MEMBERS PRESENT: ☒Cynthia Binanay, Vice-Chair, ☒Michael Boose, ☒Christopher Bostock, Chair, ☒Heidi Carter (via phone), ☐George Corvin, MD, ☐James Edgerton, ☒Lodies Gloston, ☒Phillip Golden (via phone), ☒John Griffin, Ed.D, ☒Curtis Massey, ☐George Quick, ☒William Stanford, Jr., ☒Caroline Sullivan (via phone), ☒Amelia Thorpe, ☐Lascel Webley, Jr., and ☐McKinley Wooten, Jr.

GUEST(S) PRESENT: Glenn Adams, Chair of Cumberland Board of County Commissioners; Caroline Bradstock, CFAC Chair; John Biggers, Cape Fear Valley Medical Center; Amy Cannon, Cumberland County Manager; Elizabeth Goolsby, Director of Fayetteville Veterans Affairs Medical Center; Tracy Jackson, Cumberland County Manager’s office; Jimmy Keefe, Cumberland Board of County Commissioners; and Brian Perkins, Government Relations Consultant

ALLIANCE STAFF PRESENT: Hank Debnam, Cumberland Site Director/Veteran’s Point of Contact; Joey Dorsett, Senior Vice-President/Chief Information Officer; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Carol Hammett, General Counsel; Veronica Ingram, Executive Assistant; Beth Melcher, Executive Vice-President/Clinical Operations (interim); Sara Pacholke, Senior Vice-President/Financial Operations; Vera Reinstein, Pharmacist; Robert Robinson, Chief Executive Officer; Sara Wilson, Government Relations Director, and Doug Wright, Director of Consumer Affairs.

1. CALL TO ORDER: Chairman Christopher Bostock called the meeting to order at 4:02 p.m.

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<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
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<td>2. Announcements</td>
<td>Chairman Bostock welcomed guests and asked them to introduce themselves. Glenn Adams, Chair of the Cumberland Board of County Commissioners, welcomed Board members to Cumberland County and expressed appreciation for the work done by the Board. Mr. Robinson mentioned the results from EQR (external quality review); Alliance was rated at 94.4% which was the highest score among NC MCOs. Also, Mr. Robinson mentioned that Alliance is reviewing files and requesting updated resumes/CVs for all Board members. Board members can forward these documents to Ms. Ingram.</td>
</tr>
<tr>
<td>3. Agenda Adjustments</td>
<td>There were no adjustments to the agenda.</td>
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<td>4. Public Comment</td>
<td>There were no public comments.</td>
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## AGENDA ITEMS:

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<tr>
<td>5. Committee Reports</td>
<td><strong>DISCUSSION:</strong></td>
</tr>
<tr>
<td>A. Consumer and Family Advisory Committee – page 5</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 the subcommittee meetings.</td>
</tr>
<tr>
<td></td>
<td>Caroline Bradstock, CFAC Chair, presented the report. Ms. Bradstock provided an update from the recent CFAC meetings and mentioned that artists from Arts Access attended the Wake subcommittee meeting and shared an overview of their organization which ensures access to the arts for all persons. The CFAC report is attached to and made part of these minutes.</td>
</tr>
<tr>
<td>B. Finance Committee – page 16</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 March meeting; it is attached to and made part of these minutes.</td>
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<td></td>
<td>Sara Pacholke, Senior Vice-President/Financial Operations, presented the report. She mentioned that revenues exceeded expenditures and all State mandated ratios were met. Ms. Pacholke mentioned that the budget amendment will be addressed at the next meeting as the super majority required to approve budget matters was not present.</td>
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## BOARD ACTION

The Board received the committee reports.

## 6. Consent Agenda

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<tbody>
<tr>
<td>A. Draft Minutes from March 2, 2017, Board Meeting – page 22</td>
<td>The consent agenda was sent as part of the Board packet. There were no comments or discussion about the consent agenda.</td>
</tr>
<tr>
<td>B. Executive Committee Report – page 28</td>
<td></td>
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<td>C. Human Rights Committee Report – page 31</td>
<td></td>
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<tr>
<td>D. Network Development and Services Committee Report – page 80</td>
<td></td>
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<td>E. Policy Committee Report – page 105</td>
<td></td>
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<tr>
<td>F. Quality Management Committee Report – page 108</td>
<td></td>
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<tr>
<td>G. Draft Minutes from March 21, 2017, Board Budget Retreat – page 169</td>
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**BOARD ACTION**

A motion was made by Dr. John Griffin to approve the consent agenda; seconded by Mr. William Stanford. Motion passed unanimously.
### AGENDA ITEMS:

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<tr>
<td><strong>7. Recommendation for Appointment</strong> – page 226</td>
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<tr>
<td>As noted in the by-laws the Area Board is given the task of advertising, accepting applications, interviewing and recommending appointment of prospective Board members to the respective boards of county commissioners. Chairperson Bostock shared that the Executive Committee interviewed applicants for the vacant seat representing Wake County. He stated that the Executive Committee recommends that the Area Board recommend that the Wake Board of County Commissioners appoint Marilyn Avila to the vacant seat.</td>
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<tr>
<td><strong>BOARD ACTION</strong></td>
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<tr>
<td>A motion was made by Mr. Curtis Massey to recommend that the Wake Board of County Commissioners appoint Marilyn Avila; seconded by Ms. Lodies Gloston. Motion passed unanimously.</td>
</tr>
<tr>
<td><strong>8. Electronic Advertising of Bids</strong> – page 227</td>
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<tr>
<td>NC General Statute Chapter 143 Article 8, requires that Alliance, as a political subdivision of the State, formally advertise its large bids for construction ($500,000 and greater) and purchase of goods ($90,000 and greater) electronically and/or via newspaper. A decision to advertise solely by electronic means for all contracts that are subject to Article 8, Public Contracts, must be approved by the governing board of the political subdivision at a regular meeting. There were no questions or discussion about the proposal.</td>
</tr>
<tr>
<td><strong>BOARD ACTION</strong></td>
</tr>
<tr>
<td>A motion was made by Dr. John Griffin to approve the proposal to authorize formal bids made pursuant to statute to be advertised solely by electronic means when deemed proper in the discretion of the Purchasing Manager; seconded by Ms. Lodies Gloston. Motion passed unanimously.</td>
</tr>
<tr>
<td><strong>9. Training: Opioid Dependency</strong> – page 228</td>
</tr>
<tr>
<td>Vera Reinstein, Pharm. D, Clinical Pharmacist, provided background of current opioid dependency, statistics regarding prescription and non-prescription use, and mortality rates. Additionally, Dr. Reinstein provided the Board with Alliance’s current efforts to address the opioid epidemic which are directed by the Governor’s task force work and strategic plan. This strategic plan was developed by a committee of internal and external stakeholders and is focused on the following areas: medication assisted treatment, partnerships with NC Harm Reduction Coalition (NCHRC), and crisis facilities to increase education and access to naloxone. Fayetteville LEAD (law enforcement assisted diversion) is a partnership with Alliance, the criminal justice system, the district attorney’s office and NCHRC and TASC (treatment accountability for safer communities). The LEAD program is a pilot program; it is the first of its type in the South. Lastly, Dr. Reinstein reviewed next steps which include education for Alliance staff, providers and community stakeholders; prevention, collaboration, and advocacy.</td>
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Thursday, April 06, 2017
711 Executive Place, Fayetteville, NC 28305
4:00-6:00 p.m.

**AGENDA ITEMS:**

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<td><strong>10. Updates</strong></td>
<td>Board members discussed the STOP act, effective communication, follow-up treatment after Narcan is administered, current and potential partnerships, additional advocacy for nurse practitioners to be able to dispense Narcan, and treatment for adolescents. The opioid dependency training is attached to and made part of these minutes.</td>
</tr>
<tr>
<td><strong>11. Chairman’s Report</strong></td>
<td>The Board accepted the training as presented; no additional action required.</td>
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<tr>
<td><strong>12. Closed Sessions</strong></td>
<td>Brian Perkins, Government Relations Strategic Advisor, provided an update on current topics and actions in the North Carolina General Assembly.</td>
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<tr>
<td><strong>13. Adjournment</strong></td>
<td>Chairman Bostock reminded the Board that next month’s meeting will be at Alliance’s home office.</td>
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**BOARD ACTION**

- The Board accepted the training as presented; no additional action required.
- A motion was made by Vice-Chair Cynthia Binanay to enter closed session pursuant to NCGS 143-318.11 (a) (6) and NCGS 143-318.11 (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; seconded by Ms. Lodies Gloston. Motion passed unanimously.

The Board returned to open session.

**Next Board Meeting**

**Thursday, May 04, 2017**

**4:00 – 6:00**

Robert Robinson, Chief Executive Officer

Date Approved
ITEM: Consumer and Family Advisory Committee (CFAC) Report

DATE OF BOARD MEETING: April 6, 2017

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

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

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

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

REQUEST FOR AREA BOARD ACTION: Receive draft minutes from the subcommittees.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Caroline Ambrose, CFAC Chair; Doug Wright, Director of Consumer Affairs
1. WELCOME AND INTRODUCTIONS: Welcome by Steve Hill, Chair of the Durham CFAC Subcommittee. Members and guests introduced themselves.

2. REVIEW OF THE MINUTES: Minutes reviewed. Dave motioned for minutes to be approved as is, Steve seconded the motion. Minutes approved.

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<td>Public Comment</td>
<td>Guest, Jessica Martinez, shared her concerns regarding the lack of case management in the current system. She shared her interest and advocacy in seeing that there be laws in place that mandate discharge plans and case management after hospitalization.</td>
<td>-record the meeting proceedings.</td>
<td></td>
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<td>Membership Update</td>
<td>Steve shared current membership numbers with the Durham subcommittee. Yancee shared Allison’s resignation. Recruitment efforts to be made by CFAC members. Much of this was discussed last meeting and at the CFAC retreat held at the beginning of February. Jessica Martinez inquired of CFAC, as to its purpose. Doug shared the mandate from the state for CFACs to exist, and their purpose in advising and advocacy in the system. CFAC members shared what it was that motivated them to serve as members of the Alliance CFAC.</td>
<td>Recruit membership by committing to the plan compiled by CFAC members at the CFAC retreat in February. Challenged to bring a potentially interested person to the next meeting.</td>
<td>Ongoing</td>
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<td>Advocacy Efforts</td>
<td>Steve and Yancee shared their most recent experience in participating with the RCNC Addiction Recovery Advocacy Day held on February 28th. Steve shared that Israel Pattison (Wake CFAC member) had met briefly with a representative and has plans for a more formal meeting to discuss the concerns surrounding the single-stream funding for the LME/MCO to continue network development and service delivery. Doug shared that the Legislative Priorities document, spoken about by Rob Robinson and Brian Perkins at the last all-county Alliance CFAC meeting, is finished and will be sent out to CFAC members to view and utilize as talking points if desired. Other opportunities exist for further advocacy efforts below: NAMI Legislative Priorities: <a href="https://naminc.org/advocacy/2017-policy-legislative-priorities/">https://naminc.org/advocacy/2017-policy-legislative-priorities/</a> RCNC Education and Training: <a href="http://rcnc.org/recovery-supports/recovery-message-training/">http://rcnc.org/recovery-supports/recovery-message-training/</a> 2017 Disability Advocacy Conference Thursday, April 20, 2017: “The Friday Center” at UNC-Chapel Hill.</td>
<td>Doug to share the Legislative Priorities document with CFAC members. CFAC members to participate in advocacy efforts and utilize information from NAMI, RCNC, etc. as talking points. Consider participation in future events.</td>
<td>Ongoing</td>
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<td>CFAC Retreat Breakout Discussion</td>
<td>See Attachment: <a href="attachment.png">Image</a></td>
<td>Develop action steps to move forward with discussion points formulated at the CFAC Retreat.</td>
<td>Ongoing</td>
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| CFAC ELT By-laws Discussion   | Web address for current by-laws draft: israelpattison.atlassian.net  

Discussion held as to current structure of the Alliance CFAC and the Durham Subcommittee. If there is to be a change in how often meetings take place in the Durham Subcommittee, there is a potential that Monday night meeting times would need to change, as there are meetings for the all-county Alliance CFAC every other month at the Alliance corporate office.  

By-laws govern the number of people that can participate (as members) on the Alliance CFAC, they also detail the purpose and function of a CFAC, as well as the structure of when and how meetings will take place.  

Israel (CFAC member working on drafting new by-laws) shared at the last ELT meeting, his intention to complete the draft by June/July in alignment with a new fiscal year, and CFAC officer elections. See CFAC ELT minutes for further details: | CFAC members to access web link to view current by-laws being drafted and make comments. Durham subcommittee members to consider if/when Durham subcommittee meetings are moved to month-to-month, what day besides Monday members might be able to meet. | June/July 2017      |
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<td>ELT minutes 2-27-17.docx</td>
<td>Doug shared that the Governor’s budget proposal is out currently, yet the House and Senate must look at the budget and discuss/make changes and agree upon the final budget. The current budget, however proposes to restore the state funding that was cut, increase funding related to opioid overdose and an additional 1,000 IDD Innovations slots with 1,000 slots added for lower level/med-intensity supports. Doug also shared that the State CFAC is writing a letter to the state in regards to the significant salary difference for the CEO of Cardinal Innovations.</td>
<td>Email C.J. Lewis for a revised copy of the state updates if interested: <a href="mailto:Chris.J.Lewis@dhhs.nc.gov">Chris.J.Lewis@dhhs.nc.gov</a></td>
<td>Ongoing</td>
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<td>LME-MCO &amp; State Updates</td>
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<td>Budget Retreat Tuesday, March 21st Opportunity for CFAC members to present Consider reviewing presentation and adding feedback.</td>
<td>Dave, Jim, and Amelia to volunteer at the IDD Resource Fair to staff the CFAC table. Yancee to share further details. Dave, Tammy, and Amelia to volunteer at the NAMI Walk to staff a CFAC table.</td>
<td>April/May 2017 Ongoing</td>
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<td>Opportunities/Announcements</td>
<td>Alliance IDD Resource Fair: Wednesday, April 26th from 3 p.m. to 7 p.m. Opportunity exists for CFAC to have a table. NAMI Walk is Saturday, May 6th in Raleigh. Does CFAC want a table? Potential recruitment opportunity.</td>
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<td></td>
<td>Autism Speaks Event April 29th &amp; April is World Autism Month</td>
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<td><a href="https://www.autismspeaks.org/advocacy">https://www.autismspeaks.org/advocacy</a></td>
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5. ADJOURNMENT:
    7:15 p.m.
Membership

- Explore and map out connections existing within CFAC to further recruitment efforts
- Conversation regarding reaching out to individuals and families in the beginning stages of their attempt to navigate services
- Possibly create an ad hoc committee to work on recruitment strategies and ideals to employ upon recruitment and retention of new members; possible areas of focus: vulnerability (i.e. it’s ok that you don’t understand everything right now), how to best “pitch” the idea of participating on CFAC, addressing benefits, motive, opportunity, etc.
- CFAC members to explore their reasons for initially participating to further inform talking points to new members; offering mentorship
- Move the meeting to a variety of locations to cater to varied transportation challenges faced by individuals that might be interested
- As incentive for new members and benefit to current members, bring resource-related speakers in to broaden knowledge and understanding of what supports exist within the Durham community
- For the above, a work group might form to schedule approximately 6 months’ worth of speakers for upcoming subcommittee meetings

Personal Commitment

- If information is not understood, it is ok to ask for information to be re-framed for understanding
- Explore incentives and motives to continue to engage
- Have more regularly scheduled “retreats” to re-group and ensure everyone is on the same page moving forward
- Consider changing the quorum requirements and CFAC meeting structure to have fewer members needed for a quorum and possibly more monthly county subcommittee meetings (as opposed to current alternating month subcommittee/all-county CFAC meeting schedule), so that when CFAC members do “show up” work can get completed
- Consider participating in and providing feedback regarding the above to Israel on the rules/by-laws subcommittee

Community Collaboration & Outreach

- Consider hosting a monthly CFAC information/education session to the public
- CFAC members to go out to key areas to share this information- who, what, when, where, why
- Collaborate with like-minded groups to host an event/listening session/awareness opportunity for the community to elicit feedback
- Participate in advocacy opportunities and community events and educate the public regarding the MH/DD/SUD system
- Obtain legislative priorities (from Alliance, NAMI, RCNC) in order to be better informed and move forward with any advocacy efforts
Dial +1 (267) 507-0012  
Access Code: 632-365-705

**1. WELCOME AND INTRODUCTIONS:** Carrie was not available to attend this meeting. Israel welcomed all participating and led the meeting.

**2. REVIEW OF THE MINUTES:** No minutes for review

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<td>Board Budget Retreat Presentation</td>
<td>Date(s) for the upcoming Board Budget Retreat to be determined Thursday of this week. Israel and Steve both reviewed the presentation sent out via email early last week, and had no further additions or edits. Once the date(s) are determined, CFAC members to be alerted and volunteer to present information at the Board Budget Retreat.</td>
<td>Doug to send an email when a date has been decided upon. CFAC members to volunteer to present information.</td>
<td>Thursday, February 2, 2017</td>
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<tr>
<td>By-Laws</td>
<td>Israel share a website where CFAC members are able to access the current by-laws document as well as the new drafted document. That web address is: israelpattison.atlassian.net CFAC members are encouraged to access this web-site to view and comment on the current by-laws draft. Article 4 of the draft focuses on the future structure of CFAC.</td>
<td>CFAC members and Alliance staff to log on to the web address and comment/read the current by-laws draft. Ensure this information is given out at the subcommittee meetings in March.</td>
<td>March 2017</td>
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</table>
| **Executive Leadership Team** | Yancee posed the question of ability to transition to the new proposed framework by introducing it at the upcoming county subcommittee meeting(s).

Israel explained that there is likely more work to be done, as the by-laws are essentially being developed from scratch. However the idea would be for the subcommittees to elect two representatives to participate as ambassadors to the LME/MCO, and that these individuals could be separate from the subcommittee chair. The subcommittees would also be responsible for adopting their own work agreement/charter.

