. |
| 5. Public Comment | There were no public comments. |
**AGENDA ITEMS:**

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<tr>
<th>6. Committee Reports</th>
<th>DISCUSSION:</th>
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<tr>
<td><strong>A. Consumer and Family Advisory Committee</strong> – page 3</td>
<td>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 December from the Steering, Durham, and Wake meetings, the Durham January draft minutes and supporting documents.</td>
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<td>Israel Pattison, CFAC Chair, presented the report. Mr. Pattison provided an overview of recent CFAC meetings and subcommittee meetings. He mentioned CFAC’s desire to engage more members of the community, changes in CFAC membership and a brief overview of upcoming meetings. The CFAC report is attached to and made part of these minutes.</td>
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<tr>
<td><strong>B. Finance Committee</strong> – page 25</td>
<td>The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Area Board. This month’s report included draft minutes from the December 7, 2017, meeting, the Statement of Net Position budget to actual report, and ratios for the period ending December 31, 2017.</td>
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<td></td>
<td>James Edgerton, Committee Chair, presented the report. He reviewed today’s Committee meeting and shared that all State mandated ratios were met. He mentioned that most of today’s Committee meeting covered topic 9: Non-Medicaid Spending Review and Discussion. The Committee report is attached to and made part of these minutes.</td>
</tr>
<tr>
<td><strong>C. Policy Committee</strong> – page 32</td>
<td>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 proposed revisions to the By-Laws; the revisions were presented to the Board at the December 7, 2017, meeting.</td>
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<td></td>
<td>Mr. Massey reviewed the proposed revisions to the by-laws and noted that any changes to the by-laws require at least thirty-days’ notice and a super-majority approval. Both requirements were met. The Committee report is attached to and made part of these minutes.</td>
</tr>
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</table>

**BOARD ACTION**

A motion was made by Ms. Lodies Gloston to approve the revisions to the by-laws; motion seconded by Mr. Christopher Bostock. Motion passed unanimously.
AGENDA ITEMS: | DISCUSSION:
--- | ---
B. Executive Committee Report – page 50  
C. Human Rights Committee Report – page 55  
D. Network Development and Services Committee Report – page 111  
E. Quality Management Committee Report – page 125  

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 Mr. William Stanford to approve the consent agenda; motion seconded by Mr. Lascel Webley. Motion passed unanimously.

8. Request for Extension of Waiver of Reporting Requirements (5 minutes) – page 193 | In accordance with *Incident Reporting Requirements for Category A* (licensed facilities) and *Category B Providers* (non-licensed periodic or community-based services), network providers are required to submit quarterly reports to Alliance summarizing any Level I, II, and III incidents. On December 4, 2014, the Board submitted a request to the Department of Health and Human Services (DHHS) to waive the requirement for providers to submit these Quarterly Incident Report Summaries (Form QM-11), per Subsection (e) of 10A NCAC 27G.0604. The waiver was approved by the NC DHHS Secretary through calendar year 2017. Staff and the CEO recommend that the Board request a renewal of this Waiver.

Ms. Wolff reminded Board members of the earlier request and approval. Board members clarified the request and noted how it increases efficiency as the information is captured in other reports.

**BOARD ACTION**
A motion was made by Vice-Chair George Corvin to request the NC DHHS Secretary to extend the waiver of the QM-11 reporting requirements indefinitely for applicable Alliance providers and authorize the CEO to sign and send the letter of request; motion seconded by Mr. George Quick. Motion passed unanimously.

9. Non-Medicaid Spending Review and Discussion – page 194 | For the past five years, Alliance Behavioral Healthcare has maintained a consistent way of managing state dollars that has adhered to both the historical nature of the funding as well as to the desire of our County partners and Board members. In consideration of long-term sustainability, Alliance has spent the last few months doing a comprehensive service review of our state and local dollars including several stakeholder meetings.

Mr. Robinson mentioned that the intent is to present information today and provide an update at the Board’s budget retreat. He provided background and rationale for this presentation and pending proposal. Additionally, he discussed proposal goals.
<table>
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<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
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<tr>
<td>Ms. Goodfellow provided a high-level overview of the fiscal year 2017-2018 budget, funding needs, current fiscal year non-Medicaid funding, historical commitments of non-Medicaid funding, and how funds are used (benefit plan and available funding comparison).</td>
<td></td>
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<tr>
<td>Sean Schreiber, with Shift Consulting, reviewed comprehensive system and spending review, a summary of meetings with stakeholder groups, and current fiscal year claims and financial data summary. As part of the process for seeking feedback, Mr. Schreiber distributed a survey to Board members and asked that they return the completed forms.</td>
<td></td>
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<tr>
<td>Commissioner Portman requested comparative data among NC MCOs (managed care organizations) and trends since Alliance’s inception (quality of life data, percentage needing services v. percentage receiving services, etc.).</td>
<td></td>
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</table>
| **BOARD ACTION**  
The Board received the presentation; no additional action required. |
| In accordance with NC General Statute 122C-118.1.d and the By-Laws of the Alliance Board, the initial terms of Alliance Board members were staggered with each initial term being considered a full term. Accordingly, the initial terms of some members were designated to end after one year, others after two, and others after three. NC Senate Bill 191 revised G.S. 122C-118.1.d to allow members to be reappointed for two additional three-year terms. Chair Binanay provided a brief overview of two applicants for vacant seats; this information was sent to Board members last week. |
| **BOARD ACTION**  
A motion was made by Mr. Christopher Bostock to recommend that the Wake Board of County Commissioners appoints Donald McDonald to Alliance’s Board; motion seconded by Mr. William Stanford. Motion passed unanimously. |
| **BOARD ACTION**  
A motion was made by Mr. James Edgerton to recommend that the Cumberland Board of County Commissioners appoints Duane Holder to Alliance’s Board; motion seconded by Mr. Christopher Bostock. Motion passed unanimously. |
| 11. Legislative Update | Brian Perkins, Senior Vice-President/Strategy and Government Relations, and Sara Wilson, Director of Government Relations, provided a legislative update. Mr. Perkins mentioned current agenda topics for the upcoming North Carolina General Assembly session, in particular bills that could impact NC MCOs. |
Additionally, Ms. Wilson mentioned the NC Department of Health and Human Services (DHHS) released a report today. She or Mr. Perkins will forward the report to Board members. She, Mr. Perkins and other Alliance staff requested to participate on the State’s MCAC (Medical Care Advisory Committee) subcommittees. NC DHHS is still reviewing over 150 requests to participate on MCAC committees. Additional information about MCAC can be found at [https://dma.ncdhhs.gov/medical-care-advisory-committee](https://dma.ncdhhs.gov/medical-care-advisory-committee).

Mr. Perkins mentioned that the legislative priorities will be presented at the February Executive Committee and March Board meetings; they will be designed to be used as speaking points by advocates. Also, he mentioned yesterday’s behavioral health urgent care open house which was conducted to demonstrate what people experience when they come to seek services. Additional tours are available.

**BOARD ACTION**
The Board received the update.

12. Chair’s Report
Chair Binanay reminded the Board that the March meeting will be at Alliance’s Home Office on Emperor Boulevard in Durham.

13. Closed Sessions

**BOARD ACTION**
A motion was made by Commissioner Heidi Carter to enter closed session pursuant to NCGS 143-318.11 (a) (6) and 143-318.11 (a) (1) to consider the qualifications, competence, and performance of an employee and to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1; motion seconded by Mr. William Stanford. Motion passed unanimously.

The Board returned to open session.

14. Adjournment
With all business being completed the meeting adjourned at 6:56 p.m.

Next Board Meeting
**Thursday, March 01, 2018**
4:00 – 6:00 pm
ITEM: Audit and Compliance Committee Report

DATE OF BOARD MEETING: March 1, 2018

BACKGROUND: 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 and to assist the Area Board in fulfilling its oversight responsibilities.

This Committee report includes notes from its August meeting. Quorum was not present.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Lascel Webley, Committee Chair; Monica Portugal, Chief Compliance Officer
APPOINTED MEMBERS PRESENT: ☐ Chris Bostock, BSIM, ☐ George Quick, M.B.A, ☒ Lascel Webley, Jr., M.B.A., M.H.A. (Committee Chair) (phone)

BOARD MEMBERS PRESENT: Cynthia Binaynay, Board Chair (phone)

GUEST(S) PRESENT: None

STAFF PRESENT: Monica Portugal, Chief Compliance Officer; Ken Marsh, Medicaid Program Director

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – Minutes were not reviewed since quorum was not present.

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<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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<tbody>
<tr>
<td>3. Updates</td>
<td>Annual Single Audit: Portugal provided an update on preliminary findings. EQR Best Practice Recommendations: Marsh provided a progress report related to implementing Best Practice Recommendations. Annual Block Grant Audit: Marsh provided an overview of the scope of the audit, findings, and response to findings.</td>
<td>No follow up required</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Annual Review of Corporate Compliance Policies</td>
<td>Committee members reviewed the policies and had no revisions. Staff proposed no revisions.</td>
<td>Portugal will submit policies to the Board Policy Committee</td>
<td>9/5/2017</td>
</tr>
<tr>
<td>5. Annual Conflict of Interest Disclosures</td>
<td>Portugal reported update regarding one Board Member’s submission of the disclosure form. The required form has not been submitted</td>
<td>Committee Chair will follow up with the Member.</td>
<td>8/31/2017</td>
</tr>
<tr>
<td>6. Quarterly Dashboard</td>
<td>Committee reviewed the quarterly Compliance Dashboard for FY17, including Network Compliance and Corporate Compliance. Committee asked questions and discussed overpayments and provider actions and sanctions issued in the fourth quarter.</td>
<td>No follow up required</td>
<td>N/A</td>
</tr>
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</table>

7. ADJOURNMENT: next meeting will be November 15, 2017, from 3:00 p.m. to 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: Executive Committee Report

DATE OF BOARD MEETING: March 1, 2018

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 February 20, 2018, meeting.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Cynthia Binanay, Board Chair; Robert Robinson, CEO
APPOINTED MEMBERS PRESENT: ☒ Cynthia Binanay, M.A., Board Chair; ☒ Christopher Bostock, B.S.I.M., Previous Board Chair, ☒ George Corvin, M.D., Board Vice-Chair/Quality Management Committee Chair, ☒ James Edgerton, B.S., Finance Committee Chair (via phone @ 4:10 pm), ☒ Lodies Gloston, M.A., Human Rights Committee Chair (via phone), ☒ Curtis Massey, J.D., Policy Committee Chair (via phone), ☒ Lascel Webley, Jr., M.B.A., M.H.A, Audit and Compliance Committee Chair (via phone; exited at 5:39 pm), and ☒ McKinley Wooten, Jr., J.D., Network Development and Services Committee Chair (via phone; entered at 4:10 pm; exited at 5:15 pm)

BOARD MEMBERS PRESENT: William Stanford, Jr.

GUEST(S): None

STAFF PRESENT: Veronica Ingram, Executive Assistant; Brian Perkins, Senior Vice-President/Strategy and Government Relations; Robert Robinson, CEO; and Carol Wolff, General Counsel

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the January 16, 2018, Executive Committee meeting were reviewed; a motion was made by Mr. Bostock and seconded by Vice-Chair Corvin to approve the minutes. Motion passed unanimously.

