
GUEST(S) PRESENT: Caroline Ambrose, CFAC Chair (via phone); Carol Beaumont, Johnston County Mental Health Board; Jeffrey Carver, Johnston Board of County Commissioners; Rick Hester, Johnston County Manager; Terry Keene, Johnston County Mental Health Board; and Jason Phipps, Johnston County Mental Health Board/Johnston CFAC Chair

ALLIANCE STAFF PRESENT: Michael Bollini, Chief Strategy Officer; Hank Debnam, Cumberland Site Director/Veterans Point of Contact; Joey Dorsett, CIO; Kelly Goodfellow, CFO; Amanda Graham, Chief of Staff; Veronica Ingram, Executive Assistant; Janis Nutt, Johnston Site Director; Sara Pacholke, Controller; Monica Portugal, Chief Compliance Officer; Al Ragland, Chief HR Officer; Rob Robinson, CEO; Sean Schreiber, Chief Clinical Officer; 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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| 2. Announcements | A. INTRODUCTIONS: Chairman Bostock thanked Dr. Janis Nutt for hosting today’s meeting. Commissioner Jeffrey Carver welcomed attendees to Johnston County.  
B. MAKING A DIFFERENCE BREAKFAST: Mr. Robinson notified Board members that this year’s annual Making a Difference Breakfast in Durham is on May 5, 2016, from 8:30-10:00 a.m. It is an opportunity to thank and honor community partners involved with system of care. All Board members are invited to attend the breakfast.  
C. UPCOMING MEETINGS WITH LEGISLATORS: Mr. Robinson mentioned upcoming meetings with NC legislators on April 19, 2016; he invited Board members to contact him if they are able to attend.  
D. FUTURE DEVELOPMENT WORKGROUP: Mr. Robinson reminded Board members that the next meeting will be Tuesday, April 5 at 4:00 pm. This is a staff workgroup that meets monthly. Board members are invited to attend this meeting. |

3. Agenda Adjustments | There were no adjustments to the agenda. |
4. Public Comment | There were no public comments. |
5. Committee Reports | A. Consumer and Family Advisory Committee – page 5  
The Alliance Consumer and Family Advisory Committee (CFAC) is composed of consumers and/or family members from Durham, Wake, or Cumberland counties who receive mental health, intellectual/developmental disabilities or substance
**AGENDA ITEMS:**

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<td>use/addiction services. This month’s report included draft minutes from the Alliance CFAC’s June meeting, a recap of snapshot surveys, a copy of alcohol awareness training, and the CFAC monthly board report summary.</td>
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<td>The committee reports were sent as part of the Board packet; Caroline Ambrose, CFAC Chair, presented the report. Ms. Ambrose mentioned a recent mental health first aid training for Cumberland CFAC subcommittee members and the Cumberland community; new Consumer Relations Specialist, Starlett Davis; recent participation in Alliance’s annual Board budget retreat; and a presentation on accessing I/DD services. Additionally, Ms. Ambrose mentioned development of a strategic plan to meet legislative requirements and a recent demonstration of navigating Alliance’s website.</td>
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<td>B. Finance Committee – page 48</td>
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<td>The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Area Board. This month’s report included draft minutes from the February meeting. James Edgerton, Finance Committee Chair, presented the report. Mr. Edgerton noted that revenue exceeds expenditures; he mentioned Alliance’s excellent performance on State mandated ratios and discussions being made on changes to two of the ratio definitions.</td>
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**BOARD ACTION**

The Board received the reports; no additional action required.

**6. Consent Agenda**

A. Draft Minutes from March 3, 2016, Regular Board Meeting – page 57
B. Audit and Compliance Committee Report – page 62
C. County Commissioners Advisory Committee Report – page 70
D. Executive Committee Report – page 73
E. Network Development and Services Committee Report – page 76
F. Quality Management Committee Report – page 115
G. 457 and 401K Plan Provisions – page 169

Chairman Bostock stated that the consent agenda was sent as part of the Board packet; there were no questions or discussion about the consent agenda.

**BOARD ACTION**

A motion was made by Mr. William Stanford to accept the consent agenda; seconded by Ms. Lodies Gloston. Motion passed unanimously.
**AGENDA ITEMS:**

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<th>7. Training</th>
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**DISCUSSION:**

A. Data Analytics Roadmap – page 170

Alliance is committed to expanding and enhancing its current analytic capabilities to improve business reporting, quality of care, the cost of care and member experience. Michael Bollini, Chief Strategy Officer, provided an overview of the progress of the data analytics roadmap and noted changes in staff roles to implement this program. He shared about performance metrics and characteristics of analytics delivery maturity; Dr. Bollini concluded with the overall benefit of the analytics program: to provide data to best determine next steps, to provide aggregate data to providers, and to provide data regarding social determinants and varying population demographics (for the catchment area and local communities).

Board members discussed applicable uses and requested a timeline for program implementation milestones. Dr. Bollini mentioned that the data discovery milestone is August 2016 and that an update will be provided to the Board if requested. The presentation of the data analytics roadmap is attached to and made part of these minutes.

B. Strategic Plan Goal #5: Attract and Retain a Talented Workforce – page 183

Al Ragland, Chief HR Officer, reviewed the following: Alliance’s performance management system and its alignment to the strategic plan; training series for supervisors, management and executive leadership; employee development system with nearly 9,000 hours of training within the past year; newly initiated wellness program and reward and recognition program; ongoing internal communications plan; social committee activities (including annual All-Staff training); current staff demographics, turnover and time to fill rates.

Mr. Robinson shared the positive impact from the activities that the social committee coordinates. He commended social committee chair, Anita Hoggard, Training Specialist. Board members requested information regarding turnover rate with other NC MCOs, state and county agencies. Mr. Ragland shared that for the information currently available, Alliance’s rates are better. He will provide an update when additional information is available. Additionally, Board members requested information regarding if future wellness programs could be used to impact insurance coverage (enrollment in wellness plan could lower premium rates). Mr. Ragland shared that this is being pursued; he also stated that as Alliance is self-insured, it has produced over 10% projected savings. The presentation of the strategic plan goal five update is attached to and made part of these minutes.

**BOARD ACTION**
The Board received the trainings; no additional action required.
AGENDA ITEMS:

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| 8. Updates   | A. Senate Bill 208 – page 206  
Kelly Goodfellow, CFO, presented an update on SB 208 audit performed by an external consultant (HMS) per legislative guidelines/requirements. Ms. Goodfellow noted that Alliance received results from the September review of March-August 2015; she noted all findings were favorable. The data from all NC MCOs is also provided to NC DHHS Secretary, Rick Brajer. The presentation of the Senate Bill 208 audit is attached to and made part of these minutes.  
B. Medicaid Reform/Consolidation  
Mr. Robinson reminded Board members of Secretary Brajer’s Medicaid reform plan. He mentioned the State’s 1115 innovations waiver application and how it moves physical healthcare to a capitated rate plan under which MCOs already operate. The secretary’s plan includes three state-wide commercial managed care companies and up to twelve PLEs (provider led entities). MCOs are left as is through July 1, 2023. The draft 1115 waiver is currently being vetted primarily through a series of twelve listening sessions convened by the DHHS across the North Carolina.  
Also, Mr. Robinson mentioned the March 17, 2016, meeting with Secretary Brajer and NC LME/MCO CEOs; at this meeting Secretary Brajer shared his plan regarding MCO consolidation; this included his plan for a merger between Alliance and Sandhills LME/MCOs. |
| 9. Chairman’s Report | Chairman Bostock reminded Board members that next month’s Board meeting is at Alliance’s corporate site. |
| 10. Closed Session | BOARD ACTION  
A motion was made by Dr. George Corvin to enter closed session pursuant to per § 143-318.11 (a) (6) to consider the qualifications, competence, and performance of an employee; seconded by Dr. John Griffin. Motion passed unanimously.  
The Board returned to open session. |
| 11. Adjournment | With all business being completed the meeting adjourned at 6:30 p.m. |

Next Board Meeting  
Thursday, May 05, 2016  
4:00 – 6:00
ITEM: Consumer and Family Advisory Committee (CFAC) Report

DATE OF BOARD MEETING: April 7, 2016

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

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

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

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

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

REQUEST FOR AREA BOARD ACTION:
The Alliance CFAC subcommittees met in Wake and Durham County. The Cumberland subcommittee hosted a Mental Health First Aid Youth training at the Cumberland office in March. Minutes and supporting documents are included for your review.

CEO RECOMMENDATION:
Receive the draft minutes.

RESOURCE PERSON(S):
Caroline Ambrose, CFAC Chair; Doug Wright, Director of Consumer Affairs

(Back to agenda)
**MEMBERS PRESENT:** Joe Kilheimer, Steve Hill, Tammy Harrington, Dan Shaw, Brynda Saunders  
**Alliance Staff:** Doug Wright, Yancee Pérez  
**GUEST(S) PRESENT:** Marjorie Young, C.J. Lewis (State Liaison)

1. **WELCOME AND INTRODUCTIONS:** Steve welcomed everyone and the meeting began at 5:30 p.m.

2. **REVIEW OF THE MINUTES:** Minutes were reviewed but not approved as there was not a quorum present.

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<td>Public Comment</td>
<td>No public comment made.</td>
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<td>Consumer/Family Concerns</td>
<td>No consumer/family concerns mentioned.</td>
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<td>Call In Meetings- Steve Hill</td>
<td>Steve asked the CFAC members present if setting up a call-in number was of interest. CFAC members replied that this would be helpful. Doug and Steve spoke about the technicalities of setting up a phone number for the next meeting. Doug will put the phone number on the next meeting’s agenda.</td>
<td>Doug and Steve to connect regarding the set-up of a call-in number.</td>
<td>Next Durham Subcommittee meeting: May 2016</td>
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<td>Subcommittee Ideas and Work Meeting Set-Up</td>
<td>Yancee presented an opportunity for discussion regarding the subcommittee workgroups: Services, Rules, Communication. One suggestion from an ELT member was to consider setting up a time, space, and location for members to meet, however many CFAC members agreed that this was not the most practical way to meet as many subcommittee members span across counties. It was decided that a phone in meeting would be most suitable. Yancee further inquired as to past subcommittees that were formed and their responsibilities and tasks. Doug replied that the data-com subcommittee historically had been responsible for the CFAC newsletter that served as communication with the community and the state. Also, this committee looked at data from the LME-MCO and what it was doing to meet the goals of the division and reporting.</td>
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<td>IDD Listening Session Update</td>
<td>back concerning that information. After a lack of generated conversation on this topic, Doug encouraged the Durham members to pose the question of why these subcommittees were formed, at the full CFAC meeting next month. Finally the group decided that the subcommittee chairs were responsible for contacting Doug to set up the next phone-in meeting.</td>
<td>Brynda to contact Doug to set up a Services subcommittee phone-in meeting.</td>
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Yancee gave a quick update as to the Innovations Waiver changes from the listening session held on March 3rd in Raleigh. C.J. Lewis said that he would provide the power point presentation via e-mail to CFAC members (it is also listed on this document for viewing, just click the link - >) Yancee noted concerns from individuals in the audience at the listening session, one of which was the blending of personal care services and the in home skill building services. There will be an increase in the reimbursement rate for personal care services, but a decrease in the reimbursement rate for in home skill building. The concern voiced was that individuals primarily receiving in home skill building with little personal care services would receive poorer quality of care. Doug further explained the differences in the definition and reimbursement of in home skill building and personal care services. | 2015 Listening Tours kb.pptx |

Budget Subcommittee Presentation/Gaps and Needs Response | Doug presented the power point that will be shown to the Alliance Board of Directors at the Board Budget Retreat to be held at the end of March. The CFAC chair, Carrie Ambrose, along with others will aid in presenting the information in this power point to the Alliance Board of Directors. Highlighted items that were reviewed in the presentation were: the scope of influence CFAC members have (ex: | |

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<td>SWOT Analysis- C.J. Lewis</td>
<td>Organizations belonging to within the community, the sources from which CFACs information comes from (ex: snap shot surveys and advocacy groups), showcasing how concerns are communicated to the board of directors (ex: gaps and needs report, annual report), and also reviewing the gaps and needs from this year’s findings. For more information or to view the power point.</td>
<td>Please complete and bring to the Alliance CFAC April 4th</td>
<td>Annual local CFAC - self assessment quest</td>
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<td>Alliance Website Navigation/Feedback</td>
<td>C.J. Lewis, the State CFAC Liaison, presented the CFAC members with a questionnaire to determine a baseline as to how each CFAC perceives itself with its ability to fulfill the statutory requirements. The staff members of the Community Engagement &amp; Empowerment Team are asking that CFAC members complete this simple two page questionnaire and bring it to your next CFAC meeting. See attachment.</td>
<td></td>
<td>Local CFAC- SWOT analysis blank grid.docx</td>
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<td>CFAC Collaborative</td>
<td>Doug guided the Durham CFAC members through the Alliance website, answering questions and showing where information can be found and accessed. Feedback from those present regarding the website was overall positive.</td>
<td>If interested in the Statewide CFAC Collaborative please email Doug before Friday 3/18/16, that he may make arrangements for your registration and lodging.</td>
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<td>NAMI Walk</td>
<td>There is a Statewide CFAC Collaborative meeting hosted by Smoky Mountain LME/MCO CFAC on Friday, April 22nd. This will be in downtown Asheville. Doug would like to know if there is anyone interested in attending this as a representative from the Durham community.</td>
<td>You are welcome to contact Yancee Perez if you need assistance signing up for the NAMI Walk 2016 or if you would like to volunteer at the CFAC table.</td>
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<tr>
<td>MCO Updates</td>
<td>No MCO updates given at this time.</td>
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<td>State Updates</td>
<td>State updates were reviewed by C.J. Lewis and the Consumer Empowerment Team document was passed out to all in attendance.</td>
<td>If you need an electronic copy please contact either Yancee Pérez: <a href="mailto:yperez@AllianceBHC.org">yperez@AllianceBHC.org</a> or C.J. Lewis: <a href="mailto:Chris.J.Lewis@dhhs.nc.gov">Chris.J.Lewis@dhhs.nc.gov</a> and they are able to send one via email.</td>
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<tr>
<td>Announcements</td>
<td>No additional announcements were made.</td>
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5. **ADJOURNMENT**
Meeting adjourned
7:35 p.m.
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – minutes were not reviewed due to the lack of a quorum.

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<tr>
<td>Public Comment/Consumer and Family Challenges and Solutions</td>
<td>None</td>
<td>N/A</td>
<td>N/A</td>
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<td>MCO Updates – budget retreat presentation</td>
<td>Doug presented the power point presentation for the board budget retreat on March 29th. Members were pleased with the presentation and had no additional feedback.</td>
<td>Budget Presentation</td>
<td>March 29th</td>
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<td>State Updates</td>
<td>CJ reviewed the state Consumer Empowerment Team quarterly update. He also passed out information on the CFAC collaboration meeting being held in Asheville on April 22nd. CJ ask members to complete a questionnaire about CFAC, would like to do a SWOT analysis, not enough members to do that tonight.</td>
<td>N/A</td>
<td>N/A</td>
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| NAMI Walk | NAMI Carolina Walk:  
 **Location:** Dorothea Dix Campus, Raleigh  
 **Date:** 05/07/2016  
 **Distance:** 2 Miles  
 **Check-in:** 9:00 AM  
 **Start Time:** 10:00 AM  
 CFAC Table – volunteers – members were reminded of their commitment to this event. Israel will participate, Denise will be out of town. | Participate | May 7th |
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<td>I/DD Presentation</td>
<td>Doug presented information on I/DD and the services provided by Alliance. Members valued the information and felt it was presented well.</td>
<td>N/A</td>
<td>N/A</td>
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<td>Subcommittee Ideas/solutions</td>
<td>Israel took the time to review the Rules Committee’s work so far on the by-laws. We went through the changes, made comments and got clarification. Additional sections to be reviewed and updated and the final product to be presented to the CFAC ELT. A discussion was had around the lack of attendance, some we knew about, others were just no shows. Expectations of participation need to be clear in the new by-laws.</td>
<td>Present to the CFAC ELT for inclusion at a regular meeting of the full CFAC.</td>
<td>March/April</td>
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<td>Snap Shot Surveys</td>
<td>Members were reminded to complete snap shot surveys.</td>
<td>Collect</td>
<td>Ongoing</td>
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5. ADJOURNMENT
Intellectual/Developmental Disabilities and the Services Provided by the Alliance Provider Network
How NC Defines I/DD

A severe, chronic disability of a person:

• Attributable to a mental or physical impairment or a combination of both

• Manifested before age 22, unless caused by traumatic brain injury at any age

• Needs special, interdisciplinary, generic services, individual supports, or other assistance of a lifelong or extended duration
How NC Defines I/DD

• Likely to continue indefinitely, with substantial functional limitations in three or more areas of major life activity:
  o Self-care
  o Receptive (understanding) and expressive language
  o Learning mobility (ability to move)
  o Self-direction (motivation)
  o Capacity for independent living
  o Economic self-sufficiency
How NC Defines I/DD

• An individual aged 0-9 with a substantial developmental delay or congenital or acquired condition, without meeting three “areas of major life activities”
  o If the individual has a high probability of meeting those criteria later in life without services and supports
Common DD Diagnoses

• Down syndrome
• Asperger’s syndrome
• Autism
• Traumatic Brain Injury (TBI) caused by blunt force trauma
• Cerebral palsy
• Intellectual disability (IQ < 70)
• Spina bifida
NC Innovations Eligibility

• Medicaid Waiver for children and adults with I/DD

• Eligible for Medicaid based on assets/income, family income is ‘waived’ for minor children

• Resident of Durham, Wake, Cumberland or Johnston counties (for the purposes of Medicaid eligibility)
NC Innovations Eligibility

• Live in an ICF-MR facility and wish to leave or at high risk of placement in an ICF-MR

• Choosing to participate in NC Innovations rather than live in an institution (ICF-MR)

• Need for NC Innovations services as specified in the person-centered Individual Support Plan

• Requires using at least one NC Innovations service monthly
NC Innovations Eligibility

AND

• Health, safety, well-being can be maintained in the community under NC Innovations within the $135,000 annual waiver cost limit

AND

• Live in a private residence or in a licensed facility with six or fewer persons

• Unrelated to the owner of the facility
NC Innovations Eligibility

• Individual’s needs meet ICF-MR (Intermediate Care Facility for those with ID) level of care
Meeting ICF-MR Level of Care

• Require active treatment
  o Aggressive, consistent program of specialized and generic training, treatment and health services
  o Does not include service to maintain generally independent persons able to function with little supervision or without an active treatment program
AND

• Diagnosis of Intellectual Disability (ID) or a closely-related condition
  - Characterized by significant limitations in intellectual functioning and adaptive behavior as expressed in conceptual, practical and social skills
  - Must occur before the age of 18
  - Refers to individuals with severe, chronic disability attributable to cerebral palsy or epilepsy that occurred before the age of 22
Meeting ICF-MR Level of Care

OR

• Any condition (other than mental illness) closely related to ID because it results in impairment of general functioning or adaptive behavior similar to a person with ID

• Manifested before the person reaches age 22

• Likely to continue indefinitely
Meeting ICF-MR Level of Care

AND

• Substantial functional limitations in three or more of the following areas of life activity:
  o Self-care
  o Understanding/use of language
  o Learning
  o Mobility
  o Self-direction
  o Capacity for independent living
Registry of Unmet Needs

• If funding is not available for needed NC Innovations services at the time of enrollment of an individual potentially eligible for NC Innovations

• Placed on Registry for their county of residence until funding available

• Prioritized for funding based on the date and time of referral to NC Innovations
Registry of Unmet Needs

- People with emergency needs who meet specific criteria are offered emergency reserved capacity funding, if available
  - When funds not available, alternative resources identified to ensure health and safety

- Available funding assigned geographically in each counties where NC Innovations operating
  - Based on Medicaid per capita population
Alliance I/DD Services

• Community Guide
  o Advocacy and assistance in developing social networks and connections in the community

• Vocational/Day Activity Services
  o Long-term follow-along support to help maintain employment once employed
  o Facility-based programs (ADVP) for individuals not ready for or capable of competitive employment
  o Leisure and Retirement services for older adults
Alliance I/DD Services

- **Skill Development**
  - Periodic one-on-one skill development/training

- **Residential Services**
  - ICF-MR group homes
  - Group living for adults
  - Alternative family living
  - Semi-independent and supported living

Serving Durham, Wake, Cumberland and Johnston Counties
Alliance I/DD Services

• Respite Care
  o In-home supervision and care to provide relief for primary caregivers
B3 Medicaid Services

• Community Guide and Respite
• For individuals with Medicaid who are not on Innovations
• Funded through projected cost savings
• Obtained through regular authorization procedures
• Must meet medical necessity
Inclusion: A Basic Tenant

• Inclusion is about ALL of us
• About living full lives and learning to live together
• Makes the world our classroom for a full life
• Treasures diversity and builds community
• About our “abilities” and how to share them
• NOT just a “disability” issue
Community Resources

• The Arc of NC
  www.arcnc.org

• Autism Society of NC
  www.autismsociety-nc.org

• Brain Injury Association of NC
  www.bianc.net

• Disability Rights North Carolina
  www.disabilityrightsnc.org
Community Resources

• NC Council on Developmental Disabilities  
  www.nc-ddc.org

• NC Dept. of Health and Human Services  
  www.ncdhhs.gov

• NC Division of Medical Assistance (Medicaid)  
  www.ncdhhs.gov/dma

• Alliance CFAC  
  www.alliancebhc.org/about-alliance/alliance-cfac
WHO WE ARE?