There are still some specifics that Israel would like to work on in regards to the current by-laws draft in order that transition take place in an organized manner, with a thorough understanding of how things would unfold. | Israel to complete the by-laws by the new fiscal year. This is to align with elections within CFAC. | June/July 2017 |
| **Executive Leadership Team** | Will we still need this group or should the home office group fulfill these responsibilities? | Yes this group would still continue. | N/A |
| **Facebook** | Israel obtained permission from Doug to be an administrator of the Alliance CFAC Facebook page. He has since posted the meeting schedule for all Alliance CFAC meetings. CFAC members are encouraged to like and follow the page. The idea would be to potentially have a group of members be responsible for the upkeep of the page and have subcommittee members funnel information or posts to the group that would be responsible for posting information on the page. This may be an opportunity for what used to be the “communications” subcommittee. | CFAC members to like and follow the Facebook page, and encourage others to do so as well. Consumer Affairs Staff to share this information at the upcoming March subcommittee meetings. | March 2017 |
**Advocacy Opportunity**

Last Wednesday Israel went to a town hall meeting called by Cynthia Ball, who sits on the House Appropriations Committee and is a democrat newly elected to North Carolina House District 49. Israel took the opportunity to meet briefly with her and ask her what she knew regarding the topic of LME/MCO single stream funding. Israel was asked by Cynthia to make an appointment with her to discuss this. Israel would like to extend the opportunity to CFAC members. He will make an appointment and send an invitation to CFAC members to participate alongside him.

Israel to make the appointment with Cynthia Ball and send an invitation to CFAC members for participation.

March 2017

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5. **ADJOURNMENT:**
meeting concluded 4:50 P.M.
MEMBERS PRESENT: Israel Pattison, Carrie Bradstock, Eric Hall, Cynthia Hall, Denise Wood, Kurtis Taylor
GUEST(S) PRESENT: Stacy Guse, Doug Wright, Jamie Katz, Emily Catherine Mealor, Hilary Kinlaw

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES - Minutes from 1-17-17 were approved.

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<td>Israel Patterson</td>
<td>Mental Health First Aid Project&lt;br&gt;Israel brought up the discussion about how the Wake CFAC could engage community partners and offer Mental Health First Aid through Alliance and the trainers available. The group liked the idea and decided to have a training for themselves and community members first on April 29th. They will then decide where to target the training opportunities in the community.</td>
<td>Stacy to schedule training on April 29th.</td>
<td>April 29, 2017</td>
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<tr>
<td>I/DD Resource Fair</td>
<td>Does CFAC want to man a table for the Durham and Wake Fair at Corporate April 26 3-7 pm. Volunteers were asked for this event at the home office of Alliance. Some members volunteered and will participate.</td>
<td>Participate in the event on April 26th.</td>
<td>April 26, 2017</td>
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<td>Betsy Ludwig</td>
<td>Doug put in a request for Betsy to come to the meeting and talk about the Arts-waiting for her to respond. Several members from Arts Access came and presented to the group their desire to ensure arts are accessible to people with disabilities. A discussion was had about different venues, costs, free events, etc. The group agreed to disseminate the information to people they knew.</td>
<td>Disseminate the information and take advantage of the opportunities.</td>
<td>Ongoing</td>
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5. ADJOURNMENT
ITEM: Finance Committee Report

DATE OF BOARD MEETING: April 6, 2017

BACKGROUND: The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Area Board. The Finance Committee meets monthly at 3:00 p.m. prior to the regular Area Board Meeting.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): James Edgerton, Committee Chair; Robert Robinson, CEO; Kelly Goodfellow, CFO
Thursday, March 02, 2017  BOARD FINANCE COMMITTEE

APPOINTED MEMBERS PRESENT: ☒ James Edgerton, Chair; ☒ George Quick, MBA, ☐ John Griffin;
BOARD MEMBERS PRESENT: n/a
GUEST(S) PRESENT: Mary Hutchings, Wake County Internal Auditor

STAFF PRESENT: Rob Robinson, CEO; Kelly Goodfellow, CFO, Sara Pacholke, Controller

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the 2/2/17 meeting was reviewed; however because a quorum was not met they were not approved.

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</table>
| 3. The monthly financial reports were discussed which includes the Statement of Revenue and Expenses – Actual to Budget, Senate Bill 208 Required Ratios, and DMA Contract Ratios  
  a) Statement of Revenue and Expenses – Actual to Budget as of January 31, 2017 – Alliance currently has revenues exceeding expenses of $19,248,873. The majority of this is related to Medicaid and Medicaid risk reserve as well as local funds. The amount of savings will likely come down as more is spent on claims and administrative functions. Earnings for this time of year are lower than previous years, however that is to be expected as we move forward in the managed care environment (savings are higher in the beginning).  
  b) Senate Bill 208 Ratios - Alliance is currently meeting and exceeding all required Senate Bill 208 ratios (current ratio and percent paid).  
  c) DMA Contract Ratios – Alliance is currently meeting all DMA contractual required ratios (defensive interval and MLR).  |  |  |  |
| 4. Rob Robinson discussed the state working on solvency standards for LME/MCO’s. Currently they are looking at LME/MCO’s having 60 days’ cash on hand (using cash on hand less current liabilities). | Sara Pacholke to research options so we can present a recommendation to the State |  |  |

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>Kelly Goodfellow discussed the upcoming budget retreat. She shared the presentation outline draft and asked for feedback.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>The budget transfer policy was discussed. It was determined that the final changes are acceptable and it will go to the policy committee for approval.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. **ADJOURNMENT**

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
# Statement of Revenue and Expenses (Budget and Actual) - As of February 28, 2017

<table>
<thead>
<tr>
<th></th>
<th>Original Budget</th>
<th>Current Period</th>
<th>Year to Date</th>
<th>Balance</th>
<th>% Received/ Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Grants</td>
<td>$36,874,048.00</td>
<td>$2,225,676.60</td>
<td>$19,660,951.30</td>
<td>$17,213,096.70</td>
<td>53.32%</td>
</tr>
<tr>
<td>State &amp; Federal Grants</td>
<td>55,113,711.00</td>
<td>2,850,269.36</td>
<td>23,571,884.46</td>
<td>31,541,826.54</td>
<td>42.77%</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>348,220,800.00</td>
<td>30,327,713.96</td>
<td>240,622,233.45</td>
<td>107,598,566.55</td>
<td>69.10%</td>
</tr>
<tr>
<td>In Kind</td>
<td>-</td>
<td>-</td>
<td>1,372,449.37</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>440,208,559.00</td>
<td>35,403,659.92</td>
<td>285,227,518.58</td>
<td>156,353,489.79</td>
<td>64.79%</td>
</tr>
<tr>
<td><strong>Administrative</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Administration</td>
<td>369,835.81</td>
<td>30,874.65</td>
<td>246,997.20</td>
<td>122,838.61</td>
<td>66.79%</td>
</tr>
<tr>
<td>LME Administrative Grant</td>
<td>4,359,385.00</td>
<td>363,282.00</td>
<td>2,906,256.00</td>
<td>1,453,129.00</td>
<td>66.67%</td>
</tr>
<tr>
<td>Medicaid Waiver Administration</td>
<td>44,330,623.20</td>
<td>3,940,054.22</td>
<td>31,299,632.09</td>
<td>13,030,991.11</td>
<td>70.60%</td>
</tr>
<tr>
<td>Miscellaneous Revenue</td>
<td>100,000.00</td>
<td>44,961.63</td>
<td>161,276.26</td>
<td>(61,276.26)</td>
<td>161.28%</td>
</tr>
<tr>
<td><strong>Total Administrative Revenue</strong></td>
<td>49,159,844.01</td>
<td>4,379,172.50</td>
<td>34,614,161.55</td>
<td>14,545,682.46</td>
<td>70.41%</td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td>489,368,403.01</td>
<td>39,782,832.42</td>
<td>319,841,680.13</td>
<td>170,899,172.25</td>
<td>65.36%</td>
</tr>
<tr>
<td><strong>EXPENSES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Services</td>
<td>36,874,048.00</td>
<td>2,755,119.52</td>
<td>15,106,335.94</td>
<td>21,767,712.06</td>
<td>40.97%</td>
</tr>
<tr>
<td>State &amp; Federal Services</td>
<td>55,113,711.00</td>
<td>4,469,971.72</td>
<td>34,185,718.10</td>
<td>20,927,992.90</td>
<td>62.03%</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>348,220,800.00</td>
<td>28,691,773.28</td>
<td>218,290,797.73</td>
<td>129,930,002.27</td>
<td>62.69%</td>
</tr>
<tr>
<td>In Kind Expenses</td>
<td>-</td>
<td>-</td>
<td>1,372,449.37</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td><strong>Total Service Expenses</strong></td>
<td>440,208,559.00</td>
<td>35,916,864.52</td>
<td>268,955,301.14</td>
<td>172,625,707.23</td>
<td>61.10%</td>
</tr>
<tr>
<td><strong>Administrative</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operational</td>
<td>6,749,177.51</td>
<td>295,075.48</td>
<td>3,268,422.84</td>
<td>3,480,754.67</td>
<td>48.43%</td>
</tr>
<tr>
<td>Salaries, Benefits, and Fringe</td>
<td>34,017,214.69</td>
<td>2,671,875.48</td>
<td>23,525,166.86</td>
<td>10,492,047.83</td>
<td>69.16%</td>
</tr>
<tr>
<td>Professional Services</td>
<td>8,293,451.81</td>
<td>676,147.79</td>
<td>4,621,046.57</td>
<td>3,672,405.24</td>
<td>55.72%</td>
</tr>
<tr>
<td>Miscellaneous Expense</td>
<td>100,000.00</td>
<td>-</td>
<td>-</td>
<td>100,000.00</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Total Administrative Expenses</strong></td>
<td>49,159,844.01</td>
<td>3,643,098.75</td>
<td>31,414,161.55</td>
<td>17,645,207.74</td>
<td>63.90%</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>489,368,403.01</td>
<td>39,559,963.27</td>
<td>300,369,937.41</td>
<td>190,270,914.97</td>
<td>61.38%</td>
</tr>
<tr>
<td><strong>CHANGE IN NET POSITION</strong></td>
<td>$222,869.15</td>
<td>$19,471,742.72</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Current Ratio** = Compares current assets to current liabilities. Liquidity ratio that measures an organization’s ability to pay short term obligations. The benchmark is 1.0.

**Percent Paid** = Percent of clean claims paid within 30 days of receiving. The benchmark is 90%.
**Defensive Interval** = Current assets divided by average daily operating expenses. This ratio shows how many days the organization can continue to pay expenses if no additional cash comes in. The benchmark is 30 days.

**Medical Loss Ratio (MLR)** = Total Services Expenses plus Administrative Expenses that go towards directly improving health outcomes divided by Total Medicaid Revenue less Risk Reserve Revenue. The benchmark is 85% however we are held harmless until July 2017. Beginning July 2017 Risk Reserve will be included in revenue.
ITEM: Draft Minutes from the March 2, 2017, Board Meeting

DATE OF BOARD MEETING: April 6, 2017

REQUEST FOR BOARD ACTION: Approve the draft minutes from the March 2, 2017, meeting.

CEO RECOMMENDATION: Approve the minutes.

RESOURCE PERSON(S): Robert Robinson, CEO; Veronica Ingram, Executive Assistant
MEMBERS PRESENT: ☒Cynthia Binanay, Vice-Chair; ☒Michael Boose, ☒Christopher Bostock, Chair (via phone); ☒Heidi Carter (entered at 4:05 pm); ☒George Corvin, MD; ☒James Edgerton; ☒Lodies Gloston (entered at 4:06 pm); ☒Phillip Golden; ☐John Griffin, Ed.D; ☒Curtis Massey; ☒George Quick; ☐Vicki Shore; ☐William Stanford, Jr.; ☒Caroline Sullivan; ☒Amelia Thorpe; ☒Lascel Webley, Jr., and ☒McKinley Wooten, Jr.

GUEST(S) PRESENT: Gary Bass, CEO of Pride of North Carolina; Caroline Bradstock, CFAC Chair (via phone); Yvonne French, NC DMH/DD/SAS; Denise Foreman, Wake County Manager’s Office; Mary Hutchinson, Wake County Finance Department; and Brian Perkins, Legal/Legislative Consultant

ALLIANCE STAFF PRESENT: Damali Alston, Director of Provider Networks; 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; Moyer Foster, interim Senior Vice-President/Clinical Operations; Kelly Goodfellow, Executive Vice-President/Chief Financial Officer; Amanda Graham, Senior Vice-President/Operational Development; Carol Hammett, General Counsel; Tina Howard, Quality Review Manager; Veronica Ingram, Executive Assistant; Geyer Longenecker, Director of Quality Management; Ken Marsh, Medicaid Program Manager; Sara Pacholke, Controller; Monica Portugal, Chief Compliance Officer; Rob Robinson, Chief Executive Officer; Matthew Ruppel, Director of Program Integrity; Sara Wilson, Government Relations Director; and Doug Wright, Director of Consumer Affairs

1. CALL TO ORDER: Vice-Chair Cynthia Binanay called the meeting to order at 4:02 p.m.

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Oath of Office</td>
<td>There was no oath of office.</td>
</tr>
</tbody>
</table>
| 3. Announcements | A. UPCOMING INTERVIEWS OF BOARD APPLICANTS: Vice-Chair Binanay informed the Board that the Executive Committee will interview two applicants for the vacant seat representing Wake County on Tuesday, March 21, 2017. All Board members are invited to attend the Executive Committee meeting and participate in the interviews. 

Vice-Chair Binanay mentioned that Vicki Shore submitted her resignation from the Board due to personal reasons. Ms. Shore expressed gratitude for the Board and the positive impact on the individuals Alliance serves. 

B. REQUEST FOR UPDATED RESUME/CVS: Mr. Robinson informed the Board that Alliance is updating its Board member files; he requested an updated resume/CV from all Board members and asked Board members to forward them to Ms. Ingram. |
| | C. STAFF INTRODUCTION: Mr. Robinson introduced newly hired Government Relations Director Sara Wilson. |
| | D. RFP AND FACILITIES UPDATE: Mr. Robinson mentioned that Alliance was awarded two RFPS by the State: one for child case management and the second for start-up funding to establish a child crisis facility. |
| 4. Agenda Adjustments | There were no adjustments to the agenda. |
### AGENDA ITEMS:

<table>
<thead>
<tr>
<th>5. Public Comment</th>
<th>DISCUSSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>There were no public comments.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Committee Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Consumer and Family Advisory Committee – page 6</td>
</tr>
<tr>
<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 the February meeting.</td>
</tr>
</tbody>
</table>

The committee reports were sent as part of the Board packet; Caroline Bradstock, CFAC Chair, presented the CFAC report. Ms. Bradstock provided an update from the CFAC retreat, updates from Alliance staff, continued concerns about the state and federal Medicaid reform process and the future of NC Medicaid funding. |

<table>
<thead>
<tr>
<th>B. Finance Committee – page 28</th>
</tr>
</thead>
<tbody>
<tr>
<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 February meeting. James Edgerton, Committee Chair, presented the Finance Committee report. He mentioned that revenues exceeded expenditures and all State mandated ratios were met or exceeded. He mentioned that the date of the budget retreat will be decided today.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Policy Committee – page 34</th>
</tr>
</thead>
<tbody>
<tr>
<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 draft minutes from the February meeting, policies recommended for continued use, policies with recommended changes, and one new draft policy.</td>
</tr>
</tbody>
</table>

Curtis Massey, Committee Chair, presented the Policy Committee report. The following policies were submitted as part of the packet for continued use: Coordination of Care for Special Health Care Populations; Clients’ Rights to Dignity, Privacy and Humane Care; Client’s Right to Confidentiality; Consumer Choice; Customer Services; Letters of Support; Provision of Services by Relatives/Legal Guardians; Rule Waiver Requests; Consumer, Provider and Stakeholder Satisfaction; Management and Investigation of Grievances; Management of Incidents; Accessibility of Utilization Review/Utilization Management Process; Pre-Review Screening for Certification; Utilization Review Criteria; Appealing Utilization Management Decisions; and Financial Eligibility. |

Mr. Massey noted that the recommended changes in the following policies were cosmetic: Advanced Directives/Advanced Instructions; Selection and Retention of Providers; and Utilization Review Process. Mr. Massey reviewed a new draft policy: Corporate Communications. There were no questions or discussion about the policies. |
**AGENDA ITEMS:**

<table>
<thead>
<tr>
<th>DISCUSSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BOARD ACTION</strong></td>
</tr>
<tr>
<td>A motion was made by Mr. Lascel Webley to approve the policies for continued use and with recommended changes; motion seconded by Dr. George Corvin. Motion passed unanimously.</td>
</tr>
<tr>
<td>A motion was made by Mr. Phillip Golden to approve the new policy: Corporate Communications; motion seconded by Mr. McKinley Wooten. Motion passed unanimously.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Consent Agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Draft Minutes from February 2, 2017, Board Meeting – page 63</td>
</tr>
<tr>
<td>B. Executive Committee Report – page 68</td>
</tr>
<tr>
<td>C. Quality Management Committee Report – page 72</td>
</tr>
<tr>
<td>The consent agenda was sent as part of the Board packet. There were no comments or discussion about the consent agenda.</td>
</tr>
</tbody>
</table>

| **BOARD ACTION** |
| A motion was made by Mr. George Quick to approve the consent agenda; motion seconded by Ms. Caroline Sullivan. Motion passed unanimously. |

| 8. Confirm Date for 2017 Budget Retreat – page 140 |
| An annual budget retreat is held to provide information to the Area Board as part of the process to establish the upcoming fiscal year’s budget. Vice-Chair Binanay reminded Board members of the options for the 2017 retreat dates. |

| **BOARD ACTION** |
| A motion was made by Dr. George Corvin to hold the budget retreat on March 21, 2016; motion seconded by Mr. James Edgerton. Motion passed unanimously. |

| 9. Legislative Agenda – page 141 |
| Brian Perkins, Legal/Legislative Consultant, distributed handouts and presented an overview of the recommended legislative priorities for 2017-2018. He reviewed each handout with Board members and key talking points for conversations with external stakeholders, specifically North Carolina legislators. |
| Board members discussed the following: including the amount of the single stream funding and what could be done with this money if this funding is restored; continuing to include stories of constituents in verbal conversations with legislators; including metrics related to veterans; and including CFAC members in this initiative. The legislative priorities handouts are attached to and made part of these minutes. |