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<tr>
<th>AGENDA ITEMS:</th>
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<tr>
<td>3. Updates</td>
<td>a) Medicaid Reform/NC Legislation: Mr. Robinson provided an update on recent activity with NC legislators; he mentioned that the NC General Assembly has recessed until May 2018. Mr. Perkins provided additional information regarding the State’s waiver application.</td>
<td>a) None specified.</td>
<td>a) N/A</td>
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<td></td>
<td>b) Board Vacancies: Chair Binanay provided an update on recent appointment recommendations to local Boards of County Commissioners.</td>
<td>b) None specified.</td>
<td>b) N/A</td>
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<td></td>
<td>c) Board Member Remote Participation: Ms. Ingram shared that an update will be provided at the next Committee meeting.</td>
<td>c) Ms. Ingram will provide an update at the next meeting.</td>
<td>c) 3/20/18</td>
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<td></td>
<td>d) Non-Medicaid Spending Review: Mr. Robinson reviewed the pending agenda for the non-Medicaid service system redesign schedule and mentioned changing the date for the March workgroup meeting; this is a staff meeting that Board members are invited to attend. Committee and staff agreed to hold the staff workgroup meeting on March 14, 2018, at 2:00 pm.</td>
<td>d) Ms. Ingram will forward an updated calendar invitation to Committee members.</td>
<td>d) 2/20/18</td>
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<td></td>
<td>e) Mr. Robinson will present additional information at an upcoming meeting.</td>
<td>e) Mr. Robinson will present additional information at an upcoming meeting.</td>
<td>e) 3/20/18</td>
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</table>

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

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<tr>
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<tr>
<td>e) Wake Crisis Facility: Mr. Robinson mentioned a proposal to the Board is forthcoming for this project. Additional information will be presented at an upcoming meeting.</td>
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<td>4. Legislative Priorities</td>
<td>Mr. Perkins reviewed the legislative priorities.</td>
<td>Mr. Perkins will present the priorities at the March Board meeting.</td>
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<tr>
<td>5. Vermilion Loan</td>
<td>Ms. Wolff discussed a proposal for an affordable housing complex in Durham. The developer has a need for 1.8 million; the request to Alliance is for 300,000.00 in exchange for 12 reserved units for twenty years for the people Alliance serves. This would be contingent on NCHFA (North Carolina Housing Finance Agency) providing 1.5 million. Units could be available as early as spring/summer of 2018.</td>
<td>Ms. Wolff will forward the documents for the proposal to Ms. Ingram to include in the agenda for the March Finance Committee and Board meetings.</td>
</tr>
<tr>
<td>6. August 6, 2015, Area Board Draft Agenda</td>
<td>Chair Binanay reviewed the draft agenda; committee members provided direction.</td>
<td>Ms. Ingram will forward the updated agenda to staff.</td>
</tr>
<tr>
<td>7. Applicant Interview</td>
<td>The Committee interviewed an applicant for a vacant seat representing Durham County.</td>
<td>Ms. Ingram will add topic to March Board agenda.</td>
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</table>

**COMMITTEE ACTION**

A motion was made by Vice-Chair Corvin to recommend that the Board recommends that the Durham Board of County Commissioners appoint David Curro to Alliance’s Board; motion seconded by Mr. Bostock. Motion passed unanimously.

**COMMITTEE ACTION**

A motion was made by Vice-Chair Corvin to enter closed session pursuant to NCGS 143-318.11 (a) (1) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1. Motion seconded by Mr. Bostock. Motion passed unanimously.

**9. ADJOURNMENT:** the next Committee meeting will be March 20, 2018, 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: March 1, 2018

BACKGROUND: The committee reviews progress on the agency’s network development plan and progress on service development. The committee reports to the 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 February 14, 2018, 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
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the December 13, 2017, meeting were reviewed; a motion was made by Mr. Stanford and seconded by Ms Avila to approve the minutes. Motion passed unanimously.

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<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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<tr>
<td>3. Presentation on initiatives to address the opioid epidemic</td>
<td>Committee reviewed the national and state statistics related to opioid use and response. Reviewed the state opioid plan objectives and Alliance initiatives to address including increased access to services, developing best practice treatment response, and creating access to medication. Also reviewed parameters of new funding to address the crisis.</td>
<td>Committee will hear presentation on initiatives related to long term services and supports at next meeting</td>
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4. ADJOURNMENT: next meeting will be March 14, 2018, from 4:00 p.m. to 5:00 p.m.
What is Opioid Addiction?

• Opioids are a class of drugs that include the illicit drug heroin as well as prescription pain relievers oxycodone, hydrocodone, codeine, morphine, fentanyl and others

• Opioids are chemically related and interact with opioid receptors on nerve cells in the brain and nervous system to produce pleasurable effects and relieve pain.

• Addiction is a primary, chronic and relapsing brain disease characterized by an individual pathologically pursuing reward and/or relief by substance use and other behaviors
Public Awareness of the Epidemic

• Drug overdose is the leading cause of accidental death in the US

• There are 91 deaths in the US every day due to an opiate overdose

• Rate of opiate overdose deaths has quadrupled from 2010 to 2016
A Brief History of the Opioid Epidemic

- Four in five new heroin users started out misusing prescription painkillers.

- 94% of respondents in a 2014 survey of people in treatment for opioid addiction said they chose to use heroin because prescription opioids were “far more expensive and harder to obtain”
Contributors to the Opioid Epidemic

- Medical practice changes: pain added as ‘5th vital sign’
- Aggressive marketing of medications such as OxyContin
- Oversupply of unused pain medication
- Increased availability and lower cost of black tar heroin
- Increased supply of more potent drugs such as fentanyl and synthetic opioids
- Congressional reduction in DEA authority over pharmaceutical distributors
Impact on North Carolina

- Each day, 4 people in NC die from an opioid overdose
- From 1999 to 2016, more than 12,000 North Carolinians died from opioid-related overdoses.
- Health and societal risks include HIV, hepatitis C, crime, violence, unemployment, foster care placements
- $1.3 billion NC annual cost of opioid deaths
Impact on NC Death Rates


1989 – Pain added as 5th Vital Sign

*Per 100,000, age-adjusted to the 2000 U.S. Standard Population
α - Transition from ICD-8 to ICD-9
β – Transition from ICD-9 to ICD-10

Source: Death files, 1968-2015, CDC WONDER
Analysis by Injury Epidemiology and Surveillance Unit
Impact on Alliance

• Each month, **15 people** in Alliance counties die from opioid overdoses, **23** are hospitalized after an overdose, and **41** are seen in hospital EDs.

• From 1999 to 2016, more than **1,300** in Alliance counties died from opioid-related overdoses, and the death rate increased by **574%**.

Alliance Opioid Deaths: 1999-2016

![Graph showing opioid deaths from 1999 to 2016 with categories: Heroin, Methadone, Rx. Opioid, and Synthetics.](https://example.com/graph.jpg)
Opioid Overdose ED Visits December 2017
North Carolina’s Response

• Priority of Governor’s office, Attorney General, DHHS and NC Association of County Commissioners

• STOP Act (Strengthen Opioid Misuse Prevention) strengthens opioid prescription oversight and improves access to naloxone and syringe exchanges

• NC Opioid Action Plan

• 21st Century Cures Grant from SAMHSA
NC Opioid Action Plan

1. Create a coordinated infrastructure
2. Reduce oversupply of prescription opioids
3. Reduce diversion of prescription drugs and flow of illicit drugs
4. Increase community awareness and prevention
5. Make naloxone widely available and link overdose survivors to care
6. Expand treatment and recovery oriented systems of care
7. Measure our impact and revise strategies based on results
Current Plans and Initiatives

• Policy changes
• Changes in healthcare practice, oversight and education
• Changes in pain management practice
• Increased use of Controlled Substances Reporting System
• Organized drug takeback programs
• Safe storage initiatives
• Public education and prevention activities
• Law enforcement and other diversion efforts
• Increased access to naloxone, syringe exchange programs
## Multiple Approaches and Partners

<table>
<thead>
<tr>
<th>Government</th>
<th>Healthcare</th>
<th>Stakeholders</th>
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<tbody>
<tr>
<td>Most levels of government</td>
<td>Hospitals</td>
<td>Recovery community</td>
</tr>
<tr>
<td>DHHS</td>
<td>Emergency Departments</td>
<td>Community Coalitions</td>
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<tr>
<td>Law Enforcement</td>
<td>Primary and Specialty Care</td>
<td>Faith Community</td>
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<tr>
<td>Criminal Justice</td>
<td>Pain Management</td>
<td>Recovery support agencies</td>
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<tr>
<td>Jails and prisons</td>
<td>Pharmacies</td>
<td>Professional organizations</td>
</tr>
<tr>
<td>EMS / first responders</td>
<td>Behavioral healthcare providers</td>
<td>Licensure boards</td>
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<tr>
<td>Medical Examiner</td>
<td>MCOs, healthcare payors</td>
<td>Recovery housing</td>
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<tr>
<td>Public Health</td>
<td>Dentists</td>
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<tr>
<td>Epidemiology</td>
<td>Alternative pain management practitioners</td>
<td>Media</td>
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</table>
Treatment Initiatives

Service engagement
- Overdose follow-up and engagement
- Recovery Courts and Law Enforcement Assisted Diversion (LEAD)
- Use of peer supports for engagement and transition

Access to effective treatment models
- Comprehensive opioid treatment including medication, counseling, case management and peer support
- Increased access to Medication Assisted Treatment
- Training of additional physicians to use MAT
- Integrated behavioral health/primary care

Initiatives to address social determinants such as housing, transportation & employment
21st Century Cures Grant

• Federal funding from SAMHSA to DMHDDSA: State Targeted Response to the Opioid Crisis
• NC has received over $31M for FY18 and FY19
• New target population added to benefit plan (ASOUD) for reimbursement and tracking
• New funds for service expansion, and MCOs must demonstrate maintenance of prior funding commitment to Opioid Treatment
• Must adhere to MCO-specific benchmarks for service expansion (additional number served and “person months”)
Opioid Population Workgroup Goals

1. Improved understanding of population characteristics of individuals with opioid use disorders

2. Development of network capacity for evidence-based opioid treatment

3. Identification of population health strategies for addressing opioid use
## Opioid Population Workgroup Goals

<table>
<thead>
<tr>
<th>Guiding Question</th>
<th>Project Plan Initiative</th>
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<tbody>
<tr>
<td>What do we know about the population of individuals with opioid use disorders that will help us prepare effective care and supports?</td>
<td>1. Develop clinical and demographic profile of the Alliance opioid use population</td>
</tr>
<tr>
<td>What current resources are available in each community?</td>
<td>2. Evaluate provider and community capacity to address identified needs of individuals with opioid use disorders</td>
</tr>
<tr>
<td>Which practices and standards of care will improve outcomes best for the opioid use population?</td>
<td>3. Identify evidence-based treatments and practice standards for MAT</td>
</tr>
<tr>
<td>How do we improve engagement in treatment for individuals who are transitioning from inpatient, non-hospital detoxification and crisis care?</td>
<td>4. Improve coordination of care and effective transition between systems</td>
</tr>
<tr>
<td>How do we improve access, engagement and retention in treatment for individuals who are uninsured?</td>
<td>5. Increase access to Opioid Treatment for uninsured individuals through NC STR/21st Century Cures grant service expansion</td>
</tr>
</tbody>
</table>
1. Clinical & Demographic Profile

• Conduct analysis of clinical, sociodemographic, service utilization and other information that describes the Alliance opioid use population

• Explore options for identifying individuals at risk of developing opioid use disorders through data analysis/predictive modeling
2. Provider & Community Capacity

• Review data regarding provider network adequacy, capacity, and service utilization, and conduct inventory of OUD services and providers

• Identify OTP and OBOT prescribers within community and network and evaluate capacity needs and opportunities

• Conduct inventory of existing community initiatives, projects, and partnerships
3. MAT Practice Standards

• Identify evidence-based treatments and practice standards for MAT

• Coordinate with Medical Supports Think Tank to identify best practices and standards

• Develop plans for service and fidelity monitoring, in collaboration with Provider Network Evaluation staff
4. Coordination & Transition of Care

- Identify barriers to service access, engagement and retention, and develop recommendations for addressing

- Implement plans for improving access, engagement, retention and service quality

- Promote engagement and self-management strategies within SUD services, in collaboration with Engagement & Self-Management Think Tank
5. Increase Access for Uninsured

- Develop dashboard and metrics for monitoring progress on grant benchmarks
- Evaluation impact and outcomes of service expansion
- Expand contracts for State-funded Outpatient Opioid Treatment
- Provide training and technical support for providers
- Identify service barriers and unmet needs and develop recommendations for further service expansion
Actions Taken So Far

• Developed multiple reports and data requests to evaluate population characteristics and network adequacy.