Alliance CFAC

Wake Subcommittee

Board of Directors

Durham Subcommittee

Cumberland Subcommittee

Johnston CFAC Interlocal Agreement
Scope of Influence

Peer Support Specialist
Board Member, The Arc of the Triangle
Board Member, Durham County Community Living Program
Wellness City Citizen
NAMI Wake
NAMI Durham
NAMI Cumberland/Harnett/Lee
Americans with Disabilities Act, Cumberland Chapter
Special Olympics
Advocacy and Leadership Committee, NC Council on Developmental Disabilities
State CFAC
First in Families
Homeless Veteran’s Council
Alliance Human Rights Committee
SOURCES OF INFORMATION

• SNAP SHOT SURVEYS
• COMMUNITY OUTREACH ACTIVITIES (resource fair, Anonymous People film showing)
• PERSONAL EXPERIENCE – as well as those experiences shared with us by community members.
• ADVOCACY GROUPS
Snap Shot Survey

1) In thinking in this very minute - what suggestion would you make to have CFAC be a more meaningful experience?

2) Name two goals that you would like CFAC to accomplish in the next 4 months.

3) In thinking about your community at this very moment - is there a gap in services or a service that needs addressing?

4) Please note any areas of concern as it relates to the cultural competence of Alliance or the providers in our network.

5) In thinking about CFAC's "advisory" role - make a suggestion that you think the Alliance BHC Board should take on or address.

Members are encouraged to fill out a Snap Shot Survey at each meeting attended and whenever they have concerns or ideas they feel the need to share.
HOW WE COMMUNICATE OUR CONCERNS TO ALLIANCE AND THE BOARD OF DIRECTORS

• ANNUAL REPORT
• MONTHLY MINUTES AND REPORTS
• GAPS AND NEEDS ANALYSIS
• BUDGET RETREAT
• PARTICIPATION ON GLOBAL QUALITY MANAGEMENT AND HUMAN RIGHTS COMMITTEES
SOCIAL DETERMINANTS OF HEALTH

Note of interest: In every forum or avenue utilized to gather input, these common themes around healthy communities were repeated often.

• AFFORDABLE AND ACCESSIBLE HOUSING
• TRANSPORTATION
• EMPLOYMENT
• EDUCATION
I/DD SERVICE GAPS AND NEEDS

• INNOVATIONS SLOTS
• DIRECT CARE WORKERS – the shortage of qualified workers is having a major impact on authorized services being utilized.
• ASSISTIVE TECHNOLOGY
• CRISIS RESPITE
• CASE MANAGEMENT
• EFFECTIVE SCHOOL INCLUSION
MENTAL HEALTH GAPS AND NEEDS

- PEER RUN RESPITE
- RECOVERY CENTERS
- PSYCHIATRIC APPOINTMENTS – especially for females preferring same gender services
- EFFECTIVE PEER SUPPORT
- ACCESSIBLE SERVICES
- CRISIS SERVICES FOR CHILDREN – Cumberland County
SUBSTANCE USE DISORDERS
GAPS AND NEEDS

• MEDICAL DETOXIFICATION
• SOCIAL DETOXIFICATION
• EXPANDED TREATMENT OPTIONS – most SUD consumers don’t have insurance, not many options or at best long wait lists.
• RECOVERY CENTERS
• YOUTH SERVICES
SPECIALTY POPULATIONS

- LGBTQ — CULTURALLY APPROPRIATE SERVICES
- DEAF COMMUNITY — ACCESS AND AVAILABILITY
- NON ENGLISH SPEAKING — ACCESS AND AVAILABILITY
- TRANSITIONS AGE YOUTH
- VETERANS AND FAMILIES
SYSTEMIC CONCERNS

- MEDICAID EXPANSION
- COLLABORATIVE/INTEGRATED SERVICES
- THE DIGITAL DIVIDE
- TRUST IN THE SYSTEM
- CONTINUED STATE FUNDING CUTS
- STIGMA
SYSTEMIC CONCERNS

ALLIANCE BENEFIT PLANS

Currently every community has a different benefit plan for state and indigent services.

This is not only confusing but reinforces the idea of the “haves and the have nots.”
CLOSING

Thanks for having us participate today, we will leave you with a quote that was used in the Recovery and Self Determination Trainings.

You can never change things by fighting the existing reality.
To change something, build a new model that makes the existing model obsolete.”

Buckminster fuller
ITEM: Finance Committee Report

DATE OF BOARD MEETING: April 7, 2016

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, February 04, 2016  BOARD FINANCE COMMITTEE

APPOINTED MEMBERS PRESENT: ☒ James Edgerton, Chair; ☒ George Quick, MBA, ☐ John Griffin; ☒ Vicki Shore ☐ Chris Bostock
BOARD MEMBERS PRESENT: Kenneth Edge, Amelia Thorpe
STAFF PRESENT: Rob Robinson, CEO; Kelly Goodfellow, CFO; Sara Pacholke, Controller

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the 12/3/2015 meeting were reviewed; a motion was made by Vicki Shore and seconded by George Quick.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
</table>
| 3.           | The monthly financial reports were discussed which includes the Statement of Net Position, Statement of Revenue and Expenses – Actual to Budget, Senate Bill 208 Required Ratios, and DMA Contract Ratios  
   a) Statement of Net Position as of December 31, 2015  
   b) Statement of Revenue and Expenses – Actual to Budget as of December 31, 2015 – Alliance currently has revenues exceeding expenses of $21,811,000. The majority of this is related to Medicaid and Medicaid risk reserve.  
   c) Senate Bill 208 Ratios - Alliance is currently meeting and exceeding all required Senate Bill 208 ratios.  
   d) DMA Contract Ratios - Alliance is not currently meeting the Medicaid Expense Ratio. The ratio requirement changed to only calculate based on the current year (previously it was from the life of the program) and the ratio benchmark was increased to 85% to align with private sector’s benchmark (previously it was 80%). There is a 6 month grace period to allow time for service expenses to build up during the year. MCO’s are still in discussion with DMA regarding the way the ratio is calculated. MCO’s are proposing certain administrative costs are included in the expense portion of the ratio calculation (activities that contribute to the quality of care). The private sector includes these costs in their calculation, however the | Sara Pacholke will continue to update the finance committee on the results of discussions with DMA regarding how the Medical Expense Ratio is calculated. | |

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
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</thead>
<tbody>
<tr>
<td>current DMA calculation excludes these costs. George Quick requested that we include the current ratio calculation as well as the proposed ratio calculation on the reports.</td>
<td></td>
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</tr>
<tr>
<td>4.</td>
<td>Kelly Goodfellow discussed the proposed budget amendment. There is a proposed increase of $45,559,953. The majority of this is related to Medicaid services, Medicaid risk reserve and Medicaid administration due to a change in projections. In addition, a fund balance appropriation was included to offset the state funding reductions. A motion from George Quick was seconded by Vicki Shore to approve the budget amendment.</td>
<td>The Finance Committee will recommend that the Board approve the budget amendment.</td>
<td></td>
</tr>
</tbody>
</table>

4. ADJOURNMENT

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
## APPOINTED MEMBERS PRESENT:
- ☐ James Edgerton, Chair;
- ☒ George Quick, MBA;
- ☒ John Griffin;
- ☐ Vicki Shore
- ☐ Chris Bostock

## BOARD MEMBERS PRESENT:

## STAFF PRESENT:
- Kelly Goodfellow, CFO;
- Sara Pacholke, Controller, Kelly Phillips, Director of Budget and Financial Analysis

### 1. WELCOME AND INTRODUCTIONS

### 2. REVIEW OF THE MINUTES

A quorum was not met so the minutes from the 2/4/2016 meeting will be reviewed and approved at the next meeting.

### AGENDA ITEMS:

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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</thead>
<tbody>
<tr>
<td>3.</td>
<td>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</td>
<td>Sara Pacholke will continue to update the finance committee on the results of discussions with DMA regarding the ratio change in the contract.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) Statement of Revenue and Expenses – Actual to Budget as of January 31, 2015 – Alliance currently has revenues exceeding expenses of $27,811,000. The majority of this is related to Medicaid and Medicaid risk reserve.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Senate Bill 208 Ratios - Alliance is currently meeting and exceeding all required Senate Bill 208 ratios.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) DMA Contract Ratios – Alliance is currently meeting and exceeding the defensive interval ratio. Alliance is not currently meeting the Medicaid Expense Ratio. MCO’s are negotiating with DMA to change the ratio to the Medical Loss Ratio (MLR). This ratio includes certain administrative costs in the expense portion of the ratio calculation (activities that contribute to the direct quality of care). The private sector includes these costs in their calculation, however the current DMA calculation excludes these costs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Kelly Phillips discussed the agenda for the budget retreat (March 29, 2016). She requested the Finance Committee share any topic suggestions with her.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>Kelly Goodfellow went over the reinvestment plan that she will be presenting at the full board meeting.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. **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 29, 2016

<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>$36,294,009.00</td>
<td>$2,078,931.75</td>
<td>$25,264,602.79</td>
<td>$11,029,406.21</td>
<td>69.61%</td>
</tr>
<tr>
<td>State &amp; Federal Grants</td>
<td>54,491,655.00</td>
<td>3,591,199.33</td>
<td>29,701,938.43</td>
<td>24,789,716.57</td>
<td>54.51%</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>372,401,144.00</td>
<td>30,399,452.63</td>
<td>242,799,296.76</td>
<td>129,601,847.24</td>
<td>65.20%</td>
</tr>
<tr>
<td>In Kind</td>
<td>-</td>
<td>-</td>
<td>1,051,365.04</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>463,186,808.00</td>
<td>36,069,583.71</td>
<td>298,817,203.02</td>
<td>165,420,970.02</td>
<td>64.51%</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>364,086.00</td>
<td>20,789.33</td>
<td>252,275.47</td>
<td>111,810.53</td>
<td>69.29%</td>
</tr>
<tr>
<td>LME Administrative Grant</td>
<td>4,395,385.00</td>
<td>363,282.13</td>
<td>2,906,256.50</td>
<td>1,453,128.50</td>
<td>66.67%</td>
</tr>
<tr>
<td>Medicaid Waiver Administration</td>
<td>47,325,972.00</td>
<td>3,950,047.97</td>
<td>31,545,752.34</td>
<td>15,780,219.66</td>
<td>66.66%</td>
</tr>
<tr>
<td>Miscellaneous Revenue</td>
<td>100,000.00</td>
<td>5,483.10</td>
<td>22,436.44</td>
<td>77,563.56</td>
<td>22.44%</td>
</tr>
<tr>
<td><strong>Total Administrative Revenue</strong></td>
<td>52,149,443.00</td>
<td>4,339,602.53</td>
<td>34,726,720.75</td>
<td>17,422,722.25</td>
<td>66.59%</td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td>515,336,251.00</td>
<td>40,409,186.24</td>
<td>333,543,923.77</td>
<td>182,843,692.27</td>
<td>64.72%</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>36,294,009.00</td>
<td>6,653,084.80</td>
<td>23,912,420.79</td>
<td>12,381,588.21</td>
<td>65.89%</td>
</tr>
<tr>
<td>State &amp; Federal Services</td>
<td>54,491,655.00</td>
<td>5,085,305.93</td>
<td>36,644,229.68</td>
<td>17,847,425.32</td>
<td>67.25%</td>
</tr>
<tr>
<td>Medicaid Waiver Services</td>
<td>372,401,144.00</td>
<td>25,425,313.48</td>
<td>216,433,200.54</td>
<td>155,967,943.46</td>
<td>58.12%</td>
</tr>
<tr>
<td>In Kind Expenses</td>
<td>-</td>
<td>-</td>
<td>1,051,365.04</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td><strong>Total Service Expenses</strong></td>
<td>463,186,808.00</td>
<td>37,163,704.21</td>
<td>278,041,216.05</td>
<td>186,196,956.99</td>
<td>60.03%</td>
</tr>
<tr>
<td><strong>Administrative</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operational</td>
<td>7,160,467.00</td>
<td>412,040.85</td>
<td>3,664,694.75</td>
<td>3,495,762.25</td>
<td>51.18%</td>
</tr>
<tr>
<td>Salaries, Benefits, and Fringe</td>
<td>36,090,150.00</td>
<td>2,562,054.62</td>
<td>20,246,666.85</td>
<td>15,843,483.15</td>
<td>56.10%</td>
</tr>
<tr>
<td>Professional Services</td>
<td>8,798,836.00</td>
<td>465,305.15</td>
<td>3,995,700.81</td>
<td>4,803,135.19</td>
<td>45.41%</td>
</tr>
<tr>
<td>Miscellaneous Expense</td>
<td>100,000.00</td>
<td>-</td>
<td>100,000.00</td>
<td>-</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Total Administrative Expenses</strong></td>
<td>52,149,443.00</td>
<td>3,439,400.62</td>
<td>27,907,062.41</td>
<td>24,142,380.59</td>
<td>53.51%</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>515,336,251.00</td>
<td>40,603,104.83</td>
<td>305,948,278.46</td>
<td>210,339,337.58</td>
<td>59.37%</td>
</tr>
</tbody>
</table>

### CHANGE IN NET POSITION

<table>
<thead>
<tr>
<th></th>
<th>Original Budget</th>
<th>Current Period</th>
<th>Year to Date</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>($193,918.59)</td>
<td>$27,595,645.31</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 Expense Ratio (MER)** = Total Service Expenses divided by Total Medicaid Revenue less Risk Reserve Revenue. The benchmark is 85%. This is the ratio requirement per our contract with DMA. MCO’s are held harmless through July 2017.

**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%. This is the ratio that is currently being negotiated with DMA.
ITEM: Draft Minutes from the March 3, 2016, Board Meeting

DATE OF BOARD MEETING: April 7, 2016

REQUEST FOR BOARD ACTION:
Approve the draft minutes from the March 3, 2016, Board Meeting.

CEO RECOMMENDATION:
Approve the minutes.

RESOURCE PERSON(S):
Robert Robinson, CEO; Veronica Ingram, Executive Assistant
## AGENDA ITEMS:

### DISCUSSION:

#### 2. Announcements

| A. | FUTURE DEVELOPMENT WORKGROUP: Chairman Bostock reminded Board members of the next staff workgroup on April 5, 2016, at 4:00 p.m. Board members are invited to attend this meeting and may contact Ms. Ingram to confirm their attendance. |
| B. | LEGISLATIVE LUNCHEON: Chairman Bostock reminded Board members that Alliance’s legislative luncheon is Friday, March 18 from 12:00-2:00 p.m. at the corporate site. |
| C. | BUDGET RETREAT: Additionally, Chairman Bostock reminded Board members of the annual Board budget retreat on Tuesday, March 29 from 12:30-4:30 p.m. Additional details are forthcoming. |

#### 3. Agenda Adjustments

There were no adjustments to the agenda.

#### 4. Public Comment

There were no public comments.

#### 5. Committee Reports

A. Consumer and Family Advisory Committee (5 minutes) – page 5

The Alliance Consumer and Family Advisory Committee (CFAC) is composed of consumers and/or family members from Durham, Wake, or Cumberland counties who receive mental health, intellectual/developmental disabilities or substance use/addiction services. This month’s report included draft minutes from the February CFAC meeting.
AGENDA ITEMS: | DISCUSSION:
The committee reports were sent earlier as part of the Board packet; Doug Wright, Director of Consumer Affairs, presented the report. He provided an update from a recent meeting and announced an upcoming statewide CFAC meeting. Mr. Wright mentioned an update on the recovery and self-determination training, plans to host a table at the upcoming NAMI walk, and participation at the Board budget retreat later this month.

B. Finance Committee (10 minutes) – page 28
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.

George Quick presented the Finance Committee report. Mr. Quick noted that revenues exceeded expenditures and all State required ratios were met except one. As stated previously the medical expense ratio is being replaced by the medical loss ratio. Six of the eight NC MCOs currently do not meet the current medical expense ratio. Staff are working on implementing the new definition requirements. Additionally, Mr. Quick reminded Board members of the upcoming budget retreat and reinvestment plan. Mr. Robinson shared that the medical loss ratio methodology and definition have changed and MCOs are held harmless through July 2017; steps are being taken to ensure Alliance meets this new requirement.

C. Policy Committee – page 35
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. This month’s report included draft minutes from the February meeting.

Curtis Massey, Committee Chair, presented the report. He noted that the following policies are being recommended for approval for without revision: Client Rights to Confidentiality; Client Rights to Dignity, Privacy, and Humane Care; Consumer Choice; Coordination of Care for Special Health Care Populations; Advanced Directives and Advanced Instructions; Management of Incidents Policy; Management of Investigation of Grievances; Consumer, Provider and Stakeholder Satisfaction; Selection and Retention of Providers; Letters of Support; Rule Waiver Requests; Utilization Review Criteria; Utilization Review Process; Appealing Clinical Utilization Management; Pre-Review Screening for Certification; Accessibility of Utilization Review/Utilization Management Process; and Financial Eligibility.

Mr. Massey provided detailed information regarding the recommended revisions for three policies: Customer Services; Area Board Conflict of Interest; and Provision of Services by Relatives/Legal Guardians.
## AGENDA ITEMS:

<table>
<thead>
<tr>
<th>BOARD ACTION</th>
<th>DISCUSSION:</th>
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<tbody>
<tr>
<td><strong>A motion was made by</strong> Mr. McKinley Wooten <strong>to approve the submitted policies; seconded by Dr. John Griffin. Motion passed unanimously.</strong></td>
<td></td>
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</tbody>
</table>
B. Executive Committee Report – page 72  
C. Network Development and Services Committee Report – page 81  
D. Quality Management Committee Report – page 149 |
| There were no comments or discussion about the consent agenda. | |
| **BOARD ACTION** | A motion was made by Vice-Chair Cynthia Binanay to approve the consent agenda; seconded by Mr. William Stanford. Motion passed unanimously. |
| 7. Reinvestment Plan – page 248 | Kelly Goodfellow, CFO, and Sean Schreiber, Chief Clinical Officer, presented a detailed overview of Alliance’s reinvestment plan. The overview included background behind the purpose for the plan and an outline of the two-year reinvestment strategy through FY16 and into FY17. Mr. Schreiber provided a detailed review of eight focus areas. Ms. Goodfellow provided information regarding funding, projections, management of the reinvestment plan and a sustainability plan.  
Board members discussed the plan and requested to include it in the upcoming legislative luncheon on March 18, 2016. Also, Board members mentioned that the reinvestment plan is an opportunity for NC Legislators to invest in public behavioral health without increasing funding. The reinvestment plan is attached to and made part of these minutes. | |
| **BOARD ACTION** | A motion was made by Commissioner Kenneth Edge to approve the reinvestment plan; seconded by Commissioner Caroline Sullivan. Motion passed unanimously. |
Geyer Longenecker, Quality Management Director, provided an update on the report. He reviewed Alliance’s performance compared to the previous year and the statewide average for MCOs. Mr. Longenecker noted that for the second consecutive year Alliance is top rated among NC MCOs in overall provider satisfaction. A copy of the report overview is attached to and made part of these minutes. |
**AGENDA ITEMS:**

<table>
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<tr>
<th></th>
<th>DISCUSSION:</th>
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</table>
| B. | Status of State’s Application for 1115 Waiver  
Mr. Robinson provided an update from the March 1, 2016, Legislative Oversight Committee meeting. He mentioned that most of the conversation was about moving toward a capitated model for physical care. Mr. Robinson shared that the application will most likely change as the State is seeking feedback and most likely CMS (Centers for Medicare and Medicaid Services) will make recommendations: State officials are hosting twelve listening sessions across the state, and there will be additional opportunities for public comment. The State’s waiver application is due to CMS by June 1, 2016. |

**BOARD ACTION**

The Board received the updates. No additional action required.

9. Chairman’s Report  
Chairman Bostock reminded Board members that next month’s meeting will be held in Johnston County. Also, Chairman Bostock invited Board members to attend the March 15, 2016, Executive Committee meeting and participate in the closed session. The Executive Committee will evaluate the CEO and bring a recommendation to the Area Board at the April Area Board meeting.

10. Adjournment  
With all business being completed the meeting adjourned at 5:47 p.m.

---

**Next Board Meeting**  
**Thursday, April 07, 2016**  
**4:00 – 6:00**
ITEM: Audit and Compliance Committee Report

DATE OF BOARD MEETING: April 7, 2016

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

The Committee has met three times this year; quorum was not met for two meetings. This report includes draft minutes for September 10, 2015, meeting and notes for November 19, 2015, and March 10, 2016, meetings.

REQUEST FOR AREA BOARD ACTION:
Accept the report.

CEO RECOMMENDATION:
Accept the report.

RESOURCE PERSON(S):
Lascel Webley, Committee Chair; Monica Portugal, Chief Compliance Officer
APPOINTED MEMBERS PRESENT: ☒Curtis Massey, B.A., J.D., (via telephone) ☐George Quick, B.A., M.B.A., ☒Lascel Webley, Jr., Committee Chair, B.S., M.B.A., M.H.A., ☒McKinley Wooten, Jr., B.A., J.D.