<p>| <strong>BOARD ACTION</strong> |
| A motion was made by Mr. McKinley Wooten to approve the 2017-2018 legislative priorities; motion seconded by Mr. Lascel Webley. Motion passed unanimously. |</p>
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
</tr>
</thead>
</table>
| 10. Training(s) | A. Quality Management Department (15 minutes) – page 142  
Geyer Longenecker, Quality Management Director, presented an overview of Alliance’s Quality Management unit; the unit is tasked with identifying and addressing opportunities for improvement within internal operations and the local service system.  
During his presentation Mr. Longenecker reviewed Alliance’s CQI (continuous quality improvement) structure and highlighted projects, tasks, and data that is reviewed on a regular basis to make decisions and improve quality of care. He also mentioned oversight by internal committees, external reviewers, the Board Quality Management Committee and the Area Board. Mr. Longenecker concluded his presentation with an update on current quality improvement projects.  
Dr. Corvin, Board Quality Committee Chair, congratulated the unit on their work and what they provide for the Committee; he mentioned that this information is equivalent to vital signs for how the agency is performing.  
B. Key Performance Indicators (10 minutes) – page 143  
Michael Bollini, Executive Vice-President/Chief Operating Officer, presented an overview of current key performance indicators. He shared that Alliance leadership reviews monthly key performance indicators to ensure organizational performance is on track and where needed course corrections are identified and implemented.  
Dr. Bollini reviewed year-to-date metrics for key areas and provided examples of how these measures impact the organization and the impact of changes made based on these metrics. He mentioned that this information will be provided to the Board on a quarterly basis. Board members discussed adding additional items such as access to care and noted that this type of information is typically presented during the Board Quality Management Committee meetings.  
**BOARD ACTION**  
The Board accepted the trainings as presented; no additional action required. |
| 11. Updates | Vice-Chair Binanay shared that next month’s Board meeting is scheduled to be at Alliance’s community site in Fayetteville; there will be a reception starting at 3:30 pm to view the newly renovated space and meet local stakeholders.  
Vice-Chair Binanay mentioned that Wake Med accepted the bid on a crisis facility of $967,500.00 for 500 West Ransom Street in Fuquay-Varina. Ms. Hammett mentioned that a motion to approve per sixty days of due diligence is needed by the Board. |
### AGENDA ITEMS:

<table>
<thead>
<tr>
<th></th>
<th>DISCUSSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BOARD ACTION</strong></td>
<td>A motion was made by Ms. Lodies Gloston to authorize the CEO to execute a purchase agreement for the property at 500 West Ransom Street in Fuquay-Varina for $967,500.00 to allow Alliance to begin its due diligence process; motion seconded by Mr. McKinley Wooten. Motion passed unanimously.</td>
</tr>
<tr>
<td>12. Chairwoman’s Report</td>
<td>Vice-Chair Binanay requested the creation of an ad hoc committee to begin the preliminary annual review of the CEO; she proposed that the ad hoc committee be comprised of Executive Committee members and that the committee bring its recommendations to the Area Board for approval.</td>
</tr>
<tr>
<td><strong>BOARD ACTION</strong></td>
<td>A motion was made by Mr. Phillip Golden to appoint the Executive Committee as an ad hoc committee to perform preliminary evaluation of the CEO and present those recommendations to the Area Board for approval; motion was seconded by Ms. Caroline Sullivan. Motion passed unanimously.</td>
</tr>
<tr>
<td>13. Closed Session</td>
<td><strong>BOARD ACTION</strong> A motion was made by Mr. George Quick to enter closed session pursuant to NC General Statute 143-318.11 (1) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1; motion seconded by Ms. Caroline Sullivan. Motion passed unanimously. The Board returned to open session.</td>
</tr>
<tr>
<td>14. Adjournment</td>
<td>With all business being completed the meeting adjourned at 6:34 p.m.</td>
</tr>
</tbody>
</table>

**Next Board Meeting**

**Thursday, March 02, 2017**

4:00 – 6:00
ITEM: Executive Committee Report

DATE OF BOARD MEETING: April 6, 2017

BACKGROUND: The Executive Committee sets the agenda for Area Board meetings and acts in lieu of the Area Board between meetings. Actions by the Executive Committee are reported to the full Area Board at the next scheduled meeting. Draft minutes from the March 21, 2017, meeting are attached.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Christopher Bostock, Area Board Chair; Robert Robinson, CEO
APPOINTED MEMBERS PRESENT: ☒Cynthia Binanay, Board Vice-Chair, B.S.N, M.A.; ☒Christopher Bostock, Board Chair, B.S.I.M.; ☒George Corvin, Quality Management Committee Chair, M.D.; ☒James Edgerton, Finance Committee Chair, B.S.; ☒Lodies Gloston, Human Rights Committee Chair, B.A., M.A.; ☐Curtis Massey, Policy Committee Chair, B.A., J.D.; ☒William Stanford, Previous Board Chair, B.A., J.D.; and ☒Lascel Webley, Audit and Compliance Committee Chair, B.S., M.B.A., M.H.A

BOARD MEMBERS PRESENT: None
GUEST(S) PRESENT: None
ALLIANCE STAFF PRESENT: Kelly Goodfellow, CFO; Carol Hammett, General Counsel; Veronica Ingram, Executive Assistant; Rob Robinson, CEO

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the February 21, 2017, Executive Committee meeting were reviewed; a motion was made by Mr. Stanford to approve the minutes; motion seconded by Mr. Edgerton. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
<th>NEXT STEPS</th>
<th>TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Updates</td>
<td>Next Future Development Workgroup Meeting: Chairman Bostock mentioned that the April meeting is cancelled. This is a staff workgroup that Board members are invited to attend. The next meeting will be May 2, 2017.</td>
<td>None specified.</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Interview Board Applicants</td>
<td>The Committee interviewed two applicants for the vacant seat representing Wake County. COMMITTEE ACTION A motion was made by Dr. Corvin to advise the Area Board to recommend that the Wake Board of County Commissioners appoint Marilyn Avila to Alliance’s Board; motion seconded by Mr. Stanford. Motion passed unanimously.</td>
<td>The recommendation will be added to the agenda for the April Board meeting.</td>
<td>4/6/17</td>
</tr>
<tr>
<td>5. Cumberland County</td>
<td>Ms. Goodfellow provided an update from a recent meeting with the Cumberland County Finance staff. She mentioned the discussion regarding Cumberland County’s potential FY18 budget and how it may impact their FY18 funding to Alliance.</td>
<td>Ms. Goodfellow will forward the additional information to the Executive Committee.</td>
<td>3/21/17</td>
</tr>
<tr>
<td>6. Closed Session</td>
<td>COMMITTEE ACTION A motion was made by Ms. Gloston to enter closed session pursuant to NCGS 143-318-11 (1) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1; seconded by Dr. Corvin. Motion passed unanimously. Committee returned to open session.</td>
<td>None specified.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME: |
---|---|---|---|
7. April 6, 2017, Area Board Draft Agenda | Committee reviewed the draft agenda and provided input. | Ms. Ingram will forward the agenda to staff. | 3/22/17 |
8. Closed Session | COMMITTEE ACTION
A motion was made by Ms. Gloston to enter closed session pursuant to NCGS 143-318.11 (a) (6) and NCGS 143-318.11 (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.; seconded by Vice-Chair Binanay. Motion passed unanimously.
Committee returned to open session. | None specified. | N/A |

9. ADJOURNMENT: the next Committee meeting will be April 18, 2017, at 4:00 p.m.
ITEM: Human Rights Committee Report

DATE OF BOARD MEETING: April 6, 2017

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

The Human Rights Committee functions include:

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

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

The Human Rights Committee is a Board Committee with at least 50% of its membership being either consumers or family members that are not Board Members. All members and the chair are appointed by the Chair of the Alliance Board of Directors. The Committee is currently chaired by Ms. Lodies Gloston. The committee received the attached annual training as required by statute.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Lodies Gloston, Committee Chair; Doug Wright, Director of Consumer Affairs; May Alexander, QM Data Manager
APPOINTED MEMBERS PRESENT: ☒ Lodies Gloston, Board member, M.A. (Committee Chair), ☒ Dan Shaw, ☐ William Stanford, Jr., Board member, J.D., ☒ Dr. Michael Teague, ☐ Amelia Thorpe, Board member, B.A., ☒ Ira Wolfe, ☒ McKinley Wooten, Jr., Board member, J.D.

APPOINTED, NON-VOTING MEMBERS PRESENT:

BOARD MEMBERS PRESENT:

GUEST(S) PRESENT:

STAFF PRESENT: Doug Wright, Director of Consumer Affairs, Yancee Perez, Star Davis, Stacy Guse

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES - The minutes from the September 1, 2016, meeting were reviewed; a motion was made by Click here to enter text. and seconded by Click here to enter text. to approve the minutes. Choose an item.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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<tbody>
<tr>
<td>Annual Training</td>
<td>The attached annual training was received by the committee.</td>
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5. ADJOURNMENT: next meeting will be April 13, 2017 from 4:00 p.m. to 5:30 p.m.
Human Rights Committee Training
Human Rights Committee

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

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

• Alliance provides staff support to the Committee
Committee Responsibilities

• Assuring that consumer rights protections reviewed through routine provider monitoring
• Compliance with consumer rights and advance instruction
• Compliance with the protection of consumer in the community
• Assuring confidentiality
• Review of complaint and appeal data
Committee Responsibilities

- Report system issues which negatively impact the rights of persons served to the Board
- Work with state and local agencies to protect consumer rights
- Report to the Board at least quarterly
Makeup of the Committee

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

• Majority of members must not be Board members

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

• Representation from each county

• Staff members do not vote
Conflict of Interest & Confidentiality

• Members required to sign conflict of interest disclosure forms and Alliance confidentiality agreements

• A conflict may prohibit a member from serving or restrict them from some votes

• Members may not represent themselves as independent representatives of or act independently on behalf of the Committee
Meeting Structure

• Committee meets at least quarterly at the Alliance corporate office

• Emergency meetings may be called for unexpected circumstances

• Quorum (chair plus 50% of members) required to conduct a meeting
  o If quorum not met, informal discussion may be held with unanimous consent of members present
Meeting Structure

• Minutes recorded at each meeting

• Consumers are not identified in minutes or in written or oral reports

• Any discussion of provider-specific information must adhere to Alliance Provider Confidentiality procedure
Meeting Structure

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

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

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

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

Each board shall establish at least one HR Committee

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

• Board must implement policy on:
  o Composition, size and method of appointment of committee members
  o Training and orientation of members
  o Frequency of meetings (at least quarterly)
  o Rules of conduct for meetings and voting procedures
  o Procedures for monitoring the effectiveness of existing and proposed methods and procedures for protecting consumer rights
Board must implement policy on:
  - Requirements for routine reports to the Board regarding seclusion, restraint and isolation time out
  - Other operating procedures
• Committee oversees the following client rights protections for contracted services:
  o Compliance with G.S. 122C, Article 3
  o Compliance with provisions of 10A NCAC 27C, 27D, 27E, and 27F governing the protection of client rights, and 10A NCAC 26B governing confidentiality
Committee oversees the following client rights protections for contracted services:

- Establishment of review procedure for any of the following which may be brought by a client, client advocate, parent, legally responsible person, staff or others:
  - Client grievances
  - Alleged violations of the rights of individuals or groups, including cases of alleged abuse, neglect or exploitation
NC Statutes & Administrative Rules

- Concerns regarding the use of restrictive procedures
- Failure to provide needed services that are available
Nothing herein precludes authority of:

- A county DSS to investigate abuse, neglect, or exploitation
- Disability Rights of North Carolina to conduct investigations regarding alleged violations of consumer rights

Human Right Committees established by contract agencies shall carry out the provisions of this Rule
NC Statutes & Administrative Rules

• Each Committee shall be composed of a majority of non-board members, with a reasonable effort made to have all applicable disabilities represented, with consumer and family member representation

• Staff serving on the Committee shall not be voting members
• Committee shall maintain minutes of its meetings.

• Clients shall not be identified by name in minutes or in written or oral reports.
• Committee shall review grievances regarding incidents which occur within a contract agency after the governing body of the agency has reviewed the incident and had opportunity to take action

  o Incidents of actual or alleged violations, the facts of the incident, and the action, if any, made by the contract agency shall be reported to the area director within 30 days of the initial report of the incident, and to the board within 90 days
• Committee members must disclose a conflict or the appearance of a conflict of interest depending on the circumstances
  o May be prohibited from serving or restricted in voting based on the disclosure

• Members may not represent themselves as independent representatives of or acting independently on behalf of the Committee
  o Noncompliance may result in removal
• If the Committee cannot resolve the conflict of interest, the Committee Chair shall notify the Board Chair, who shall make the final decision regarding the disposition of all conflict of interest issues.
Duties of Alliance CFAC

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

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

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

• Review and comment on the Alliance program budget

• Participate in all quality improvement measures and performance indicators

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

- 21-member self-governing and self-directed advisory organization, composed entirely of consumers and family members of consumers

- Provides input and conduct oversight of the Division’s operations and efforts to accomplish the strategic outcomes of the State Plan

- Advises DHHS and the General Assembly on the planning and management of the State’s public MH/DD/SA services system
Five Components of Self-Advocacy

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

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

• Keep informed and ask questions

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

• When contacting a resource insist that explanations are clear and understandable
Responsibilities of the Self-Advocate

• Be clear about what you need and want
• Always go to meetings
• Ask who is at your meetings and why
• Keeping all your papers
• Never sign blank copies of forms
• Document what happens; taking notes or have someone else do it
Responsibilities of the Self-Advocate

- If you need help, taking someone along
- Know the laws that regulate your services
State and Federal Laws

- Most services provided because of state or federal laws
- Laws have regulations that provide guidance about how that law should be implemented
- There are always rules about how to spend money, sometimes in regulation or policy
- Laws include definitions for eligibility and services
Working With Providers

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

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

• Best practices help to justify requests for services

• Request clear written information on your grievances/appeal rights within an agency and outside an agency
Fact Finding and Documentation

• Keep good records and document what happens – this will become your proof

• Keep notes about times, dates and who you talked to and what you were told

• If required services are not being provided when promised, write it down
Figure Out if it’s Working

• Ask questions about when where and how often the service is going to happen
• Keep a log – write down when services happen
• If services don’t happen, know whom to call
• Evaluate happiness with services provided
• Always ask for any decision or change to be put in writing and wait for it
Figure Out if it’s Working

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

• Before expressing dissatisfaction, write down the essential points

• Stay calm

• Make the conversation brief and clear

• Be willing to listen

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

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

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

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

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

• Everyone deserves to live happily and usefully whole
Recovery

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

• Alliance supports and encourages them as they embark upon their personal journeys
The Alliance Service System

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

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

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

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

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

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

• Services that are effective
  o Based in research about what works and measured by best-practice quality standards
The Alliance Service System

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

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

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

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

• Evidence-based to help ensure positive treatment outcomes
Provider HR Committees

- Providers required to establish committees as well
- Multiple providers may agree in writing to form joint committees
- Responsibilities mirror those of LME-MCO committees
- Submission of annual report to the LME-MCO no longer required
ITEM: Network Development and Services Committee Report

DATE OF BOARD MEETING: April 6, 2017

BACKGROUND: The committee reviews progress on the agency’s network development plan and progress on service development. The committee reports to the Area Board and provides guidance and feedback on development of the needs and gaps assessment to meet state and agency requirements. This month’s report includes draft minutes and materials from the March 8, 2017, meeting.

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): William Stanford, Committee Chair; Beth Melcher, Senior VP of Network Development and Evaluation
APPOINTED MEMBERS PRESENT: ☒ Cynthia Binanay, M.A., ☐ George Corvin, M.D., ☐ John Griffin, Ed.D., ☒ William Stanford, Jr., J.D. (Committee Chair), ☒ McKinley Wooten, Jr., J.D.

BOARD MEMBERS PRESENT: Chris Bostock
GUEST(S) PRESENT: None
STAFF PRESENT: Beth Melcher, Senior VP Network Development and Evaluation; Damali Alston, Director of Provider Evaluation; Carlyle Johnson, Director Strategic Initiatives

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the January 11, 2017, meeting were reviewed; a motion was made by Mr. Wooten and seconded by Ms. Binanay to approve the minutes. Motion passed unanimously.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Results of Needs and Gaps Stakeholder Survey Results</td>
<td>Reviewed process of gathering stakeholder input on needs and gaps survey as well as results.</td>
<td>Results of the survey will be incorporated into the needs and gaps assessment.</td>
<td>Committee will review draft needs and gaps assessment at its next meeting</td>
</tr>
<tr>
<td>Proposed Medicaid Outcome measures for FY18</td>
<td>Damali reviewed overview of approach to identifying provider outcomes to be included in the FY18 Medicaid contracts as well as the process for implementing over the course of the year. Outcomes will be collected by Alliance and shared with provider types in a way that can promote discussion, technical assistance, and quality improvement.</td>
<td>Continue to review with provider groups and implement in July following implementation schedule</td>
<td></td>
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<tr>
<td>Proposed topics for May meeting</td>
<td>Review draft Needs and Gaps Analysis</td>
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4. ADJOURNMENT: next meeting will be May 10, 2017, from 4:00 p.m. to 5:00 p.m.
Community Needs Assessment

- LME/MCO Community Needs Assessment, Provider Capacity and Gaps Analysis
- DMH and DMA contract requirements
- Annual report due June 1
- Assessment of adequacy of provider network
- Reflects feedback from, consumers and families, stakeholders, staff, providers
- Results in FY18 plan for addressing needs and gaps
Primary Questions

• Is the network sufficient to provide access and choice of providers?
• Which groups are underserved or have more difficulty obtaining needed care?
• What are the most significant service needs and gaps in the community?
• What are the most significant barriers to accessibility of services?
• What progress has been made on last year’s identified needs and gaps?
Community Feedback

- Input from consumers and families, providers and stakeholders
- On-line surveys by e-mail and website
- Community group assistance to publicize survey via web pages, e-mail and meetings
- Review of recent surveys, needs assessments, and other documentation of service needs
- Feedback from consumer, stakeholder and provider groups (e.g., group discussions of needs and gaps resulting in collective response)
Stakeholder Input

- Consumer and Family Advisory Committee (CFAC), including input from local CFAC meetings
- Alliance Provider Advisory Council (APAC), including separate feedback from each county PAC
- Juvenile Justice (JJSAMHP) partnerships in Durham and Wake
- Community Collaboratives for Children & Families in Cumberland, Durham and Wake
- Judicial input from Cumberland and Durham
Stakeholder Input

• Hospital and Crisis Stakeholders, including EMS, law enforcement, magistrates and others
  • Quarterly Hospital Partners meetings
  • Crisis Collaboratives in Cumberland, Durham and Wake

Provider Collaboratives:
• Therapeutic Foster Care
• Substance Use Providers
• PSR, Peer Support, IIH

• E-mail distribution to other stakeholders
Alliance Staff Input

• Clinical Operations
  • Medical Director and Senior Psychologist
  • Utilization Management
  • Care Coordination
• Access / Call Center
• Community Relations: played active role in obtaining stakeholder input
• Alliance staff electronic survey
Stakeholder Questions

• Which groups have you identified as being underserved, having special needs, or having more difficulty obtaining needed care?