• Compiled practice guidelines for review in identifying evidence-based practice standards for opioid treatment.

• Developed survey to improve understanding of care coordination and transition barriers.

• Initiated Opioid Treatment Collaborative and plans for on-site review of OTP programs.
Actions Taken So Far

• Expanded Opioid Treatment Program contracts for uninsured and now have services in each county

• Provided training and technical assistance to OTP providers

• Developed grant monitoring dashboard and new reports for ongoing tracking of STR/Cures grant

• Prepared nasal naloxone kits and collaborated with NCHRC for distribution to OUD providers
Next Steps

• Adding Peer Hospital Transition services to improve engagement in services and Peer Support Services to promote recovery and service retention

• Adding Office-Based Opioid Treatment (OBOT) services

• Expanding access to Medication Assisted Treatment with Suboxone and Vivitrol

• Working with local hospital Eds to initiate treatment and to transition to care with assistance from Peer Supports
Discussion
ITEM: Global Quality Management Committee Report

DATE OF BOARD MEETING: March 1, 2018

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; 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 February 2018 meeting are attached (the committee did not meet in January). There was a quorum. The October, November, and December meeting minutes were approved. Old business was presented to the committee. The revised dashboard requested by the Executive Committee of the Board has been drafted and will be presented to Board. The committee will receive final version of dashboard when it is available. The committee learned that EQR (federal) audit took place in January and Alliance is waiting for results. Finally, the committee received an update on the Clinical Guideline review of opioid treatment. It was recently discovered that data was missing due to the state “scrubbing” (removing) data on substance abuse treatment due to confidentiality rules. New guidance from SAMHSA potentially may allow more flexibility in sharing information for audit and evaluation purposes. The committee requested more details at next meeting.
New business was presented to the committee. The first topic was a review of the contractor (considered a “delegate” by URAC) performing peer (additional) reviews of authorizations not approved by UM clinicians. Since this company is also URAC accredited, Alliance does not need to conduct a more thorough review. The contractor met all URAC requirements and are approved through the end of the fiscal year.

Another topic brought to the committee was an overview of technical assistance Alliance offers to providers in our network. Specific tasks include conducting site visits prior to finalizing contracts and assisting in building the network for services.

The committee received an update on Alliance’s performance on certain measures. Data indicated that all measures met expectations except for incident reporting and access to care. Alliance is addressing late incident reports and has had a QIP in place for several years to improve access to care data.

The committee received an update Quality Improvement Projects. There are 9 active QIPs—two of which the committee approved to close due to meeting the benchmark. Other successful QIPs involve increasing the number of individuals in the TCLI who are housed in private units (project already met benchmark) and improvement in show rate of individuals who call our Call Center (although benchmark is not yet met). Projects struggling to show improvement include one that focuses on improving show rate of individuals who call the Call Center and need care in 2 days (Access to Care-Urgent QIP) and another focused on reducing closures of Crisis and Assessment services in Wake County (Crisis Services QIP). On a related topic, the committee received an overview and updated status on crisis services in all of our counties.

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
VOTING MEMBERS PRESENT:  ☒ George Corvin, MD, Chair (Area Board);  ☒ Phillip Golden, BA, Co-Chair (Area Board);  ☒ William Stanford, Jr. (Area Board);  ☒ Joe Kilsheimer, MBA (CFAC)

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

STAFF PRESENT:  ☒ Tina Howard, MA (Quality Review Manager);  ☒ Wes Knepper, LPC (Quality Management Director);  ☒ Damali Alston, Director of Network Evaluation;  ☐ Katherine Knutson (Chief Medical Officer);  ☒ Doug Wright (Director Individual & Family Affairs);  ☒ Linda Losiniecki, (Executive Assistant)

GUEST(S) PRESENT:  Heidi Middendorf, MD, Associate Medical Director;  Aimee Izawa, Provider Network Development Specialist

REVIEW OF THE MINUTES:  A motion was made by Joe Kilsheimer to approve the October 5, 2017, November 2, 2017 and December 7, 2017 meeting minutes, the motion was seconded by Phil Golden.  Motion carried and the minutes were approved.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome &amp; Introductions:</td>
<td>Welcome: Chair Dr. Corvin opened the meeting and welcomed guests and committee members.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Dashboard for Board (Wes/Damali)</td>
<td>Discussion on the new Reporting Dashboard is still in DRAFT form, the Board wants to revise the draft.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Old Business:</td>
<td>EQR Update (Wes)</td>
<td>The review appeared to go well. Waiting on the official report, EQR has 30 days to respond. The results should be here in the next couple of weeks.</td>
<td></td>
</tr>
<tr>
<td>Clinical Guideline Review-Update (Tina)</td>
<td>This is an EQR requirement. The review consists of using data to determine if providers are adhering to key elements of the approved guidelines.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Tina raised topic again because additional issues had been identified with the Opioid Treatment review. It was discovered the opioid data is not complete due to the state “scrubbing” data (not allowing MCOs access to individual-level data because of confidentiality rules). Alliance has access to all data related to claims paid by us but does not have the data on services (particularly medication-assisted treatment) that providers bill directly to the state. New guidance released by the federal government appears to allow additional information sharing “for the purpose of conducting [an] audit or evaluation”, although, we have not received additional clarification from our legal team. The GQMC will revisit this topic at the next meeting.

<table>
<thead>
<tr>
<th>3. New Business:</th>
</tr>
</thead>
</table>

**Delegated Contractor-UM Reviews (Tina)**
This is a URAC requirement. Some peer reviews are being sent to an outside Peer Review Contractor. The Contractor has met all the requirements and are approved through FY18.

UM collects the data and ensures they are following requirements. QM conducts a second-level review and researches complaints. The appeal denial rate is low.

**Technical Assistance Report (Aimee)**
Aimee briefed the group with the processes of Provider Network Specialists providing technical assistance to our provider network. Specific tasks include conducting site visits prior to finalizing contracts and assisting in building the network for services. Currently there is push to develop special services for TCL, Supported Employment, TBI Waiver and HCBS Initiative. Alliance has specific staff to assist Providers who are interested and want to offer these services.

**Performance Dashboard (Wes)**
Data on most recent dashboard indicated that all measures met expectations, with the exception of access to care standards (not surprising) and incident reporting. Individuals on the Innovations waiver that have a Level 2 and 3 incident need to have it reported by a provider within specific timeframes. Due to an unusually large number of late reports from providers outside our catchment area, Alliance did not meet this requirement for the previous quarter.

Dr. Heidi will provide the denial rate to Tina. Tina will forward to committee total number and % reviewed by contractor.
QIP Updates (Tina)
There are nine open active QIPs. Three additional QIPs were closed in FY 17. There are two QIPs that are being recommended to this committee for closure:

1. Improve Person Centered Plans. The benchmark of 65% has been met in the post-intervention period.
2. Timeliness of Innovation Services. FY17 data showed substantial improvement and met the benchmark for 4 quarters.

Data will be taken one year after last measurement for closed QIPs to ensure improvement has been sustained.

Motion to close the two QIP was made by Phil Golden to close the 2 QIPs, seconded by Bill Stanford, all ayes, motion carried.

Tina provided an overview of the rest of the active QIPs. Active QIPs that are showing success are Access to Care-Routine intervention of reminder calls and the TCLI Private Housing QIP. With the Access to Care QIP, reminder calls have been most successful with individuals who have Medicaid. On the other hand, the show rate for Urgent callers is decreasing or staying the same. The show rate for individuals releasing from incarceration is particularly low, about half of other populations. Alliance recently began an intervention of sending reminder letters to this population. Data on the impact of this initiative will be available next quarter. Results from the TCLI project indicated that the goal of housing 11 individuals in Wake County has already been met. TCLI staff will continue outreach efforts and signing bonuses to private landlords.

QIPs struggling to meet benchmarks include the Access to Care-Urgent project mentioned above and Improving Crisis Services. The Crisis project focused on Cumberland and Wake Counties. There was substantial improvement in the Cumberland measure, although it did not meet the benchmark. In Wake County, there was also improvement in the measures although the improvement was not due to the intervention. The Project Advisory Team is deciding whether to recommend closure of this project due to failure.

Tina will send out the child facility address to the group.
More details on progress of QIPs can be found in the presentation. A special report on access and availability will discussed next month.

**Special Report: Crisis Services (Damali)**

Damali provided an overview of crisis service utilization and initiatives to improve crisis services. The report is a 2 – 3 year trend for crisis services utilized in each county, with the exception of Wake County (data was not received).

Durham shows improvement from the previous year with over 600 consumers receiving services from Durham’s Behavioral Health Urgent Care (BHUC). Some of the services included a brief mental health assessment and referral, wellness check, meals, and discharge planning. Data also indicated that 72% of those, who were seen by a psychiatrist (80% see a psychiatrist the same day they show), received a prescription for medication. The BHUC model may be expanded to other counties. Cumberland’s crisis facility is still not operating on a 24/7 basis. Cumberland is meeting with representatives from the Durham facility to share ideas about expanding hours and successfully managing individuals on IVC (involuntary commitment).

A regional child Crisis Facility will open in 2019 in Wake County.

**Upcoming Meeting:**

Dr. Corvin encourages attendance for the March meeting. Topics to be discussed:
- Revisit the Substance Use Confidentiality rules.
- Special report on access and availability

Next meeting is scheduled for March 1, 2018 *(Time: 2:00 – 3:30 pm)* **Location:** Home Office.

**Adjournment:**

Meeting adjourned at 3:30 p.m.
UM Delegation

A contractor is responsible for the provision of professional external reviews and consulting services.
- This organization conducts peer reviews for Alliance Behavioral Healthcare (ABH).
- They are URAC accredited and therefore are reviewed only under Core 8

Results of 2017 Review:
- Contractor has a fully executed contract with Alliance until 6/30/2018
- There were no reported complaints or grievances specific to contractor
- Internal monitoring plan was reviewed and updated-no immediate concerns
UM Delegation Review-Process

Monitoring:

• Data collection of contractor’s monthly reporting
• Periodic meetings with contractor, as needed
• Retrieval of data on complaints and/or grievances of contractor from QM Data Manager
• Monitoring of appeals filed as a result of contractor decisions
• Medical Director will conduct a Peer review of a sample of decisions to ensure Inter Rater Reliability (IRR)
UM Delegation Review-Process

Appeals Reporting:
Individual and Family Affairs department will:
• Review and report on appeals of peer decisions completed by contractor quarterly
• Review of patterns and trends detected during the data analysis and report on data quarterly

Other Reporting:
• Contractor’s Inter Rater Reliability (IRR) findings will be reviewed quarterly at UM Committee by Medical Director
Provider Network Development Department

Alliance Behavioral Healthcare
Provider Network Development Team

- Provider Network Development Department is directly responsible for supporting the development and management of the Provider Network and fostering a solution focused atmosphere within the network.
Provider Network Development Team

PND Specialists cover the four county area with one person that completes onsite reviews in out of catchment counties and other states when necessary.