BOARD MEMBERS PRESENT: Chris Bostock (via telephone)

STAFF PRESENT: Robert Robinson, Chief Executive Officer; Monica Portugal, Chief Compliance Officer; Sandy Valdes, Administrative Assistant

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – None

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documents Provided:</td>
<td>Minutes: None Draft Charter, Audit Reporting Schedule</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Overview of Committee</td>
<td>Ms. Portugal discussed purpose and overview of the committee including existing compliance program activities and the Board’s oversight responsibilities. Also discussed communication from committee to the Board.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Review of Draft Charter</td>
<td>Mr. Wooten asked for clarification of function of internal audits. Ms. Portugal gave overview of internal auditor functions including the independence of the auditor/s under the Chief Compliance Officer. Ms. Portugal stated language is included as protection for the Board and Alliance and Mr. Webley reiterated that it is in the best interest of the Board and the organization if it is ever needed. Committee discussed Audit Reporting Schedule; annual process and date of event when external and internal audits occur and when results are released. Committee decided the audit schedule is not predictable enough to schedule meetings around it.</td>
<td></td>
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</tbody>
</table>
### AGENDA ITEMS:

<table>
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<tr>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee discussed Conflict of Interest forms and process. Mr. Robinson will set up a meeting with General Counsel and Chief Compliance Officer to discuss the Conflict of Interest disclosure process.</td>
<td>Ms. Portugal will verify DMA contract for rotation of independent auditor.</td>
<td>October 15, 2015</td>
</tr>
<tr>
<td>Committee suggested changing language for rotation of independent auditor to three years instead of five.</td>
<td>Ms. Portugal will make proposed revisions of Charter, review with General Counsel and send to committee for review.</td>
<td>October 15, 2015</td>
</tr>
<tr>
<td>Mr. Wooten asked about IT audits and system security. Ms. Portugal clarified there are strict policies/procedures for IT system security. Alliance conducted a full Security Risk Assessment 1.5 years ago and are planning to conduct another assessment this year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr. Webley requested an overview of each audit activity at the next meeting.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Other:                                                                 |                                                                                   |                   |
| Committee suggested meeting quarterly. Mr. Massey suggested scheduling a meeting in October. | Meeting scheduled for October 15, 2015.                                           | October 15, 2015  |

3. **ADJOURNMENT:** next meeting will be October 15, 2015, from 4:00 p.m. to 6:00 p.m.

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – Quorum was not met so minutes were not reviewed.

<table>
<thead>
<tr>
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<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documents Provided:</td>
<td>9/10/16 Minutes, Charter, Conflict of Interest Process</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Conflict of Interest Process</td>
<td>Ms. Portugal discussed the proposed process for the Board of Director Conflict of Interest. Members suggested adding language to have COI forms submitted by due date of August 31 each fiscal year. Proposed process should be referred to Board Policy Committee to be incorporated to the current Conflict of Interest policy.</td>
<td>Proposed Conflict of Interest Process will be submitted to Board Clerk for inclusion in the December 3, 2015 Board Packet</td>
<td>November 23, 2015</td>
</tr>
<tr>
<td>Mercer Review &amp; External Quality Review</td>
<td>Mr. Marsh presented overview and results of Mercer report for 2015. Tracking log is kept to manage efforts of how Alliance implements corrective actions and best practice suggestions. Discussed process, reviews from the CMS, Mercer, External Quality Review Organization (EQRO) and corrective actions from the EQR. All information is tracked and monitored by the state through quarterly reports and meetings (IMTs). Mr. Webley asked for clarification if items are audited internally based upon the findings. Mr. Marsh and Ms. Portugal clarified that systemic findings are</td>
<td>N/A</td>
<td>N/A</td>
</tr>
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<td>AGENDA ITEMS:</td>
<td>DISCUSSION:</td>
<td>NEXT STEPS:</td>
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<tr>
<td>Results of Compliance Risk Assessment &amp; Annual Work Plan FY16</td>
<td>Ms. Portugal presented the Compliance Work Plan for FY16. Risk identification requires input from throughout the organization. Identified risk is scored and prioritized. The work plan covers all seven elements including training and education, communication, policies and procedures and standards of conduct, communication, internal audits and monitoring, investigations and remediation. Mr. Webley asked if Johnston county site has access to intranet and if they go through Alliance’s trainings. Ms. Portugal clarified that they have access to the intranet and must follow the Alliance policies and procedures. Compliance and HIPAA training is provided to all Johnston employees. Mr. Webley had questions about monitoring of sanctions list. Ms. Portugal clarified that data is imported from the OIG and SAM exclusions lists and checked against all providers for matches on a monthly basis. Alliance also checks employees and Board members upon hire and minimum annually thereafter.</td>
<td>Ms. Portugal will send out proposed dates to schedule the next meeting in December.</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>The Compliance Department will be present at Alliance’s sites once per month to provide training, technical assistance, monitoring and to be available to employees and supervisors.</td>
<td></td>
<td>November 30, 2015</td>
</tr>
</tbody>
</table>

3. **ADJOURNMENT:** next meeting will be , 2015, from 4:00 p.m. to 6:00 p.m.

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
**APPOINTED MEMBERS PRESENT:** ☒Curtis Massey, B.A., J.D., ☐George Quick, B.A., M.B.A., ☒Lascel Webley, Jr., Committee Chair, B.S., M.B.A., M.H.A., ☐McKinley Wooten, Jr., B.A., J.D.,

**BOARD MEMBERS PRESENT:** Chris Bostock,

**GUEST(S) PRESENT:** None

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

### 1. WELCOME AND INTRODUCTIONS

### 2. REVIEW OF THE MINUTES – Quorum was not met so minutes were not reviewed.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
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<tbody>
<tr>
<td>Meeting Schedule</td>
<td>Two meeting dates were selected for the rest of this year: April 18th and May 11th.</td>
<td>Ms. Portugal will coordinate the next meeting.</td>
<td>April 18, 2016</td>
</tr>
<tr>
<td>Board Member Annual Conflict of Interest Disclosures</td>
<td>All but five disclosure forms have been submitted to the Chief Compliance Officer. It was noted that no conflict which has not already been approved was disclosed. Board members who have not yet submitted their forms should be allowed no more than one additional week to turn in the forms.</td>
<td>Ms. Portugal will send an email to the Board members requesting that disclosure forms are submitted within one week.</td>
<td>One week</td>
</tr>
<tr>
<td>Quarterly Reports</td>
<td>Ms. Portugal reviewed the Corporate Compliance dashboard for FY16 first and second quarters. The dashboard covers internal investigations, internal audits and monitoring, HIPAA incidents, Network Compliance, and Special Investigations. Ms. Portugal provided clarification and answers to questions related to the data.</td>
<td>3rd quarter data will be reported out at the next meeting.</td>
<td>April 18, 2016</td>
</tr>
<tr>
<td>Annual Compliance Work Plan FY16 Update</td>
<td>Committee members received a work plan update in the areas of training and education, communication, policies and procedures and standards of conduct, internal auditing and monitoring. The Compliance Department has fully completed or is in the process of completing 71% of the work plan items. They are implementing a new Compliance software and are currently going through the hiring process for an internal auditor. Once the software is in place.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
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</table>
AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME: |
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External Quality Review Results | has been fully implemented and the auditor hired, the remaining items on the work plan will be initiated. | N/A | N/A |

3. **ADJOURNMENT:** next meeting will be April 18, 2016, from 4:00 p.m. to 6:00 p.m.

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
Alliance External Quality Review (EQR) Summary Report

Alliance 2015 EQR Total Score: 85.64%.
   Met – 85.64%
   Partially Not Met – 7.73%
   Not Met – 0.55%
   Not Evaluated – 6.08%

Alliance 2014 EQR Total Score: 70.17%

LME-MCO function area scores 2015 compared to 2014:

- Administration: 100% / 2014 was 100%
- Provider Services: 100% / 2014 was 62.07%
- Enrollee Services: 58.54% / 2014 was 58.54%
- Quality Improvement: 71.43% / 2014 was 85.71%
- Utilization Management: 89.13% / 2014 was 73.91%
- Delegation: 100% / 2014 was 100%
- State-Mandated Services: 100% / 2014 was 50%

Corrective Action Items: This year Alliance had 15 CAIs to correct as a result of the EQR versus last year’s total of 33. Alliance completed all CAI’s on December 31st.

Best Practice Recommendations (BPRs): This year Alliance has 8 BPRs and last year 18. Alliance will work the BPRs through the quarterly DHHS IMT Meeting review process.
ITEM: County Commissioners Advisory Committee Report

DATE OF BOARD MEETING: April 7, 2016

BACKGROUND:
As stated in Alliance’s by-laws the County Commissioner Advisory Committee’s duties include serving as the chief advisory board to the area authority and to the director of the area authority on matters pertaining to the delivery of services for individuals with mental illness, intellectual or other developmental disabilities and substance abuse disorders in the catchment area. The draft minutes from the March 3, 2016, meeting are attached.

REQUEST FOR AREA BOARD ACTION:
Accept the report.

CEO RECOMMENDATION:
Accept the report.

RESOURCE PERSON(S):
Robert Robinson, CEO
1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the March 3, 2016, meeting were not reviewed.

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<thead>
<tr>
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<tbody>
<tr>
<td>3. Legislative Update</td>
<td>None presented.</td>
<td>Mr. Robinson will discuss the legislative update during the Board meeting.</td>
<td>3/3/2016</td>
</tr>
<tr>
<td>4. Needs and Gaps</td>
<td>NEEDS AND GAPS ANALYSIS: per Mr. Robinson Alliance’s needs and gaps analysis will identify priorities within our communities and will be used to develop the budget. Committee discussed the following services: emergency department admissions, access to care, opioid services, I/DD services for children in Wake county, crisis services, residential services, housing and the need for additional awareness/education about services. Commissioner Edge requested the needs and gaps analysis for Cumberland County by May so County staff may review before preparing the County budget. Also, Dr. Bollini noted that part of the reinvestment plan is building resources over time and at a sustainable rate. CRISIS CONTINUUM: Alliance Behavioral Healthcare (Alliance) continues to pursue additional crisis facilities with the goal of increased assessments to enhance stabilization, particularly for adolescents diverted from PRTF.</td>
<td>a) Mr. Robinson will include the Needs and Gaps analysis in an upcoming Board agenda. b) Mr. Robinson will direct staff to complete the Needs and Gaps analysis by May 2016; he will provide a copy to the Commissioners. c) Mr. Robinson will add better education and communication</td>
<td>a) None specified. b) March 2016; May 2016 c) March 2016 d) March 2016</td>
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<tr>
<td>AGENDA ITEMS:</td>
<td>DISCUSSION:</td>
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<tr>
<td>PREVENTION:</td>
<td>Committee discussed early education programs to increase awareness within the community of available services and to facilitate early treatment (i.e. providing additional brochures to schools to help consumers understand the services available within the community).</td>
<td>to the needs/gaps analysis for all counties. d) Mr. Robinson will add increased communication with VA to needs/gaps analysis.</td>
<td></td>
</tr>
<tr>
<td>SUBSTANCE ABUSE:</td>
<td>Mr. Robinson will determine if opioid addiction is added or needs to be added to the needs and gaps list. Commissioner Sullivan suggested including Wake County pill drop dates and times on Alliance’s website.</td>
<td></td>
<td></td>
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<tr>
<td>HOUSING:</td>
<td>Chairman Bostock shared that homelessness continues to be a major concern. Committee discussed potential technology that could be used for monitoring the number of consumers that are going to veteran services. Commissioner Edge shared that the grant from CTI is helping consumers transition from the detention centers.</td>
<td>Committee discussed services that Tricare provides and those that Alliance provides. Committee discussed need to clarify for stakeholders which services Tricare and Alliance provide.</td>
<td></td>
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5. **ADJOURNMENT**: next meeting will be June 2, 2016, from 3:00 p.m. to 4:00 p.m.
ITEM: Executive Committee Report

DATE OF BOARD MEETING: April 7, 2016

BACKGROUND:
The Executive Committee sets the agenda for Area Board meetings and acts in lieu of the Area Board between meetings. Actions by the Executive Committee are reported to the full Area Board at the next scheduled meeting. Attached are the draft minutes from the March 15, 2016, meeting.

REQUEST FOR AREA BOARD ACTION:
Accept the report.

CEO RECOMMENDATION:
Accept the report.

RESOURCE PERSON(S):
Chris Bostock, Area Board Chair; Robert Robinson, CEO
BOARD EXECUTIVE COMMITTEE MEETING - REGULAR MEETING
4600 Emperor Boulevard, Durham, NC 27703
4:00-6:00 p.m.

APPOINTED MEMBERS PRESENT: □Ann Akland, Services Committee Chair, B.S.; ☒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. (via phone); ☒James Edgerton, Finance Committee Chair, B.S.; ☒Lodies Gloston, Human Rights Committee Chair, B.A., M.A. (entered at 4:09 pm); ☒Curtis Massey, Policy Committee Chair, B.A., J.D. (via phone; exited at 5:39 p.m.); ☒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): None
STAFF PRESENT: Amanda Graham, Chief of Staff; 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 16, 2016, Executive Committee meeting were reviewed; a motion was made by Mr. Stanford and seconded by Dr. Corvin to approve the minutes. Motion passed unanimously.

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<tr>
<th>AGENDA ITEMS:</th>
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<tr>
<td>3. Updates</td>
<td>a) NEXT FUTURE DEVELOPMENT WORKGROUP MEETING: Chairman Bostock reminded the Committee that the next meeting is Tuesday, April 6, 2016, at 4:00 pm.</td>
<td>a) Committee members will confirm attendance with Ms. Ingram.</td>
<td>a) 4/6/2016</td>
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<td></td>
<td>b) MARCH 18, 2016, ALLIANCE LEGISLATIVE LUNCHEON: Chairman Bostock reminded Committee members that Alliance’s legislative luncheon is Friday, March 18 at noon.</td>
<td>b) Board members will attend the legislative luncheon.</td>
<td>b) 3/18/2016</td>
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<tr>
<td></td>
<td>c) BOARD SEAT VACANCY – WAKE COUNTY: Mr. Robinson provided an update on the current search and encouraged the Committee to consider additional criteria in filling this seat (i.e. managed care experience)</td>
<td>c) None specified.</td>
<td>c) None specified.</td>
</tr>
<tr>
<td>4. April 7, 2016, Area Board Draft Agenda</td>
<td>Committee reviewed draft agenda and provided input.</td>
<td>Ms. Ingram will forward the agenda to staff to prepare Board packet.</td>
<td>3/15/2016</td>
</tr>
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</table>

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

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<thead>
<tr>
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<th>TIME FRAME:</th>
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<tr>
<td>5. 457 Plan Loan Provision Amendment to Match 401K Provision</td>
<td>Mr. Ragland mentioned that when Alliance was set up the 401K plan was set up to allow loans, but the 457 plan was not. Both plans were set up by Board resolution so changes require a Board vote. Mr. Ragland requested a similar set up for both the 457 and 401K plans.</td>
<td>Ms. Ingram will add the topic to the April Board agenda.</td>
<td>3/15/2016</td>
</tr>
<tr>
<td>6. Closed Session</td>
<td>The Executive Committee held a closed session pursuant to §143-318.11 (a)(6) to consider the qualifications, competence, and performance of an employee. <strong>COMMITTEE ACTION:</strong> A motion was made by Vice-Chair Binanay and seconded by Ms. Gloston to enter closed session pursuant to §143-318.11 (a)(6) to consider the qualifications, competence, and performance of an employee. Motion passed unanimously. The committee returned to open session. Chairman Bostock noted that no action was taken during closed session.</td>
<td>The Executive Committee will hold an additional meeting on March 29, 2016, at 11:30 a.m.</td>
<td>3/29/2016</td>
</tr>
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</table>

7. **ADJOURNMENT:** the next Committee meeting will be March 29, 2016, at 11:30 a.m.

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

DATE OF BOARD MEETING: April 7, 2016

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 9, 2016, meeting.

REQUEST FOR AREA BOARD ACTION:
Accept the report.

CEO RECOMMENDATION:
Accept the report.

RESOURCE PERSON(S):
Ann Akland, Committee Chair; Beth Melcher, Chief of Network Development and Evaluation
**WELCOME AND INTRODUCTIONS**

2. **REVIEW OF THE MINUTES** – The minutes from the February 10, 2016, meeting were reviewed; a motion was made by Mr. Stanford and seconded by Ms. Binanay to approve the minutes. Motion passed unanimously.

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<tr>
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<th>TIME FRAME:</th>
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<tr>
<td>3.</td>
<td>Network Development Plan Update</td>
<td>Committee heard a status update on the network development plan. 14 of the 38 initiatives have been completed and the remainder are on track for completion by the end of the fiscal year. Ann asked about the hours of expansion for open access at Monarch. Current hours at their new offices on Navaho Dr. across from Duke Raleigh on Wake Forest Rd. are 5-7 pm on Tuesdays and Thursdays. This means that they will stop accepting people at 5 so that they can be through the process and seen by 7 pm.</td>
<td>Continue work on initiatives</td>
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<td></td>
<td>Overview of Needs and Gaps Assessment</td>
<td>Carlyle provided overview of process of needs and gaps analysis and reviewed results of analysis. Child and Adolescent Day Treatment and Opioid treatment were the only areas where Alliance did not meet choice and access expectations and we will request waiver from the state. Reviewed areas identified as gaps/needs through stakeholder feedback. These will be incorporated into next year’s network development plan.</td>
<td>Needs and gaps analysis will be submitted to the state and posted on Alliance web site</td>
</tr>
<tr>
<td></td>
<td>Support and Development of PSR Programs</td>
<td>Reviewed history of PSR programs, expectations in service definition and best practices associated with PSR programs. Discussed challenges with PSR programs including low reimbursement, inconsistency in models, and Alliance intends to facilitate a PSR provider collaborative</td>
<td></td>
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</table>

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
AGENDA ITEMS: | DISCUSSION: | NEXT STEPS: | TIME FRAME:
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| quality concerns.Reviewed two evidence based/best practice models Alliance would like to support: ICCD Clubhouse model and the Boston University Rehabilitation model. | to identify and promote best practices, recovery orientation, and model consistency. Will also be reviewing potential rate increases or tiered rates to support best practice models. | |

4. **ADJOURNMENT:** next meeting will be April 13, 2016, from 4:00 p.m. to 5:00 p.m.
# FY16 Network Development Plan Update 3-9-16

## Status Summary

<table>
<thead>
<tr>
<th># of Initiatives</th>
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<tbody>
<tr>
<td>Completed</td>
<td>14</td>
</tr>
<tr>
<td>Almost complete</td>
<td>1</td>
</tr>
<tr>
<td>In progress</td>
<td>23</td>
</tr>
<tr>
<td>Grand Total</td>
<td>38</td>
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</table>