• What are the most significant service needs and gaps in the community?

• What are the most significant barriers to accessibility of services?

• Identify times when the system worked well and which factors led to a positive outcome.
Underserved Populations

- Non-English service access
- Uninsured and underinsured
- Transition-Age Youth
- Dually Diagnosed IDD/MI
- Individuals transitioning from criminal justice system
- Homeless
- Elderly
- Others: LGBTQ, Veterans, individuals in crisis, especially those with special needs (e.g., IDD, children)
Service Needs and Gaps

- **Substance Use Disorder continuum**: comprehensive array of service, funding for uninsured, adolescent treatment and enhanced withdrawal management

- **IDD services and supports**: benefit plan consistency, lack of services for non-Innovations, long waiting lists

- **Services for high needs youth**: residential treatment, school supports, crisis services, transition age youth, gang-involved youth interventions

- **General accessibility of care**: timely access, services for individuals with complex needs, provider capacity

- **Knowledge and awareness of system**
Barriers

- **Funding**: limited funds for uninsured, providers reaching budget caps, underinsured access, benefit plan limitations, low provider reimbursement rates

- **Knowledge of system**: confusion by consumers and stakeholders about system navigation, Alliance roles

- **General access barriers**: timely access, evening and weekend hours, providers not accepting referrals, especially for complex needs, waiting lists

- **Language**: bilingual/bicultural providers, language lines, tracking of bilingual/bicultural services

- **Transportation**
Strengths

• Alliance staff (Claims, Care Coordination, leadership)
• Care Review
• EBP implementation: IIH EBPs, Alliance focus on EBPs in general
• New services: alternative service definitions, CST Plus, OPT Plus, Rapid Response database
• Judicial initiatives: CIT, LEADS, Drug Treatment Court, Jail initiatives
• Warm hand-offs, transitions between levels of care
• New programs and specific providers (e.g., OASIS)
Next Steps

• Completion of geographic access analysis
• Integration of survey data and stakeholder feedback
• Request for access and choice waivers
• Preparation of draft report
• Submission of report by June 1
• Preparation and submission of Network Development Plan by June 30
Discussion and Questions
Provider Network
Evaluation Process and Outcomes

Clinical Service Evaluation Team
Overview

• DMA Requirement to include outcomes in provider contracts

• Identify outcomes associated with national or state standards

• Promote population and health outcomes

• Identify outcomes with data elements that Alliance can produce and analyze

• Use outcomes to work collaboratively with our providers to develop capacity use outcomes to improve quality of care
Reporting Structure

- Service, provider or catchment area-specific data provided by Alliance that address 3 areas
- Providers submit Provider Outcomes report that responds to data
- Report Review by ABH
- Outcomes, lessons learned, technical assistance to prepare for next set of data and outcomes report
GROUP TYPES

INTENSIVE    IIH, MST, CST, and ACTT

DAY         Day Treatment, PSR, SAIOP, and SACOT

RESIDENTIAL  PRTF and Residential Levels I-IV

CRISIS      Inpatient, Mobile Crisis, Rapid Response and FBC/CEO
<table>
<thead>
<tr>
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<th>Intensive</th>
<th>Day</th>
<th>Residential</th>
<th>Crisis</th>
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<tbody>
<tr>
<td>April 2017</td>
<td>Collaboratives</td>
<td>Data/baseline collection</td>
<td>Data/baseline collection</td>
<td>Data/baseline collection</td>
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<tr>
<td>July 2017</td>
<td>ABH provides data to provider</td>
<td>Collaboratives</td>
<td>Data/baseline collection</td>
<td>Data/baseline collection</td>
</tr>
<tr>
<td>Oct 2017</td>
<td>Provider submits Annual Report</td>
<td>ABH provides data to provider</td>
<td>Collaboratives</td>
<td>Data/baseline collection</td>
</tr>
<tr>
<td>Jan 2018</td>
<td>Annual reports reviewed</td>
<td>Provider submits Annual Report</td>
<td>ABH provides data to provider</td>
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</tr>
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<td>Review outcomes with collaboratives, Technical assistance, etc.</td>
</tr>
</tbody>
</table>
3 Outcome Measures

1. **HEDIS**: Health Effectiveness Data and Information Set. Health Care Performance Measures developed by the National Committee for Quality Assurance (NCQA).

Integrated Care: Percentage of Adults and Children who had a primary care or preventative care visit during the measurement year
2. DMA Measure: DMA establishes performance measures of LME/MCOs.

Thirty (30) Day Readmission Rates for Adult and Child Psychiatric Patients
3. Service Specific Measure:

**Intensive – Child**

At Discharge (for youth who received at least 90 days of service and at least 24 contacts):

- 80% of youth are discharged home with family or are living independently.

At six (6) and twelve (12) Months Post Discharge:

- Less than 10% of youth have been placed in a residential treatment center.
Where we are in the process:

• This outcomes evaluation process was developed by a multi-departmental subgroup that includes provider representation.

• The overview and possible measures have been presented to APAC and the All Provider meeting.

• Measures have been identified and reports are being finalized and validated.

• Rolling out to broader provider community through CPAC and Provider Collaboratives over the next two months.

• Outcomes will be added to Medicaid contracts for FY 18.

• “Intensives” service group will receive their data on or around 7/1/2017 and will submit their Provider Outcomes report by 9/30/2017.

• This rollout is ahead of schedule!
ITEM: Policy Committee Report

DATE OF BOARD MEETING: April 6, 2017

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.

Policy reviewed at the March 7, 2017, Board Policy Committee special meeting; review to be finalized at a special meeting on April 4, 2017: Area Board By-Laws

REQUEST FOR AREA BOARD ACTION: Accept the report.

CEO RECOMMENDATION: Accept the report.

RESOURCE PERSON(S): Curtis Massey, Committee Chair; Monica Portugal, Chief Compliance Officer
**AGENDA ITEMS:** Area Board By-Laws; By-Laws Presentation  

**DISCUSSION:** Pursuant to Article IV, Sec. D of Alliance’s Area Board By-Laws, the Area Board Policy Committee conducted its annual review of the Area Board By-Laws. 

**NEXT STEPS:** Ms. Hammett to draft Settlement Claims and Government Policy, and review 122C authorities. 

**TIME FRAME:** April 4, 2017  

**Board Principles**

Other topics of discussion:

- **Conduct of Meetings**
- **Number of Board seats and composition**
- **Potential Separate Governance Policy (includes conduct of meetings, mission vision value, etc.)**
- **Update committees to reflect current composition**
- **Ultimately will require a revised Joint Resolution**

**Next Steps**

- **The Area Board and Policy Committee will reconvene on April 4, 2017 to conclude its review of the By-Laws.**
- **Executive Committee will forward recommendations to Policy Committee for review.**
- **Policy committee will review recommendations and move the item to the Board for final approval.**
3. ADJOURNMENT: @ 4pm. Next regular meeting will be May 11, 2017, from 4:00 p.m. to 5:30 p.m.
**ITEM:** Quality Management Committee Report

**DATE OF BOARD MEETING:** April 6, 2017

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

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

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

The final minutes from February 2017 are attached. The minutes needed to be revised due to an error discovered after the meeting.

The draft minutes and materials from the March meeting are also attached. At the meeting, the Committee received a report on provider monitoring, as required by Alliance’s contract with the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The report highlighted improvements in compliance of Licensed Independent Practitioners (LIPs) and the continued compliance of agencies (an average score of 93%). Geyer provided a quick update on the EQR visit at the end of February. The final report is expected in early April. Dr. Corvin talked briefly about the data dashboards that are being created for the Area Board. The quarterly dashboards will include key performance indicators. The Committee received a presentation on the progress of Quality Improvement Projects (QIPs): 9 projects are open and active, while 3
projects have been closed. Progress made on First Responder and Crisis Services QIPs (such as WakeBrook CAS closures decreasing). Challenges: Crisis Services – intervention does not seem to be impacting CAS closures; Access to Care – continued poor show rate for all urgency levels. Alliance is implementing several new interventions to improve Access to Care performance. Finally, the committee reviewed data on preventative care for Medicaid recipients. An average of 89% of recipients attend a primary care visit at least once in a 15-month time period.

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

**CEO RECOMMENDATION:** Accept the report.

**RESOURCE PERSON(S):** George Corvin, Committee Chair, and Geyer Longenecker, Quality Management Director
VOTING MEMBERS PRESENT: ☒ George Corvin, MD, Chair (Area Board); ☒ Phillip Golden, BA, Co-Chair (Area Board); ☐ Chris Bostock (Area Board); ☒ Amelia Thorpe, BA (CFAC/Area Board); ☒ Lascel Webley, Jr., BS, MBA, MHA (Area Board) ☐ Joe Kilsheimer, MBA (CFAC)

NON-VOTING MEMBERS PRESENT: ☒ Tim Ferreira, BA (Provider Representative, I/DD); ☒ Jeremy Reed MH/SA (Provider Representative)

STAFF PRESENT: ☐ May Alexander, MS, LMFT (Quality Management Data Manager); ☒ Tina Howard, MA (Quality Review Manager); ☒ Geyer Longenecker, JD (Quality Management Director); ☒ Tedra Anderson-Brown, MD (Medical Director); ☒ Doug Wright (Director of Consumer Affairs); ☒ Linda Losiniecki, (Administrative Assistant)

GUEST(S) PRESENT: Amy Johndro, Provider Network Evaluator Supervisor (Alliance Behavioral Healthcare), Mary Hutchins, Auditor (Wake County Internal Audit)

REVIEW OF THE MINUTES: GQMC Meeting minutes from February 2, 2017 were read. Tina noted that she incorrectly reported that the Community Paramedic program was expanding to Cumberland County. She will make that correction in the February meeting minutes. Phil Golden moved that the minutes be approved as amended by Tina, Laschel Webley seconded the motion. The motion was approved by the committee.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Welcome &amp; Introductions:</td>
<td>Welcome: Chair Dr. Corvin opened the meeting and welcomed guests.</td>
<td></td>
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<tr>
<td></td>
<td>Community Paramedic Program/Cumberland Crisis Update to Cumberland Crisis Services: More information has been added to the previous meeting’s presentation. Rob Robinson (Alliance CEO) will be meeting with the executive leadership form Cape Fear regarding IBC.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 2. Old Business: | Tina presented an update to the Committee:  
- There is currently no planned expansion of the Community Paramedic program to Cumberland County  
- Programs are operating in Wake, Durham and Johnston Counties  
- As part of the program, County EMS Paramedics take CIT (Critical Incident Training), additional details in description (see attached) | | |
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
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<th>TIME FRAME:</th>
</tr>
</thead>
</table>
| Provider Monitoring Report | Amy Johndro presented the provider monitoring report (Handout/Presentation):  
- The statistics were presented through the report.  
- Routine Monitoring is conducted for consistency and compliance of Contracted Providers, LIP’s, and unlicensed AFL’s are performed every 2 years  
- Full monitoring consists of Routine Tool, Staff Tool and Post-Payment Tool. The provider must have a score of 85% or greater in each sub-section of the tool.  
- Post-Payment Routine Tool reviews are conducted for licensed homes who are not reviewed on an annual basis.  
- Agencies score an average of 93%  
- Areas in need of improvement (agencies): incomplete release of information, incomplete right notification, lack of coordination of care, and missing staff trainings and supervision  
- Team focused on improving compliance of LIPs this year. A LIP Survey was conducted by QM. Of 156 providers surveyed, 99 responded. Some feedback included:  
  o The monitoring tool is difficult in understanding the requirements and outline.  
  o Positive feedback was indicated for Alliance providing adequate training for the Independent Practitioners.  
  o Preference for training through self-directed webinars.  
- Actions by Monitoring Team: technical assistance, created webinars, developed easy to use forms, created webpage specifically for LIPs, and resumed monitoring in February 2017 | | |
| EQR Update | Geyer presented the process and update on the review:  
- This year’s was Alliance’s 3rd review. The EQR review is now combined with the Mercer review. A 2-day panel who conduct staff interviews, review documentation, analytics/surveys and reports. | | |
<table>
<thead>
<tr>
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</tr>
</thead>
</table>
|             | • EQR asked about provider participation and decision making with Committees and the Board (Geyer gave examples of increases over year, such as providers serving on QIP Project Advisory Teams).  
• Alliance feels that we followed up on all best practice recommendations made by EQR last year. For example, QM completed Clinical Practice Guideline reviews for ADHD and Schizophrenia consumers involving the usage of medications and services. Reviews led to increase training for providers and general letters on best practices.  
The final report from EQR will be delivered in approximately 30 days, and will consist of any corrective action plans and best practice recommendations. |             | QM will gather and catalogue the data that is sent to the state. |             |
|             | **Snapshot Reports for Board**  
Dr. Corvin provided feedback from the Board on reporting:  
• The current report presented to the Board contains just the financial Key Performance Indicators.  
• Board would like to see a simple presentation of quarterly data that could include more specific areas of clinical data.  
• A quarterly report can be generated with the data that QM sends to the state. |             |             |             |
|             | **QIP Updates**  
Tina provided updates (Handout/Presentation):  
• 9 projects are open and active  
• 3 projects have been closed  
• Tina provided an overview of progress on QIPs  
• Progress made on First Responder and Crisis Services QIPs (such as WakeBrook CAS closures decreasing)  
• Challenges: Crisis Services – intervention does not seem to be impacting CAS closures; Access to Care – continued poor show rate for all urgency levels  
• New interventions for Access to Care-Urgent involving population that is releasing from incarceration, data for Urgent and Routine urgency levels presented to each provider receiving a referral, data will be presented as aggregate to All-Provider meeting (provider names removed) |             |             |             |
## AGENDA ITEMS:

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
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</tr>
</thead>
</table>
| **Access to Primary Care – Medicaid Recipients** | Geyer presented the data on Alliance Medicaid consumers receiving preventative care over a 15-month period (Handout/Presentation):  
- Data was displayed across the various age and disability groups. The youth numbers were highest.  
- The state’s focus and emphasis is on Integrated Care. The state provides claims data which will be helpful with implementation. | | |
| **Upcoming Meetings:** | No April Meeting – Spring Break  
May 4, 2017 (Time: 2:00 – 3:30 pm Location: Corporate Site) | | |
| **Adjournment:** | Meeting adjourned at 3:30 p.m. | | |

**Thursday, March 02, 2017**

GLOBAL QUALITY MANAGEMENT COMMITTEE
**VOTING MEMBERS PRESENT:** ☐ George Corvin, MD, Chair (Area Board); ☒ Phillip Golden, BA, Co-Chair (Area Board); ☒ Chris Bostock (Area Board); ☐ Amelia Thorpe, BA (CFAC/Area Board); ☒ Lascel Webley, Jr., BS, MBA, MHA (Area Board) ☐ Joe Kilsheimer, MBA (CFAC)

**NON-VOTING MEMBERS PRESENT:** ☒ Tim Ferreira, BA (Provider Representative, I/DD); ☒ Jeremy Reed MH/SA (Provider Representative)

**STAFF PRESENT:** ☒ May Alexander, MS, LMFT (Quality Management Data Manager); ☒ Tina Howard, MA (Quality Review Manager); ☒ Geyer Longenecker, JD (Quality Management Director); ☒ Tedra Anderson-Brown, MD (Medical Director); ☒ Doug Wright (Director of Consumer Affairs); ☐ Linda Losiniecki, (Administrative Assistant)

**GUEST(S) PRESENT:** Jose Lopez, MS, Quality Review Coordinator II (Alliance Behavioral Healthcare), Mary Hutchins, Auditor (Wake County Government)