Currently there are:

- 7 allotted positions for Provider Network Development Specialist I
- 2 allotted positions for Provider Network Development Specialist II
Provider Network Development Team

Each PND specialist has a primary responsibility for an assigned list of providers in which they are the liaison person for issues that may arise. Every provider has an assigned specialist.
Provider Network Development Team

Specialists are responsible for developing Scopes of Work for identified providers, and for the ongoing review of the requirements of the scope of work.

Scope of Work reviews:

- Completed onsite 1-2 times a year depending on funding requirement and how well provider is managing program.
- This review is used to provide additional technical assistance through ongoing communication, program evaluation and support with provider throughout life of program.
Provider Network Development Team

Specialists are responsible for providing technical assistance and feedback for the use of local and state funds, for service delivery and adherence to best practice standards, and for contractual requirements.

- Primary point of contact for network providers
Provider Network Development Team

Specialists take leadership roles in:

- Service specific collaboratives
- Lead county provider advisory councils (PACs)
- Attend and support Alliance Provider Advisory Council (APAC)
- Participate in and conduct research for Request for Proposals (RFP’s) for new and existing services
- Execute waiver requests and letters of support
- Evaluate need for out of network agreements
- Complete initial on-site reviews for new providers and sites
Provider Network Development Team Updates

This year two Provider Network Development Specialist II positions were created in order to assist in special projects. These Specialists work closely with the development of large agency wide initiatives such as:

- Transition to Community Living
- Supported Employment
- Traumatic Brain Injury Waiver
- HCBS initiative

Specialists in this position have project management skills necessary to get programs running and coordinating among different departments.
Technical Support

Interactions that provide support to providers, their sustainability, and competency can be direct and indirect:

- Communication/discussions with internal departments related to service delivery and scope requirements
- Phone calls (to/from providers and internal staff)
- Collaborative meetings internally as well as with external stakeholders
Any Questions?

- Amy Johndro MSW, LCSW
- Provider Network Development Supervisor
- 919-651-8454
- ajohndro@alliancebhc.org
Executive Summary

Improvements since last year:

- Behavioral Health Urgent Care (BHUC) in Durham offers a diversion from the use of EDs or hospitals to address individuals experiencing behavioral health crises. The BHUC offers an array of services including brief assessment, stabilization, nursing assessment, psychiatric intervention, case management, and discharge planning.
- Open Access expansion in Wake County after regular business hours 5 days/week.
- Three providers manage eight Rapid Response beds for youth throughout the catchment area as a diversion from out of home placement or a higher level of care.
Executive Summary

Challenges that continue:

• Incomplete data from WakeBrook. Continued issues around CAS closures and law enforcement drop offs/IVC
• Crisis services for youth
• Cape Fear Crisis, Evaluation and Observation continues to report not accepting individuals on IVC due to risk and liability issues. As a result, law enforcement officers are more likely to take individuals to the Emergency Department.
Executive Summary

How we are addressing Challenges in next 12-18 months:

• Child crisis facility to open in 2019
• Utilization of Centralized Dispatch model for Mobile Crisis
• Utilization of Peer Support in local EDs targeting SUD individuals
Addendum – County Level Data
<table>
<thead>
<tr>
<th>Provider</th>
<th>Number of Chairs/Beds</th>
<th>23 Hour Chair</th>
<th>Facility Based Crisis</th>
<th>Alcohol Detox Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Mental Health Center at Cape Fear Valley (Roxie Avenue Center)</td>
<td>*8</td>
<td></td>
<td>16 adults</td>
<td>(Transitional FBC and/or ADU)</td>
</tr>
<tr>
<td>Recovery Response Center (Recovery Innovations/Formerly DCA)</td>
<td>10</td>
<td></td>
<td>16</td>
<td>(Transitional FBC and/or ADU)</td>
</tr>
<tr>
<td>Mental Health Division Johnston Co. Health Dept.</td>
<td>**7</td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>UNC Health Care at WakeBrook (CAS)*</td>
<td>12</td>
<td>16</td>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>

*Cumberland 8 chairs available – using 4-6 depending on staffing levels
**Johnston – Holding Beds used for observation and stabilization are inside the ED; counted as ED Admission
# Psychiatric Inpatient Beds

<table>
<thead>
<tr>
<th>Contract Hospitals</th>
<th>Contracted 3-Way Beds</th>
<th>Total Inpatient Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cape Fear Valley Hospital</td>
<td>10</td>
<td>24*</td>
</tr>
<tr>
<td>Duke University Health</td>
<td>4</td>
<td>41</td>
</tr>
<tr>
<td>Johnston Health</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>UNC-Wakebrook</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>26</strong></td>
<td><strong>113</strong></td>
</tr>
</tbody>
</table>

*Cape Fear Valley Behavioral Health Care has 32 licensed beds but currently using 24.*
Since 2015, as the average monthly use of Cape Fear CES increased by 63% and FBC/ADU admission increased by 30%, Inpatient admissions decreased by more than 50% per month. The average length of stay in FBC/ADU has remained 5 days over the 3 year period.
Recovery Innovations began operating Durham’s Recovery Response Center in January 2016. Since 2016, utilization of Crisis Observation Services has increased by 18% per month with an increase of 42% being admitted to 23-Hour Observation Chairs per month. The average chair time has increased from 17:10 to 19:25 in 2017. FBC/ADU admissions increased by 19% with the average LOS decreasing from 3.7 days to 3.4 days.
When an individual is in crisis and seeking services, he/she may walk-in to Johnston Public Health or go to the Emergency Department (ED).

Utilization of the Johnston County Public Health Walk-in Clinic increased by 18% in 2017. The ED maintains psychiatric beds in a separated area, which they refer to as “stabilization beds.” In 2017, utilization of these beds increased by 42%. Although decreased in 2017 the average stay in the stabilization beds is 24:24 hours.

*Provider Submitted Monthly Reports*
Quality Improvement Projects

Presentation to the Global Quality Management Committee (February 2018)
Quality Improvement Projects

Summary:

- Open/Active: 9 projects
- Closed (in 2017): 3 projects

Successes:

- Requesting that Global Quality Management Committee close: Initiation in IDD services and Improve PCPs
- Improve PCPs – 66% of plans fully met all health/safety quality elements, an increase from 57%
- Initiation in IDD services – successfully met benchmark for all four quarters in FY 17 and after interventions
Quality Improvement Projects

Successes (continued):

- TCLI Private Housing Project – Met benchmark of housing 11 individuals in private housing in Wake County, as of January 2018

- Access to Care-Urgent/Routine – Continued significant improvement (an increase of 7% from baseline) in show rate after reminder calls for Routine callers, particularly for individuals with Medicaid (in FY18 Q1, 55% showed for care in 14 days compared to 48% at baseline)
Quality Improvement Projects

Red Flags:

- **Crisis QIP: Wake County** – while closures of CAS have decreased, it is highly doubtful that it was due to the intervention of Open Access clinic opening after regular business hours; Project Advisory Team has requested a re-analysis of data to identify another intervention.

- **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.
Detailed Results for 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); Centralized Dispatch started December 1, 2017 (delayed)
- 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, Q3: Jan-Mar 2017</th>
<th>FY 17, Q4: Apr-Jun 2017</th>
<th>FY 18, Q1: Jul-Sept 2017</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>67%</td>
<td>69%</td>
<td>67%</td>
<td>54%</td>
<td>53%</td>
<td>52%</td>
<td>77%</td>
</tr>
</tbody>
</table>

- Mobile Crisis Team response time improved to 73% through FY 17, Q2, then started to decrease to 50% in FY 18, Q1
- Centralized Dispatch delayed until December 1, 2017
- Medical team considering revising definition
- Project Advisory met in December: Provider Network Clinical Evaluation follow up with Teams re: response times, monitor for another quarter (Quarter 3) after start of Central Dispatch

*Percent met revised after error detected.*
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 & FY 18

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

*All claims for Q2 most likely not submitted, yet.*
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)
### Routine Callers: Results

#### Percent Met
- The table below illustrates performance based on claims:

<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>316</td>
<td>48%</td>
</tr>
<tr>
<td>FY 18, Q1 (Jul-Sep 2017)**</td>
<td>563</td>
<td>262</td>
<td>47%</td>
</tr>
</tbody>
</table>

*Intervention: Reminder Calls*

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*Data re-run and validated in October 2017.
**Data re-run and validated in January 2018.
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 significantly to 46% of callers in the 1\textsuperscript{st} post-intervention time period (FY 16, Quarters 3 & 4) and 47% in the 2\textsuperscript{nd} post-intervention time period received services in 14 days*. Improvement continued through the 3\textsuperscript{rd} post-intervention period. Best outcomes were detected from individuals/guardians who talked directly to Call Center staff, second best: message left on voicemail. Reminder calls continuing.

A Chi-Square statistic was used to calculate significance of difference. In both post-tests, results were found to be statistically significant, FY 16 Q3-4: $X^2 (1, n=3,593) = 5.41, p=0.20$; FY 17 Q1-2: $X^2 (1, n=3,461) = 5.62, p=0.18$. Significance was also found using the Fisher’s Exact Test (FY 16 Q3-4: $p=.021$ (two tailed); FY 17 Q1-2: $p=.018$ (two tailed)). **Note: Percent revised after error detected and corrected.**
This graph clearly shows a difference in results by insurance type. Individuals with Medicaid are more likely to show for care within 14 days of the call than those without the benefit. This difference has increased from 15% in FY 16 Q1 to 20% in FY 18 Q1. The non-Medicaid show rate declined in FY 18 to its lowest level since before reminder calls started.

*Data re-run and validated in January 2018.*
Routine Callers: Interventions

• Provider feedback letters – in the Fall, all provider receiving referrals from the Access Center received a letter on performance.

  One example of a success story: A provider reported that, after receiving our letter, the number of days between referral and assessment in two Durham programs was reduced by as much as 10-21 days.