## NDP Objective

<table>
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<tr>
<th>NDP Objective</th>
<th>Project</th>
<th>Status / Updates</th>
<th>% Complete</th>
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</thead>
<tbody>
<tr>
<td>Expand services to meet geographic access and choice standards</td>
<td>Expand Medicaid (b)(3) Individual Support (Cumberland, Johnston)</td>
<td>Completed; selected providers in all counties through RFP process.</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Expand Opioid Treatment availability for Medicaid (Cumberland) and State-funded consumers (Cumberland, Durham, Johnston and Wake).</td>
<td>Developed modified services definition and contract scope of work for Medication-Assisted Treatment with Buprenorphine. Cost model developed and approved by Rate Setting, Budget &amp; Finance and UM committees. The modifier will increase options for provision of evidence-based medication assisted treatment for SA and enable tracking of EBP use. The next step is adding this service to contracts.</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td>Develop Medication Assisted Treatment programs in all counties</td>
<td></td>
<td></td>
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<tr>
<td>Add State-funded PSR services in Cumberland County.</td>
<td>Add State-funded PSR services in Cumberland County</td>
<td>Completed; added contract for state-funded PSR in Cumberland County.</td>
<td>100%</td>
</tr>
<tr>
<td>Add State-funded SACOT in Durham County</td>
<td>Add State-funded SACOT in Durham County</td>
<td>Completed; added contract for state-funded SACOT in Durham County.</td>
<td>100%</td>
</tr>
<tr>
<td>Develop a more uniform State benefit package across the four-county Alliance area</td>
<td>Develop a more uniform State benefit package across the four-county Alliance area</td>
<td>Reviewed Alliance benefit plan for state-funded services to identify county-specific variation and developed recommendations for addressing disparities. Results will be included in 2016 Community Needs Assessment and will be</td>
<td>100%</td>
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<tr>
<td>NDP Objective</td>
<td>Project</td>
<td>Status / Updates</td>
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<tr>
<td><strong>Expand capacity for crisis, hospital diversion and respite services for all ages/disabilities</strong></td>
<td>Assure the availability of high quality, accessible and effective Mobile Crisis services in all counties and increase capacity</td>
<td>Completed review of Mobile Crisis data and potential services models. Preparing Scope of Work for mobile crisis management that will reflect recommendations for service models and scope of mobile crisis coverage.</td>
<td>75%</td>
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<tr>
<td></td>
<td>Expand access to and capacity of walk-in crisis centers (Behavioral Health Urgent Care Centers), including evening hours (Tier II Same Day Access)</td>
<td>Completed inventory of Same Day Access providers and developed survey regarding service accessibility and barriers to SDA implementation. Survey completed and additional review of Monarch's Same Day Access model is in process. Obtained funding for expansion of Same Day Access to include evenings, and Monarch will begin offering expanded evening hours 4/1/16. Further analysis will assist with identifying challenges, opportunities and cost model assumptions for further development.</td>
<td>75%</td>
</tr>
</tbody>
</table>
|                                                                              | Expand/Enhance Capacity of Facility Based Crisis                        | *Completed RFP process for Durham Crisis services and selected provider.  
*Posted RFP for additional Wake crisis facility and vendor, Monarch, has been selected. Implementation plans are being developed and Monarch is exploring potential facility locations. | 75%        |
<p>|                                                                              | Provide education to urgent care and primary care practices about Alliance and crisis response resources and how to access them, including Open Access, mobile crisis, facility based crisis | Obtained information from CCNC to identify priority practices for training. Met with CCNC to develop joint training information, and setting up primary care/behavioral health provider meetings. Purchased software to run routine reports on primary care practices with high number of behavioral health consumers. Integrated Care Director has been hired and started Feb. 2. CMT has been implemented with initial focus on notification for consumers who did not fill antipsychotic medication prescriptions and notifying PCPs about potential opioid abuse issues. Part of communication | 58%        |</p>
<table>
<thead>
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<tr>
<td></td>
<td>Implement Advanced Practice Paramedics program in Durham</td>
<td>strategy will be to education primary care physicians about non-ED crisis services available to their patients.</td>
<td></td>
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<td></td>
<td>Develop capacity for IDD Crisis Respite</td>
<td>Coordinated training program for Durham CIT-certified EMS paramedics to receive additional on-line training. Both Wake and Durham EMS have completed webinar training. We received allocation letters for Wake and Durham to be reimbursed for alternative drop off destinations.</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Review outcomes for rapid response crisis diversion services for children and adolescents</td>
<td>Working with provider, New Hope, to identify and implement service model for short-term (30-45 days) PRTF for children with autism. New Hope is evaluating models from other states.</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>Implement Critical Time Intervention (CTI) in Cumberland</td>
<td>Completed selection of provider through RFP and have implemented services in Cumberland.</td>
<td>100%</td>
</tr>
<tr>
<td>Increase breadth, access and quality of residential options</td>
<td>Evaluate transitional living outcomes and capacity and determine need for expansion</td>
<td>Project initiated and assigned to Tamara Smith. Project Advisory Team convened and project charter and data analysis have been completed.</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>Develop Comprehensive Assessment for youth with complex needs prior to referral to residential services</td>
<td>Identified provider, reviewed list of standard measures that will be required in assessment, and requested rate proposal from provider. Contract pending with UNC to provide this service, with services expected to begin in January-February 2016.</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Complete residential continuum study- Add recommendations from study</td>
<td>TAC report completed; Alliance will hire director of housing and this position will implement specific project plan to address housing gaps. TAC report was presented to Alliance Board Services Committee on 11/18.</td>
<td>90%</td>
</tr>
<tr>
<td>NDP Objective</td>
<td>Project</td>
<td>Status / Updates</td>
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<tr>
<td>Increase capacity to serve dually diagnosed (IDD/MI) consumers</td>
<td>Implement pilot Youth Villages Choices model for dually diagnosed (IDD/MI) youth</td>
<td>Identified three CHOICES consumers through Care Coordination, and referrals are in process for initial pilot implementation. Augmenting pilot with addition of residential services through RFP.</td>
<td>100%</td>
</tr>
<tr>
<td>Evaluate increased funding support for NC START</td>
<td></td>
<td>Funding has been identified for adolescent START program, based on proposal submitted by Easter Seals UCP. Contract is pending, NC START has hired clinical team lead, and in-home supports team lead, with plan to begin services in mid-January.</td>
<td>100%</td>
</tr>
<tr>
<td>Offer dual diagnosis (IDD/MI) training for Mobile Crisis teams</td>
<td></td>
<td>Completed training.</td>
<td>100%</td>
</tr>
<tr>
<td>Offer training on IDD/MI dual diagnosis issues to large behavioral health practices</td>
<td></td>
<td>Completed training</td>
<td>100%</td>
</tr>
<tr>
<td>Develop plan to address service gaps between enhanced benefit and outpatient services and to address need for case management</td>
<td>Develop alternative service definition for Medicaid-funded outpatient treatment</td>
<td>Working with consultant, Partners MCO and providers to develop proposed alternative service definition. Draft completed and submitted to DMA.</td>
<td>75%</td>
</tr>
<tr>
<td>Develop service definition to fill service gap between ACTT and CST</td>
<td></td>
<td>Working with consultant, Partners MCO and providers to develop proposed alternative service definition. Working on cost model and revision of service definition.</td>
<td>75%</td>
</tr>
<tr>
<td>Increase availability, tracking and oversight of specialty services and evidence-based practices</td>
<td>Increase number of evidence based practices meeting fidelity for substance abuse providers</td>
<td>Working with SA providers through SA Treatment Provider Collaborative, and developed contract to provide individualized provider consultations on EBPs. Requested proposals from SA providers and selected six providers who will received individualized on-site consultations. Consultation has been completed with Cape Fear and written recommendations are being prepared.</td>
<td>70%</td>
</tr>
<tr>
<td>NDP Objective</td>
<td>Project</td>
<td>Status / Updates</td>
<td>% Complete</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td></td>
<td>Contract for EBP models for IIH and require independent fidelity reviews</td>
<td>Meeting monthly with IIH providers to implement change in contract requiring family-oriented EBPs. Multiple meetings and workgroups with providers, developers and implementation resources to refine implementation plans. Developing cost models for training and long-term sustainability of EBPs, in collaboration with providers and EBP developers. Developing contract scopes of work for IIH EBPs for addition to Medicaid contracts effective 7/1/16.</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Develop process for development and implementation of evidence-based practices with external fidelity verification</td>
<td>Completed.</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Promote EBPs for PSR programs including peer led programs, recovery oriented programs, and for dually diagnosed (MH/IDD)</td>
<td>Gathering information about PSR services, EBP models and will prepare written recommendations.</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>Provide Training and Consultation for Providers to promote improved quality and implementation of evidence based practices</td>
<td>Peer Support training was held on November 20 and is scheduled for December 14 for both providers and Alliance staff.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Completed DBT training 11/2-11/6. Working with Behavioral Tech and providers regarding DBT sustainability planning.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Providing SE Collaborative to promote evidence-based MH/SA IPS model supported employment services.</td>
<td>75%</td>
</tr>
<tr>
<td>ID high cost/high need populations and match with EBP</td>
<td>Implement pilots for Youth Villages Intercept model, Kidspeace TFC and Mentor Family Centered Treatment model for high needs youth</td>
<td>Pilots all launched effective July 1.</td>
<td>100%</td>
</tr>
<tr>
<td>NDP Objective</td>
<td>Project</td>
<td>Status / Updates</td>
<td>% Complete</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Implement First Episode Psychosis Program in Wake County</td>
<td>Completed implementation.</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Improve access to services for non-English speaking consumers</td>
<td>Conduct survey of providers with identified services for non-English speaking consumers. Clarify service availability and capacity for more robust bilingual/bicultural program emphasis.</td>
<td>Worked with Alliance Cultural Competency committee to develop provider survey and have posted on website for provider input. Results will be included in 2016 Community Needs Assessment.</td>
<td>85%</td>
</tr>
<tr>
<td>Increased capacity to serve TBI population</td>
<td>Participate in TBI HRSA grant</td>
<td>Screening for TBI through Call Center and collecting data for state analysis. Working with Brain Injury Association of NC and neuroresource facilitator to develop TBI-specific trainings for provider community. *Met with new TBI Specialists at DMH (Scott Pokorny and Travis Williams). Will begin reviewing data through TBI Grant Steering Committee. *DHHS has announced plans for a TBI waiver that will be piloted with Alliance in the first year of the waiver. There are 49 slots attached to the waiver for Alliance.</td>
<td>75%</td>
</tr>
<tr>
<td>Expand integrated behavioral health/medical care</td>
<td>Conduct Inventory of current integrated care initiatives (e.g., Turning Point, Lincoln, UNC WakeBrook; Johnston Public Health, exploring Duke/CBC co-location and reverse co-location; FHR Dartmouth In-Shape, Southlight)</td>
<td>Completed inventory.</td>
<td>100%</td>
</tr>
<tr>
<td>Implement integrated healthcare pilots</td>
<td>Developed charters and project plans for each pilot. Hired consultant to evaluate pilots. Contracts pending for new initiatives with Carolina Outreach, Family Preservation and Easter Seals UCP.</td>
<td></td>
<td>85%</td>
</tr>
<tr>
<td>NDP Objective</td>
<td>Project</td>
<td>Status / Updates</td>
<td>% Complete</td>
</tr>
<tr>
<td>------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Increase availability of resources for transportation</td>
<td>Conduct evaluation of current integrated behavioral health/medical care initiatives and development of recommendations for further expansion</td>
<td>Hired consultant to evaluate pilot projects. Evaluation in process. Consultation report expected Sept. 2016.</td>
<td>60%</td>
</tr>
<tr>
<td>Increase availability of resources for employment</td>
<td>Review transportation initiatives in other states, inventory provider and stakeholders efforts and develop recommendations</td>
<td>Review of transportation initiatives in progress.</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>Increase number of persons receiving MH/SA SE/LTVS</td>
<td>Conducted RFP for SE/LTVS services in Cumberland, selected vendor and in the process of expanding services in Cumberland. Meeting regularly with SE/LTVS providers through collaborative. *NC is now working with several other states and federal government through Vision Quest and Office of Disability and Employment Policy (ODEP) to look at sustainability of IPS at a statewide level. Alliance is participating in this planning process. *We are looking at feasibility of aligning b3 rate and service definition with state rate and service definition. * Project planning with SPMO on increasing TCLI numbers and IPS SE.</td>
<td>67%</td>
</tr>
<tr>
<td></td>
<td>Evaluate impact of MH/SA SE-LTVS</td>
<td>QM will be scheduling brainstorming meeting to begin project.</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>Explore models and supports for consumer-run businesses</td>
<td>Review of consumer-run models in progress.</td>
<td>40%</td>
</tr>
</tbody>
</table>
FY16 Community Needs and Gaps Assessment

Alliance Board Services Committee
March 9, 2016
Overview

• DHHS contract requirement
• Due to State on Friday, April 1
• Requirements include:
  • Geographic access and consumer choice
  • State benefit plan geographic discrepancies
  • Community feedback about needs and gaps
  • Underserved populations
  • Updates on DHHS initiatives
  • Update on FY16 Network Development Plan and initial goals for FY17 Network Development Plan
<table>
<thead>
<tr>
<th>Gap</th>
<th>Type of Gap</th>
<th>Funding Source</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial Rehabilitation</td>
<td>Access</td>
<td>State (provider needed in Cumberland)</td>
<td>Resolved: State contract added in Cumberland</td>
</tr>
<tr>
<td>Child &amp; Adolescent Day Treatment</td>
<td>Choice</td>
<td>Medicaid</td>
<td>• Continue Choice Waiver for Medicaid</td>
</tr>
<tr>
<td></td>
<td>Access</td>
<td>State</td>
<td>• Address through single case agreements</td>
</tr>
<tr>
<td>Opioid Treatment</td>
<td>Access &amp; Choice</td>
<td>Medicaid</td>
<td>• NDP priority</td>
</tr>
<tr>
<td></td>
<td>Access</td>
<td>State</td>
<td>• Continue Choice Waiver for Medicaid</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Request State Access Waiver or identify funding</td>
</tr>
</tbody>
</table>
Benefit Plan Discrepancies

• New DHHS requirement for FY17
• Applies to State-funded enhanced services, DMH service definitions, ACTT and IPS SE/LTVS
• Required response elements:
  • Describe geographic discrepancies in benefit plan, including exclusions and stricter eligibility requirements
  • Explain reasons for discrepancies
  • Indicate whether there is a plan in place to ensure equal access
Community Feedback

Feedback Sources:

• CFAC and APAC input
• Community survey: consumers & families, stakeholders, providers, staff
• Collective feedback from 15 stakeholder, staff and provider groups
  • Crisis, SOC and JJSAMHP collaboratives, Hospital Partners
  • Care Coordinators, UM, Call Center, Compliance, Network Evaluators
Community Survey Questions

- Separate questions for IDD, Child MH/SA, & Adult MH/SA
- Added section on TBI
- Ratings of access to services
- Services that were needed but not available
- Barriers to accessing care
- Underserved populations
- Housing needs and gaps
- Employment needs and gaps
Survey Responses

- 573 responses, including over 50 hard copy responses

<table>
<thead>
<tr>
<th>Response Group</th>
<th>Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer and Family</td>
<td>126</td>
</tr>
<tr>
<td>Provider</td>
<td>242</td>
</tr>
<tr>
<td>Stakeholder</td>
<td>72</td>
</tr>
<tr>
<td>Staff</td>
<td>133</td>
</tr>
<tr>
<td>TOTAL</td>
<td>573</td>
</tr>
</tbody>
</table>
## Survey Responses by County

<table>
<thead>
<tr>
<th>County</th>
<th>Consumers &amp; Families</th>
<th>Providers</th>
<th>Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland</td>
<td>54</td>
<td>64</td>
<td>27</td>
</tr>
<tr>
<td>Durham</td>
<td>13</td>
<td>74</td>
<td>17</td>
</tr>
<tr>
<td>Johnston</td>
<td>7</td>
<td>69</td>
<td>7</td>
</tr>
<tr>
<td>Wake</td>
<td>42</td>
<td>150</td>
<td>25</td>
</tr>
</tbody>
</table>

*Note: providers and stakeholders may serve multiple counties*
Community Feedback: Needs & Gaps

• Limited services for uninsured, for IDD non-Innovations, and county variability of service access
• Need for enhanced crisis continuum, including access to respite
• Continued development of services between outpatient and enhanced benefit levels of care
• Services for individuals with co-occurring IDD/MI
• Development of comprehensive SA continuum
• Improved service accessibility, including development of Same Day Access
Community Feedback: Needs & Gaps

• Improved access and quality of residential services
• Access to safe and affordable housing
• Access to psychiatric services and medication
• Expanded evaluation and consultation services
• Services for underserved populations, including Spanish language, elderly, transition-age youth
• Services to support employment
• Transportation access
Community Feedback: Other

- Request for more public education and awareness
- Quality of care concerns
- Feedback about Alliance processes and systems issues
## FY16 DHHS Initiatives

<table>
<thead>
<tr>
<th>FY16</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery-Oriented System of Care</td>
<td>Recovery is Possible</td>
</tr>
<tr>
<td>Crisis Solutions Initiative</td>
<td>Crisis Solutions Initiative</td>
</tr>
<tr>
<td>Employment</td>
<td>Employment</td>
</tr>
<tr>
<td>Housing</td>
<td>Housing Options</td>
</tr>
<tr>
<td>Integration of physical and behavioral health care</td>
<td>Integration of Behavioral and Physical Health Service</td>
</tr>
<tr>
<td>Children’s Initiatives</td>
<td>The Resilient Child and Family</td>
</tr>
<tr>
<td>Advancing Technology</td>
<td>Opioid and Prescription Drug Abuse</td>
</tr>
</tbody>
</table>
Discussion

• March 11: Draft revision submitted to ELT for review

• March 18: ELT feedback due

• April 1: Final report submitted to DHHS
Psychiatric / Psychosocial Rehabilitation

• Gained prominence through deinstitutionalization movement and gaps identified in preparing for community living and social interaction and inclusion

• Refers to variety of services and can occur in wide range of settings, program models, staffing disciplines and organizational structures

• Promotes recovery, full community integration, and improved quality of life

• Goals are to assist persons with mental illness to regain skills and maximize functioning in the community

• Focus on helping develop skills and access resources
Best Practices in Psychiatric Rehabilitation

• Focus on SMI population
• Promotion of growth in multiple domains (home, school, work) and types of functioning (physical, emotional, intellectual)
• Individualized
• Maximize natural supports
• Community inclusion and involvement
• Transparency
• Integration into network of services, resources and supports
Psychosocial Rehabilitation (PSR) in NC

Promotion of:

• Recovery
• Symptom stability
• Increased coping skills
• Management of illness
• Skill and resource development
• Ability to live as independently as possible
• Achievement of highest level of functioning in community
Psychosocial Rehabilitation (PSR) in NC

- Community living, e.g., housekeeping, shopping, cooking, use of transportation, money management
- Personal care, e.g., health care, medication self-management, grooming
- Social relationships
- Use of leisure time
- Educational activities, assistance with accessing education services
- Prevocational activities focusing on development of work habits
Psychosocial Rehabilitation (PSR) in NC

Requirements:

• Licensure by DHSR
• Must operate at least 5 hours/day, 5 days/week
• May be provided on weekends or in the evening
• Supervision by QP
• Cannot be provided in conjunction with ACTT
## Alliance PSR Provider Information

<table>
<thead>
<tr>
<th>County</th>
<th>Medicaid Contracts</th>
<th>State Contracts</th>
<th>Number Served (July-Dec. 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland</td>
<td>4</td>
<td>1</td>
<td>215</td>
</tr>
<tr>
<td>Durham</td>
<td>6</td>
<td>1</td>
<td>104</td>
</tr>
<tr>
<td>Johnston</td>
<td>2</td>
<td>2</td>
<td>124</td>
</tr>
<tr>
<td>Wake</td>
<td>7</td>
<td>4</td>
<td>318</td>
</tr>
<tr>
<td>TOTAL</td>
<td>19</td>
<td>8</td>
<td>761</td>
</tr>
</tbody>
</table>
## Alliance PSR Providers

<table>
<thead>
<tr>
<th>Cumberland</th>
<th>Durham</th>
<th>Johnston</th>
<th>Wake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agape Unit Care Services</td>
<td>House of Care</td>
<td>Johnston County Industries</td>
<td>Aspire Supportive &amp; Counseling Services</td>
</tr>
<tr>
<td>C &amp; C Outreach</td>
<td>Securing Resources for Consumers</td>
<td>Southeastern Healthcare</td>
<td>Monarch (Club Horizon)</td>
</tr>
<tr>
<td>Carolina Residential Services</td>
<td>Sunrise Clinical Associates</td>
<td></td>
<td>Eagle Healthcare</td>
</tr>
<tr>
<td>Professional Family Care Services</td>
<td>Threshold</td>
<td></td>
<td>Fellowship Health Resources (Cary)</td>
</tr>
<tr>
<td></td>
<td>Upward Change</td>
<td></td>
<td>Fellowship Health Resources (Raleigh)</td>
</tr>
<tr>
<td></td>
<td>Visions Counseling Studio</td>
<td></td>
<td>Healing Interventions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Southeastern Healthcare</td>
</tr>
</tbody>
</table>
Alliance Network PSR Program Examples

• Wellness Recovery and Action Planning (WRAP)
• Wellness Management and Recovery (WMR)
• Whole Health Action Management (WHAM)
• Physical health education/wellness, exercise & fitness classes, nutrition education, cooking classes
• Studio 35: healing arts recovery program
• Educational and support groups: SA, CBT, depression and anger management groups, gender issues, domestic violence, ex-offender re-entry
• Services for deaf/hard of hearing (Club Horizon)
Alliance Network PSR Program Examples

- Housing support
- Help with food, clothing, transportation, benefits
- GED preparation, remedial support in math and reading, tutoring
- Daily meals
- Laundry room, showers
- Computer lab
- Member-operated hair salon, snack bar, small vocational business
Challenges

• Providers report insufficient Medicaid rates
• Quality concerns
• Lack of clear expectations regarding service model
• Inconsistent models, approaches and practices
• Concerns about consumer choice and appropriate service use by some group home residents
• Consistent alignment with recovery orientation
• Incorporation of evidence-based practices within PSR service definition
Strategies and Opportunities

• Identify preferred practices, models and EBPS
• Develop contract Scope of Work with clear expectations
• Increased rates for providers meeting higher standards such as program accreditation or EBP fidelity
• Focused provider monitoring
• Outcomes evaluation
• Training and provider collaborative
PSR Models

- Clubhouse Model
- Rehabilitation Model (Boston University)
Clubhouse Model

- Began in 1948 with creation of Fountain House in NY
- Consumer roles as members and participants
- Work-ordered day: member roles in jobs essential to clubhouse functioning
- Transitional employment
- Not time-limited
- Clubhouse International accreditation (ICCD)
- Two ICCD Clubhouses in Alliance catchment area:
  - Club Horizon (Monarch) and Threshold
Rehabilitation Model

• Recovery-oriented
• Broad range of interventions and settings
• Focus on multiple domains (role functioning, employment, housing, etc.)
• Boston University Choose-Get-Keep model
  • Focus on choosing, getting and keeping rehabilitation goals based on individual needs and wants
  • Engage, support and teach people how to drive and master their own rehabilitation process
  • Positive outcomes demonstrated in areas of quality of life, housing status, work status, other role functioning
Discussion
ITEM: Global Quality Management Committee Report

DATE OF BOARD MEETING: April 7, 2016

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 the December and February meetings are attached, along with the draft minutes from March. At the March meeting, the committee received the brief update on our Corrective Action Plan in response to the EQR visit in November and approved the changes. The committee discussed attendance requirements for committee members. They developed strategies to improve and clarify attendance, along with agreeing to recruit provider representatives whose term is ending June 30. The committee also received brief updates on the review of clinical guidelines, the status of the Needs/Gaps Assessment, the Network Development Plan, and proposed integrated care measures. The committee spent time discussing the Provider Satisfaction Survey, which indicated that Alliance received the highest satisfaction rating of all LME/MCOs, and how Alliance monitors under and over utilization of services. The committee will not meet in April due to Spring Break.
REQUEST FOR AREA BOARD ACTION:
Accept the report.