**REVIEW OF THE MINUTES:** GQMC Meeting minutes from December 2016 were read. Lascel motioned for approval, Chris seconded motion. Minutes were unanimously approved as written.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Welcome &amp; Introductions:</strong></td>
<td>Welcome: Phil Golden served as Chair in Dr. Corvin’s absence. He opened the meeting and welcomed guests. Jose Lopez was introduced as the newest member of the Quality Management Team. Jose transitioned to position from Provider Networks and has several years of experience in direct care and four years of experience as a Quality Management Director for a provider in our network. Jose’s primary responsibility will be to lead several Quality Improvement Projects.</td>
<td></td>
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<tr>
<td><strong>2. Old Business:</strong></td>
<td>Question from November meeting: A question was asked, during the presentation on the TCLI presentation, about the availability and expansion of Supported Living services, in order to assist with housing options for the TCLI population. Geyer/Tina did not know, but would find out by the next meeting. Tina followed up with Sara Wilson, Provider Network Development Specialist II, who stated that most individuals in TCLI program do not qualify for Innovations services, thus, the service would not be an option.</td>
<td></td>
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<tr>
<td><strong>3. New Business – a. Crisis/Hospital/</strong></td>
<td>Tina presented an update on crisis, hospital, and inpatient services created by the new Provider Network Evaluation team. Tina highlighted the improvements, continued.</td>
<td>Tina will ask Margaret, Hospital Relations</td>
<td>By next meeting</td>
</tr>
</tbody>
</table>
**AGENDA ITEMS:** Inpatient Services  
**DISCUSSION:** challenges, and how Alliance will be addressing the challenges in the next 12-18 months:  
**Improvements**  
- Expanded capacity at Cumberland County crisis facility  
- Expanded hours, after regular business hours, for assessments in Wake County (to prevent or divert individuals, not needing crisis services, from WakeBrook Crisis & Assessment, CAS)  
- Expansion of inpatient beds on WakeBrook campus  
- Some improvement in crisis response by providers of enhanced (intensive) services  
- An increase in individuals presenting at the Durham facility  
**Challenges**  
- Rate of admissions to ED for behavioral health reasons much higher than state average in Cumberland (including youth)  
- WakeBrook CAS still closing, due to over-capacity, too frequently  
- Limited crisis services for youth  
- Low rate of IVC admissions at Durham facility, no IVC admissions at Cumberland facility  
**How Alliance is addressing challenges**  
- New crisis facility in Wake County, planned opening in June 2018; submitted proposal for child crisis facility in catchment area  
- Expanding Rapid Response, crisis prevention/step-down, service for youth  
- Renovations in Cumberland and Durham facilities expected to increase IVC admissions  
- Expanding Community Paramedic program and improving Mobile Crisis  
- Expanding after-hours assessments to Durham  

Committee and guests asked several questions about services in Cumberland County:  
Why are individuals on IVC not being admitted to crisis facility even though it is licensed to admit them? Dr. Anderson-Brown responded that all individuals in Cumberland County are medically cleared through the Emergency Department (which is not happening in Durham and Wake) including those individuals on IVC before being deemed appropriate for to admission to crisis facility. CFVMC’s Clinical Leadership is

**NEXT STEPS:** Director, about data on law enforcement drop off times.  
Tina will ask Ann Oshel for more information and status on Community Paramedicine programs.
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
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<tbody>
<tr>
<td></td>
<td>aware and reviewing this practice which was in place due to EMTALA concerns. Another question was asked about how long it takes for law enforcement to drop an individual off at crisis facility. Alliance is not currently collecting that data, but can ask for it. Another question was asked about the status of the Community Paramedicine program in Cumberland. Tina could not answer the question but promised to follow up with Ann Oshel and send the committee the information. <strong>Correction: Tina mistakenly reported that Community Paramedic Program was expanding to Cumberland, she found out after the meeting that it is not. It is currently operating in Durham, Wake, and Johnston Counties.</strong></td>
<td></td>
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<tr>
<td>3. New Business – b. QIP Updates:</td>
<td>Tina presented on two QIPs—UM Call Monitoring (part of Mystery Shopper QIP) and TCLI. Tina presented results of post-closure analysis for UM call monitoring which demonstrated successful continuation of benchmark. Tina requested vote by committee on ending post-closure analysis of UM Call Monitoring measure for MH/SA staff. Chris motioned for approval of recommendation, Lascel seconded motion. Motion was unanimously approved.</td>
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<td></td>
<td>Tina presented proposal for TCLI QIP—focus on housing units offered by private landlords. Proposed measures include: <em>Increase the # of housing units available within the private sector</em>, <em>Increase the # of units that get rented to TCLI population</em>. The QIP will address the continued struggle in identifying and obtaining affordable housing in desirable areas and is reasonably within the control of Alliance. Tina requested vote by committee on QIP proposal. Chris motioned for approval of recommendation, Lascel seconded motion. Motion was unanimously approved.</td>
<td></td>
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<tr>
<td>3. New Business – c. Performance Dashboard:</td>
<td>Geyer reported that Alliance is meeting all performance standards, except for the Access to Care standards and hiring of TCLI staff. The TCLI program is making progress in hiring needed staff.</td>
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<tr>
<td>3. New Business – d. Draft Area Board Dashboard</td>
<td>As follow up to recommendations from the Area Board survey, Geyer presented two ideas to make data easier to read and understand for Area Board members who receive almost 100 pages of information at each Board meeting. One idea is a draft of committee minutes that would include a summary of key findings and decisions at the top. Another is a dashboard of key performance indicators. Geyer presented the dashboards currently being sent to county partners as examples.</td>
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<tr>
<td>AGENDA ITEMS:</td>
<td>DISCUSSION:</td>
<td>NEXT STEPS:</td>
<td>TIME FRAME:</td>
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<tr>
<td>3. New Business – e. QM Workplan/ Evaluation Update</td>
<td>Geyer presented an update on Alliance’s FY 2017 QM Workplan and QM Evaluation documents. He noted that the QM Department has transitioned certain provider-related projects to the newly created Provider Evaluation Department.</td>
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<td>3. New Business – f. Innovations measures</td>
<td>Tina presented on the measures that LME/MCOs across the state are required to report on for Innovations services. Measures are reported either on a quarterly, semi-annual, or annual basis. This report included all measures, sent to the state in December 2016 for Fiscal Year 2016. For most of the measures, Alliance is meeting benchmarks. Tina highlighted several opportunities for improvement: % of new consumers receiving services within 45 days of plan approval (Alliance created QIP to address this measure) and agencies with required training (agencies received plans of correction). Another measure that did not meet 85% (consumers receiving type, scope, amount, and frequency of services in plan) is very complicated and difficult to measure, particularly without clear guidance from the state. Alliance has requested that guidance. Committee asked if Alliance was receiving additional grievances since the Innovations rules changed and consumers/families began receiving letters about how these changes are impacting consumers’ services. Geyer responded that Alliance is receiving about 6 -10 additional grievances/month. Individuals are referred to their Care Coordinator for guidance.</td>
<td></td>
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<tr>
<td>4. Upcoming Meetings:</td>
<td>March 2, 2017 (Time: 2:00 – 3:30 pm Location: Corporate Site)</td>
<td></td>
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<tr>
<td>5. Adjournment:</td>
<td>Meeting adjourned at 3:30 p.m.</td>
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Provider Monitoring

Global QMC Presentation
March 2017
Routine Monitoring

- The Routine Monitoring Process and Tools were developed by a DHHS/LME-MCO/Provider workgroup to ensure consistent regulatory compliance measures to monitor providers across the state.
- The Routine Monitoring Process states that providers will be monitored every 2 years.
- Currently the Provider Network Evaluation team reviews contracted agencies, licensed Independent Practitioner (LIPS) in both group and solo settings and Unlicensed Adult Family Living (AFL) homes.
  - Unlicensed AFL’s are reviewed whenever there is a change in the providing agency, a consumer move or when a location is added
  - Provider Network Specialist complete the new unlicensed location tool.
- Began Monitoring LIP’s in 2015 and Therapeutic Foster Care 2016
Monitoring Tool

• Routine Monitoring typically consists of a routine, post-payment and staff review tools.

• There are a number of post-payment tools. Tools are based on the type of service, such as Innovations, Residential, PTRF etc.

• Providers must score 85% on each subsection of the routine tool or post-payment tools to pass that section.
  • Plans of correction are required when providers do not pass or if systemic issues are identified.
  • Recoupment is required for claims found out of compliance on the post payment tools.
Monitoring Tool

There are several options for monitoring:

• Full routine includes Routine Tool, Post-Payment and Staff specific when necessary
• Post-Payment Routine is when there are some claims that are done on the routine tool, all claims addressed on post-payment and staff specific tabs.
• Post-Payment Only: Only complete post-payment and staff tabs. This is for services that are licensed and not reviewed on an annual basis. Ex: Group home, residential, TFC, etc.
Monitoring Tool

• Providers contracted with multiple MCOs have raised the concern about duplication of monitoring efforts. Legal has been working on reciprocity agreements in which we can accept each other’s routine monitoring tools. However, each MCO is required to conduct their own post payment reviews.

• The movement on reciprocity has become stagnant. In a recent meeting with MCO’s regarding changing the monitoring tool the issue around reciprocity has come back up again with little guidance from the state. Providers continue to express concerns about duplication of effort, we have conducted only the post payment review for providers whose corporate site is outside our catchment area but within North Carolina.
# Monitoring Results for FY 2016 and first half 2017

<table>
<thead>
<tr>
<th>Category</th>
<th>1/16 to 7/16</th>
<th>Average score</th>
<th>8/16 to 1/31/2017</th>
<th>Average score</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>43</td>
<td>93.10%</td>
<td>80</td>
<td>92.90%</td>
<td>123</td>
</tr>
<tr>
<td>LIP</td>
<td>86</td>
<td>71.40%</td>
<td>0</td>
<td>0</td>
<td>86</td>
</tr>
<tr>
<td>Unlicensed AFL</td>
<td>78</td>
<td>100%</td>
<td>88</td>
<td>100.00%</td>
<td>166</td>
</tr>
<tr>
<td>New Unlicensed Site Review</td>
<td>28</td>
<td>94.40%</td>
<td>35</td>
<td>100.00%'</td>
<td>63</td>
</tr>
</tbody>
</table>

Total 438
## Provider Monitoring Year to Year Comparison from 2014 to Present

<table>
<thead>
<tr>
<th>Agency/LIP Monitoring</th>
<th>2014</th>
<th>2015</th>
<th>2016 to date</th>
<th>2017 completed to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>99</td>
<td>181</td>
<td>200</td>
<td>25</td>
</tr>
</tbody>
</table>
Common findings:

Agencies:

✓ Incomplete Release of Information
✓ Incomplete Rights notification
✓ Lack of coordination of care
✓ Missing staff trainings and supervision

LIP’s

Not following guidelines in Clinical Coverage Policy 8C and The Records and Documentation Manual regarding paperwork

✓ Incomplete assessments and treatment plans
✓ Lack of 24 hour crisis response
✓ Lack of coordination of care
✓ Missing policy and procedure around protection of records
Actions taken to assist LIPs

• Monitoring staff provided considerable technical assistance including:
  • Sending copies of the tools with monitoring announcements
  • Informing them about the available information on the website
  • Sending copies of regulatory requirements such as Clinical Coverage Policy, APSM 45-2
  • Individual technical assistance by phone and email.

• Around August of 2016 there was a decision to put LIP monitoring on hold and implement several interventions and trainings to help bring LIP’s into compliance.

• This was a multi-step process that included:
  • Formed a project team with Beth Melcher, Monica Portugal, 6 licensed monitoring staff
  • Survey sent out to all LIP’s monitored so far
  • Taking feedback and implementing it
  • Getting out the information to providers and professional associations.
Summary of LIP survey

- A survey was sent to 156 providers that were monitored since the beginning.
- 99 Responded
- Asked several questions including:
  - Credentials
  - County/Counties worked in
  - Satisfaction questions regarding the monitoring experience
  - Preferences for the delivery of training
  - Preferred method of receiving information (email, Alliance website, phone, etc.)
<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Unable to rate/do not know</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understand Alliance's expectations of its network providers.</td>
<td>14.43%</td>
<td>60.82%</td>
<td>15.46%</td>
<td>7.22%</td>
<td>2.06%</td>
<td>97</td>
</tr>
<tr>
<td>I know where to find the tool that Alliance uses to monitor its network providers.</td>
<td>20.20%</td>
<td>54.55%</td>
<td>19.19%</td>
<td>5.05%</td>
<td>1.01%</td>
<td>99</td>
</tr>
<tr>
<td>I saw the monitoring tool that Alliance uses prior to their first monitoring visit.</td>
<td>30.30%</td>
<td>52.53%</td>
<td>12.12%</td>
<td>4.04%</td>
<td>1.01%</td>
<td>99</td>
</tr>
<tr>
<td>The monitoring tool is easy to understand.</td>
<td>8.25%</td>
<td>31.96%</td>
<td>36.08%</td>
<td>18.56%</td>
<td>5.15%</td>
<td>97</td>
</tr>
<tr>
<td>I understand how to comply with the requirements outlined in the monitoring tool.</td>
<td>9.09%</td>
<td>44.44%</td>
<td>34.34%</td>
<td>8.08%</td>
<td>4.04%</td>
<td>99</td>
</tr>
<tr>
<td>I am notified, or know how to find information, about changes to requirements in the monitoring tool.</td>
<td>6.06%</td>
<td>39.39%</td>
<td>39.39%</td>
<td>9.09%</td>
<td>6.06%</td>
<td>99</td>
</tr>
<tr>
<td>Alliance provides adequate training on requirements for independent practitioners.</td>
<td>4.08%</td>
<td>28.57%</td>
<td>27.55%</td>
<td>22.45%</td>
<td>17.35%</td>
<td>98</td>
</tr>
</tbody>
</table>

Greatest % of disagree-ment (dissatisfaction)
Q5 Indicate your preference for the delivery of training (select all that are most convenient for you):

Answered: 97  Skipped: 2
LIP Interventions and Trainings

- Utilizing survey feedback the Provider Network Evaluation team with the help from compliance and risk management developed several forms that providers can use to:
  - Inform members of their rights
  - Inform consent
  - Release of information that meets standards
  - Develop a policy and procedure around the safety and maintenance of records.
LIP Interventions and Trainings continued

• PNE supervisor and 6 licensed monitors developed PowerPoint trainings on 10 aspects of the tool. Those PP presentations were then recorded using voice over.

• A webpage specifically for the Licensed Independent Professionals/Practitioners that includes information relevant regulations, monitoring, clinical coverage policy, forms and trainings.

• This information was sent out to current and newly enrolled LIPs through Provider Network Specialists and Contracts
Completion of Reviews: Strategies

• The number of monitoring activities have increased significantly over the years due to the addition of LIP monitoring.
• The staff hired went from 8 to 12. The team is currently full with 6 Licensed and 6 unlicensed staff.
• With the LIP interventions in place the team has begun reviewing LIP’s again in February.
  – Preliminary finding are that for providers that are going through the process the second time are much more successful. Most are hitting the 85% and above.
  – Reduction in time spent walking the LIP’s through the process.
The Future of Monitoring

- Beginning in November 2016 LME/MCO representatives met with the state to discuss changing monitoring for those providers who receive accreditation including Joint Commission, COA, CARF and CQL.
- In December 2016 at the final meeting LME/MCO’s have voted in favor of the changes that would include:
  - Dropping the routine monitoring tool completely for those agencies with accreditation
  - Post-payment would remain in place with some changes to the tool to make it more quality based (i.e. more focus on adhering to Clinical Coverage Policy service definitions)
- A meeting of the LME/MCO’s CEOs was in early January and the plan was proposed to them at that time.
- No further movement on this subject since then.
Completion of Reviews: Barriers

- The number of LIP providers is the largest barrier to completing reviews of all providers within 2 years. Many providers have 5 or less members that they see.
- Alliance has a large number of contracted providers compared to most LME/MCO’s.
- Monitoring efficiency is dependent upon Evaluator and provider availability. Technical assistance to LIPs, reviewing POCs and implementation of POCs requires considerable time and decreases the number of new reviews which can be completed.
- Contacting LIP’s to set up monitoring activities is challenging. Often information has changed and significant time is spent getting more accurate contact information through other departments.
• QUESTIONS?

• Contact:
  Amy Johndro LCSW
  919-651-8454
  ajohndro73@gmail.com
Quality Improvement Projects

Presentation to the Alliance Global Quality Management Committee
(March 2017)
Quality Improvement Projects

Executive Summary:

- Open/Active: 9 projects (TCLI proposal approved)
- Closed (Conduct post-closure analysis in 2017): 3 projects

Successes:

- First Responder QIP – Continued improvement in satisfactory calls following Compliance actions
- Crisis Services QIP - WakeBrook CAS closures sharp decrease starting in October 2016 (hours closed - Jun-Sep 2016: 892 (back) & 375 (front), Oct 2016-Jan 2017: 420 (back) & 244 (front), decrease not due to seasonal differences)
- QM formally ended monitoring of measure for 1 project due to sustained improvement (UM call monitoring)
Quality Improvement Projects

Red Flags:

- Crisis QIP: Fewer individuals showing to Monarch after-hours even though facility is open more days, will open later on Fridays starting in April
- Access to Care QIP: Continued poor show rate of individuals identified as urgent showing for care within 2 days (standard set by state)
Detailed Results for QIPs
Access to Care - *Improve Show Rate for Emergent Callers*

**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: Spring 2017, rate being negotiated)
- Improve internal coding and data entry (start: January 2017)
## FY 17 QIPs

### Access to Care - Improve Show Rate for Emergent Callers

#### Results:

<table>
<thead>
<tr>
<th>Baseline (FY16Q4: Apr-Jun 2016)</th>
<th>FY 17, Q1: Jul-Sep 2016</th>
<th>FY 17, Q2: Oct-Dec 2016</th>
<th>FY 17, 3: Jan-Mar 2017</th>
<th>FY 17, Q4: Apr-Jun 2017</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>67%</td>
<td>84%</td>
<td>59%</td>
<td></td>
<td></td>
<td>77%</td>
</tr>
</tbody>
</table>

#### Next Steps:

- Project Advisory Team will meet in March to review barrier analysis and impact of internal review of data entry
Access to Care – *Improve initiation in services for Routine & Urgent callers*

**Goals:**

- Increase consumer initiation in services based on need:

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Revised Baseline (FY15Q3)</th>
<th>Goals</th>
<th>State Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent (within 2 days)</td>
<td>52%</td>
<td>62%</td>
<td>82%</td>
</tr>
<tr>
<td>Routine (within 14 days)</td>
<td>53%</td>
<td>63%</td>
<td>75%</td>
</tr>
</tbody>
</table>
FY 17 QIPs

Access to Care-Routine/Urgent

Methodology changes for FY 17

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

Interventions-Routine:

- Reminder calls a few days before appointment (start: January 2016)
- Feedback letters to providers (start: February 2017)
Access to Care-Routine/Urgent

**Interventions-Urgent:**

- Expansion of Open Access on Fridays and Saturdays (under development)
- Interventions to improve engagement of CJ population (under development)
- Feedback letters to providers (start: February 2017)
FY 17 QIPs

Access to Care-Routine/Urgent

Results:

Overall*

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>FY 16, Q1: Jul-Sept 2015 (rev. baseline-Routine)</th>
<th>FY 16, Q2: Oct-Dec 2015</th>
<th>FY 16, Q3: Jan-Mar 2016</th>
<th>FY 16, Q4: Apr-Jun 2016 (rev. baseline-Urgent)</th>
<th>FY 17, Q1: Jul-Sep 2016</th>
<th>FY 17, Q2: Oct-Dec 2016</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent (within 2 days)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>19%/27%</td>
<td>19%/26%</td>
<td>15%/28%</td>
<td>62%</td>
</tr>
<tr>
<td>Routine (within 14 days)</td>
<td>40%</td>
<td>45%</td>
<td>48%</td>
<td>45%/58%</td>
<td>48%</td>
<td>37%</td>
<td>63%</td>
</tr>
</tbody>
</table>

*Data reflects performance based solely on claims (first %), then by claims + attendance, per provider report (second %). Attendance for Routine will be pulled once/year because it is a resource-intensive manual process.
Impact of Reminder Calls: Attended vs. No Show*

Of those individuals who attended their appointments, 52% made direct contact with an Access staff person reminding them of their appointment. Another 28% received a message. A total of 80% received some kind of reminder about their appointment. Conversely, only 31% of those callers indicated as “No Show” to their appointment spoke to an Access staff person regarding the appointment and 28% received a message. In total, 59% of individuals not showing for appointment received a reminder call.