• Provider meetings – In Spring of 2017, Alliance met with providers in Durham and Johnston to discuss barriers/solutions; implementation of ideas in progress.
Above is a list of the providers that receive more than 20 referrals from the Call Center. The chart compares performance in FY 16 (before letter was sent) to performance in FY 17 (after letter was sent). Additionally, providers received a presentation on this QIP which included difference in provider performance (no provider names were used on presentation) and the five providers receiving the most referrals were invited to a meeting with Alliance. 6 of the 10 agencies improved performance (only 2 of the 4 who attended the meetings improved, although the difference in performance is very slight, -3%).
Urgent Callers: Results

Percent Met

- The table below illustrates performance based on claims:

<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>101</td>
<td>22%</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>421</td>
<td>60</td>
<td>14%</td>
</tr>
<tr>
<td>FY 18, Q1 (Jul-Sep 2017)*</td>
<td>406</td>
<td>80</td>
<td>20%</td>
</tr>
</tbody>
</table>

*Data re-run and validated in January 2018.
Urgent Callers: Interventions

• Letters to inmates – recently started in July, letters sent to home addresses, no letters sent if person is releasing to homeless shelter (currently measuring impact)

• Enhanced rate for performance:
  • Proposed pilot program in Wake to pay enhanced rate for 90791 if provider delivers initial service within 2 days from call/release date and bills for service
  • Presented proposal to New Services group in early November, they enthusiastically supported proposal
  • Next steps: Work with Network Evaluation to combine efforts to improve performance on this metric along with show rate after discharging from crisis
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:
- Clarification of “First Contact” definition
- Additional drop-down boxes to define contact attempts
- Training all Care Coordination staff-Supervisors and direct care

Next Steps:
- Completed training
- Take another measurement in early 2018
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/Open Access (Tier II) after 3:00 PM by 20%
- Reduce percentage of time that WakeBrook CAS in Wake County is on diversion by 2%

Interventions:

- (Cumberland) Family Centered Treatment (FCT) and Enhanced Therapeutic Foster Care (TFC) pilots
- (Wake) Encourage a provider offering Open Access (Tier II) to open after regular business hours
1. **Reduction in ED Admits for youth in FCT & ETFC (Cumberland County)**

Goal: Less than 5% (consider closing measure)

- Baseline (April 2015-February 2016): 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): 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): Less than 10/831 (.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): Less than 10/189 (3.70%)
- Measure #5 (May – July 2017): 43/374 (11.49%)
- Measure #6 (Aug – Oct 2017): 41/343 (11.95%)
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. Even though the number served began to increase in May, the clinic is still serving half of the individuals they served in early 2016.
Improve Crisis Services

Crisis QIP Measures: 3. Reduce % of operating hours that CAS’ back door (IVC) is closed (Wake County)

Goal: 21%; Baseline (Jan-June 2014): 23%
## Improve Crisis Services

**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%

**Measurements:**
- #1 (Jan – June 2015): 24%
- #2 (Jan – June 2016): 21%
- #3 (Jan – June 2017): 17%

### Graph

*Graph showing the trend from Jan 2013 to Dec 2017 with different years represented by different colored lines.*

<table>
<thead>
<tr>
<th>Year</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
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<td>16%</td>
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<td>27%</td>
<td>20%</td>
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<td>10%</td>
<td>7%</td>
<td>2%</td>
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</tbody>
</table>
Crisis QIP Measures 2, 3, & 4 (Wake County)

Conclusions:

• Measure #2 (% of individuals served in Open Access after regular business hours) met goal for two reporting periods
• With that said, there is no evidence suggesting that intervention (Open Access offering later hours) had an impact on closures – question asking individuals if they would have presented to CAS was not administered
• Plus, data suggests that other factors influenced reduction in closures:
  • Additional inpatient beds - average length of stay for individuals disposed to the WBIPU decreased significantly from 46:27 hours (1.94 days) in 2016 to 23:41 hours (0.99 days) in 2016*

*Significance based on T Test: $t (229) = 5.07, p < .001$
Improve Crisis Services

Crisis QIP Measures 2, 3, & 4 (Wake County)

Conclusions, continued:

- Data suggests that other factors influenced reduction in closures:
  - Administrative changes - Beginning of October, there were sharp decreases in closures (avg % closed):

Next steps: PAT to consider new interventions or closure due to failure
First Responder

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 previous 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
Results:

<table>
<thead>
<tr>
<th>Call Cycle</th>
<th>1st Measurement</th>
<th>2nd Measurement</th>
<th>3rd Measurement</th>
<th>4th Measurement</th>
<th>Overall</th>
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<tbody>
<tr>
<td>Satisfactory</td>
<td>65% (N=17)</td>
<td>81% (N=34)</td>
<td>79% (N=22)</td>
<td>64% (N=9)</td>
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<td>35% (N=9)</td>
<td>19% (N=8)</td>
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<td>Total calls made</td>
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<td>42</td>
<td>27</td>
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</table>

- 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)
- PAT meeting today to consider recommendations for increased compliance actions for poor performers
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:

- Increase the percent of plans meeting full (health and safety) quality ratings to 65%.

Interventions:

- Distribution of feedback letters to providers whose PCPs were reviewed
- Training and technical assistance to providers participating in Substance Use Collaborative
- Assessed training needs, provided crisis planning training in every county
Results:

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>PCP Profile</th>
<th>Integrated Care</th>
<th>Risk Factors</th>
<th>Natural Supports</th>
<th>Current Medications</th>
<th>Medical/Dental Concerns</th>
<th>Supports for the Individual</th>
<th>Crisis Plan Prevention</th>
<th>Crisis Plan Intervention</th>
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<td>90</td>
<td>140</td>
<td>116</td>
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<td>10</td>
<td>16</td>
<td>24</td>
<td>16</td>
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</tbody>
</table>

**Improve Quality of PCPs**

- Baseline (March 2016): 57%
- Post-Intervention (Oct 2016): 66%
Improve Person Centered Plans

Results:

- 66% of plans fully meet health/safety elements (exceeded benchmark of 65%)

Next Steps:

- Recommendation for closure due to achievement of benchmark being presented to Global Quality Management Committee in February
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:

I/DD Services Received in 45 days

FY 16, Q1: 69%
FY 16, Q2: 75%
FY 16, Q3: 77%
FY 16, Q4: 79%
FY 17, Q1: 100%
FY 17, Q2: 94%
FY 17, Q3: 88%
FY 17, Q4: 100%

Benchmark=85%

Outcome
DMA Standard = 85%

Recommendation for closure due to achievement of benchmark being presented to Global Quality Management Committee in February
Goal:

- Increase the # of individuals (in TCLI population) housed in private housing to 11 (in Wake County)

Baseline: Only 6 individuals were housed privately in all FY 17 (Wake county)

Interventions:

- Standardized 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
- Created 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 created brochure, landlord packet, revamped website, created videos, and presenting program at conferences
- Outreach to landlords – landlords in “preferred” zip codes of Raleigh identified, received marketing blast and invitation to attend training, incentives approved for new landlords, smaller training took place in September, larger training took place in December (6 participants)
TCLI-Increase private housing

Results:

- Goal already met!
ITEM: Appointment Recommendation for Alliance Board of Directors

DATE OF BOARD MEETING: March 1, 2018

BACKGROUND: In accordance with NC General Statute 122C-118.1.d and the By-Laws of the Alliance Board, the initial terms of Alliance Board members were staggered with each initial term being considered a full term. Accordingly, the initial terms of some members were designated to end after one year, others after two, and others after three. NC Senate Bill 191 revised G.S. 122C-118.1.d to allow members to be reappointed for two additional three-year terms. A seat representing Durham County is currently vacant. The Board Executive Committee is recommending David Curro for this seat, with a term ending March 31, 2020.

REQUEST FOR AREA BOARD ACTION: The Board is requested to recommend to the Durham Board of County Commissioners the appointment of David Curro.

CEO RECOMMENDATION: Recommend to the Durham Board of County Commissioners the appointment of David Curro.

RESOURCE PERSON(S): Cynthia Binanay, Board Chair; Robert Robinson, CEO
**ITEM:**  Grant to Vermilion Homestead, LLC

**DATE OF BOARD MEETING:**  March 1, 2018

**BACKGROUND:**  The Developer, Vermilion Homestead, LLC is seeking a grant from Alliance in the amount of $300,000 in consideration for 12 townhome type units for 20 years located at 1311 Cooke Road in Durham. This money will allow the Developer to complete construction of the units, which are underway but have experienced some setbacks through the construction phase. These funds are included in the 2017-2018 Alliance Budget for housing initiatives.

The 12 Units will be restricted for our use via recorded Deed Restrictions. The project is named Vermilion and is a 60-unit affordable rental townhome development targeting a family population, specifically households earning no more than 30%, 50% and 60% of the county median income. The sixty residential buildings will contain 36 two-bedroom units and 24 three-bedroom units. Six of the units will be fully accessible for persons with disabilities. Vermilion will house working families who earn a gross annual household income within the range of $18,000 to $44,000, adjusted for family size.

The location is ideal for our purpose. There is a DATA Route bus stop located within convenient walking distance, 2 police stations nearby, and there is a large cluster of medical offices less than 3 miles south of the site on Fayetteville St. Each unit has its own private entrance with a covered porch and exterior door with a single lever deadbolt and eye viewer.

The property includes fully accessible public areas, covered picnic area with two tables and a grill, outdoor sitting areas with benches, gazebo playground and tot lot, connecting broad sidewalks, multipurpose room, management office, computer center and fitness center. Residents may utilize the multi-purpose room for classes and special events and the computer center for various educational and career advancement opportunities. The gazebo, covered picnic area, outdoor sitting areas, gazebo, playground and tot lot offer the opportunity to socialize and build community spirit. Each resident’s apartment will meet or exceed the energy star requirements and feature a range, dishwasher, frost-free refrigerator, washer/dryer connection, large closets, storage, carpet, resilient flooring, and Energy Efficient Heat Pumps.

The Grant is contingent upon the approval of Vermilion Homestead, LLC’s Integrated Supportive Housing Program (ISHP) loan application from NCHFA in the amount of $1.5 million dollars. Attached is (i) Vermilion’s ISHP application to the NCHFA (ii) information about the ISHP loans, and (iii) the request to Alliance for grant funds from Vermilion.
REQUEST FOR AREA BOARD ACTION: Review the material and approve the issuance of a Grant in the amount of $300,000 to Vermilion Homestead, LLC in consideration of the 12 units to be reserved for use by Alliance, all subject to the approval of the ISHP loan.

CEO RECOMMENDATION: Approve the proposal.

RESOURCE PERSON(S): Carol Wolff, General Counsel; Ann Oshel, Senior Vice-President/Community Relations
Fund a Development

The North Carolina Housing Finance Agency provides funding to government entities, nonprofit and for-profit organizations who serve certain vulnerable populations to provide housing to North Carolinians who are homeless, have mental, physical or developmental disabilities, are children in or aging out of foster care or adults released from correctional facilities. Two funding sources are available:

- Integrated Supportive Housing Program
- Supportive Housing Development Program

Integrated Supportive Housing Program (ISHP)

The Integrated Supportive Housing Program is a collaboration between the North Carolina Housing Finance Agency and the North Carolina Department of Health and Human Services. Interest-free loans of up to $1,500,000 is available for rental developments in which no more than 20% of the apartments are integrated and set aside for persons with disabilities.

Developments can include, but are not limited, to the following:

- new construction
- acquisition and rehabilitation
- rehabilitation only
- refinancing.

The portion of the apartments financed by the Agency must house individuals and families who earn below 50% of area median income. Rent and utilities cannot exceed 30% of the targeted income.

How Do I Apply for Funding?

Nonprofits, for-profits and local governments interested in applying must schedule a pre-application meeting and site visit prior to application. The site must be approved by the NC Housing Finance Agency and the regional Local Management Entities/Managed Care Organizations (LMEs/MCO). To request a site visit, please submit the Project Description and Site Visit Request Form to the address listed in the Application Guidelines.

After the site is approved, the LME/MCO must submit an ISHP-DHHS Project Proposal to DHHS.

Following a site visit, ISHP-DHHS Project Proposal approval and review of the Application Guidelines, applicants then submit a formal application:

Application Part 1 (word template)
Application Part 2 (excel spreadsheet)
**What Is The Funding Cycle?**

Applications will be accepted on an open basis for the 2017 funding cycle until Monday, April 30, 2018 or until all funds are committed. For more information on how to apply for Integrated Supportive Housing Program financing, please contact Margrit Bergholz (919-877-5633 or mcbergholz@nchfa.com) or Gwen Belcredi (919-877-5648 or sgbelcredi@nchfa.com).