CEO RECOMMENDATION:
Accept the report.

RESOURCE PERSON(S):
George Corvin, Committee Chair; Geyer Longenecker, Quality Management Director; Tina Howard, Quality Review Manager
VOTING MEMBERS PRESENT: ☒ Ann Akland, BS (Area Board); ☒ George Corvin, MD, Chair (Area Board); ☒ Phillip Golden, BA (Area Board); ☒ Joe Kilsheimer, MBA (CFAC); ☐ vacant (CFAC); ☒ Lascel Webley, Jr., MBA, MHA (Area Board)

NON-VOTING MEMBERS PRESENT: ☒ Tim Ferreira, BA (Provider Representative, I/DD); ☒ Nicole Novello Olsen, MSM (Provider Representative, MH/SA)

STAFF PRESENT: ☐ May Alexander, MS, LMFT, Quality Management Data Manager; ☒ Tina Howard, MA, Quality Review Manager; ☒ Geyer Longenecker, JD, Quality Management Director; ☐ Alison Rieber, LCSW, Network Evaluator Supervisor; ☐ Khalil Tanas, MD, Medical Director; ☒ Doug Wright, Director of Consumer Affairs; ☒ Sandra Ellis, Administrative Assistant/Scribe

GUEST(S) PRESENT: ☐

WELCOME AND INTRODUCTIONS

Chair George Corvin convened the committee meeting at 2:00 p.m. He determined that a quorum of committee members was present.

REVIEW OF THE MINUTES: November 5, 2015 minutes were APPROVED. Phil motioned for the approval and Ann Akland seconded the motion.

<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>OLD BUSINESS:</td>
<td><strong>Training Report (Tina):</strong></td>
<td>• Inquire of Carla Alston-Daye, Alliance Training Manager:</td>
<td>February 4, 2016 Meeting</td>
</tr>
<tr>
<td></td>
<td>• The purpose of internal training is to create a motivated, skilled and effective workforce that shapes the human resources necessary for Alliance to achieve its organizational goals.</td>
<td>o How Alliance compares to other MCO/LMEs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Alliance continues to utilize the same report format as before, which the committee liked.</td>
<td>o A copy of the Relias Quarterly Report to allow GQMC to see the tracking costs of training and the benefits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The DMHDDSAS contract requires that this information is brought before the Quality Management Committee for discussion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The Training Report provides the name of trainings offered, the mode, who completed this training, the total number of individuals who completed it and the training type.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AGENDA ITEMS:</td>
<td>DISCUSSION:</td>
<td>NEXT STEPS:</td>
<td>TIME FRAME:</td>
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</tbody>
</table>
|              | • A majority of the staff training is offered by Relias, an on-line data-based training tool.  
  • Some training (face-to-face) is provided through a contract with AHEC.  
  • Alliance also provides a number of trainings (face to face, webinar, and presentations) to providers.  
  • PCP Training is a part of our Quality Improvement Project. Results after the training have shown some improvement on the plans.  
  • Doug Wright, Director of Consumer Affairs, has begun work with hospitals for CIT trainings. | | |

<table>
<thead>
<tr>
<th>NEW BUSINESS:</th>
<th>Initial Feedback from EQR (Geyer):</th>
<th></th>
<th></th>
</tr>
</thead>
</table>
|               | • Alliance’s second annual EQR review was conducted November 12-13, 2015  
  • A 152-page results report was received December 1, 2015. This document is available for review by anyone who wishes to do so.  
  • Alliance’s overall performance met increased to 85.6%; a marked increase from 70.2% in 2014.  
  • Results – Quality Management’s score was 71% met and 21% partially met, a decrease from 2014. It is important to note that reviewers were looking for greater detail and sophistication this year. All are just small issues and we have the ability to appeal or seek information.  
  • EQR requires a Corrective Action Plan for compliance issues, which will be addressed and easily submitted by the December 31, 2015 deadline. | | |

<table>
<thead>
<tr>
<th>Performance Standards Dashboard (Geyer):</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
| • Within the Dashboard routine update, there were a couple of red marks which have been or will be addressed.  
  • Areas in need of improvement include: 85% of individuals admitted to ED should be assigned to Care Coordination in timely manner—Alliance did not meet standard in October; | • A meeting will be scheduled with Sean Schreiber to see how better to address concerns with Care Coordination assignment.  
  • Provide update on Access to Care QIP | Update at Feb. 4 meeting | |
<table>
<thead>
<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care performance is still not meeting benchmarks (state has promised to revise standards based on more realistic goals); Timely initiation in Innovations services – may be a result of late claims, performance improves every quarter when data is re-run for previous quarters.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FY 2016 QM Work plan Update (Geyer):</strong></td>
<td>Solicit feedback on all projects from CQI Committee members.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Spreadsheet shows all quality projects Alliance is involved with at this time. This is a report which EQRO would like us to provide. This information is derived from a variety of sources and yellow highlights indicates changes or reviews.</td>
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<td>• Geyer provided a brief update on several projects. Details are provided in the spreadsheet.</td>
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<td><strong>Transitioning to Community Living Evaluation (Geyer):</strong></td>
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<td>February 4</td>
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<tr>
<td>• This is a Report of an Independent Reviewer, contracted by the US DOJ to review NC’s progress in meeting settlement goals.</td>
<td>• Provide update on TCLI at next meeting</td>
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<td>• The report highlighted strengths and concerns which may result in the state not meeting goals by the deadline. Major findings (related to LME/MCOs and Alliance) are: 1) Reviewer noted strong LME/MCO leadership with this initiative; 2) Non-compliance with two supported employment provisions—address systemic problems with Supported Employment service and expand use of evidence-based IPS model; 3) Falling behind on meeting thresholds for Housing Slots; 4) Gaps in community mental health services; and 5) Access to services/resources less for individuals in state inpatient facilities and those already placed in Adult Care Homes. There are a lot of challenging issues in making a team approach to reach these individuals who are falling in the cracks. Committee members noted: We are not seeing people who get in homes; most want to be in Wake and housing is simply not there. We can get them into the pipeline and can’t go further.</td>
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<td>AGENDA ITEMS:</td>
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|               | • Housing has not been a big part of what MCOs do so far as housing component because it is such a large challenge. Alliance is doubling effort and hope to see some progress there. Housing is a big problem and our CEO, Rob Robinson, is working directly with counties to repurpose housing needs.  
• Alliance is addressing concerns through new director dedicated to project. Staff is being doubled in all four counties with focus directly on housing and reviewing employee providers. Alliance is also considering a restructuring of the initiative to improve effectiveness.  
• To address gaps in services, Alliance is currently conducting needs and gaps assessment, which will be shared with the newly board chartered New Services Committee. | | |

**Housing Evaluation (Geyer):**  
• Alliance contracted with the Technical Assistance Collaborative (TAC) to perform a comprehensive review of Alliance’s housing resources in the catchment area. The review included an inventory and costs of residential services for all populations.  
• TAC made recommendations for each population and, overall, a senior leadership position (Director of Housing) to oversee and engage providers and stakeholders in implementation.

| UPCOMING MEETINGS: Dates and locations are same as Board, topics are tentative | January 2016 (cancel)  
February 4, 2016—Location TBD – will notify of location as soon as we learn where the board will be meeting.  
March 3, 2016 – Location TBD  
April 2016 (cancel)  
May 5, 2016 – Location TBD - QIP Proposals & updates, other topics-TBD | | |
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<td></td>
<td>June 2, 2016 – Location TBD - Vote on QIP Proposals, Performance Standards Dashboard, other topics - TBD</td>
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<td>ADJOURNMENT:</td>
<td>The committee adjourned at 3:18 PM.</td>
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</table>
VOTING MEMBERS PRESENT: ☐ Ann Akland, BS (Area Board); ☐ George Corvin, MD, Chair (Area Board); ☐ Phillip Golden, BA (Area Board); ☐ Joe Kilsheimer, MBA (CFAC); ☐ Amelia Thorpe (CFAC); ☒ Lascel Webley, Jr., MBA, MHA (Area Board)

NON-VOTING MEMBERS PRESENT: ☒ Tim Ferreira, BA (Provider Representative, I/DD); ☐ Nicole Novello Olsen, MSM (Provider Representative, MH/SA)

STAFF PRESENT: ☐ May Alexander, MS, LMFT, Quality Management Data Manager; ☐ Tina Howard, MA, Quality Review Manager; ☒ Geyer Longenecker, JD, Quality Management Director; ☒ Alison Rieber, LCSW, Network Evaluator Supervisor; ☒ Tedra Anderson-Brown, Medical Director; ☒ Doug Wright, Director of Consumer Affairs; ☒ Sandra Ellis, Administrative Assistant/Scribe

GUEST(S) PRESENT: ☐

WELCOME AND INTRODUCTIONS

Neither Chair nor Co-Chair were in attendance. No actions was taken because the quorum was not met.

REVIEW OF THE MINUTES: December 3, 2015 minutes were not reviewed or acted upon. Will be reviewed at the March 3, 2016 meeting.

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<tr>
<th>AGENDA ITEMS:</th>
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| OLD BUSINESS: 2015 EQR REVIEW (Geyer) (Submitted by the Carolinas Center for Medical Excellence External Quality Review) | **Unable to vote as a quorum was not present.**
- Reviewed EQR #11, Quality Management evaluation, the final compliance action report but no vote was taken. A couple of pages were drafted for the committee to look at next month for a vote.
- The QM Department has drafted the following assessment of its FY 2015 goals. The assessment was presented in February 2016 (no vote) to the CQI Committee and Global Quality Management Committee for review and approval, and added to its FY 2015 QM Program Assessment.
- The majority of the goals were met, such as providers included in the Credentialing Committee. There are some policy issues which need to be addressed prior to having providers on the CQI Committee or the QIP Project Advisory Teams. This is under consideration.
- The few performance measures which were out of line have been corrected. We are now down to two this year. | • Review for a vote. | March 3, 2016 Meeting |
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| **NEW BUSINESS: Monitoring Report (Alison Rieber):** | • Alison gave an in-depth overview on Monitoring Reporting. The last information was shared with the committee in October 2015.  
• There is a routine monitoring tool used for every provider every two years. This monitoring has been expanded to include therapeutic foster care and agencies, not sites, are monitored.  
• Reciprocity agreements were a big push last year but monitoring cannot be postponed as it is required every two years beginning in 2013. The Routine Monitoring Process states that providers will be monitored every two years.  
• Since monitoring first began in 2013, the evaluation team has completed routine monitoring for all provider agencies except those providing primarily therapeutic foster care and hospitals providing outpatient services. Monitoring of providers of therapeutic foster care will begin in April 2016.  
• The monitoring supervisor will work with Alliance’s Hospital Relations Director to understand the hospital contracts and arrange monitoring of hospitals providing outpatient services.  
• Alliance began monitoring LIPs in October 2014 and monitored ninety-six LIP practices by January 2016. However, 130 LIP practices with current billing have not yet been monitored. These routine reviews cannot be completed within the two-year time frame beginning in March 2014, when the tools were revised and the new Routine Monitoring Process began.  
• Approximately 67% of these LIP practices are billing Alliance for five or fewer consumers over a period of three months.  
• In FY 2015, Alliance was fourth in LME/MCOs in number of reviews completed. In the first two quarters of FY 2016, Alliance was second in the number of routine reviews completed. | | |
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<td>Since the Routine Review Monitoring Process was resumed in March 2014, Alliance has increased the number of routine reviews/month from 10.25 to 17.5. This has been accomplished by hiring additional evaluators. The team has gained two positions since March 2014. Will be adding one more position for a total of twelve positions.</td>
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<td>Increasing scheduling efficiency in monitoring of small agencies.</td>
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<td>Geyer spoke to the NC DHHS LME/MCO Performance Summaries for September, October and November 2015. These are summary reports of LME/MCO performance that are routinely sent.</td>
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<td>Alliance has made a real effort to comply with the routine basic reports from the State and takes these reports very seriously in making sure we are meeting goals.</td>
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<td>Areas out of compliance include Care Coordination initial contact, the finance report, NCTOPPS, CDW submissions, and Access to Care. QM staff met with Care Coordinators Team Leads to address compliance, which resulted in improved performance.</td>
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<td>The CDW submissions have been a point of focus for 1 ½ years. The status of CDW submissions on one element was out of compliance but Alliance has already made progress on that number.</td>
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<td>The reason the finance report was deemed incomplete is because staff indicated no claims were submitted for Path MOE instead of entering a zero. That has been corrected.</td>
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<td>NC-TOPPS is an ongoing issue due to timeliness. Actions taken during Q1 FY2016 included removing two closed agencies from the online database and hiring a new NC-TOPPS staff member dedicated to the task.</td>
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| Crisis/Hospital/ED Report (Tina) | • An analysis on recent innovations information and is being done to see why it was not completed. Driving the numbers would be a lot of times within forty-five days claims have not been filed.  
• Alliance is making progress and we can be proud of the submission report; waiting for information of Access to Care Report.  
• Presented an update from this time last year. Of the noted challenges for last year, some improvements has been made in intensive services for juveniles and an expansion of peer services.  
• This year’s presentation included inpatient data and progress on key Process and Performance Indicators.  
• Of note, there was a slight improvement in crisis calls returned to the QM tester within an hour in the 2nd Quarter of FY 16. A new intervention of referring to Compliance was added in 2015.  
• Cumberland crisis services expanded hours and there is a planned expansion of another crisis facility and inpatient services in Wake County.  
• Continued challenges include: improving Mobile Crisis, complete transition of new provider in Durham, and continuing to expand hours in Cumberland. | | |
| QIP Updates (Tina) | • First several slides were a summary.  
• Quality Improvement Projects; met EQRO standards of meeting  
• We are on target for all QIPs, with the exception of Access to Care, Care Coordination (IDD), and Mystery Shopper (IDD).  
• Committee members are encouraged to review slides in more detail and send questions/concerns to Tina. | | |
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<tr>
<td>UPCOMING MEETINGS: Dates and locations are same as Board, topics are tentative</td>
<td>March 3, 2016 (location: Corporate) – Performance Standards Dashboard, Clinical Guideline Reviews, Other Topics – TBD</td>
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<td>April 2016 (not meeting – Spring Break)</td>
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<td>May 5, 2016 (location: Corporate) – QIP Proposals &amp; Updates, other topics – TBD – will keep committee updated during the next couple months when not meeting.</td>
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<td>June 2, 2016 (location: Corporate) – Vote on QIP Proposals, Performance Standards Dashboard, other topics – QM program evaluation is due by the end of August</td>
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<td>ADJOURNMENT:</td>
<td>The committee adjourned at 3:30pm</td>
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VOTING MEMBERS PRESENT: ☒ Ann Akland, BS (Area Board); ☐ George Corvin, MD, Chair (Area Board); ☒ Phillip Golden, BA (Area Board); ☒ Joe Kilsheimer, MBA (CFAC); ☐ Amelia Thorpe (CFAC); ☒ Lascel Webley, Jr., MBA, MHA (Area Board)
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GUEST(S) PRESENT: ☐

WELCOME AND INTRODUCTIONS

REVIEW OF THE MINUTES: December 3, 2015 and February 4, 2016 minutes were reviewed. The December minutes were motioned by Joe and seconded by Lascel. The February minutes were motioned by Phil and seconded by Lascel. Both sets of minutes were approved as written by the committee.

<table>
<thead>
<tr>
<th>AGENDA ITEMS: OLD BUSINESS: EQRO Update (Geyer)</th>
<th>DISCUSSION: Board approval of “EQR 11 – Quality Management Program Evaluation”</th>
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<tbody>
<tr>
<td></td>
<td>• Seeking Board approval of “EQR 11 – Quality Management evaluation”</td>
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<tr>
<td></td>
<td>• “The Quality Program Evaluation should include appropriate measure results trended over time (if applicable), any barriers identified for not meeting specific goals or objectives, recommended interventions, and any program changes needed.”</td>
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<td>• <strong>Response:</strong> The QM Department has drafted the assessment of its FY 2015 goals. The assessment will be presented in February 2016 to the CQI Committee and Global Quality Management Committee for review and approval, and added to its FY 2015 QM Program Assessment.</td>
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<td>• The Evaluation has been revised based on feedback from EQR. EQR requested evaluations be updated and improved from a year ago to pinpoint goal progression for Alliance.</td>
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<td>• The revised version needs to be approved by the committee.</td>
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<td>NEXT STEPS:</td>
<td>The Committee voted to approve the “EQR 11 – Quality Management Evaluation”. Vote was motioned by Lascel and seconded by Joe.</td>
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Page 1 of 5
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<td>Of note, five of the seven benchmarks were met. The unmet measures were: Meet 100% of performance measures and Review 100% of Alliance committee reports to identify QM risk factors.</td>
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<td>Alliance met 80% of performance measures and 50% of committees reported risk factors.</td>
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<td>Barriers and interventions have been identified and are in progress.</td>
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**OLD BUSINESS:**

**Crisis/Inpatient Report**

- Crisis/ED/Inpatient Report – Report will be revised to incorporate state facility data. It was not initially included because we were unsure of the accuracy. The accuracy has been confirmed. Committee members will receive an email with the revised presentation.

**NEW BUSINESS:**

**Membership/Attendance (Committee)**

- The committee discussed how to increase regular attendance at meetings.
- Discussed Alliance procedures for Global Quality Management Committee attendance. Procedures state that all terms will be for two years and members are expected to attend at least 80% of meetings.
- In contrast, the Alliance By-laws state there must be a minimum of six meetings per year. The Committee typically meets nine times/year.
- The procedure also states that committee will include at least one non-voting provider representative.
- The committee made the following suggestions:
  - Revise Alliance procedures to align with Board By-Laws
  - Require attendance (in procedures) for at least 6 of 9 meetings to remain on committee, although members are encouraged to participate in all meetings
  - Set up the GoTo Meetings option for every meeting, so that members who cannot participate in person can still participate by conference call
  - Ensure at least one member of Alliance staff is physically present at the Corporate site to run the computer and GoTo meeting application when the Committee meetings are moved to another site for the month; members unable to do so will be notified in advance.

- Tina to revise provider representative application. The Committee will accept applications and select provider members at June meeting in order for them to begin serving by the August meeting.

- Present revised application at next meeting.
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<tr>
<td>QM Workplan</td>
<td>The work plan is a catalog of various activities QM uses to provide updates for the committee. It contains a list of 33 major activities taking place within the QM Department.</td>
<td>Committee is asked to review list and send feedback/questions to Geyer</td>
<td>Next meeting</td>
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<tr>
<td>Update on Clinical Guideline Reviews (Tina)</td>
<td>Clinical Guideline reviews are required by EQR. They are difficult to measure because the guidelines include many elements for clinical practice. QM decided to choose two elements from two guidelines—an element expected at the beginning of services and another either at the middle of end of services. QM chose to start review with ADHD and Schizophrenia guidelines. We had conducted an initial review of the using data from the Alpha database. It did not include all data because one of the two elements involved pharmacy data. Alliance purchased a data management system, called CMT, which includes pharmacy data. The review is on hold until data can be extracted from the new database system.</td>
<td>Update committee on progress</td>
<td>Next meeting</td>
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| Provider Satisfaction Survey (Geyer) | Alliance recently received results from state contractor on provider satisfaction:  
• Alliance scored the highest of all LME/MCOs in providers indicating overall satisfaction with LME/MCO  
• Alliance was at or above state average for 20 of 23 elements (87%)  
• Even though Alliance is higher than the state average, there are opportunities for improvement. For example, additional provider training and education were requested, particularly in the area of quality management | | |
**AGENDA ITEMS:**

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<tr>
<td><strong>Improved information on usage and training of providers is needed for NC-TOPPS.</strong></td>
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<td><strong>Needs/Gaps Assessment &amp; Network Development Plan (Geyer)</strong></td>
<td>Bring Needs/Gaps Assessment to committee for review</td>
<td>After April 1</td>
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<td>• Shared current update of the Needs/Gaps Assessment which is required every year and due on April 1 of this year. The final Gaps Analysis Plan will be shared with this Committee</td>
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<td>• Network Development Plan – update on last year’s progress: 11 elements have been completed, one is nearly complete, and 26 are in progress (for a total of 38 objectives)</td>
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<td><strong>Utilization of Services &amp; Mechanisms to Detect Over &amp; Under Utilization (Geyer)</strong></td>
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<td>• Following are reports used by Alliance to detect the over and under-utilization of services:</td>
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<td>o Authorized Services Outliers – determined by established criteria</td>
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<td>o Clinical Dashboard – reports elements used</td>
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<td>o Daily Census – Daily census is down and points to a focus for the provider to improve care. Report counts consumers in Inpatient, Intensive In-Home and PRTF services by provider.</td>
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<td>o High-Cost Consumers – report calculates Medicaid, Medicaid B, Medicaid C and State expenditures per consumer</td>
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<td>o Key Cost Drivers – includes reporting elements</td>
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<td>o Provider High-Billers – determines paid amount, consumers served by provider and service line</td>
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<td>o Provider Service utilization graphs – ALOS vs. Expenditures per patient</td>
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<td>o Service Analysis Report – Distinct patients, service units, expenditures per episode of care</td>
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<td>• Implemented tools were shown as they aid in identifying outliers. UM Committee has this tool available for their review on regular basis.</td>
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<td>• For example, over-utilization of PRTF was identified in the data and clinical staff implemented efforts to monitor service more closely.</td>
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<td>AGENDA ITEMS:</td>
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<tr>
<td><strong>State’s Proposed Integrated Care Measures (Geyer)</strong></td>
<td>The state released several proposed indicators to measure integrated care. The measures are primarily based on nationally-tested, best practice HEDIS (Healthcare Effectiveness Data and Information Set) measures. However, questions have been raised about how the data will be collected, tested, and reported in a consistent way to the state. Alliance, along with other LME/MCOs, have sent feedback to the state on the measures (see meeting materials). Along with responding to specific concerns about each measure, Alliance is recommending that the state wait to set a statewide benchmark until the data are tested and baseline data collected.</td>
<td>Review list of measures and send your comments to Geyer</td>
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</table>

**UPCOMING MEETINGS:**

*Dates and locations are same as Board, topics are tentative*

- April 2016 (not meeting – Spring Break)
- May 5, 2016 (location: Corporate) – QIP Proposals & Updates, updates on obtaining data on access to primary care & service patterns/costs of high risk consumers
- June 2, 2016 (location: Corporate) – Vote on QIP Proposals, Performance Standards Dashboard, other topics TBD

**ADJOURNMENT:**

The committee adjourned at 3:30pm
Comment: “The Quality Program Evaluation should include appropriate measure results trended over time (if applicable), any barriers identified for not meeting specific goals or objectives, recommended interventions, and any program changes needed.”