*The appointment status for the remaining calls were coded as Other: canceled, error in data, consumer did not meet criteria for Care Coordination, etc.
FY 17 QIPs

Access to Care-Routine/Urgent

Next Steps:

- Continue to conduct reminder calls, making every effort to contact the consumer or guardian directly
- Make the reminder calls at different times of the day (even after regular business hours) if it increases the likelihood of making direct contact with consumer or guardian
- Conduct Multivariate statistical analysis of reminder calls with larger samples sizes to control for confounding variables

---

FY 17 QIPs

Improve Care Coordination for Individuals Discharging from Inpatient

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

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

Next Steps:
- Project Advisory Team met 2/20, decided to revise measures to include contact with consumer AND provider
Improve Crisis Services in Wake and Cumberland Counties

Goals:

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

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

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

Update:
- Measure #1-Promising results from Cumberland pilots (Baseline: 19%, lower ED/Crisis/Inpatient admissions post discharge)
- Wake: Provider expanded hours of Tier II on 4/18, now open until 7 PM on Mondays - Thursdays, will add Friday in April (Baseline: 0.24%)
QIP Measures

2. Increase # of consumers using Open Access after 3 PM (Wake County)

Data Drill-Down:

<table>
<thead>
<tr>
<th>Same Day Access Monarch</th>
<th>3-Month Breakdown</th>
<th>12:00-4:59 000-459</th>
<th>5:00-8:59 500-859</th>
<th>9:00-11:59 900-1159</th>
<th>12:00-2:59 1200-1459</th>
<th>3:00-4:59 1500-1659</th>
<th>5:00-6:59 1700-1859</th>
<th>7:00-9:00 1900-2059</th>
<th>9:00-11:59 2100-2359</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumers Presenting (but not admitted) to WakeBrook CAS</td>
<td>Feb-Apr 2016</td>
<td>11</td>
<td>28</td>
<td>76</td>
<td>91</td>
<td>42</td>
<td>30</td>
<td>26</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>May-July 2016</td>
<td>16</td>
<td>43</td>
<td>79</td>
<td>88</td>
<td>44</td>
<td>35</td>
<td>28</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Aug-Oct 2016</td>
<td>12</td>
<td>17</td>
<td>69</td>
<td>65</td>
<td>45</td>
<td>35</td>
<td>22</td>
<td>32</td>
</tr>
<tr>
<td># of Individuals presenting to Monarch</td>
<td>Feb-Apr 2016 (Baseline)</td>
<td>not open</td>
<td>254</td>
<td>392</td>
<td>183</td>
<td>*</td>
<td>0</td>
<td>not open</td>
<td>not open</td>
</tr>
<tr>
<td></td>
<td>May-July 2016 (Intervention began 1 day/week)</td>
<td>not open</td>
<td>209</td>
<td>338</td>
<td>140</td>
<td>21</td>
<td>11</td>
<td>not open</td>
<td>not open</td>
</tr>
<tr>
<td></td>
<td>Aug-Oct 2016 (Intervention expanded x2 days)</td>
<td>not open</td>
<td>191</td>
<td>415</td>
<td>137</td>
<td>11</td>
<td>*</td>
<td>not open</td>
<td>not open</td>
</tr>
</tbody>
</table>

Even though Open Access has continued to expand hours, the number of individuals presenting during those hours, after the initial three months, has decreased. Data from Nov-Jan is being analyzed to determine if trend continues. Open Access is now, as of Feb. 1, open for 4 days/week—Mondays, Tuesdays, Wednesdays, and Thursdays.

*Indicates that number is less than 10
QIP Measures

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

Back Door Diversions

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>18%</td>
<td>11%</td>
<td>1%</td>
<td>4%</td>
</tr>
<tr>
<td>2014</td>
<td>6%</td>
<td>12%</td>
<td>24%</td>
<td>27%</td>
<td>34%</td>
<td>32%</td>
<td>24%</td>
<td>35%</td>
<td>43%</td>
<td>22%</td>
<td>32%</td>
<td>25%</td>
</tr>
<tr>
<td>2015</td>
<td>32%</td>
<td>34%</td>
<td>56%</td>
<td>50%</td>
<td>54%</td>
<td>38%</td>
<td>30%</td>
<td>36%</td>
<td>51%</td>
<td>42%</td>
<td>44%</td>
<td>30%</td>
</tr>
<tr>
<td>2016</td>
<td>41%</td>
<td>43%</td>
<td>43%</td>
<td>50%</td>
<td>50%</td>
<td>32%</td>
<td>27%</td>
<td>33%</td>
<td>30%</td>
<td>7%</td>
<td>6%</td>
<td>20%</td>
</tr>
<tr>
<td>2017</td>
<td>24%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Goal: 21%
Baseline (Jan-June 2014): 23%, Measure #1 (Jan – June 2015): 44%, Measure #2 (Jan – June 2016): 43%
4. Reduce % of operating hours that CAS’ front door ("full diversion") is closed (Wake County)

**Goal:** 13%

QIP Measures

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

**Front Door:** Sharp decrease in closures starting in October (leadership change at CAS; Additional Beds added to Inpatient), Avg % closed:
- **Oct 2016 – Jan 2017:** 14%
- Prior to changes:
  - Jun-Sept 2016: 31%
  - Oct 2015 – Jan 2016: 39%
  - Oct 2014 – Jan 2015: 28%

**Back Door (IVC):** Similar trend in decreases of closures starting in October 2016, Avg % closed:
- **Oct 2016 – Jan 2017:** 8%
- Prior to changes:
  - Jun-Sept 2016: 13%
  - Oct 2015 – Jan 2016: 16%
  - Oct 2014 – Jan 2015: 18%
Next Steps:

- Network Development is scheduling a meeting with Monarch and WakeBrook to discuss the low number showing at Open Access after regular business hours and communication between the two agencies.
FY 17 QIPs

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

Results:

<table>
<thead>
<tr>
<th>Call Cycle</th>
<th>1&lt;sup&gt;st&lt;/sup&gt; Measurement</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; Measurement</th>
<th>3&lt;sup&gt;rd&lt;/sup&gt; Measurement</th>
<th>4&lt;sup&gt;th&lt;/sup&gt; Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfactory</td>
<td>65% (N=17)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unsatisfactory</td>
<td>35% (N=9)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total calls made</td>
<td></td>
<td>26</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- No Plans of Correction (POCs) issued after 1<sup>st</sup> Measurement
- Calls for 2<sup>nd</sup> measurement currently taking place
FY 17 QIPs

**Intensive In-Home** – Improve quality of IIH services

**Goals:** Reduce use of crisis services, reduce behavioral health interference with daily activities, and decrease severity of mental health symptoms.

Project Start Date: 1/1/2013; Project End Date: still active

**Interventions:**

- IIH providers to implement specific, family-focused EBP with external fidelity monitoring
- Training and technical assistance to providers
FY 17 QIPs

Intensive In-Home QIP

Update:

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

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

Interventions:
- Focus on service lines with fewest health/safety elements met (substance abuse services)
- Reached out to SA providers for input on improving performance, will provide targeted training
- Revised review tool to expand on health/safety elements
Improve Timeliness of Services for IDD Consumers

Improve timeliness of services for individuals who recently received Innovations slots

**Goal:**
- 85% receive services within 45 days of plan approval

**Update:**
- Project Advisory Team, along with other subject matter experts, conducted comprehensive process map to identify bottlenecks in process
- Gathering more data on bottlenecks to identify interventions
TCLI – Increase private housing options for TCLI population

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

Interventions (under development by PAT):
  - Training to property owners on Alliance, housing program, anti-stigma and recovery oriented system of care.
  - Look at measuring level of change in renters’ outlook and if there was a difference in their willingness to rent to this population.
Closed QIPs - Conduct post-closure analysis

Reduce Errors in Grievance Module

Results:

Post-Closure Analysis Due:

- May 2017
Closed QIPs- Conduct post-closure analysis

Inter-Rater Reliability – I/DD UM staff

Results:

Post-Closure Analysis Due:

- March 2017
Closed QIPs-Conduct post-closure analysis

UM Call Monitoring– I/DD UM staff

Results: 98.6% met (June 2016)

Post-Closure Analysis Due:

- June 2017
Preventive Care Services - CY 2016
Alliance Behavioral Healthcare
March 1, 2017

1. Overall

Alliance Consumers Receiving Preventive Care Services - CY 2016

<table>
<thead>
<tr>
<th></th>
<th>Ages 3-17</th>
<th>Ages 18+</th>
<th>Total (Ages 3+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2016 Q1</td>
<td>93.70%</td>
<td>86.01%</td>
<td>89.41%</td>
</tr>
<tr>
<td>CY 2016 Q2</td>
<td>94.06%</td>
<td>86.10%</td>
<td>89.49%</td>
</tr>
<tr>
<td>CY 2016 Q3</td>
<td>93.78%</td>
<td>86.28%</td>
<td>89.59%</td>
</tr>
<tr>
<td>CY 2016 Q4</td>
<td>95.30%</td>
<td>85.36%</td>
<td>89.63%</td>
</tr>
</tbody>
</table>

2. Details

<table>
<thead>
<tr>
<th>MH/SA/IDD</th>
<th>Ages 3-17</th>
<th>Total Consumers</th>
<th>% Receiving Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Receiving Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q1</td>
<td>11,751</td>
<td>12,541</td>
<td>93.70%</td>
</tr>
<tr>
<td>CY 2016 Q2</td>
<td>10,313</td>
<td>10,964</td>
<td>94.06%</td>
</tr>
<tr>
<td>CY 2016 Q3</td>
<td>11,715</td>
<td>12,492</td>
<td>93.78%</td>
</tr>
<tr>
<td>CY 2016 Q4</td>
<td>13,255</td>
<td>13,908</td>
<td>95.30%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MH/SA/IDD</th>
<th>Ages 18+</th>
<th>Total Consumers</th>
<th>% Receiving Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Receiving Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q1</td>
<td>13,630</td>
<td>15,847</td>
<td>86.01%</td>
</tr>
<tr>
<td>CY 2016 Q2</td>
<td>12,715</td>
<td>14,768</td>
<td>86.10%</td>
</tr>
<tr>
<td>CY 2016 Q3</td>
<td>13,677</td>
<td>15,852</td>
<td>86.28%</td>
</tr>
<tr>
<td>CY 2016 Q4</td>
<td>15,801</td>
<td>18,510</td>
<td>85.36%</td>
</tr>
<tr>
<td>MH/SA/IDD</td>
<td>Total (Ages 3+)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
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<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td></td>
<td>Receiving Services</td>
<td>Total Consumers</td>
<td>% Receiving Services</td>
</tr>
<tr>
<td>CY 2016 Q1</td>
<td>25,381</td>
<td>28,388</td>
<td>89.41%</td>
</tr>
<tr>
<td>CY 2016 Q2</td>
<td>23,028</td>
<td>25,732</td>
<td>89.49%</td>
</tr>
<tr>
<td>CY 2016 Q3</td>
<td>25,392</td>
<td>28,344</td>
<td>89.59%</td>
</tr>
<tr>
<td>CY 2016 Q4</td>
<td>29,056</td>
<td>32,418</td>
<td>89.63%</td>
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<table>
<thead>
<tr>
<th>MH/SA</th>
<th>Ages 3-17</th>
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<tbody>
<tr>
<td></td>
<td>Receiving Services</td>
<td>Total Consumers</td>
<td>% Receiving Services</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q1</td>
<td>11,228</td>
<td>11,989</td>
<td>93.65%</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q2</td>
<td>9,828</td>
<td>10,449</td>
<td>94.06%</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q3</td>
<td>11,196</td>
<td>11,946</td>
<td>93.72%</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q4</td>
<td>12,667</td>
<td>13,293</td>
<td>95.29%</td>
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</table>

<table>
<thead>
<tr>
<th>MH/SA</th>
<th>Ages 18+</th>
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<tbody>
<tr>
<td></td>
<td>Receiving Services</td>
<td>Total Consumers</td>
<td>% Receiving Services</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q1</td>
<td>12,354</td>
<td>14,281</td>
<td>86.51%</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q2</td>
<td>11,440</td>
<td>13,202</td>
<td>86.65%</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q3</td>
<td>12,425</td>
<td>14,331</td>
<td>86.70%</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q4</td>
<td>14,412</td>
<td>16,806</td>
<td>85.76%</td>
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</table>

<table>
<thead>
<tr>
<th>MH/SA</th>
<th>Total (Ages 3+)</th>
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<tbody>
<tr>
<td></td>
<td>Receiving Services</td>
<td>Total Consumers</td>
<td>% Receiving Services</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q1</td>
<td>23,582</td>
<td>26,270</td>
<td>89.77%</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q2</td>
<td>21,268</td>
<td>23,651</td>
<td>89.92%</td>
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</tr>
<tr>
<td>CY 2016 Q3</td>
<td>23,621</td>
<td>26,277</td>
<td>89.89%</td>
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</tr>
<tr>
<td>CY 2016 Q4</td>
<td>27,079</td>
<td>30,099</td>
<td>89.97%</td>
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<table>
<thead>
<tr>
<th>IDD</th>
<th>Ages 3-17</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Receiving Services</td>
<td>Total Consumers</td>
<td>% Receiving Services</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q1</td>
<td>1,343</td>
<td>1,407</td>
<td>95.45%</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q2</td>
<td>1,150</td>
<td>1,205</td>
<td>95.44%</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q3</td>
<td>1,327</td>
<td>1,386</td>
<td>95.74%</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q4</td>
<td>1,605</td>
<td>1,663</td>
<td>96.51%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>IDD</th>
<th>Ages 18+</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Receiving Services</td>
<td>Total Consumers</td>
<td>% Receiving Services</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q1</td>
<td>2,250</td>
<td>2,664</td>
<td>84.46%</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q2</td>
<td>2,141</td>
<td>2,538</td>
<td>84.36%</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q3</td>
<td>2,222</td>
<td>2,601</td>
<td>85.43%</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q4</td>
<td>2,579</td>
<td>3,036</td>
<td>84.95%</td>
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<tr>
<td>IDD</td>
<td>Total (Ages 3+)</td>
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<tr>
<td></td>
<td>Receiving Services</td>
<td>Total Consumers</td>
<td>% Receiving Services</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q1</td>
<td>3,593</td>
<td>4,071</td>
<td>88.26%</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q2</td>
<td>3,291</td>
<td>3,743</td>
<td>87.92%</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q3</td>
<td>3,549</td>
<td>3,987</td>
<td>89.01%</td>
<td></td>
</tr>
<tr>
<td>CY 2016 Q4</td>
<td>4,184</td>
<td>4,699</td>
<td>89.04%</td>
<td></td>
</tr>
</tbody>
</table>
ITEM: Draft Minutes from 2017 Budget Retreat

DATE OF BOARD MEETING: April 6, 2017

BACKGROUND: An annual budget retreat is held to provide information to the Area Board regarding the upcoming fiscal year budget. The presentation and draft minutes from the March 21, 2017, budget retreat are attached.

REQUEST FOR AREA BOARD ACTION: Approve the minutes.

CEO RECOMMENDATION: Approve the minutes.

RESOURCE PERSON(S): Kelly Goodfellow, EVP/CFO
**MEMBERS PRESENT:** ☒Cynthia Binay, Vice-Chair, ☐Michael Boose, ☒Christopher Bostock, Chair, ☒Heidi Carter, ☒George Corwin, MD, ☒James Edgerton, ☒Lodies Gloston, ☒Phillip Golden, ☐John Griffin, Ed.D, ☒Curtis Massey (via phone), ☐George Quick, ☐Vicki Shore, ☒William Stanford, Jr., ☒Caroline Sullivan, ☐Amelia Thorpe, ☒Lascel Webley, Jr., and ☐McKinley Wooten, Jr.