Excerpts from the ISHP Application Guidelines found at:


**1.3. PROJECT FINANCING**

1.3.1 Uses of Funds
Financing is only available for real property that will result in integrated, community-based permanent supportive housing, as defined in Paragraph 2.4 (Eligible Projects).

1.3.2 Funding Available
ISHP has up to $10,000,000 available for the program. It is intended that awards shall not exceed $1,500,000 and the cost per set-aside unit will not exceed $150,000. If a project receives a commitment for funding from a LME/MCO it will receive bonus points. The Housing Developer will need to provide a Letter of Financial Participation from the LME/MCO to document the amount of funds the LME/MCO plan to commit to the project (see Appendix G).

1.3.3 Ineligible Uses of Funds
Program funds may not be used for:
A. Supportive services expenses, operating costs, or administrative costs.
B. Construction or rehabilitation of office space or space for supportive services not in conjunction with housing units.
C. Relocation costs.
D. Rental assistance.

1.3.4 Financing Commitment
Projects selected for financing will receive a conditional commitment from NCHFA. Housing Developers with a conditional commitment will have 12 months to receive final written commitments for the balance of construction and permanent financing from other sources. When written commitments for all other project funds have been obtained, the Housing Developer will receive a final commitment of Program funds. Please see Appendix D for a full list of requirements at each stage of the program.

1.3.5 Loan Terms
All ISHP funding will be in the form of a 20 year non-forgivable, 0% interest, permanent mortgage loans. Other loan terms will be considered if necessary to comply with other funding requirements.

1.3.6 Types of Loans
Amortizing and deferred loans are available under the Program, depending on the ability of the project to pay debt service. NCHFA prefers to make amortizing loans so program funds can be recycled to fund additional projects. All loans will include a Promissory Note, Deed of Trust, Declaration of Deed Restrictions and a Loan Agreement. Deferred loans with a balloon payment may be refinanced at the request of the borrower and at the discretion of NCHFA, providing the project continues to be used for a mutually acceptable supportive housing purpose.
Alliance Behavioral Healthcare
Attn: Ann Oshel
4600 Emperor Boulevard
Durham, NC 27703

February 19, 2018

Dear Ms. Oshel,

Please find the executed ISHP-DHHS Project Proposal for the Vermilion Project, located at 1311 Cook Road in Durham, attached to this correspondence. DHHS approves this project. This approval is contingent upon subsequent discussions, determinations and DHHS approvals related to the Tenant Selection Plan and associated Regulatory Agreement. These documents are currently being drafted and will be finalized in the coming months.

Please feel free to reach out with any questions or concerns.

Thank you,

Jessa Johnson
Supportive Housing Policy Director
Office of the Secretary
North Carolina Department of Health and Human Services

919 855 4800 main
919 855 4931 office
919 715 4645 fax
Jessa.johnson@dhhs.nc.gov

MSC 2001
101 Blair Drive

Enclosure: DHHS Approved ISHP-DHHS Project Proposal
NORTH CAROLINA DEPARTMENT OF
HEALTH AND HUMAN SERVICES

INTEGRATED SUPPORTIVE HOUSING PROGRAM
ISHP-DHHS PROJECT PROPOSAL

2017 PROGRAM YEAR

FOR INFORMATION CONTACT:
JESSA JOHNSON, SUPPORTIVE HOUSING POLICY DIRECTOR,
OFFICE OF THE SECRETARY, NC DHHS
919-855-4931
jessa.johnson@dhhs.nc.gov
Introduction

The North Carolina Department of Health Services (DHHS), in consultation with the North Carolina Housing Finance Agency (NCHFA), has developed this proposal as a required document submitted with the Integrated Supportive Housing Program (ISHP) Notice of Funds Available (NOFA) application process by the local housing developer. This proposal serves to outline, clarify and provide structure related to the role of the Local Management Entities/Managed Care Organizations, their successor and/or designee (herein referenced as LME/MCO) and their collaboration with the housing developer.

DHHS contracts with Local Management Entities/Managed Care Organizations to oversee the provision of services and subsidy administration for individuals living with Serious Mental Illness (SMI) and Severe and Persistent Mental Illness (SPMI) who participate in the Transitions to Community Living Initiative. Within this structure, the LME/MCO may subcontract with local providers, subject to receiving DHHS written approval. In collaboration with local housing developers, LME/MCOs ensure site suitability, provision of supportive services, tenancy selection and subsidy administration.

The ISHP proposal may be submitted by the LME/MCOs to DHHS at any time for review, discussion, consideration, and collaboration, but it is a required part of the ISHP NOFA final application submission. Information on active, local Housing Developers is available by contacting DHHS or NCHFA.

Upon final approval by DHHS, this proposal becomes the project agreement between DHHS and the respective LME/MCO.

Background

In 2014, the North Carolina General Assembly established the Community Living Housing Fund (CLHF) (G.S. 122E-3.1) to provide funding for the transition of individuals diagnosed with serious mental illness or severe and persistent mental illness from institutional settings to integrated, community based supportive housing. The CLHF is composed of the unexpended, unencumbered balance of funding appropriated to Transitions to Community Living Initiative Funds at the end of each fiscal year. The CLHF, as a subset of the Housing Trust Fund, is administered by the NCHFA, in consultation with DHHS, and is to be used to provide permanent, community based housing in integrated settings for individuals with serious mental illness and severe and persistent mental illness. The ISHP NOFA and Proposal process were developed to foster collaboration with local housing developers and LME/MCOs.
ISHP-DHHS Project Proposal Process

Application Process

NOFA Published

Housing Developer & LME/MCO develop mutually agreeable project proposal
(location, project type, services, referral process, leasing structure)

Housing Developer submits ISHP Pre-Application to NCHFA & LME/MCO

Site Visit is conducted with Housing Developer, LME/MCO, DHHS, NCHFA
If site is approved, then

LME/MCO submits ISHP-DHHS Project Proposal to DHHS

If ISHP-DHHS Project Proposal is approved by DHHS, then

LME/MCO sends the approved ISHP-DHHS Project Proposal to Housing Developer
to include in the ISHP Full Application

Housing Developer submits Full Application to NCHFA
SECTION 1. PROJECT INFORMATION

A. Amount of ISHP Funding Request

$1,500,000. Alliance Behavioral Healthcare will make an additional $300,000 investment to cover an overage of construction costs.

B. Project budget (total development cost), including all funding sources

$9,909,075

C. LME/MCO:

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<thead>
<tr>
<th>Name</th>
<th>Alliance Behavioral Healthcare</th>
</tr>
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<tbody>
<tr>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>4600 Emperor Boulevard, Suite 200</td>
</tr>
<tr>
<td>City</td>
<td>Durham</td>
</tr>
<tr>
<td>State</td>
<td>NC</td>
</tr>
<tr>
<td>Zip Code</td>
<td>27703</td>
</tr>
<tr>
<td>Contact Person</td>
<td>Ann Oshel</td>
</tr>
<tr>
<td>Telephone</td>
<td>(919) 651-8855</td>
</tr>
<tr>
<td>Fax</td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:aoshel@AllianceBHC.org">aoshel@AllianceBHC.org</a></td>
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D. Project Name and Address

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<tbody>
<tr>
<td>Address</td>
<td>1311 Cook Road</td>
</tr>
<tr>
<td>City</td>
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</tr>
<tr>
<td>Zip Code</td>
<td>27713</td>
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<tr>
<td>County</td>
<td>Durham</td>
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E. Housing Developer/Owner Information

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<td>Address</td>
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</tr>
<tr>
<td>City</td>
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</tr>
<tr>
<td>State</td>
<td>NC</td>
</tr>
<tr>
<td>Zip Code</td>
<td>27516</td>
</tr>
<tr>
<td>Contact Person</td>
<td>Jim Yamin</td>
</tr>
<tr>
<td>Title</td>
<td>Managing member</td>
</tr>
<tr>
<td>Telephone</td>
<td>828-351-9151</td>
</tr>
<tr>
<td>Fax</td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:jim@workforcehomestead.com">jim@workforcehomestead.com</a></td>
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DHHS ISHP Proposal 2017
SECTION 2. PROJECT DESCRIPTION

A. Project Name and Address

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<tr>
<td>Address</td>
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</tr>
<tr>
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<td>Durham</td>
</tr>
<tr>
<td>Zip Code</td>
<td>27713</td>
</tr>
<tr>
<td>County</td>
<td>Durham</td>
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B. Project Type

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<tbody>
<tr>
<td></td>
<td>Renovation of Rental Properties for 20% Set Aside</td>
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C. Total Number of Units

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<tbody>
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<td>Disablity Set Aside</td>
<td>Combination/Other (please describe)</td>
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D. Narrative Description of Project

Vermilion is a 60 unit affordable rental townhome development targeting a family population, specifically households earning no more than 30%, 50% and 60% of the county median income. The sixteen residential buildings will contain 36 two-bedroom units and 24 three-bedroom units. Six of the units will be fully accessible for persons with disabilities. Vermilion will house working families who earn a gross annual household income within the range of $18,000 to $44,000, adjusted for family size.

The development will also feature a free-standing community building that will contain site management offices, a multipurpose room with full kitchen, computer center, fitness center and coinoperated laundry (all residential units will also contain washer/dryer hookups). Site amenities will include a playground, tot lot, picnic shelter, covered patio and at least three benches.

The community will employ a full-time site manager and full-time maintenance manager.

There is a DATA Route 5K bus stop located within convenient walking distance just 900 feet from the project on MLK Blvd. There are 2 police stations nearby, one 2.4 miles west on MLK Blvd, and another 1.9 miles north on Fayetteville Street. The nearest fire station is 3 miles SW on...
Hope Valley Road. There is a large cluster of medical offices 2.7 miles south of the site on Fayetteville St. Duke University Medical Center is 6.9 miles away. A broad range of social services in downtown Durham is 4.3 miles to the north. The exterior of the building will have an attractive percentage of brick veneer with high quality, low maintenance vinyl siding, including color variations between the lower and upper floors which provide additional definition to the design of the buildings and enhances the neighborhood. The roofing finish will be 30 year Architectural anti-fungal shingles. Standard features include carpeting throughout the living and bedrooms, quality resilient flooring in the kitchen, dining area, entrance area, and bathrooms; raised panel interior doors; high quality cabinetry in the kitchen and bathrooms; a pantry, under range Hood mounted fire suppression systems in the kitchen; mini blinds throughout; washer/dryer hook-ups; exterior storage closet; and a highly energy efficient HVAC system. The kitchen includes all energy star appliances, including dishwasher and frost free refrigerator with freezer, and 30" range. Each unit has its own private entrance with a covered porch and exterior door with a single lever deadbolt and eye viewer. All exterior doors and double pane vinyl windows are insulated. There are lighted ceiling fans, telephone jacks and cable connections in the living and bedrooms; lighted walk-in closets; and exterior lighting at the unit's entry doors. Fully accessible public areas, covered picnic area with 2 tables and a grill, outdoor sitting areas with benches, gazebo playground and tot lot, connecting broad sidewalks, multipurpose room, management office, computer center and fitness center. Residents may utilize the multipurpose room for classes and special events and the computer center for various educational and career advancement opportunities. The gazebo, covered picnic area, outdoor sitting areas, gazebo, playground and tot lot offer the opportunity to socialize and build community spirit. Trees, bushes and plantings will be drought resistant and native to Eastern North Carolina. A variety of plantings will be clustered together for maximum appeal and will be used to soften building lines, screen equipment and naturalize parking areas. Each resident's apartment will meet or exceed the energy star requirements and feature a range, dishwasher, frost free refrigerator, washer/dryer connection, large closets, storage, carpet, resilient flooring, and Energy Efficient Heat Pumps.