Response: The QM Department has drafted the following assessment of its FY 2015 goals. The assessment will be presented in February 2016 to the CQI Committee and Global Quality Management Committee for review and approval, and added to its FY 2015 QM Program Assessment.

FY 2015 Quality Management Goals Assessment

Goal 1: Meet 100% of performance measures.

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

Performance: During FY 2015, Alliance met 80.3% (196 of 244) of its contractual performance measures. These included:

- LME-MCO monthly report: 155 of 156 99.4%
- Performance Submission quarterly report: 8 of 14 57.1%
- Access to Care quarterly report: 3 of 36 8.3%
- Innovations reports: 26 of 30 87.7%
- NC-TOPPS report: 4 of 8 50.0%

Result: Alliance did not meet its goal for FY 2015, and will include this goal in its FY 2016 work plan.

Barriers: Alliance identified the following barriers during FY 2015:

- LME-MCO report: Alliance did not meet all performance standards for Care Coordination assignment. QM Department staff determined that the assignment process complicated and does not make assignments by default.

- Performance Submission report: Alliance has not meet all Consumer Data Warehouse submission requirements because of: a lack of resources at the state to implement requested corrections; and the need for additional Alliance staffing to oversee data integrity.

- Access to Care: Alliance has identified issues in staff training, IT system configuration, and data integrity.

- NC-TOPPS: Alliance has identified a number of providers who have consistently not met NC-TOPPS reporting requirements.
Interventions:

- LME-MCO report: Alliance has implemented changes in its Care Coordination assignment process to assure assignment in all cases.

- Performance Submission report: Alliance has submitted formal Compliance Action Plans to the state, and created inter-departmental work groups to implement the plans.

- Access to Care: Alliance has implemented new criteria develop by the state, which is expected to set new Access to Care performance measures based on actual LME-MCO performance rather than historic standards.

- NC-TOPPS: Alliance has implemented a compliance program requiring Plans of Correction from non-compliant providers. Those providers who receive three POCs in a year are referred to the Compliance Department for additional review and action.

Goal 2: Establish QM reporting in 100% of Alliance committees.

Description: Description: Alliance is committed to a QM program that is data-driven. The QM Department will review the activities and data requirements of the Global QM Committee, CQI Committee, and various Alliance subcommittee. The QM Department will facilitate the development of relevant reporting, including the creation of "dashboards" to assess fundamental performance, and the development of reports required by contract or accreditation.

Performance: During FY 2015, the QM Department worked with the nine internal CQI Committees and the board’s Global Quality Committee to assess current reporting, and identify and develop additional reporting. Dashboard reports were created for all committees.

Result: Alliance meet its goal for FY 2015.

Goal 3: Review 100% of Alliance committee reports to identify new QM risk factors.

Description: The QM Department will review all reports created by the various Alliance committees, identify areas of risk or non-performance, and facilitate the mitigation of these issues.

Performance: All CQI subcommittees met regularly in FY 2015. Committee leaders were asked to provide reports to the CQI Committee at its monthly meetings. However, subcommittees did actually report only 50% of the time, ranging from 100% for the UM Committee to 20% for the IT Committee.

Result: Alliance did not meet its goal for FY 2015, and will include this goal in its FY 2016 work plan.

Barriers: The CQI subcommittees have not been formally charged with identifying and reporting on quality issues. In addition, the reporting process has not been formally documented.

Interventions:

- The QM Department will facilitate the creation of new committee charters specifying the reporting requirement for each subcommittee.
• A reporting form will be developed and implemented.

• Subcommittee agendas will include reviewing quality issues and completing the reporting form.

• Subcommittee reports will be included on the CQI Committee agenda.

**Goal 4:** Create a rapid QM response program and train 100% of department heads on its use.

**Description:** The QM Department has identified the need for a quick and user-friendly way for Alliance departments to request QM assistance. QM staff will develop an online request form for QM assistance and associated training materials. QM staff will train 100% of department heads on how to access the system and submit a request for QM review.

**Performance:** The QM Department created a form for requesting a rapid quality review. The form was placed on the shared server where it could be accessed by all staff. The QM Department informed all staff of the rapid review process via a series of all-Alliance emails.

**Result:** Alliance meet its goal for FY 2015.

**Goal 5:** Review HEDIS standards and implement relevant performance measures.

**Description:** Developed by the NCQA, the HEDIS program is a set of performance measures that allow MCOs to better evaluate their performance against national standards. The QM Department will review the HEDIS measures, identify the measures that are relevant to Alliance’s behavioral health activities, and facilitate the creation of reports on those HEDIS measures.

**Performance:** The QM Department reviewed the latest HEDIS reporting standards. The QM Department then reviewed current state-required performance measures and confirmed that the state measures are HEDIS-based. The QM Department concluded that Alliance is meeting relevant HEDIS reporting requirements via its current state-mandated reporting.

**Result:** Alliance meet its goal for FY 2015.

**Goal 6:** Develop provider QM education and inform 100% of providers.

**Description:** Continuous quality improvement is the responsibility of all stakeholders in Alliance, including providers. The QM Department will create guides, templates, and training materials to help providers create effective QM programs. The QM Department will inform 100% of providers about the availability of these materials.

**Performance:** The QM Department developed an “Introduction to Quality Management” training program aimed at providers. The program was presented at the June 2015 All-Provider meeting. The presentation was posted on the Alliance website, and providers were notified about its availability.

**Result:** Alliance meet its goal for FY 2015.

**Goal 7:** Evaluate the establishment of provider outcomes.
Description: The establishment of provider outcomes is the next great step in improving the effectiveness and efficiency of patient care. The QM Department will evaluate current methods for establishing outcomes; and assess the relevancy of those methods to Alliance.

Performance: During FY 2015, Alliance completed the following activities:

- The QM Department completed a literature review of current performance measures used to evaluate behavioral health providers.

- The QM Department contributed to the development of three pilot programs to evaluated extended Intensive In-Home services offered by providers KidsPeace, Youth Villages and Mentor. QM staff reviewed existing performance measures, and developed uniform measures to allow a comparison of the three programs.

- The QM Department implemented a process for evaluating provider compliance with clinical practice guidelines. The process identifies two or more essential requirements and tracks provider compliance. The analysis will be used to develop general provider training, and to identify specific providers for focused training. The QM Department has started its reviews with clinical practice guidelines for ADHD in children and schizophrenia in adults.

Result: Alliance meet its goal for FY 2015.
<table>
<thead>
<tr>
<th>Item</th>
<th>Source</th>
<th>Activity</th>
<th>Owner</th>
<th>Updates</th>
<th>% Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>QM Plan Goal</td>
<td>Meet Performance Measures</td>
<td>Geyer Longenecker</td>
<td>11/24/2015 - 283 of 344 measures (82.3%) met through October 2015.</td>
<td>20</td>
</tr>
<tr>
<td>2</td>
<td>QM Plan Goal</td>
<td>Review Committee Reports</td>
<td>Geyer Longenecker</td>
<td>11/15/2015 - At least one report received from each CQI subcommittee</td>
<td>50</td>
</tr>
<tr>
<td>3</td>
<td>QM Plan Goal</td>
<td>Implement Mercer/EQR recommendations</td>
<td>Geyer Longenecker</td>
<td>11/24/2015 - 100% of 2014 Mercer recommendations implemented; 100% of 2015 EQRO recommendations implemented; 20% of 2015 Mercer recommendations implemented</td>
<td>60</td>
</tr>
<tr>
<td>4</td>
<td>Strategic Planning</td>
<td>Implement provider performance measures</td>
<td>May Alexander</td>
<td>10/29/2015 - plan to catalogue existing performance measures launched Measures gathered from all departments including suggestions for what to measure. 2/24/2016 - Information was reviewed with the project team and is now awaiting review with the Chief. Information was also given to the re-credentialing project team for use in their measure development.</td>
<td>10</td>
</tr>
<tr>
<td>5</td>
<td>QM Plan Goal</td>
<td>Revise CQI charters and reporting</td>
<td>Beth Melcher</td>
<td>9/23/2015 - Revised charters and initial monthly reports submitted to CQI Committee</td>
<td>100</td>
</tr>
<tr>
<td>6</td>
<td>QIP</td>
<td>Crisis System</td>
<td>Damali Alston</td>
<td>8/31/2015 - Annual update submitted to state indicating QIP will be continued in FY 2016; UPDATE 2/24/2016 - (Wake) Expansion of Tier II (after hours) continuing-Monarch to open later by end of FY; (Cumberland) Intensive EBPs for youth implemented</td>
<td>50</td>
</tr>
<tr>
<td>7</td>
<td>QIP</td>
<td>First Responder</td>
<td>Michelle Work/Tina Howard</td>
<td>8/31/2015 - Annual update submitted to state indicating QIP will be continued in FY 2016, test calls continue on quarterly basis; UPDATE 2/24/2016 - &quot;Test&quot; calls continue based on provider’s Tier (quarterly, semi-annual, or annual). Slight improvement in last quarter. 7 providers referred to Compliance, 5 POCs, 2 warning letters. All POCs closed except for one.</td>
<td>75</td>
</tr>
<tr>
<td>Item</td>
<td>Source</td>
<td>Activity</td>
<td>Owner</td>
<td>Updates</td>
<td>% Complete</td>
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</tr>
<tr>
<td>8</td>
<td>QIP</td>
<td>Mystery Shopper (UM call monitoring)</td>
<td>Tara Heasley</td>
<td>8/31/2015 - Annual update submitted to state indicating QIP for UM Call Monitoring will be continued in FY 2016; UPDATE 2/24/2016 - 2nd post-intervention analysis (Oct 2015): 91% of calls to/from MH/SA UM Care Managers met standard, while only 49%</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>QIP</td>
<td>IRR</td>
<td>Tina Howard</td>
<td>11/23/2015 - Final IRR test passed, QIP closed; UPDATED 2-24-2016: IDD IRR-Final test scheduled for March.</td>
<td>90</td>
</tr>
<tr>
<td>10</td>
<td>QIP</td>
<td>Access to Care</td>
<td>Tina Howard</td>
<td>8/31/2015 - Annual update submitted to state indicating QIP will be continued in FY 2016; UPDATE 2/24/2016 - Performance still below state standards, new interventions of reminder calls and QA by Call Center. Conducting root cause analysis of Emergent calls.</td>
<td>50</td>
</tr>
<tr>
<td>11</td>
<td>QIP</td>
<td>Care Coordination</td>
<td>Damali Alston/Tara Heasley</td>
<td>8/31/2015 - Annual update submitted to state indicating QIP will be continued in FY 2016; UPDATE 2/24/2016 - MH/SA: Collected new baseline-increased contact within 2 business days to 86% (from 43%)-met goal; IDD: Post-intervention analysis indicated goal not met, revising interventions</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>QIP</td>
<td>Complaints and Grievances error reduction</td>
<td>Tina Howard/Tara Heasley</td>
<td>8/31/2015 - Annual update submitted to state indicating QIP will be initiated in FY 2016; UPDATE 2/24/2016 - Interventions of training and staff reassignment implemented, conducting post-intervention analysis</td>
<td>60</td>
</tr>
<tr>
<td>13</td>
<td>QIP</td>
<td>Improve Intensive In-Home</td>
<td>Damali Alston</td>
<td>8/31/2015 - Annual update submitted to state indicating QIP will be continued in FY 2016; UPDATE 2-24-2016 - New intervention of EBPs started, training and technical assistance being provided.</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>QIP</td>
<td>Improve Person-Centered Plans</td>
<td>Tina Howard</td>
<td>8/31/2015 - Annual update submitted to state indicating that initiative was originally part of Mystery Shopper QIP, but has been moved to separate QIP. Will be continued in FY 2016 with new interventions; UPDATE 2/24/2016 - Intervention of training took place in December and another training scheduled for 2/29. Post-training reviews scheduled for Spring.</td>
<td>50</td>
</tr>
<tr>
<td>Item</td>
<td>Source</td>
<td>Activity</td>
<td>Owner</td>
<td>Updates</td>
<td>% Complete</td>
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</tr>
<tr>
<td>15</td>
<td>Strategic Planning</td>
<td>Recredentialing measure development</td>
<td>Cathy Estes</td>
<td>9/15/2015 - Organizational meeting held with Strategic Planning</td>
<td>10</td>
</tr>
<tr>
<td>17</td>
<td>Strategic Planning</td>
<td>Veterans Plan</td>
<td>Damali Alston</td>
<td>9/1/2015 - QM Department analysis of veterans intake completed; UPDATED 2/24/2016 - Post intervention analysis taking place</td>
<td>90</td>
</tr>
<tr>
<td>18</td>
<td>Network Development</td>
<td>Rapid Response review (3.7)</td>
<td>Michelle Work</td>
<td>11/23/2015 - Draft Rapid Response evaluation reviewed; additional review scheduled for January upon collection of expanded provider data.</td>
<td>50</td>
</tr>
<tr>
<td>19</td>
<td>Network Development</td>
<td>Transitional Living review (4.1)</td>
<td>Geyer Longenecker</td>
<td>7/1/2015 - QM will initiate in January 2016 for competition in March 2016; UPDATED 2-24-2016: Project team identified, charter created and signed. Initial analysis completed.</td>
<td>25</td>
</tr>
<tr>
<td>20</td>
<td>Network Development</td>
<td>MH/SA SE-LTWS review (13.2)</td>
<td>Tamara Smith/ Damali Alston</td>
<td>7/1/2015 - QM will initiate in January 2016 for competition in March 2016; 3/2/16 UPDATE: Transitioned to Alliance Business Process Team, closed for QM.</td>
<td>100</td>
</tr>
<tr>
<td>21</td>
<td>EQR</td>
<td>Site reassessment procedures update (II.A.4.3)</td>
<td>Geyer Longenecker</td>
<td>10/12/2015 - Revised procedure 6008 submitted to EQRO</td>
<td>100</td>
</tr>
<tr>
<td>22</td>
<td>EQR</td>
<td>Review of practitioner profiling activities (II.A.4.4)</td>
<td>Geyer Longenecker</td>
<td>10/12/2015 - Revised procedure 6032 submitted to EQRO</td>
<td>100</td>
</tr>
<tr>
<td>23</td>
<td>EQR</td>
<td>Complaints and Grievances process review (III.F.1)</td>
<td>May Alexander</td>
<td>9/7/2015 - QIP work group initiated review of procedures and definitions Also corresponds with with item 12. PAT met through the fall, was decided that ABH staff would only be responsible for 5 fields. Traiing was implemented in November with an implementation date of 11/21/15 of the new requirements. ABH grievance staff are responsible for the other 11 key elements. Currently collecting 3 months (Dec, Jan, Feb) post intervention data. Project will begin phase 2 when Alpha complete's it's build of the grievance module.</td>
<td>25</td>
</tr>
<tr>
<td>24</td>
<td>EQR</td>
<td>Clinical Practice Guideline compliance (IV.A.2)</td>
<td>Damali Alston</td>
<td>11/23/2015 - First data obtained and reviewed by QM staff; UPDATED 2/26/2014 - Waiting for CMT reports to be created</td>
<td>25</td>
</tr>
<tr>
<td>25</td>
<td>DHHS work group</td>
<td>Advanced Standing tool development</td>
<td>Alison Reiber</td>
<td>9/21/2015 - Tool development suspended by state work group</td>
<td>100</td>
</tr>
<tr>
<td>Item</td>
<td>Source</td>
<td>Activity</td>
<td>Owner</td>
<td>Updates</td>
<td>% Complete</td>
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</tr>
<tr>
<td>26</td>
<td>ICD-10</td>
<td>Post-launch testing of claims data</td>
<td>Geyer Longenecker</td>
<td>11/10/2015 - QM completed reviews of Claims Department reports to evaluate impact of 10/1/2015 transition to ICD-10</td>
<td>100</td>
</tr>
<tr>
<td>27</td>
<td>HCBS</td>
<td>Self-assessment IRR</td>
<td>Tara Heasley</td>
<td>9/15/2015 - IRR conducted of initial HCBS self-assessment scoring</td>
<td>100</td>
</tr>
<tr>
<td>28</td>
<td>QA</td>
<td>Provider email data improvement</td>
<td>Jessica Killette</td>
<td>11/23/2015 - Initial assessment of existing email resources underway. Collection from various ABH departments completed. 2/24/2016 - Reviewed by QM director who found error rate of 45%; clarifying objectives for the next phase.</td>
<td>20</td>
</tr>
<tr>
<td>29</td>
<td>QI Activity</td>
<td>Improve Care Review process</td>
<td>Tina Howard</td>
<td>June-present - Several meetings with Process Improvement Team to define project, map current process, and identify opportunities for improvement; UPDATED 2-24-2016: Identified areas in need of improvement, small workgroup met to implement solutions.</td>
<td>50</td>
</tr>
<tr>
<td>30</td>
<td>Network Development</td>
<td>CTI program evaluation/review</td>
<td>Michelle Work</td>
<td>Sept 2015 - Initial meetings held with Workgroup to define evaluation</td>
<td>10</td>
</tr>
<tr>
<td>31</td>
<td>QI Activity</td>
<td>Community Collaborative CQI project</td>
<td>Tina Howard</td>
<td>February-present - Facilitator received training on process, trained Cumberland site on process, implemented CQI process, identified objectives for next year using data, identified training for TFC parents as solution, training being planned and will be evaluated; expand model to all four sites</td>
<td>75</td>
</tr>
<tr>
<td>32</td>
<td>QI Activity</td>
<td>Improve Adverse Letter process</td>
<td>Tara Heasley</td>
<td>12/3/15-Final report is finished. A few letters were incorrect-UM changing process. Follow up review in January; UPDATED 2-24-2016: New templates reviewed, adhered to URAC standards</td>
<td>100</td>
</tr>
<tr>
<td>33</td>
<td>QI Activity</td>
<td>Consumer address verification</td>
<td>Geyer Longenecker</td>
<td>11/23/2015 - Three vendors products evaluated; test database of 200,000-plus consumer addresses created. 2/24/2016 - Total of 240,000 addresses reviewed for formatting, found error rate of 35-45% per county. State announced its intention to implement Pitney Bowes system.</td>
<td>25</td>
</tr>
</tbody>
</table>
2015 Provider Survey

Survey Details

• Three-weeks from Aug. 24 – Sep. 18, 2015
• Total of 532 Alliance providers invited
• Total of 260 surveys collected
• Response rate of 48.9%; state = 45.0%
• 75.8% are Medicaid providers for 6-plus years
• 62.3% are Provider Agencies
• 36.5% are LIPs
• 1.2% Community Hospitals
## 2015 Provider Survey

### Access

<table>
<thead>
<tr>
<th>Topic</th>
<th>2014</th>
<th>2015</th>
<th>Change</th>
<th>State</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>LME/MCO staff is easily accessible for information, referrals, and scheduling of appointments.</td>
<td>73.1</td>
<td>82.3</td>
<td>9.2</td>
<td>77.9</td>
<td>4.4</td>
</tr>
<tr>
<td>LME/MCO staff are referring consumers whose clinical needs match the service(s) my practice/agency provides.</td>
<td>60.8</td>
<td>72.7</td>
<td>11.9</td>
<td>64.6</td>
<td>8.1</td>
</tr>
</tbody>
</table>