**GUEST(S) PRESENT:** Caroline Bradstock, CFAC (Consumer and Family Advisory Committee) Chair; Vicki Evans, Cumberland County Finance Department; Lotta Fisher, Cumberland CFAC; Heather Harris, Cumberland County; Mary Hutchings, Wake County Finance Department; and Michael McGuire, Cumberland CFAC

**ALLIANCE STAFF PRESENT:** Michael Bollini, Executive Vice-President/Chief Operating Officer; Courtney Cantrell, Senior Vice-President/Clinical Operations; Joey Dorsett, Senior Vice-President/Chief Information Officer; Cathy Eaton, Administrative Assistant to the Finance Department; Ashley Everette, Budget Analyst; Kelly Goodfellow, Executive Vice-President, Chief Financial Officer; Cheala Garland-Downey, HR Director; Carol Hammett, General Counsel; Veronica Ingram, Executive Assistant; Beth Melcher, Executive Vice-President/Care Management (interim) and Senior Vice-President/Network Development and Evaluation; Ann Oshel, Senior Vice-President/Community Relations; Sara Pacholke, Controller; Monica Portugal, Chief Compliance Officer; Robert Robinson, Chief Executive Officer; and Doug Wright, Director of Consumer Affairs

**AGENDA ITEMS:**

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Introductions</td>
<td>Mr. Robinson welcomed attendees; attendees introduced themselves.</td>
</tr>
<tr>
<td>3. Opening Statements</td>
<td>Ms. Goodfellow provided an overview of the budgeting process which includes the annual budget retreat.</td>
</tr>
<tr>
<td>4. CFAC Perspective</td>
<td>Ms. Bradstock reviewed information from CFAC members; the input included the following areas: social determinants of health, intellectual/development disability (IDD) service gaps and needs, mental health service gaps and needs; substance use service gaps and needs; and systemic concerns.</td>
</tr>
</tbody>
</table>
| 5. Budget and Strategic Plan   | A. **ORGANIZATIONAL EFFECTIVENESS:** Dr. Bollini reviewed Alliance’s FY17 strategic plan; he noted the agency’s mission, strategic plan goals and recent internal reorganization. Dr. Bollini mentioned that the reorganization was designed to better align functional and cross functional areas to increase efficiency, efficacy and accountability. The reorganization also enhances flexibility and scalability. Dr. Bollini reviewed the organizational structure and how the reorganization can be of greater benefit to internal and external stakeholders.  

B. **CARE MANAGEMENT:** Dr. Melcher reviewed the departments within the Care Management division: provider networks, clinical operations and community relations. She provided an overview of each department and how the reorganization will increase cross-departmental functionality and improve care for those Alliance serves.  

C. **FY17 FINANCIAL REVIEW:** Ms. Goodfellow provided a mid-year financial review depicting current assets, net position, and State mandated ratios. Ms. Goodfellow and Mr. Robinson clarified the recent change in the State ratio for medical loss ratio or MLR. The new ratio requires MCOs to utilize 85% of their budget for services provided directly to consumers. The MLR will be a continued focus on a monthly basis. |
<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms. Goodfellow reviewed Alliance’s PMPM (per member per month) rate and how this capitation payment amounts to the Medicaid funding. Additionally, Ms. Goodfellow provided an overview of the PMPM and how it correlates with specific two services: PRTF (psychiatric residential treatment facilities) and IIH (intensive in-home services).</td>
<td></td>
</tr>
<tr>
<td>Ms. Goodfellow reviewed how funds are used for the reinvestment plan and specific areas of the reinvestment plan (new Wake crisis facility, new child crisis facility, implementation of behavioral health urgent care in Durham and I/DD crisis respite services). Dr. Melcher reviewed new service definitions which were implemented as part of earlier gaps and needs analysis.</td>
<td></td>
</tr>
<tr>
<td>D. FISCAL YEAR 18 PLANNING: Ms. Goodfellow covered opportunities and challenges that could impact the FY18 budget, some projected FY18 service initiatives, projected increases in specified services (new Wake crisis facility, child crisis facility, expansion of behavioral health urgent care, addressing substance use/abuse service continuum and other components of the gaps/needs assessment) and Medicaid services and funding (PMPM rate).</td>
<td></td>
</tr>
<tr>
<td>Ms. Goodfellow reviewed projected savings, projected Medicaid and non-Medicaid funding, and base benefit packages. Ms. Goodfellow reviewed Medicaid, IPRS/State funding, and county/local funding. She reviewed proposed oversight of revising the IPRS benefit package (if approved by the Board) and a potential implementation plan. Ms. Goodfellow included information about the administrative budget as it relates to staffing, IT, communications and facilities.</td>
<td></td>
</tr>
<tr>
<td>Board members discussed the potential benefits and challenges of revising the IPRS benefit package. Ms. Goodfellow shared that additional information will be presented at upcoming Board meetings prior to Board members approving any revisions.</td>
<td></td>
</tr>
<tr>
<td>The budget retreat presentation is attached to and made part of these minutes.</td>
<td></td>
</tr>
</tbody>
</table>

6. Adjournment

With all business being completed the meeting adjourned at 4:00 p.m.

Next Board Meeting

Thursday, April 06, 2017

4:00 – 6:00
Agenda Overview

- CFAC presentation
- Review of administrative strategy
- FY17 Mid-Year Review
- MCO Challenges ahead
- FY18 Financial Strategy
Social Determinants of Health

- Affordable and accessible housing
- Transportation
- Employment
- Education

In every forum or avenue utilized to gather input, these common themes around healthy communities are always a priority.
I/DD Service Gaps and Needs

• Innovations slots
  - Waitlist has grown to over 12,000 statewide and around 2,000 in the Alliance catchment

• Direct Care workers
  - Shortage of qualified workers having a major impact on authorized services being utilized

• Assistive Technology

• Crisis Respite

• Case Management
I/DD Service Gaps and Needs

• Effective school inclusion

• Retirement services
  o Members are living much longer and need meaningful activities other than work.

• Family education

• Transitional services for transitional aged youth
Mental Health Gaps and Needs

• Peer-run Respite
• Recovery Center (Cumberland, Johnston)
• Psychiatric appointments
• Effective Peer Support
• Accessible services
  ○ 30 minutes, 30 miles is not always sufficient
• Crisis services for children
Mental Health Gaps and Needs

- Cognitive Enhancement Therapy (CET)
- Case Management
- Medication Education
- Life Skills Training (Ready to Rent)
- Drop In Center (Cumberland)
- Transitional Aged Youth Focused Psychosocial Rehabilitation
- Peer-operated warm line
Substance Use Disorder Gaps and Needs

- Medical detoxification
- Social detoxification
- Recovery Centers (Cumberland, Johnston)
- Youth services
- Peer Support – Recovery Coaches
- Long-term treatment – 28-day residential
- Jail Transition services
Substance Use Disorder Gaps and Needs

- Medication-Assisted Treatment (IPRS funded)
- Substance Abuse Intensive Outpatient Service (IPRS funded)
Specialty Populations

- LGBTQ – culturally-appropriate services
- Deaf community – access and availability
- Non-English speaking – access and availability
- Transition age youth
- Veterans and families
Systemic Concerns

- Medicaid – future funding
- System Reform – transformation?
- The Digital Divide
- Trust in the system
- State funding cuts
- Stigma
- Different Benefit Plans across the catchment
Closing

Thanks for having us participate today. We are truly grateful that you take the time to hear our concerns and look forward to a year of working together to improve our communities.

The people you serve deserve and want nothing more than a life filled with hope, love, a little work and a lot of laughter.
Review of Administrative Strategy
Organizations Need Three Strategies In A Disruptive Market

- Sustainability in current environment
- Surviving the turbulence of change
- Planning for a sustainable future
FY17 Strategic Plan

Working Towards Our Mission

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

**MISSION**

**PERFORMANCE**
Optimize our business performance to meet today's needs and prepare for the future

**FUTURE**
Influence the future policy direction related to Medicaid reform

**HEALTH OUTCOMES**
Improve health outcomes of the people we serve

**PERSON-DIRECTED HEALTH**
Advance person-directed health
Why Reorganization?

• Greater focus on our people
• Better alignment of related functional areas to allow staff to work more efficiently, effectively and collaboratively
• Increased accountability
• Flexibility and scalability to meet future opportunities
• Easier cross-departmental communication
• Minimize duplicated work
Administrative Business Strategies

• Focus efforts on
  o Operational efficiency
  o Recruitment, development and retention of a talented workforce
  o Innovative IT solutions and analytic applications to enhance our business and clinical performance
Care Management Division

- Clinical Operations
- Provider Networks
- Community Relations
Care Management Division

- Three distinct departments create a scalable model to expand to meet future consolidation

- Allows a broader application of health approach to our work
  - Engage more of our members with an increased focus on prevention and outreach
  - Use data to identify targeted population groups and target interventions
  - Leverage community partners and providers to address social determinants of health for targeted populations
FY17
Mid-Year Review
Financial Summary as of January 31

- Current Assets – $123,944,456
  - $108M in cash
- Net Position
  - Restricted – $35,393,063
  - Unrestricted – $68,457,414
Current Ratio

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

<table>
<thead>
<tr>
<th>Month</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUG-16</td>
<td>3.70</td>
</tr>
<tr>
<td>SEP-16</td>
<td>3.70</td>
</tr>
<tr>
<td>OCT-16</td>
<td>3.70</td>
</tr>
<tr>
<td>NOV-16</td>
<td>3.70</td>
</tr>
<tr>
<td>DEC-16</td>
<td>3.70</td>
</tr>
<tr>
<td>JAN-17</td>
<td>3.70</td>
</tr>
</tbody>
</table>
Percent Paid

- Benchmark
- Alliance

<table>
<thead>
<tr>
<th>Month</th>
<th>Benchmark</th>
<th>Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUG-16</td>
<td>98%</td>
<td>99.91%</td>
</tr>
<tr>
<td>SEP-16</td>
<td>98%</td>
<td>99.91%</td>
</tr>
<tr>
<td>OCT-16</td>
<td>98%</td>
<td>99.91%</td>
</tr>
<tr>
<td>NOV-16</td>
<td>98%</td>
<td>99.91%</td>
</tr>
<tr>
<td>DEC-16</td>
<td>98%</td>
<td>99.91%</td>
</tr>
<tr>
<td>JAN-17</td>
<td>98%</td>
<td>99.91%</td>
</tr>
</tbody>
</table>

Overall, Alliance has a higher percentage paid compared to the benchmark.
Medical Loss Ratio

Bench Mark  MLR

<table>
<thead>
<tr>
<th>Month</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUG-16</td>
<td>70%</td>
</tr>
<tr>
<td>SEP-16</td>
<td>75%</td>
</tr>
<tr>
<td>OCT-16</td>
<td>80%</td>
</tr>
<tr>
<td>NOV-16</td>
<td>85%</td>
</tr>
<tr>
<td>DEC-16</td>
<td>90%</td>
</tr>
<tr>
<td>JAN-17</td>
<td>95%</td>
</tr>
</tbody>
</table>
Defensive Interval

- Benchmark
- Alliance

Graph showing the defensive interval from August 2016 to January 2017. The benchmark remains relatively stable, while the Alliance interval shows a decrease from 120 to 102.78 over the same period.
PMPM Trend (Actual to Budget)

- FY15: Actual $115.00, Budget $118.00
- FY16: Actual $118.00, Budget $121.00
- FY17: Actual $121.00, Budget $124.00

Actual line decreases from FY15 to FY17.
Budget line decreases from FY15 to FY17.
Intensive In-Home Services

- Actual PMPM
- Budget

<table>
<thead>
<tr>
<th>Year</th>
<th>Actual PMPM</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY15</td>
<td>$19.00</td>
<td>$17.00</td>
</tr>
<tr>
<td>FY16</td>
<td>$16.00</td>
<td>$18.00</td>
</tr>
<tr>
<td>FY17</td>
<td>$10.00</td>
<td>$16.00</td>
</tr>
</tbody>
</table>
## Reinvestment Plan Follow Up

<table>
<thead>
<tr>
<th>Program/Service</th>
<th>FY17 Projection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wake Crisis Facility</td>
<td>$2,600,000</td>
</tr>
<tr>
<td>Integrated Care/Expansion</td>
<td>575,000</td>
</tr>
<tr>
<td>Enhanced Therapeutic Foster Care</td>
<td>46,350</td>
</tr>
<tr>
<td>Trauma Informed Therapeutic Foster Care</td>
<td>25,000</td>
</tr>
<tr>
<td>ICF Transitions with B3 funds</td>
<td>68,966</td>
</tr>
<tr>
<td>Short Term PRTF beds</td>
<td>50,000</td>
</tr>
<tr>
<td>First Responders Reimbursement</td>
<td>310,000</td>
</tr>
<tr>
<td>Mobile Crisis</td>
<td>25,000</td>
</tr>
<tr>
<td>BH Urgent Care</td>
<td>2,000,000</td>
</tr>
<tr>
<td>Child Facility Based Crisis</td>
<td>1,500,000</td>
</tr>
<tr>
<td>Rapid Response</td>
<td>20,343</td>
</tr>
<tr>
<td>IDD Crisis Respite Facility</td>
<td>300,000</td>
</tr>
<tr>
<td>Intensive Wrap Around</td>
<td>28,350</td>
</tr>
<tr>
<td>Service Rate Increases</td>
<td>6,862,000</td>
</tr>
<tr>
<td>Durham Crisis Facility Renovation</td>
<td>1,000,000</td>
</tr>
<tr>
<td>Supportive Housing</td>
<td>500,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$15,911,008</strong></td>
</tr>
</tbody>
</table>
Increase in Service Spend

• New Wake Crisis facility
  ▪ Build out and operational start up costs
  ▪ Not expected to drive down ED/inpatient utilization

• New Child Crisis facility – start up costs

• Implementation of BHUC in Durham

• New service definitions
  ▪ i.e. Rapid Response, Medication Assisted Treatment, ACTT step down, CST+, Outpatient+

• I/DD Crisis respite
FY18 – The Year Ahead: Planning for a Sustainable Future in Uncertain Times
Opportunities and Challenges

- Medicaid reform
- Mergers
- Insufficient State funding
- PMPM reductions

**Number Served**

- Medicaid: 45,500
- State/Local: 18,778

**BY THE NUMBERS:**

- Total State investment of $366,040,589 required to provide a level of service equivalent to Medicaid.
## FY18 Initiatives

<table>
<thead>
<tr>
<th>Program/Service</th>
<th>FY18 Projection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wake Crisis Facility</td>
<td>$5,500,000</td>
</tr>
<tr>
<td>NC START</td>
<td>650,000</td>
</tr>
<tr>
<td>Trauma informed Therapeutic Foster Care</td>
<td>50,000</td>
</tr>
<tr>
<td>Technology Enabled Homes</td>
<td>25,000</td>
</tr>
<tr>
<td>BH Urgent Care</td>
<td>4,500,000</td>
</tr>
<tr>
<td>Child Facility Based Crisis</td>
<td>3,000,000</td>
</tr>
<tr>
<td>Peer Respite</td>
<td>300,000</td>
</tr>
<tr>
<td>Peer Transition Teams</td>
<td>200,000</td>
</tr>
<tr>
<td>IDD Crisis Respite Facility</td>
<td>600,000</td>
</tr>
<tr>
<td>Intensive Wrap Around</td>
<td>113,400</td>
</tr>
<tr>
<td>Durham Crisis Facility renovation</td>
<td>1,000,000</td>
</tr>
<tr>
<td>Supportive Housing</td>
<td>500,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$16,438,400</strong></td>
</tr>
</tbody>
</table>
Increase in Service Spend

• New Wake Crisis facility – Q4
  ○ Will prevent diversion from current facilities

• Child Crisis – Q4

• Expansion of Behavioral Health Urgent Care

• Addressing SA service continuum

• Service savings in FY19

• Gaps and needs assessment not complete
Medicaid Focus

• Evaluation of PMPM for FY18
  o Net decrease of -.2%, approximately $630K
  o Areas with increases:
    • TCLI
    • Expansion for children with Autism Spectrum Disorder
    • IMD coverage
    • Resource Allocation/Innovation services
    • Case Management for children with complex needs
    • State Facility rate increases (3.42% to 48.02%)
  o Actual decrease of about 3.5%, over $8M
Medicaid Focus

• TBI Waiver
  o Loss expected to be $311K for the first year
  o Anticipated that 41% of consumers will be above cost in first year

• Provider evaluations
  o Outcome based
  o Data driven
  o Pilot programs

• TCLI and housing efforts
# Savings Projections

<table>
<thead>
<tr>
<th></th>
<th>FY16 Actual</th>
<th>FY17 YE</th>
<th>FY18 YE</th>
<th>FY19 YE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning Fund Balance</td>
<td>$48,965,248</td>
<td>$68,457,416</td>
<td>$60,277,771</td>
<td>$58,839,371</td>
</tr>
<tr>
<td>Legislative Reductions</td>
<td>(11,066,104)</td>
<td>(12,268,637)</td>
<td></td>
<td></td>
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<tr>
<td>Available Fund Balance</td>
<td>$37,899,144</td>
<td>$56,188,779</td>
<td>$60,277,771</td>
<td>$58,839,371</td>
</tr>
<tr>
<td>Investments</td>
<td></td>
<td>(15,911,008)</td>
<td>(16,438,400)</td>
<td>(9,563,400)</td>
</tr>
<tr>
<td>Balance of FB</td>
<td>37,899,144</td>
<td>40,277,771</td>
<td>43,839,371</td>
<td>49,275,971</td>
</tr>
<tr>
<td>Annual Savings (projected)</td>
<td>30,558,272</td>
<td>20,000,000</td>
<td>15,000,000</td>
<td>10,000,000</td>
</tr>
<tr>
<td>Ending Fund Balance</td>
<td>68,457,416</td>
<td>60,277,771</td>
<td>58,839,371</td>
<td>59,275,971</td>
</tr>
<tr>
<td>Medicaid Budget (projected)</td>
<td>372,401,144</td>
<td>391,021,201</td>
<td>410,572,261</td>
<td>431,100,874</td>
</tr>
<tr>
<td>Fund Balance as % of budget</td>
<td>18.38%</td>
<td>15.42%</td>
<td>14.33%</td>
<td>13.75%</td>
</tr>
</tbody>
</table>
Non Medicaid Needs

Number Served

BY THE NUMBERS:

- Total State investment of $366,040,589 required to provide a level of service equivalent to Medicaid
# Non Medicaid Needs

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Total Spent</th>
<th>Lives</th>
<th>Needing Services</th>
<th>Receiving Services</th>
<th>% in Need Receiving Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>$343,919,619</td>
<td>228,000</td>
<td>63,840</td>
<td>45,500</td>
<td>71%</td>
</tr>
<tr>
<td>State/Local</td>
<td>$87,980,241</td>
<td>242,665</td>
<td>67,946</td>
<td>18,778</td>
<td>28%</td>
</tr>
<tr>
<td>Total</td>
<td>$431,899,860</td>
<td>470,665</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table Key:**
- Lives – number of individuals Alliance is responsible for in its four-county region
- Needing Services – prevalence rates determined by SAMHSA statistics
- Receiving Services – number served by Alliance in FY16
- % in Need Receiving Services – percentage of those needing services who actually receive them
Non Medicaid Focus