SECTION 3. PROJECT OPERATION

A. Ownership Arrangement: Describe ownership arrangement.
B. **Referrals:** Describe how referrals will be provided, include copy of proposed structure between LME/MCO and developer, property manager, owner, etc.

Referrals will come thru the Alliance Housing Specialist and TCLI team with the Housing Specialist serving as the point of contact with property management. Each week the in-reach list is reviewed internally between the housing and TCLI teams. Housing barriers are addressed as well as the person's housing preferences and projected transition date. The Housing Specialist will maintain the inventory of available units and coordinate with the property manager once a person is identified for move in. Persons will be screened in accordance with the Tenant Selection Plan prior to an application being submitted.

*Initial Lease-up:* Twelve units will be held vacant for TCLI referrals from the LME/MCO until 3 months before the LIHTC occupancy deadline. If no TCLI client has occupied the unit by that date, the unit will be released to the DHHS Regional Housing Coordinator for 30 days to make a Targeting referral to the unit (with a source of rental assistance, if appropriate). If a Targeting household is not approved by a time which is 8 weeks before the LIHTC occupancy deadline, the unit will be released back to the landlord and LIHTC-qualified applicants from the property's general waiting list and then from any source which will be considered for the unit.

*On-going Unit Turn-over (after Initial Lease-up):* After the deadline for LIHTC initial occupancy, if the property falls below the required number of ISHP set-aside units, then as units become available upon turn-over the landlord will notify the MCO and hold the unit for a TCLI referral from the MCO. The MCO will take one or some combination of the following actions:

- Send an ISHP program referral,
- Approve withdrawals from the vacancy reserve once the unit has been held for 30 days (for subsequent months) if the MCO wants to maintain access to the unit,
- Make vacancy payments once the vacancy reserve is depleted if the MCO wants to maintain access to the unit,
- After an appropriate period of time defined by the MCO, with DHHS approval, make the unit available to the DHHS Targeting Program referral process for a period of at least 30 days.
C. **Proposed Leasing Structure:** DHHS supports the following leasing structures, with guidance provided in Appendix A.

   i. Master lease held by the LME/MCO or subcontractor, with defined process for tenant to assume lease  
   ii. LME/MCO leasing agreement utilizing TCLV  
   iii. Independent tenant lease agreement  

Parties can agree to other leasing structures, including, but not limited to, independent leasing by TCLI tenants and other forms up rental subsidy (i.e. HCV, HUD CoC, VASH)

<table>
<thead>
<tr>
<th>Number of units Master Leased by LME/MCO or subcontractor</th>
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</table>
| Number of units with LME/MCO leasing agreement           | 12  
| Number of other units                                    |  

D. **Describe Leasing Structure:** Provide an outline of how the leasing of units is structured, including;

   i. The period units will be held awaiting referral from LME/MCO;  
   ii. Referral plan ensuring use by TCLI participants and back-up referral plan of eligible tenants, if inadequate referrals of TCLI participants;  
   iii. Sustainability plan for rental subsidy, identify the source of rental assistance and the back-up plan that addresses current and prospective tenants;  
   iv. Vacancy payments plan, including the source of funds for vacancy payments and the back-up plan if vacancy payments exceed the 90 day allowable DHHS timeframe.

See item B for further detail. Rental subsidy is made possible through State funding appropriated by the General Assembly with Alliance serving as the subsidy administrator. Alliance has a 3 party agreement with DHHS and HFA to make these funds possible.

E. **Describe Service Provision:** Describe how services will be delivered to tenants and the plan to continue to engage tenants.
All persons approved for housing will have a Transition Coordinator through Alliance who will continue to support the person for 90 days following move in. If a person is not eligible for an intensive mental health service such as ACT team or CST they will be assigned to a Transition Management Team with accompanying outpatient therapy as clinically indicated. All services are community based to include case management and home visits. Person centered plans to include crisis plans are developed prior to transition and reviewed regularly by the person and their support team. Each formal service along with Alliance’s Office of Individual and Family Affairs and the TCLI team include a peer support specialist who will continue to engage persons that may be hesitant to see a psychiatrist or therapist or take medication. Even if a person is not ready to actively participate in treatment Alliance will provide regular outreach in conjunction with the treatment provider to build relationships, trust and monitor their level of functioning. While most treatment services are authorized based on medical necessity there will always be levels of supports and safety nets for persons participating in the settlement.

In the event of a crisis Alliance offers the full spectrum of crisis interventions from 24/7 on call responsibility by the provider, mobile crisis teams, Crisis Intervention Teams that include a law enforcement response, community paramedicine that involve an EMS response and inpatient crisis facilities to offer further stabilization.

As part of the collaboration with property managers and landlords Alliance offers a landlord orientation that describes the treatment and crisis systems, how services are provided, etc... In addition we are also Mental Health First Aid to education landlords on the signs and symptoms of major mental illnesses and substance use as well as de-escalation skills.

SECTION 4.  PROJECT USE
A. **Targeted Use:** Please describe how this project targets individuals within TCLI. Include the following:

   i. Identify how individuals will be offered these units and waitlist process.
   ii. List all other service and/or housing programs which assist other populations at the proposed project.
   iii. Describe how the proposed program works in collaboration with the other service and/or housing programs in the community.
   iv. Provide detail around location, including access to services, pharmacy, grocery, transportation, etc.

We would use a procedure similar to that in the attached draft MOU.

There is a DATA Route 5K bus stop located within convenient walking distance just 900 feet from the project on MLK Blvd. A short walk beyond the bus stop is the Hope Valley Shopping Center, containing a Kroger supermarket, CVS Pharmacy, Family Dollar and a number of restaurants.

B. **How does this project meet specific housing goals, as defined in the Annual LME/MCO Housing Plan?**

Durham Co is considered a high value county in that a significant portion of persons participating in the settlement are choosing to live there. Alliance has certainly seen an increase in persons choosing to return to Durham from adult care homes. In addition, with the revitalization of the downtown area there is a critical shortage of affordable housing properties and creating access to these properties has been a challenge. The majority of strategies outlined in Alliance's housing plan include fostering partnerships with developers, obtaining a 20% set aside in desirable properties, master leasing and a capital investment of Alliance's own dollars.

This is a highly beneficial partnership to help Alliance meet its housing goals. It is convenient to the amenities of daily living with public transportation, grocery stores and other specialty stores being within walking distance. The Southpoint Mall is less than 5 miles away. It is new construction that is nearing completion so we would have a quicker turnaround time on occupancy. Plus, it is 2 and 3 bdrm townhouses which allows consumers a different choice in residential living. The 2 bdrms are well within the subsidy allowances and include ranch style and 2 level.

While Alliance is certainly willing to master lease this property we have mutually agreed this is not necessary based on the very flexible and
forgiving Tenant Selection Plan that has been submitted. This eliminates almost all housing barriers we have encountered accessing properties and we anticipate no issues with the persons we refer. In addition, Alliance is investing its own money which will allow for deed restrictions on the units and the developers have graciously allowed us to handpick the units that will optimize true integration.

C. List any additional partners, funding provided, and/or populations served.

CICCAR, first mortgage lender, will lend $2,460,000; NCHFA will lend a $800,000 RPP loan and a $694,174 State Refund Credit Loan; City of Durham will lend a $193,506 loan; CAHEC will syndicate $3,892,111 in federal housing tax credit equity.

SECTION 6. SIGNATURE OF LME/MCO AUTHORIZED OFFICIAL

A. By signing below, it is certified that the information provided in this application is true and complete.

B. By signing below, it is agreed that DHHS may conduct its own independent review of the information herein and the attachments, and may verify information from any source.

C. All proposals submitted become the property of the DHHS

D. Submission of a proposal does not guarantee funding. Any costs incurred prior to the issuance of approval by DHHS or project award by NCHFA are the sole responsibility of the applicant.

E. By signing below, it is certified that the information contained in this application, if approved by DHHS, will become the project agreement between DHHS and the LME/MCO.

By: [Signature]

Name: Robert Robinson
SECTION 6. SIGNATURE OF LME/MCO AUTHORIZED OFFICIAL

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By: ________________________________
Signature of LME/MCO Authorized Individual

Name ______________________________

Title: ______________________________

Date: ______________________________

FOR DHHS USE ONLY

APPROVED

By: ________________________________
Signature of Authorized Individual

Name: ______________________________

Title: ______________________________

Date: ______________________________

DHHS ISHP Proposal 2017
FOR DHHS USE ONLY

APPROVED

By: 

Signature of Authorized Individual

Name: James Yamin

Title: Managing member

Date: 1/11/18

ISHP-DHHS Project Proposal Appendix A

Acceptable Leasing Structure

In all acceptable leasing structures, the housing must meet quality standards, tenants sign a standard lease and tenant units are integrated. Agreed upon leasing structures must be formalized between the LME/MCO and the local developer/property owner.

Master Lease

A Master Lease program is structured with the LME/MCO, or approved designee, leasing the supportive housing units from the housing developer/property owner/landlord. Using a standard lease, these units will then be subleased to a program participant, with the intent of transitioning the individual to their own independent lease within a reasonable timeframe, typically at the time of lease renewal (6-12 months). The expectation at lease transition is that the individual will hold a standard lease directly with the landlord. In the Master Lease program, the Tenant pays 25% of their income toward rent, holds a lease with all the rights and autonomy of a standard lease and abides by the terms of said lease. At the point of successfully transitioning to a standard lease with the landlord, the individual completes the Master Lease program, transitions to the Transitions to Community Living Voucher program.
and is considered successfully housed in permanent supportive housing. Individuals referred to a Master Leasing program will have significant barriers to accessing quality housing without this assistance, such as a criminal record, eviction history, etc. and are commonly referred to as 'hard to house'. Some properties, typically due to project funding restrictions, may not be able to operate under a master leasing structure.

**Transitions to Community Living Voucher**

A Transitions to Community Living Voucher (TCLV) can be utilized by the tenant to lease a unit that has been created through the ISHP process. The LME/MCO performs this activity in the same way that the standard TCLV program operates currently. Tenants pay 25% of their income toward rent.

**Independent Tenant Lease**

In an independent tenant lease situation, the tenant may be participating in a rental subsidy program that is accepted by the property owner/property manager. This could include, but is not limited to, a Housing Choice Voucher, a HUD VASH voucher, or a Supportive Housing Program subsidy, outlined in a written agreement with the property owner/property manager.
February 9, 2018

Vermilion Homestead LLC
1534 Twisted Oak Drive
Chapel Hill NC 27516

Ann Oshel
Alliance Behavioral Healthcare
4600 Emperor Boulevard, Suite 200
Durham, NC 27703

Re: Grant funding request - $300,000
Vermilion Homestead LLC

Dear Ms. Oshel:

I’m writing to please request a $300,000 grant from Alliance Behavioral Healthcare to Vermilion Homestead LLC. The purpose of this grant will be to partially fund the completion of construction of the 60-unit affordable rental development. I would like to further request that this grant be made available to the project during the current construction phase.

This grant will supplement a loan in the amount of $1,500,000 as part of Vermilion Homestead LLC’s commitment to provide housing for 12 individuals who are part of the state’s Transition to Community Living Initiative.

Other funding sources include loans from CICCAR, NCHFA, the City of Durham and equity from the sale of federal housing tax credits.

The co-developers, Workforce Homestead Inc and Align Development LLC, have over 50 years combined of experience developing affordable housing.

Please let me know if I can provide any further information.