### Appeals

<table>
<thead>
<tr>
<th>Topic</th>
<th>2014</th>
<th>2015</th>
<th>Change</th>
<th>State</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>My agency is satisfied with the appeals process for denial, reduction, or suspension of service(s).</td>
<td>46.8</td>
<td>59.2</td>
<td>12.4</td>
<td>50.3</td>
<td>8.9</td>
</tr>
</tbody>
</table>
# 2015 Provider Survey

## Authorizations

<table>
<thead>
<tr>
<th>Topic</th>
<th>2014</th>
<th>2015</th>
<th>Change</th>
<th>State</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorizations for treatment and services are made within the required timeframes.</td>
<td>88.3</td>
<td>90.4</td>
<td>2.1</td>
<td>82.4</td>
<td>8.0</td>
</tr>
<tr>
<td>Denials for treatment and services are explained.</td>
<td>74.3</td>
<td>79.2</td>
<td>4.9</td>
<td>70.9</td>
<td>8.3</td>
</tr>
<tr>
<td>The authorizations issued are accurate.</td>
<td>86.0</td>
<td>91.5</td>
<td>5.5</td>
<td>82.9</td>
<td>8.6</td>
</tr>
</tbody>
</table>

## Claims

<table>
<thead>
<tr>
<th>Topic</th>
<th>2014</th>
<th>2015</th>
<th>Change</th>
<th>State</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>When I speak with staff about claims issues I am given consistent and accurate information.</td>
<td>77.2</td>
<td>76.9</td>
<td>-0.3</td>
<td>74.3</td>
<td>2.6</td>
</tr>
<tr>
<td>Claims processed in timely and accurate manner.</td>
<td>87.7</td>
<td>93.1</td>
<td>5.4</td>
<td>87.2</td>
<td>5.9</td>
</tr>
</tbody>
</table>

## Communications

<table>
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<tr>
<th>Topic</th>
<th>2014</th>
<th>2015</th>
<th>Change</th>
<th>2015</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>LME/MCOs website has been a useful tool for helping find tools and materials.</td>
<td>74.9</td>
<td>82.7</td>
<td>7.8</td>
<td>75.0</td>
<td>7.7</td>
</tr>
</tbody>
</table>
## 2015 Provider Survey

### Compliance

<table>
<thead>
<tr>
<th>Topic</th>
<th>2014</th>
<th>2015</th>
<th>Change</th>
<th>State</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>The LME/MCO staff conducts fair and thorough investigations.</td>
<td>55.0</td>
<td>65.8</td>
<td>10.8</td>
<td>65.5</td>
<td>0.3</td>
</tr>
<tr>
<td>After the audit or investigation, LME/MCO requests for corrective action plans and other supporting materials are fair and reasonable.</td>
<td>50.3</td>
<td>67.3</td>
<td>17.0</td>
<td>68.8</td>
<td>-1.5</td>
</tr>
</tbody>
</table>

### Provider Networks

<table>
<thead>
<tr>
<th>Topic</th>
<th>2014</th>
<th>2015</th>
<th>Change</th>
<th>2015</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Network meetings are informative and helpful.</td>
<td>64.3</td>
<td>63.1</td>
<td>-1.2</td>
<td>62.1</td>
<td>1.0</td>
</tr>
<tr>
<td>Provider Network keeps providers informed of changes that affect my local Provider Network.</td>
<td>77.8</td>
<td>75.8</td>
<td>-2.0</td>
<td>77.9</td>
<td>-2.1</td>
</tr>
<tr>
<td>Provider Network staff are knowledgeable and answer questions consistently and accurately.</td>
<td>70.2</td>
<td>74.2</td>
<td>4.0</td>
<td>71.9</td>
<td>2.3</td>
</tr>
<tr>
<td>How would you rate your overall satisfaction with Provider Network?</td>
<td>79.5</td>
<td>81.5</td>
<td>2.0</td>
<td>77.2</td>
<td>4.3</td>
</tr>
</tbody>
</table>
## 2015 Provider Survey

### Stakeholders

<table>
<thead>
<tr>
<th>Topic</th>
<th>2014</th>
<th>2015</th>
<th>Change</th>
<th>State</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer Service is responsive to local community stakeholders.</td>
<td>58.5</td>
<td>68.8</td>
<td>10.3</td>
<td>62.5</td>
<td>6.3</td>
</tr>
<tr>
<td>Our interests as a network provider are being adequately addressed in the local Provider Council.</td>
<td>50.9</td>
<td>56.5</td>
<td>5.6</td>
<td>52.2</td>
<td>4.3</td>
</tr>
</tbody>
</table>

### Training

<table>
<thead>
<tr>
<th>Topic</th>
<th>2014</th>
<th>2015</th>
<th>Change</th>
<th>State</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims trainings meet my needs.</td>
<td>71.3</td>
<td>71.6</td>
<td>0.3</td>
<td>69.2</td>
<td>2.4</td>
</tr>
<tr>
<td>Information Technology trainings are informative and meet my agency's needs.</td>
<td>63.2</td>
<td>64.2</td>
<td>1.0</td>
<td>65.0</td>
<td>-0.8</td>
</tr>
<tr>
<td>Trainings are informative and meet our needs as a provider/agency.</td>
<td>71.9</td>
<td>71.5</td>
<td>-0.4</td>
<td>70.4</td>
<td>1.1</td>
</tr>
</tbody>
</table>
2015 Provider Survey

Overall

<table>
<thead>
<tr>
<th>Topic</th>
<th>2014</th>
<th>2015</th>
<th>Change</th>
<th>State</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>LME/MCO staff responds quickly to provider needs.</td>
<td>74.9</td>
<td>74.6</td>
<td>-0.3</td>
<td>72.9</td>
<td>1.7</td>
</tr>
<tr>
<td>Technical assistance and information provided by staff is accurate and helpful.</td>
<td>82.5</td>
<td>81.2</td>
<td>-1.3</td>
<td>76.6</td>
<td>4.6</td>
</tr>
<tr>
<td>Please rate your overall satisfaction with the LME/MCO.</td>
<td>84.2</td>
<td>85.0</td>
<td>0.8</td>
<td>79.2</td>
<td>5.8</td>
</tr>
</tbody>
</table>

Summary

- Alliance was at or above state average for 20 of 23 elements (87%).
- Alliance had the highest score in 13 of 23 elements (57%).
- “North Carolina providers are, overall, still satisfied with the LMEs/MCOs, and at a slightly higher rate than in 2014.”
- “Of all plans, providers still seemed the most satisfied with Alliance.”
2015 Provider Survey

More Training and Education?

<table>
<thead>
<tr>
<th>Category</th>
<th>2014</th>
<th>2015</th>
<th>Difference</th>
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<td>-0.9</td>
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**Quality Management/Reporting:** Performance/outcomes, NC-TOPPs  

**Clinical Coverage Policies:** PCP training, clinical practice guidelines info  

**Provider Monitoring:** Training, technical assistance for LIPs
## FY16 Network Development Plan Update 2-10-16

### Status Summary

<table>
<thead>
<tr>
<th># of Initiatives</th>
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<tbody>
<tr>
<td>Completed</td>
<td>11</td>
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<tr>
<td>Almost complete</td>
<td>1</td>
</tr>
<tr>
<td>In progress</td>
<td>26</td>
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<td>Grand Total</td>
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### NDP Objective

#### Expand services to meet geographic access and choice standards

<table>
<thead>
<tr>
<th>Project</th>
<th>Status / Updates</th>
<th>% Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand Medicaid (b)(3) Individual Support (Cumberland, Johnston)</td>
<td>Completed; selected providers in all counties through RFP process.</td>
<td>100%</td>
</tr>
<tr>
<td>Expand Opioid Treatment availability for Medicaid (Cumberland) and State-funded consumers (Cumberland, Durham, Johnston and Wake).</td>
<td>Developed modified services definition and contract scope of work for Medication-Assisted Treatment with Buprenorphine. Cost model developed and approved by Rate Setting and Budget &amp; Finance committees, with UM Committee review pending. The modifier will increase options for provision of evidence-based medication assisted treatment for SA and enable tracking of EBP use.</td>
<td>75%</td>
</tr>
<tr>
<td>Develop Medication Assisted Treatment programs in all counties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Add State-funded PSR services in Cumberland County.</td>
<td>Completed; added contract for state-funded PSR in Cumberland County</td>
<td>100%</td>
</tr>
<tr>
<td>Add State-funded SACOT in Durham County</td>
<td>Completed; added contract for state-funded SACOT in Durham County</td>
<td>100%</td>
</tr>
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</table>

#### Develop a more uniform State benefit package across the four-county Alliance area

<table>
<thead>
<tr>
<th>Project</th>
<th>Status / Updates</th>
<th>% Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a more uniform State benefit package across the four-county Alliance area</td>
<td>In process of reviewing Alliance benefit plan for state-funded services to identify county-specific variation and develop recommendations for addressing disparities. Results will be included in 2016 Community Needs</td>
<td>90%</td>
</tr>
<tr>
<td>NDP Objective</td>
<td>Project</td>
<td>Status / Updates</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Expand capacity for crisis, hospital diversion and respite services for all ages/disabilities</td>
<td>Assure the availability of high quality, accessible and effective Mobile Crisis services in all counties and increase capacity</td>
<td>Assessment and will be discussed with Alliance Board in FY17 budget preparation process.</td>
</tr>
<tr>
<td></td>
<td>Expand access to and capacity of walk-in crisis centers (Behavioral Health Urgent Care Centers), including evening hours (Tier II Same Day Access)</td>
<td>Reviewed mobile crisis data and potential model options. Margaret Brunson is preparing Request for Proposals (RFP) that will reflect recommendations for service models and scope of mobile crisis coverage.</td>
</tr>
<tr>
<td></td>
<td>Expand/Enhance Capacity of Facility Based Crisis</td>
<td>Completed inventory of Same Day Access providers and developed survey regarding service accessibility and barriers to SDA implementation. Survey completed and additional review of Monarch’s Same Day Access model is in process. Obtained funding for expansion of Same Day Access to include evenings. Further analysis will assist with identifying challenges, opportunities and cost model assumptions for further development.</td>
</tr>
</tbody>
</table>
|                                                                                | Provide education to urgent care and primary care practices about Alliance and crisis response resources and how to access them, including Open Access, mobile crisis, facility based crisis | *Completed RFP process for Durham Crisis services and selected provider.  
*Posted RFP for additional Wake crisis facility and vendor, Monarch, has been selected. Implementation plans are being developed and Monarch is exploring potential facility locations. | 57%        |
<p>|                                                                                |                                                                        | Obtained information from CCNC to identify priority practices for training. Met with CCNC to develop joint training information, and setting up primary care/behavioral health provider meetings. Establishing new position within Clinical Operations for Director of Care Integration. Purchased software to run routine reports on primary care practices with high number of behavioral health consumers. Integrated Care Director has been hired and started Feb. 2. CMT has been implemented with initial focus on notification for consumers who did not fill antipsychotic medication prescriptions and notifying PCPs. | 58%        |</p>
<table>
<thead>
<tr>
<th>NDP Objective</th>
<th>Project</th>
<th>Status / Updates</th>
<th>% Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Implement Advanced Practice Paramedics program in Durham</td>
<td>About potential opioid abuse issues. Part of communication strategy will be to educate primary care physicians about non-ED crisis services available to their patients.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop capacity for IDD Crisis Respite</td>
<td>Coordinated training program for Durham CIT-certified EMS paramedics to receive additional on-line training. Both Wake and Durham EMS have completed webinar training. We received allocation letters for Wake and Durham to be reimbursed for alternative drop off destinations.</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>Review outcomes for rapid response crisis diversion services for children and adolescents</td>
<td>Review of Wake rapid response has been completed. We will re-evaluate after we obtain more accurate and specific data. Workgroup has been convened and is working through issues related to 131D licensure rules and crisis beds.</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Implement Critical Time Intervention (CTI) in Cumberland</td>
<td>Completed selection of provider through RFP and have implemented services in Cumberland.</td>
<td>100%</td>
</tr>
<tr>
<td>Increase breadth, access and quality of residential options</td>
<td>Evaluate transitional living outcomes and capacity and determine need for expansion</td>
<td>Project initiated and assigned to Tamara Smith. Project Advisory Team convened and project charter and data analysis have been completed.</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>Develop Comprehensive Assessment for youth with complex needs prior to referral to residential services</td>
<td>Identified provider, reviewed list of standard measures that will be required in assessment, and requested rate proposal from provider. Contract pending with UNC to provide this service, with services expected to begin in January-February 2016.</td>
<td>90%</td>
</tr>
<tr>
<td>NDP Objective</td>
<td>Project</td>
<td>Status / Updates</td>
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</tr>
<tr>
<td>Increase capacity to serve dually diagnosed (IDD/MI) consumers</td>
<td>Complete residential continuum study- Add recommendations from study</td>
<td>TAC report completed; Alliance will hire director of housing and this position will implement specific project plan to address housing gaps. TAC report was presented to Alliance Board Services Committee on 11/18.</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Implement pilot Youth Villages Choices model for dually diagnosed (IDD/MI) youth</td>
<td>Identified three CHOICES consumers through Care Coordination, and referrals are in process for initial pilot implementation. Meeting with Pinnacle to explore Therapeutic Foster Care option.</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Evaluate increased funding support for NC START</td>
<td>Funding has been identified for adolescent START program, based on proposal submitted by Easter Seals UCP. Contract is pending, NC START has hired clinical team lead, and in-home supports team lead, with plan to begin services in mid-January.</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Offer dual diagnosis (IDD/MI) training for Mobile Crisis teams</td>
<td>Completed training.</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Offer training on IDD/MI dual diagnosis issues to large behavioral health practices</td>
<td>Completed training</td>
<td>100%</td>
</tr>
<tr>
<td>Develop plan to address service gaps between enhanced benefit and outpatient services and to address need for case management</td>
<td>Develop alternative service definition for Medicaid-funded outpatient treatment</td>
<td>Working with consultant, Partners MCO and providers to develop proposed alternative service definition. Draft completed and submitted to DMA.</td>
<td>58%</td>
</tr>
<tr>
<td></td>
<td>Develop service definition to fill service gap between ACTT and CST</td>
<td>Working with consultant, Partners MCO and providers to develop proposed alternative service definition. Working on cost model and revision of service definition.</td>
<td>58%</td>
</tr>
<tr>
<td>Increase availability, tracking and oversight of specialty services and evidence-based practices</td>
<td>Increase number of evidence based practices meeting fidelity for substance abuse providers</td>
<td>Working with SA providers through SA Treatment Provider Collaborative, and developed contract to provide individualized provider consultations on EBPs. Requested proposals from SA providers and selected six providers who will received individualized on-site consultations.</td>
<td>62%</td>
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<td>Consultation has been completed with Cape Fear and written recommendations are being prepared.</td>
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<td></td>
<td>Contract for EBP models for IIH and require independent fidelity reviews</td>
<td>Meeting monthly with IIH providers to implement change in contract requiring family-oriented EBPs. Multiple meetings and workgroups with providers, developers and implementation resources to refine implementation plans. Developing cost models for training and long-term sustainability of EBPs, in collaboration with providers and EBP developers. Developing contract scopes of work for IIH EBPs for addition to Medicaid contracts effective 7/1/16.</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Develop process for development and implementation of evidence-based practices with external fidelity verification</td>
<td>Completed.</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Promote EBPs for PSR programs including peer led programs, recovery oriented programs, and for dually diagnosed (MH/IDD)</td>
<td>Gathering information about PSR services, EBP models and will prepare written recommendations.</td>
<td>55%</td>
</tr>
<tr>
<td></td>
<td>Provide Training and Consultation for Providers to promote improved quality and implementation of evidence based practices</td>
<td>Peer Support training was held on November 20 and is scheduled for December 14 for both providers and Alliance staff. Completed DBT training 11/2-11/6. Working with Behavioral Tech and providers regarding DBT sustainability planning. Providing SE Collaborative to promote evidence-based MH/SA IPS model supported employment services.</td>
<td>60%</td>
</tr>
<tr>
<td>NDP Objective</td>
<td>Project</td>
<td>Status / Updates</td>
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<td>--------------------------------------------------------</td>
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</tr>
<tr>
<td>ID high cost/high need populations and match with EBP</td>
<td>Implement pilots for Youth Villages Intercept model, Kidspeace TFC and Mentor Family Centered Treatment model for high needs youth</td>
<td>Pilots all launched effective July 1.</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Implement First Episode Psychosis Program in Wake County</td>
<td>Completed implementation.</td>
<td>100%</td>
</tr>
<tr>
<td>Improve access to services for non-English speaking consumers</td>
<td>Conduct survey of providers with identified services for non-English speaking consumers. Clarify service availability and capacity for more robust bilingual/bicultural program emphasis.</td>
<td>Worked with Alliance Cultural Competency committee to develop provider survey and have posted on website for provider input. Results will be included in 2016 Community Needs Assessment.</td>
<td>85%</td>
</tr>
<tr>
<td>Increased capacity to serve TBI population</td>
<td>Participate in TBI HRSA grant</td>
<td>Screening for TBI through Call Center and collecting data for state analysis. Working with Brain Injury Association of NC and neuroresource facilitator to develop TBI-specific trainings for provider community. *Met with new TBI Specialists at DMH (Scott Pokorny and Travis Williams). Will begin reviewing data through TBI Grant Steering Committee. *DHHS has announced plans for a TBI waiver that will be piloted with Alliance in the first year of the waiver. There are 49 slots attached to the waiver for Alliance.</td>
<td>55%</td>
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<tr>
<td>NDP Objective</td>
<td>Project</td>
<td>Status / Updates</td>
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<tr>
<td>Expand integrated behavioral health/medical care</td>
<td>Conduct Inventory of current integrated care initiatives (e.g., Turning Point, Lincoln, UNC WakeBrook; Johnston Public Health, exploring Duke/CBC co-location and reverse co-location; FHR Dartmouth In-Shape, Southlight)</td>
<td>Completed inventory.</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Implement integrated healthcare pilots</td>
<td>Developed charters and project plans for each pilot. Hired consultant to evaluate pilots. Contracts pending for new initiatives with Carolina Outreach, Family Preservation and Easter Seals UCP.</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>Conduct evaluation of current integrated behavioral health/medical care initiatives and development of recommendations for further expansion</td>
<td>Hired consultant to evaluate pilot projects. Evaluation in process.</td>
<td>40%</td>
</tr>
<tr>
<td>Increase availability of resources for transportation</td>
<td>Review transportation initiatives in other states, inventory provider and stakeholders efforts and develop recommendations</td>
<td>Pending further discussions about project objectives and timeframes.</td>
<td>0%</td>
</tr>
<tr>
<td>Increase availability of resources for employment</td>
<td>Increase number of persons receiving MH/SA SE/LTVS</td>
<td>Conducted RFP for SE/LTVS services in Cumberland, selected vendor and in the process of expanding services in Cumberland. Meeting regularly with SE/LTVS providers through collaborative. *NC is now working with several other states and federal government through Vision Quest and Office of Disability and Employment Policy (ODEP) to look at sustainability of IPS at a statewide level. Alliance is participating in this planning process.</td>
<td>67%</td>
</tr>
<tr>
<td>NDP Objective</td>
<td>Project</td>
<td>Status / Updates</td>
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<tr>
<td></td>
<td></td>
<td>*We are looking at feasibility of aligning b3 rate and service definition with state rate and service definition. * Project planning with SPMO on increasing TCLI numbers and IPS SE.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evaluate impact of MH/SA SE-LTVS</td>
<td>QM will be scheduling brainstorming meeting to begin project.</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>Explore models and supports for consumer-run businesses</td>
<td>Pending further discussions about project objectives and timeframes.</td>
<td>0%</td>
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</table>
March 3, 2016

Over and Under-Utilization Detection update
Global Quality Management Committee
Alliance Behavioral Healthcare

The following reports are used by Alliance to detect the over and under-utilization of services:

1. **Authorized Service Outliers**

Outliers are determined using the following criteria:

- Inpatient = 10+ days
- IIHS = 182+ days (~ 6 months)
- PRTF = 151+ days (~ 5 months)

2. **Clinical Dashboard**

Report elements include:

- SARs Processing
- Average Daily Census
- Average LOS
- Call Center Statistics
- Reconsiderations and Appeals

3. **Daily Census**

Report counts consumers in Inpatient, Intensive In-Home and PRTF services by provider

4. **High-Cost Consumers**

Report calculates Medicaid, Medicaid B, Medicaid C and State expenditures per consumer

5. **Key Cost Drivers**

Report elements include:

- Consumers (Distinct)
- Enrollments (Distinct)
- ALOS
- Admits
- Admits per 1000
- Cost per Consumer
- Cost per Unit
- Expenses
- PMPM
- Units
- Units per 1000
6. **Provider High-Billers**

Report determines Paid Amount, Consumers Served by Provider and Service Line

7. **Hospital Length of Stay Report**

Report calculates distinct patients (Claims) and % Distinct Patients in Month for Lengths of Stay at:

- 1-7 days
- 8-11 days
- 12-15 days
- >15 days

8. **Provider Service Utilization graphs**

ALOS vs. Expenditures per Patient

9. **Service Analysis Report**

- Distinct patients
- Service units
- Expenditures per episode of care
1) **30-day Readmission Rates for Psychiatric Patients**  
**Measure Description:** Rate of readmission to psychiatric hospitals within 30 days.  
**Data Source:** NCTracks system/Truven Advantage Suite System/MCO Encounter data.  
**Measure Source:** National Outcome Measure Set (NOMS)

2) **Follow-up after Hospitalization for Mental Illness**  
**Measure Description:** This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are typically reported: 7-day and 30-day rates.  
**Data Source:** NCTracks system/Truven Advantage Suite System/MCO Encounter data.  
**Measure Source:** National Quality Forum (NQF) and HEDIS.