• Assess and plan for any funding reductions
• Prepare for growing crisis continuum
• Growing population, shrinking dollars
• Work towards sustaining services long term
• State expectation to define services and population in base benefit plan
Non Medicaid Focus

• Goal of a Base Benefit Plan:
  o Manage for the entire catchment area
  o Meet the basic needs of the community
  o Address unique programs/services in each area
  o Uniform plan across entire catchment area
Base Benefit Package Advantages

• Manage State dollars in the same manner as Medicaid, total dollar amount instead of line item

• Flexibility to meet the needs of all communities

• Fair and equitable benefit package in each community

• Detailed reporting by county and service
Base Benefit Package Advantages

• Any reductions could be managed for the entire area; not proportionate

• Scalable for mergers
  - All other MCOs manage State dollars at catchment level

• Improve administrative inefficiencies
Basic Benefit Package

• Safety net services
  o Facility Based Crisis, Mobile Crisis, Detox

• Outpatient
  o Specialized, group, family therapy for children

• Capped services
  o SAIOP
  o ACTT
  o CST
Basic Benefit Package

- Basic I/DD package
- Residential services
Management Oversight

• Reports that breakdown service by county, numbers served, provider, service code, etc.
• Budget to actual at a total level
• Review monthly/quarterly with internal staff and Board
• Detail action steps, if any are needed
Management Oversight

- Management through Committees
  - Budget and Finance, Utilization Management
  - CQI feed
  - CEO report
Implementation Plan

• Board discussion, staff recommendations
• CFAC discussion
• Communication to all stakeholders
• Publications
• Impact meetings with providers
• Goal of final transition – July 1, 2018
Administrative Plan

• Business and strategic growth
  o Staffing – needed positions frozen due to possible mergers
  o IT/analytics investment
    • Care Management system - $1.3M first year, $500K on-going
    • Advancing data analytics
  o Branding and marketing
  o Facility planning – relocation and consolidation of sites by 1/1/2019
  o Benefit increases – 7.3% in FY17, up to 10% in FY18
Administrative Plan

• Portfolio Management
  o Prioritize project and resource allocations

• Increased focus on data analytics to optimize business performance and clinical service delivery
Retreat Takeaways

• PMPM expectations – manage and reinvest!
• Focus on operational efficiency and maximizing resources
• Reinvestment program and initiatives
• Non-Medicaid base benefit package
• Strategic plan shapes the budget
• Planning for a Sustainable Future in Uncertain Times
Next Steps

• April – preliminary review of IPRS benefit package, CFAC discussion

• May – budget recommendation

• June – budget approval
ITEM: Recommendation for Appointment to Alliance Board of Directors

DATE OF BOARD MEETING: April 6, 2017

BACKGROUND: As noted in the by-laws the Area Board is given the task of advertising, accepting applications, interviewing and recommending appointment of prospective Board members to the respective boards of county commissioners.

Area Board membership may consist of the following:
1. Consumer or family member representing the interest of individuals with mental illness, intellectual or other developmental disabilities or substance abuse.
2. CFAC member
3. An individual with health care expertise and experience in the fields of mental health, intellectual or other developmental disabilities or substance abuse services.
4. Individual with financial expertise
5. Individual with provider experience in a managed care environment.

The Area Board shall assure that there is at least one representative of each of the three disability categories, i.e., mental illness, intellectual/developmental disabilities and substance abuse, on the board. Terms of membership shall be for three years. Appointments for vacant seats shall be for the remainder of the unexpired term.

REQUEST FOR AREA BOARD ACTION: The Executive Committee is requesting that the Area Board recommend to the Wake Board of County Commissioners the appointment of Marilyn Avila to the vacant seat on Alliance’s Board.

CEO RECOMMENDATION: Recommend to the Wake Board of County Commissioners the appointment of Marilyn Avila to Alliance’s Board.

RESOURCE PERSON(S):
Christopher Bostock, Board Chairman; Robert Robinson, CEO
ITEM: Electronic Advertising of Bids

DATE OF BOARD MEETING: April 6, 2017

BACKGROUND: NC General Statute Chapter 143 Article 8, requires that Alliance, as a political subdivision of the State, formally advertise its large bids for construction ($500,000 and greater) and purchase of goods ($90,000 and greater) electronically and/or via newspaper. Due to the anticipated increase of construction contracts and purchase of goods that are subject to these formal bidding laws, it is recommended that Alliance avail itself to the right to advertise such bids solely by electronic means (i.e. on Alliance’s website or other internet posting resources).

A decision to advertise solely by electronic means for all contracts that are subject to Article 8, Public Contracts, must be approved by the governing board of the political subdivision at a regular meeting of the Board. Therefore, the Board is requested to authorize formal bids made pursuant to Chapter 143 Article 8, of the NC General Statute to be advertised solely by electronic means when deemed proper in the discretion of the Purchasing Manager.

REQUEST FOR AREA BOARD ACTION: Approve the proposal to authorize formal bids made pursuant to statute to be advertised solely by electronic means when deemed proper in the discretion of the Purchasing Manager.

CEO RECOMMENDATION: Approve the proposal.

RESOURCE PERSON(S): Carol Hammett, General Counsel
ITEM: Opioid Dependency Training

DATE OF BOARD MEETING: April 6, 2017

BACKGROUND: Dr. Reinstein will review the opioid epidemic and Alliance’s response and future plans.

REQUEST FOR AREA BOARD ACTION: Accept the training.

CEO RECOMMENDATION: Accept the training.

RESOURCE PERSON(S): Vera Reinstein, PharmD, BCPS, Clinical Pharmacist
Overview of Opioid Initiatives

Board of Directors Meeting

Vera Reinstein, Pharm.D.
Clinical Pharmacist

April 6, 2017
OPIOID EPIDEMIC

91 AMERICANS
die every day from an opioid overdose
(that includes prescription opioids and heroin).
Welp, we’ve done it, folks. It’s finally come to this. There have been so many deaths from opioid overdose, so many addicts created, so many pills diverted, that the CDC
Path Paved with Good Intentions

Nearly two decades ago, we were encouraged to be more aggressive about treating pain, often without enough training and support to do so safely. This coincided with heavy marketing of opioids to doctors. Many of us were even taught – incorrectly – that opioids are not addictive when prescribed for legitimate pain.

Vivek Murthy, MD, MBA, 19th US Surgeon General
Rx Opioid Sales and Overdose Deaths 1999-2010
An average day in the U.S.

• > 650,000 opioid Rxs dispensed
• 3,900 people initiated nonmedical use of Rx opioids
• 580 people initiated heroin use
• 91 people died from an opioid-related overdose

https://www.hhs.gov/sites/default/files/Factsheet-opioids-061516.pdf

- Any Opioid
- Commonly Prescribed Opioids (Natural & Semi-Synthetic Opioids and Methadone)
- Heroin
- Other Synthetic Opioids (e.g., fentanyl, tramadol)

Medication or Drug Overdose Deaths by Intent
North Carolina Residents, 1999-2014

*Per 100,00, age-adjusted to the 2000 U.S. Standard Population
Source: Death files, 1968-2014, CDC WONDER
Analysis by Injury Epidemiology and Surveillance Unit
Substances Contributing to Medication or Drug Overdose Deaths
North Carolina Residents, 1999-2015

Analysis by Injury Epidemiology and Surveillance Unit
Rate of Unintentional/Undetermined Prescription Opioid Overdose Deaths and Rate of Outpatient Prescriptions Dispensed for Opioids North Carolina Residents, 2011-2015

Outpatient Dispensing per 100 persons (2014-2015)
- 41.1 - 79.9
- 80.0 - 110.9
- 111.0 - 149.9
- 150.0 +

Overdose Rates per 100,000 persons (2011-2015)
- 0 - 4
- 5 - 7
- 8 - 11
- 12+
- Rate not calculated <5 deaths

Average mortality rate: 6.4 per 100,000 persons
Average dispensing rate: 89.4 per 100 persons

*Data: Mortality - State Center for Health Statistics, NC Division of Public Health, 2011-2015
Opioid Dispensing - Controlled Substance Reporting System, 2014-2016
Figure 1. Source of prescription pain relievers for the most recent nonmedical use among past year users aged 12 or older: annual averages, 2013 and 2014

- From a friend or relative for free: 50.5%
- From one doctor: 22.1%
- Bought from a friend or relative without asking: 4.4%
- Took from friend or relative without asking: 4.8%
- Bought from drug dealer or other stranger: 3.1%
- From more than one doctor: 4.1%
- Other: 3.1%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2013 and 2014.
OPIOID CRISIS

Opioid involvement in BDZ overdose deaths

Source: National Center for Health Statistics, CDC Wonder
NORTH CAROLINA CONCERNS

- Overdose deaths
- Media/high profile
- Across communities
  - Age
  - SES
  - Geography

...led to Governor’s Task Force recommendations
• Opioid prescribing issues (case specific)

• Level III M & M Committee Review:
  o Increased opioid related deaths
  o rise in other opioid related incidents

• CMT ProAct Analytics reports
As many as **1 in 4** people receiving prescription opioids long term in a primary care setting struggle with **addiction**.
ALLIANCE OPIOID EFFORTS

• Opioid/BZD Subcommittee of CCMT
  • Internal/External stakeholders
  • ABH Cross-departmental staff
  • 3 Community Providers
  • CCNC

• Comprehensive proposal aligned
  • NC Strategic Plan to Reduce Prescription Drug Abuse
  • Governor’s Task Force on Mental Health and Substance Use Workgroup on Prescription Opioid Abuse, Heroin Resurgence and Special Topics

• 4 Major Areas of Focus/Impact
  • Physicians/Prescribers
  • Providers
  • Consumers/Families
  • Policy/Advocacy
MEDICATION ASSISTED TREATMENT

• **MAT**: SUD treatment using counseling and behavioral therapies + medications
  - Opioid agonists = methadone, Suboxone,
  - Opioid antagonists – naltrexone (Revia)

• Promote MAT (EBP)
  - Implemented enhanced rates to support best practices (CSRS and UDS)
  - Education to Providers
  - Adopted Clinical Guidelines to support EBPs
NALOXONE

• Narcan = opioid overdose antidote

• Partnered with NCHRC & UNC Crisis Facilities
  • $100,000 total
  • Provide nasal naloxone (Nasal Narcan®) kits
  • Education for consumers and families
  • Wake and Durham Detention upon release-pending
LEAD

• Law Enforcement Assisted Diversion
• “Treatment over incarceration”
• Pre-booking diversion pilot

• Police
  • Do NOT arrest for low-level offenders (buy/sell < 4gm drugs, larceny & prostitution
  • DO seek help = treatment, housing, education and employment
Why LEAD  Law Enforcement Assisted Diversion

• Criminal justice system did not fix the drug problem: cases thrown out or minimal jail time served & back on the streets

• LEAD Benefits
  • participants 58% less likely to be arrested
  • per Santa Fe: Jail 41K/year, LEAD 6K/year

• Started 2011 in Seattle, then Santa Fe, New Mexico and Albany, New York

• Fayetteville 7th US city to pilot, 1st in south
Fayetteville LEAD  Law Enforcement Assisted Diversion

• Alliance in partnership with:
  • Fayetteville Police Department
  • Cumberland County District Attorney’s Office
  • Treatment Accountability for Safer Communities (TASC) – provides case management
  • NC Carolina Harm Reduction Coalition (NCHRC)
• City received a 200K Open Society Foundation Grant to start LEAD program in Fayetteville
• Began August 2016
Alliance, in partnership with their network of treatment providers, is providing LEAD participants with:

- crisis stabilization services
- drug detox
- employment support services
- short term rental assistance
- short term emergency housing
- range of substance use & mental health services
• Support statewide efforts for utilization of standing Naloxone orders by State Medical Director

• Support provider use of North Carolina Controlled Substances Reporting System (NC CSRS) – NC version of a prescription drug monitoring program (PDMP)
CMT ProAct

- Developed workflow for report identifying concerning opioid prescribing and pharmacy use

- Considering similar report/workflow for benzodiazepines
FIGURE 3. Percentage of patients and prescription drug overdoses, by risk group — United States

- Patients seeing multiple doctors and typically involved in drug diversion
- Patients seeing one doctor, high dose
- Patients seeing one doctor, low dose
Click here to enter a date.

Dear Dr. «Prescriber» «Prescriber Address»

The information contained in this notification is intended solely for the addressee(s) named above and is confidential. This information has been disclosed to you from records whose confidentiality is protected by Federal law (Federal Regulation 42 CFR Part 2). If you are not the intended recipient or the person responsible to deliver it to the intended recipient, you are prohibited from reading or disclosing the information contained in this notification. Any examination, use, dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us at the number below.

Multiple Prescriber and Pharmacy Alert

Patient Receiving Opioid Prescriptions from Multiple Providers and Filling Prescriptions at Multiple Pharmacies

According to our data, your patient, «First Name» «Middle Initial» «Last Name» has received opioid prescriptions from more than one prescriber and filled prescriptions for opioids at two or more pharmacies in March and April of this year. (Note that this Alert describes patient behavior, not your behavior as a prescriber.)

There may be perfectly benign explanations for your patient seeing multiple prescribers and using multiple pharmacies. However, such behavior may reflect abuse or diversion of prescriptions. To inform your provision of care to your patient, this information is being provided to you in the event that you are not already aware of this situation.

Please review the information to assess whether our data are consistent with your understanding of the patient’s care. You may wish to consider discussing this matter with your patient. If you have
ALLIANCE COMMUNITY INVOLVEMENT

• Cumberland County Opioid Abuse and Awareness Task Force
• Durham County Public Health and Durham County Jail Work Group
• Lincoln Community Health Center Medication Assisted Treatment Steering Committee
• Wake County Detention Workgroup
• Wake County Drug Overdose Prevention Coalition
ALLIANCE CLINICAL PRACTICE GUIDELINES

• Adopted & Approved CPGs via Clinical Advisory Committee

• 23 disorders, currently 28 guidelines
  • Opioids-2, plus resources
  • Benzodiazepine -1
  • General Substance Use Disorders-2

• [link](http://www.alliancebhc.org/providers/alliance-clinical-guidelines/)
OTHER RESOURCES

The following websites made available to providers as well:

http://www.cdc.gov/drugoverdose/prescribing/guideline.html

http://www.cdc.gov/drugoverdose/prescribing/resources.html

http://www.cdc.gov/drugoverdose/prescribing/patients.html
### OPIOID RESOURCE LIST


INTERNAL EDUCATION

• Medical staff identified these issues via
  • Peer review
  • Level III M&M reviews
• Medical staff w/UM/CC/ACCESS: CPGs, MAT
• Pharmacist-Naloxone rescue
• NCHRC-Naloxone rescue
• State Partners-SUD and Pregnancy
• Drs. Ashwin Patkar/Steve Prakken: SUD, MAT
• STOP ACT: All Providers, Med-Clin Directors, UM, CC
EXTERNAL EDUCATION

- NC Medical Board’s Safe Opioid Prescribing Initiative
- Clinical Practice Guidelines
- Naloxone rescue (NCHRC, CCNC)
- Free on-line training (PCSS-O, PCSS-MAT)
- ABH Peer Reviewers provide 1:1 technical assistance
- AHEC Collaboration to provide free training
  - Wake AHEC – Planning Committee to assist with conference for primary care on Opioid prescribing in May 2017
  - SrAHEC  Medication Assisted Treatment (9/2016)
    Safer Opioid Prescribing October (10/2016)
- Crisis Intervention Training: ABH Criminal Justice Specialist conducts a quarterly CIT class with a block of training from Wake County EMT-Advanced Practice Paramedics. The APP’s talk to officers about overdoses, Naloxone, and resources. APP’s are a great resource for officers and most are aware of them prior to CIT
SOME NEXT STEPS

- Alliance service array
- Prevention – public awareness campaign
- Collaboration
- Training
- Advocacy: STOP Act, NCMB initiatives
• Assessment of SA/SUD Continuum-underway
  • MAT, OTPs
  • SAIOP, SACOT
  • Residential
  • FBC
  • ADATC
  • Other MH service array
  • Non paid supports/resources
For every 1 death there are...

- 10 treatment admissions for abuse\(^9\)
- 32 emergency dept visits for misuse or abuse\(^6\)
- 130 people who abuse or are dependent\(^7\)
- 825 nonmedical users\(^7\)
OPIOID OVERDOSE EPIDEMIC: THE ROLE OF THE PHARMACIST

- Enlisting the professional that often sees consumers more than any other provider
- Publicize the CPESN: Community Pharmacy Enhanced Services Network (CCNC)– making naloxone provision a standard of care
- Encourage pharmacists across all settings to understand their potential impact
- Several trainings in 2016: through NCAP (statewide), Durham-Orange Pharm Assoc, Rocky Mount AHEC, and planned for 2017 Wake and Durham-Orange Pharm Assoc
- Webinar - NC Association of Pharmacists’ Website
OPIOID OVERDOSE EPIDEMIC: COMMUNITY PHARMACY ROLE

• Understand opioid addiction as a chronic, preventable, relapsing and treatable disease
• Encourage routine screening for SA/overdose risk, patient evaluation and education around opioids
  • Education about the risks of opioids
  • No sharing; safe storage/appropriate disposal of opioids
  • Disease and drug interactions risks
  • Medication Assist Treatment CPAs

  – Participate in the naloxone standing order – offer naloxone to high risk patients for opioid overdose (initiate the conversation)

  – Encourage other harm reduction strategies
DISPOSAL KIOSKS

[Image of a disposal kiosk for medication disposal]
NALOXONE RESOURCE LIST

• DHHS Naloxone Saves http://www.naloxonesaves.org/

• Prescribe to Prevent - patient education including videos http://prescribetoprevent.org/pharmacists/pharmacy-basics/

• NC Harm Reduction Coalition http://www.nchrc.org/programs-and-services/

• Naloxone CE program for MD/DO, NP, PA, RN, RPh: http://www.opioidprescribing.com/naloxone_module_1-landing