Sincerely,

Jim Yamin
President, Workforce Homestead Inc,
managing member WHAD Vermilion LLC,
its managing member
ITEM: Overview of Jail Mental Health Initiatives

DATE OF BOARD MEETING: March 1, 2018

BACKGROUND: This report will provide an update on our jail mental health and other criminal justice initiatives. Alliance continues to have a strong collaboration with our first responders along the Sequential Intercept model and is an active participant in the Stepping Up initiative which is a national effort to reduce the number of persons with mental illness in local jails.

REQUEST FOR AREA BOARD ACTION: Accept the training.

CEO RECOMMENDATION: Accept the training.

RESOURCE PERSON(S): Ann Oshel, Senior Vice-President/Community Relations
Overview of Criminal Justice Efforts

• Responsible for the coordination of Crisis Intervention Teams (CIT) in Wake, Durham and Johnston Counties
• Developed modified CIT training specifically for detention staff
• Alliance staff certified in Public Safety module with MHFA
• Trained all sworn and non-sworn Raleigh PD personnel in MHFA
• Trained all sworn Durham PD personnel in MHFA
• Sponsor of all the regional Raise the Age forums in our catchment area
Overview of Criminal Justice Efforts

• Law Enforcement Assisted Diversion (LEAD) Program - Cumberland
• Diversion Program with DA and PD - Wake
• Mental Health Detention Units - Wake and Durham
• Veteran CIT training - Wake and Johnston
• Bridge Housing Program - Wake
• Restoring Hope-ILI Financial Assistance
• Wake and Durham CIT Apps
Crisis Intervention Teams (CIT)

- 40 hour training
- Goal is to have 20% of patrol officers certified
- 911 Communicators trained to dispatch CIT officers
- Community wide training - EMS, hospitals, municipalities, SRO’s, universities

Numbers Trained:
- Cumberland-905
- Wake-1374
- Durham-866
- Johnston-211
Stepping Up Initiative

• A national initiative to reduce the number of people with mental illness in jails

• Focuses on:
  • Building partnerships with leaders and stakeholders
  • Collecting and analyzing prevalence data in the jails
  • Build treatment and service capacity
  • Develop measurable outcomes
  • Create a process to track and report on progress

• County Commissioners have signed proclamation in Wake, Cumberland and Durham
CJ Leads/Alpha Report

• Purpose: Alliance is placing increased focus on individuals that become incarcerated who are currently in or have recently been recipients of care coordination, have had crisis or inpatient admissions within the previous 6 months of their incarceration and those with serious and persistent mental illness and Opioid Use Disorders.

• Allows an opportunity in real time to identify and intervene with the highest risk consumers

• Allows for more immediate release planning and connection to services
What the report can tell us that CJ LEADS alone can not

• Who from Alliance’s catchment area is incarcerated state wide
• Currently has a Care Coordinator
• Has had recent crisis/inpatient event and who the provider was
• Has a psychotic disorder/opioid dependence and who the current provider is
  • Run paid claims history 3 months prior to arrest and 3 months post release to assess for service engagement
• Insurance type including Medicaid Eligibility County
• Basic demographics
• Algorithm has 100% matching accuracy
The role of Alliance with CJ LEADS/ALPHA

• Report generated usual working days by Care Coordination
  • Focuses on persons with crisis episodes, Opioid Use Disorder or any Psychotic Disorder within the last 180 days
  • Report includes persons name, id #, jail date, date of birth, Medicaid eligibility, and assigned Care Coordinator. If applicable will also include name of provider and number of jail bookings
  • Report shared with jail medical provider and can be shared with detention staff with a signed release of information

• Follow up in the jail will be primarily managed by Alliance Care Coordination
  • Notifies provider that person is incarcerated
  • Coordinates with medical staff
  • Visits with inmate
  • Post release planning
  • Refer to jail medical team if deemed urgent or emergent
  • Obtains needed releases of information
FY 16-17 Wake Detention Summary

• 3348 consumers showed up on the CJ Leads/Alpha report

• 2062 had at least one “IN” booking date and one “OUT” booking date during FY 16-17

• 914/2062 people received a service billed through Alliance Behavioral Healthcare 60 days before and/or 60 days after booking

• 508/2062 (24.6%) received a service before AND after

• 282 (35.7% of those previously served) did not re-engage in services within 60 days of release

• 124 (9.7% of those known to Alliance and not previously served) were newly connected to services within 60 days of release
Demographic Breakdown of Booked Consumers FY 16-17

Insurance
- State 54%
- Medicaid B 46%

Gender
- Female 31%
- Male 69%

Age
- 18-24 20%
- 25-44 52%
- <18 6%
- 45-64 21%
- 65+ 1%
- 65+ 1%
FY 16-17 Diagnosis Breakdown: All with claims

- Substance Use: 39%
- Mood Disorder: 29%
- Schizophrenia: 13%
- Nonpsychotic Mental Disorder: 13%
- Behavioral/Emotional: 3%
- Personality Disorder: 2%
- Unknown: 1%

N = 914
FY 16-17 Diagnosis Breakdown Cont’d

Lost Services

- Personality Disorder: 1%
- Personality Disorder Unknown: 1%
- Nonpsychotic Mental Disorder: 8%
- Behavioral/Emotional: 2%
- Mood Disorder: 32%
- Schizophrenia: 9%
- Substance Use: 47%

Newly Connected to Services

- Personality Disorder: 1%
- Mood Disorder: 33%
- Schizophrenia: 13%
- Nonpsychotic Mental Disorder: 17%
- Behavioral/Emotional: 1%
- Substance Use: 34%

N = 282

N = 124
What It All Means

• Substance Use Disorders (SUD) continue to be the most prevalent diagnosis

• There is not a wide gap between uninsured and Medicaid
  • Need to ensure persons are not losing Medicaid while incarcerated

• Need to improve service engagement after release for persons with SUD followed by Mood Disorders

• The vast majority are younger persons (25-44) with already significant behavioral health histories and more difficult to engage
ITEM:  Alliance Key Performance Indicators (KPIs)

DATE OF BOARD MEETING:  March 1, 2018

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.

REQUEST FOR AREA BOARD ACTION:  Accept the report.

CEO RECOMMENDATION:  Accept the report.

RESOURCE PERSON(S):  Michael Bollini, PhD, Chief Operating Officer
ITEM: Alliance 2018 Legislative Priorities

DATE OF BOARD MEETING: March 1, 2018

BACKGROUND: These are our primary legislative priorities going into the NC General Assembly’s legislative short session, which is scheduled to commence in May 2018. Priorities may be added and adjusted on an as-needed basis to account for developments.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Brian Perkins, Senior Vice President, Strategy and Government Relations
Alliance Behavioral Healthcare:
2018 Legislative Priorities

Request to the General Assembly:
Pass legislation enabling LME-MCOs to establish and operate Behavioral Health and I/DD Tailored Plans under North Carolina Medicaid Transformation

Request to the NC Department of Health and Human Services:
Establish a plan for implementing these Tailored Plans that utilizes LME-MCOs’ experience and community relationships to best integrate care for individuals with significant behavioral health disorders, complex health needs, substance use disorders, and social/environmental challenges

Background:
LME-MCOs are uniquely positioned to integrate behavioral health and physical health services for individuals with complex needs:

- **Continuity of Care for Consumers**
  Ensure that LME-MCOs play a lead role in implementing the State’s proposal to integrate behavioral health and physical health services to serve the needs of individuals with significant behavioral health (BH) disorders, intellectual and developmental disabilities (I/DD), and traumatic brain injury (TBI) through specialized behavioral health and I/DD tailored plans (BH I/DD TPs).\(^1\)
  - These Tailored Plans are a significant evolution for advancing whole-person care for the specialized populations Alliance serves.
  - LME-MCO leadership will make sure that care is not disrupted for the thousands of consumers that will select the new, integrated plans.

- **Build on Success and Experience**
  Enabling LME-MCOs to establish and operate BH I/DD TPs will build upon the strengths of our State’s public managed care system.
  - For more than five years, Alliance has operated as a managed care entity and built a proven system of care for effectively serving individuals with significant BH disorders, complex health needs, substance use disorders, and compounding social and environmental challenges.
  - Alliance has increased the number of individuals with Medicaid served every year since FY13, from about 25,000 in FY13 to over 46,000 in FY17. And, our clinical service denial rate is less than 2%, meaning we have expanded access to care by focusing on early interventions of proven practices rather than by restricting service.
  - We have successfully developed integrated care programs, systematically coordinating behavioral and physical healthcare, in all of the counties we serve. This integration

\(^1\) The State does not currently have legislative authority to integrate behavioral health services into a Medicaid managed care program. Implementation of this integration is contingent upon action by the General Assembly.
produces the best outcomes and provides an effective approach to caring for individuals with multiple healthcare needs.

○ We have specialized expertise in handling multiple complex health payer sources. In addition to Medicaid, LME-MCOs manage behavioral health services funded with non-Medicaid federal, State, and local funding in accordance with applicable State and federal laws and regulations.

• **Established Community Relationships and Local Presence**
  Alliance has built a comprehensive and community-based continuum of services and supports.
  ○ This infrastructure and its associated community relationships take years to develop and locally-connected expertise to foster.
  ○ The local presence of LME-MCOs allows for close monitoring of consumer care, innovative partnerships with community stakeholders and providers, and the ability to leverage resources from all funding streams to build local service systems.

• **Provide Certainty for a Vulnerable Population**
  Defining LME-MCOs’ role in Medicaid Transformation will confirm the future of the State’s behavioral health system and remove uncertainty that has caused instability in a currently stable environment for a vulnerable population.
Request to the General Assembly:
Stop the cuts to State Single-Stream Funding that are severely restricting our State’s ability to meet the Mental Health, Intellectual/Developmental Disabilities, and Substance Use Disorder service needs of uninsured North Carolinians

- Restore LME-MCO Single-Stream Funding to the 2015 level for mental health, substance abuse diagnosis, and intellectual/developmental disabilities (MH/SA/IDD) services.
- End the recurring portion of the Single-Stream cuts contained in the current State budget. These recurring cuts are particularly devastating because they permanently remove funds from our system that are intended to serve the uninsured and underinsured.

Background:
- Single-Stream Funding is the State appropriation for the MH/SA/IDD service needs of uninsured and underinsured North Carolinians. Single-Stream Funding is separate from Medicaid funding.
- The current State budget included cuts to Single-Stream Funding to NC’s behavioral healthcare system of almost $178 million over two years. This $178 million cut is in addition to $262 million in Single-Stream cuts included in the previous budget.
- Significant portions of this latest cut are recurring reductions, meaning that these funds are permanently removed from the public behavioral health system.
- The budget requires LME-MCOs to continue offering at least the 2015 level of State-funded services despite the designated funds for those particular services being cut significantly.
- LME-MCOs are having to make up this State funding shortfall by using their Medicaid savings designated for community reinvestment, including initiatives designed to reduce unnecessary emergency department admissions and divert people with behavioral health issues from the criminal justice system.
  - Alliance has been forced to halt planned service expansions and building projects. For example, we have had to stop work on:
    - Opening a new Adult Crisis Facility to respond to the rapidly-growing demand in Wake County
    - Expanding our Behavioral Health Urgent Care Centers in several communities throughout our catchment area.
  - Because the crisis facility and urgent care centers would serve a high proportion of uninsured and underinsured individuals, lack of current and future State Single-Stream funding makes operating such facilities unsustainable.
- The unfortunate reality is that these budget cuts, and the threat of further cuts, have required LME-MCOs to halt investments in care innovation in order to meet current service obligations.