3) **Integrated Care**  
**Measure Description:** The percentage of continuously enrolled Medicaid enrollees with at least one MH/DD/SA visit who had a primary care or preventative care visit during the measurement year (reported separately for children, 3-20, and adults, 21+).  
**Data Source:** NCTracks system/Truven Advantage Suite System/MCO Encounter data.  
**Measure Source:** National Committee for Quality Assurance (NCQA) and HEDIS.

4) **Getting Treatment Quickly Composite Score**  
**Measure Description:** The percentage of patients who reported how often they get treatment quickly, reported separately for child/adolescents and adults.  
**Data Source:** Effectiveness of Care Health Outcomes Survey.  
**Measure Source:** [https://cahps.ahrq.gov/surveys-guidance/echo/about/index.html](https://cahps.ahrq.gov/surveys-guidance/echo/about/index.html)

5) **Metabolic Monitoring for Children and Adults Taking Antipsychotic Medications**  
**Measure Description:** For patients who were taking an antipsychotic medication at any point in the past 12 months, the percent with a Lipid and Glucose Screening.  
**Data Source:** NCTracks system/Truven Advantage Suite System.  
**Measure Source:** National Committee for Quality Assurance (NCQA) and HEDIS.

6) **SBIRT Alcohol and Substance Abuse Screening for Children and Adults in brief intervention services provided in primary care and outpatient settings**  
**Measure Description:** SBIRT services included in emergency departments and mental health settings (with the exception of co-located mental health and primary care services) are excluded from the measure.  
**Data Source:** NCTracks system/Truven Advantage Suite System/MCO Encounter data.  
**Measure Source:** SAMHSA--[http://www.integration.samhsa.gov/clinical-practice/sbirt](http://www.integration.samhsa.gov/clinical-practice/sbirt)

7) **Measure Name: Medical Assistance with Smoking cessation**  
**Measure Description:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.  
**Data Source:** NCTracks system/Truven Advantage Suite System.  
**Measure Source:** [http://www.qualitymeasures.ahrq.gov/content.aspx?id=48676#Section593](http://www.qualitymeasures.ahrq.gov/content.aspx?id=48676#Section593)

8) **Measure Name: Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (Test Measure)**  
**Measure Description:** The percentage of members age ≥12 with a diagnosis of major depressive disorder or dysthymia who had a PHQ-9 or PHQ-A tool administered at least once during a 4 month period.  
**Data Source:** NCTracks system/Truven Advantage Suite System.  
Complete Measure Descriptions

1) **Measure Name: 30-day Readmission Rates for Psychiatric Patients**
Measure Description: Rate of readmission to psychiatric hospitals within 30 days
Rationale for Including: This is an appropriate outcome for both CCNC and MCO’s to measure. It is measurable from claims data and is evidence-based. Both entities already measure these in some form.
Considerations for Future Group: if it is decided that this measure makes it to the next round for consideration, the following points need to be addressed:
- Recommend reporting on a per beneficiary basis and not on a per admission basis (i.e., the denominator is the number of enrollees, not the number of admissions)
- Measure needs to be risk-adjusted. CCNC utilizes 3M CRG’s for risk stratification, which would be an appropriate example. The Charlson Comorbidity Index may also be appropriate.
- Recommend focusing on just patients with both chronic psychiatric and medical conditions (i.e., “Quad IV”; need to be further defined).
- Recommend broadening the measure to include all-cause readmissions to any hospital (for either medical or psychiatric reasons)
Measure Source: National Outcome Measure Set (NOMS)

2) **Measure Name: Follow-up after Hospitalization for Mental Illness**
Measure Description: This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are typically reported: 7-day and 30-day rates.
Rationale for Including: One of the key drivers for preventing readmissions are timely follow-up with appropriate outpatient providers after hospital discharge. This is also an appropriate process measure for both CCNC and MCO’s to measure, particularly if the focus is on patients with comorbid conditions. It is measurable from claims data and is evidence-based. CCNC and DMA already measure this.
Considerations for Future Group: if it is decided that this measure makes it to the next round for consideration, the following points need to be addressed:
- Recommend modifying the HEDIS specs to make it more applicable to integrated care, including:
  - focusing on just patients with both chronic psychiatric and medical conditions (i.e., “Quad IV”; need to be further defined).
  - broadening the measure to include follow-up after any hospitalization (not just psychiatric)
  - broadening the measure to include follow-up with either a PCP or a behavioral health provider (or measure both separately)
Measure Source: National Quality Forum (NQF) and HEDIS

3) **Measure Name: Integrated Care**
Measure Description: The percentage of continuously enrolled Medicaid enrollees with at least one MH/DD/SA visit who had a primary care or preventative care visit during the measurement year (reported separately for children, 3-20, and adults, 21+).
Rationale for Including: This is an appropriate outcome for both CCNC and MCO’s to measure. It is measurable from claims data and is evidence-based. Both entities already measure these. Currently working to integrate the measure into the Truven Advantage Suite System
Measure Source: National Committee for Quality Assurance (NCQA)
4) **Measure Name: Getting Treatment Quickly Composite Score**

**Measure Description:** The percentage of patients who reported how often they get treatment quickly, reported separately for child/adolescents and adults. This composite measure indicates the percentage of patients who indicated how often (“Always”, “Usually”, “Sometimes”, or “Never”) they obtained treatment without long waits. The “Getting Treatment Quickly” composite measure is based on three questions on the Experience of Care and Health Outcomes (ECHO) Survey.

**Rationale for Including:** This is an appropriate outcome for MCO’s to measure.

**Considerations for Future Group:** if it is decided that this measure makes it to the next round for consideration, the following points need to be addressed:

- Which patients are included in the denominator?

**Measure Source:** Experience of Care and Health Outcomes (ECHO) Survey.

5) **Measure Name: Metabolic Monitoring for Children and Adults Taking Antipsychotic Medications.**

**Measure Description:** For patients who were taking an antipsychotic medication at any point in the past 12 months, the percent with: a) Glucose screening –had a claim for either a blood glucose or HbA1c test performed within a year +/- the date the antipsychotic was first filled, and b) Lipid screening – had a claim for a lipid panel performed within a year +/- the date the antipsychotic was first filled. Both measures reported separately for children/adolescents and adults.

**Rationale for Including:** This is an appropriate outcome for both CCNC and MCO’s to measure. It is measurable from claims data and is evidence-based. CCNC already measures this.

**Measure Source:** National Committee for Quality Assurance (NCQA).

6) **Measure Name: SBIRT Alcohol and Substance Abuse Screening for Children and Adults in brief intervention services provided in primary care and outpatient settings.**

**Measure Description:** SBIRT services included in emergency departments and mental health settings (with the exception of co-located mental health and primary care services) are excluded from the measure.

**Numerator:** CPT 99420 (with V79.1 or V82.9); CPT 99408, 99409 G0442, G0443, G0396, G0397

**Denominator:** Visits of Medicaid patients age 12 and older.

**Denominator details:**

- Unique count of members age 12 years or older of the measurement year, and having received an outpatient service as identified by the following CPT codes:
  - Office or other outpatient visits: 99201-99205, 99211-99215, 99241-99245
  - Home visits: 99341-99345, 99347-99350
  - Preventive medicine: 99383-99384, 99385-99387, 99393-99394, 99395-99397, 99401-99404, 99408, 99409, 99411, 99412, 99420, 99429, G0396, G0397, G0402, T1015, and diagnosis code v20.2

**Measure Source:** [http://www.sbirtoregon.org/incentive_measure.php](http://www.sbirtoregon.org/incentive_measure.php)

7) **Measure Name: Medical Assistance with Smoking cessation**

**Measure Description:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.
INSTRUCTIONS:
This measure is to be reported once per reporting period for patients seen during the reporting period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use.

Measure Reporting via Claims:
CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure’s denominator. CPT Category II codes are used to report the numerator of the measure. When reporting the measure via claims, submit the appropriate CPT or HCPCS codes, and the appropriate CPT Category II code
OR the CPT Category II code with the modifier.
The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Denominator:
All patients aged 18 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND Patient encounter during the reporting period (CPT or HCPCS):
90791, 90792, 90832, 90834, 90837, 90839, 90845, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99406, 99407, G0438, G0439.

Numerator:
Patients who were screened for tobacco use at least once within 24 months
AND who received tobacco cessation counseling intervention if identified as a tobacco user

Definitions:
Tobacco Use Includes use of any type of tobacco.
Cessation Counseling Intervention—Includes brief counseling (3 minutes or less), and/or pharmacotherapy.

NUMERATOR NOTE:
In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling report 4004F with 8P.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Patient Screened for Tobacco Use CPT II 4004F:
Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user
OR
Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco CPT II 1036F: Current tobacco non-user
OR
Tobacco Screening not Performed for Medical Reasons
Append a modifier (1P) to CPT Category II code 4004F to report documented circumstances that appropriately exclude patients from the denominator 4004F with 1P:
Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reasons)
Rationale:
This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.

Clinical Recommendation Statements:
The following evidence statements are quoted verbatim from the referenced clinical guidelines:

All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco use status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

All physicians should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A)

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention, whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A)

The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking. (Strength of Evidence = A)

Clinicians should encourage all patients attempting to quit to use effective medications for tobacco dependence treatment, except where contraindicated or for specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents). (Strength of Evidence = A)

The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation)
(U.S. Preventive Services Task Force, 2009)
8) **Measure Name:** Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults

**Measure Description:**

The percentage of members age ≥12 with a diagnosis of major depressive disorder or dysthymia who had a PHQ-9 or PHQ-A tool administered at least once during a 4 month period.

**Numerator:** Documented results of a PHQ-9 or PHQ-A at least once during the 4 month period.

**Denominator:** All individuals age ≥12 who had an encounter during a 4 month period with an active diagnosis of major depressive disorder or dysthymia.

**Measure Source:**

Optional Measures:

Measure Name: Depression Remission or Response for Adolescents and Adults

Measure Description:

The percentage of members 12 years of age and older with a diagnosis of major depressive disorder or dysthymia and an elevated PHQ-9 or PHQ-A score, who had evidence of response or remission within 5–7 months of the elevated PHQ-9 score.

Denominator: All individuals age ≥12 with an active diagnosis of major depressive disorder or dysthymia and an initial PHQ-9 score >9

Numerator: PHQ-9 score <5 documented at 5-7 months following the initial elevated PHQ-9 OR a 50% reduction in the PHQ-9 score documented at 5-7 months following the initial elevated PHQ-9.

Measure Source:

Measure Name: Depression Screening and Follow-up for Adolescents and Adults

Measure Description:

The percentage of members age ≥12 who were screened for clinical depression using a standardized tool and, if screened positive, who received appropriate follow-up care.

Denominator: All individuals age ≥12 with a visit during the measurement year.

Numerator: Screened positive for depression using a standardized tool and appropriate follow-up care provided within 30 days OR screened negative for depression using a standardized tool.

Measure Source:
Alliance Comments on proposed Integrated Care Measures

February 29, 2016

Re: Alliance comments on proposed Integrated Care Measures

To: Adolph Simmons, DMA, Quality Management
From: Alliance BHC

- The general comments were developed by Quality Management Director based on the NC Council QM Director Committee’s comments regarding other performance measures proposed by the state.

- The specific comments on measures listed below were collected from a variety of Alliance staff.

GENERAL COMMENTS

Measures based on NC-TRACKS:

1. The state should develop the measures only when the data in NC-TRACKS have been verified as complete and accurate.

2. In the meantime, the state should not make each LME-MCO calculate the measures themselves because (1) LME-MCOs do not have access to all medical data; and (2) LME-MCOs will not consistently calculate the measures.

3. Implementing the measures should be a multi-year process beginning only when NC-TRACKS is fully operational. In Year 1, the state will develop and test the outcomes measures; in Year 2, the state will provide the LME-MCOs with official results for further evaluation and feedback. Only in Year 3 will the state start holding the LME-MCOs accountable for their performance.

Measures based on consumer surveys:

1. The state should contract with a certified organization to administer any survey, and not conduct the survey itself.

2. The state should hire a third-party expert to validate the survey methodology and final calculations.

3. The state and LME-MCOs should review the survey methodology and calculations with the administrator prior to conducting the survey.

In general:

1. The state should not set a statewide goal for any measure, for example, all LME-MCOs will screen 90% of consumers for tobacco use.
Alliance Comments on proposed Integrated Care Measures

2. The state should instead account for the unique status of each LME-MCO when establishing goals for outcomes measures. This includes demographics, urban/rural status, provider network capacity, and consumer access to services.

3. The state should baseline each LME-MCO’s current performance, and then set a target for improvement, for example, a 10% increase in screening in the first year.

4. The state should not assess financial penalties for failure to meet any outcomes measures goal.

SPECIFIC MEASURE COMMENTS

**Measure:** Rate of readmission to psychiatric hospitals within 30 days.

**Comments:** None

**Measure:** This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are typically reported: 7-day and 30-day rates.

**Comments:**

1. If we are going to integrate care, broadening the measure to include any follow-up makes sense.

2. A consumer may not be using a specialty behavioral health provider. If that’s the case, would we have access to data? How would we be in charge of reporting?

**Measure:** The percentage of continuously enrolled Medicaid enrollees with at least one MH/DD/SA visit who had a primary care or preventative care visit during the measurement year (reported separately for children, 3-20, and adults, 21+).

**Comments:**

1. Do we have access to the primary care information through NC Tracks?

2. Not clear how we would access the information needed to report.

**Measure:** The percentage of patients who reported how often they get treatment quickly, reported separately for child/adolescents and adults.

**Comments:**

1. Is there a baseline expectation for this measure?

2. Do we know where we are in relation to any expectation?
Alliance Comments on proposed Integrated Care Measures

3. Is there a way to connect this to ease of access to treatment or to the type of service obtained by the person so we know where barriers are or whether integration of care is increasing percentage saying they get treatment quickly?

**Measure:** For patients who were taking an antipsychotic medication at any point in the past 12 months, the percent with a Lipid and Glucose Screening.

**Comments:**

1. CMT looks like it has a measure, but looking at the information seems like it's not really pulling 100% noncompliance. Can we get this through NC-Tracks looking at lab billing?

**Measure:** SBIRT services included in emergency departments and mental health settings (with the exception of co-located mental health and primary care services) are excluded from the measure.

**Comments:**

1. I think the SBIRT measure will be difficult. I think there are some billing codes used in other states to capture these activities, but I do not believe they are covered in NC currently, would not know how we would collect this data.

2. I'm unclear about the measure. I'm unclear what is meant by the exceptions of co-located providers and how we would know how to identify a co-located provider. Also SBIRT model relates to intervention so the co-located sites seem to be the ones most likely to be able to do the intervention. What is the baseline? Measuring against all visits, but same patient multiple visits you wouldn't want to keep screening. Looks like this measure has already been decided though. No comments for future groups.

**Measure:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

**Comments:**

1. Why would the measure be limited to consumers aged 18 and older as underage smoking is an issue? It would seem they would want to connect those folks with resources to stop as well.

2. Are these billing codes part of our benefit package?

**Measure:** The percentage of members age >=12 with a diagnosis of major depressive disorder or dysthymia who had a PHQ-9 or PHQ-A tool administered at least once during a 4 month period.

**Comments:**
Alliance Comments on proposed Integrated Care Measures

1. How would this be measured?

2. Are our providers currently billing for this code and do we want to pay them for using this code and screening as opposed to ongoing assessment through treatment?

3. Is this a measure designed to measure progress in specialty mental health care, or to look at access and treatment in integrated care or both?
ITEM: 457 and 401K Plans - Loan Provision

DATE OF BOARD MEETING: April 7, 2016

BACKGROUND:
When Alliance was formed in 2012, employees were offered participation in the 457 (a deferred compensation plan for State/Local Government employees) and the 401K plan (supplemental retirement income). The plans have a loan option for employees. In 2012 upon inception, the 401K plan was set up to allow loans and the 457 was not. To be consistent, we would propose that the 457 plan allow employees the option for loans which would give employees the option to secure a loan from either plan. There is no cost impact to Alliance.

REQUEST FOR AREA BOARD ACTION:
Approve the proposal.

CEO RECOMMENDATION:
Approve the proposal.

RESOURCE PERSON(S):
Al Ragland, Chief HR Officer
ITEM: Data Analytics Roadmap Update

DATE OF BOARD MEETING: April 7, 2016

BACKGROUND:
Alliance is committed to expanding and enhancing its current analytic capabilities to improve business reporting, quality of care, cost of care and member experience. Intellicog is working with Alliance to 1) Document data analytics needs and opportunities across the core functions of the business, 2) Define a data analytics capability aligned to corporate strategy and objectives, and 3) Deliver a roadmap to achieve a recommended data analytics solution framework. This training will provide an overview of progress of the data analytics roadmap.

REQUEST FOR AREA BOARD ACTION:
Accept the training.

CEO RECOMMENDATION:
Accept the training.

RESOURCE PERSON(S):
Michael Bollini, Ph.D, Chief Strategy Officer
Data Analytics
Program Update

Presentation to Alliance Board of Directors
April 7, 2016
GET ALL THE INFORMATION YOU CAN, WE'LL THINK OF A USE FOR IT LATER.
Data Analytics Program

Jump Shift
Advanced Analytics

Data Discovery Project
Developing prototype reports and dashboards to answer business questions empirically

Business Intelligence and Reporting Project
Implementation of business intelligence and reporting tool and for harnessing the data to be used for reporting and analytics

IT Strategy
Strategic, nimble planning to support business strategy through constant changes
Data Analytics Maturity

- **Data Discovery**
- **JumpShift**

Data

- **Descriptive**
  - What happened?
- **Diagnostic**
  - Why did it happen?
- **Predictive**
  - How likely is \( x \) to happen?

**Decision Support**

**Prescriptive**

- What is the optimal action?

**Decision Automation**

**Decision or Recommendation**

**Deployed Action To Operational Systems**

**Analytics**

**Human Intervention**
Business Challenge:

Do we have the right plans and benefit limits for our State and County Funded Outpatient and Community Service Team needs, or should we raise the benefit limits? If so, for who?, and by how much?

Why we need to know:

1) To ensure the **quality of care**: If plan limits are too low, we could be denying badly needed services for members.

2) To be **financially responsible**: Without data, we can make plan changes, but its impossible to know if these changes are needed universally or just for select plans/members. The data will show if the need is due to certain diagnoses, population groups, case types etc. Knowing the need enables Alliance to make sound financial decisions.

3) To be **efficient**: Approvals for Outpatient services above benefit limits require Doctor approval creating delayed services and a more costly approval process.
Discovery Examples in Progress: Community Tenure

Business Challenge:

How do we ensure we are providing the right services to our members to maximize the time they spend active and out in their community?

How long can we appropriately keep people participating in the community and out of ED, inpatient facilities?

Why we need to know:

1. Creates benchmark to **measure** Alliance programs effectiveness
2. Be able to predict which members are more likely to return for inpatient or Emergency department treatments and put **proactive** programs in place for them
3. The data enables Alliance to analyze behavior at the macro level, and then **slice and dice the data** to understand the specific drivers
Discovery Examples in Progress: Provider Scorecards

Business Challenge:
How do we identify high performing providers? Or providers that are financially at risk? Or providers that struggle to get services approved?

Why we need to know?

1. Alliance strives to develop and manage a high quality provider network. To do this, we need empirical data and a method to compare Provider performance across many areas.
2. High performing providers have practices and processes worth sharing to improve standards of care across the network.
3. Providers with high volumes of claim denials and claims issues could be at risk for financial trouble, placing our member’s health at risk. Being able to identify a trend before it is a critical problem is key to continuity of health and services.
LET'S SOLVE THIS PROBLEM BY USING THE BIG DATA. NONE OF US HAVE THE SLIGHTEST IDEA WHAT TO DO WITH.
Characteristics of Analytics Delivery Maturity

Health Analytics Value Proposition Continuum

**Core Excellence Model**
- I know what my members did yesterday
- I know who my high risk members are based on history
- I can identify the causes of the most no-show appointments
- My analysts have the tools to discover patterns in my member data
- I can measure the impact of intervention programs

**Jump-Shift Enabled Model**
- I know what my members will do next week/month
- I know how to engage my members to change behaviors and decrease risk
- I can target multiple tailored solutions to no-show appointments with projected lift and value to each solution
- My analysts employ machine learning to detect patterns and retrain analytical models
- I can determine which actions have the greatest influence on positive impact
Business Challenge:
One of the hospitals frequented by Alliance members has an average length of stay at nearly double all other institutions in the network, creating higher costs, limiting availability of high demand inpatient beds, and hindering access to a walk-in assessment center.

Why we need to know?
This challenge impacts access to care for crises and inpatient beds, inflates costs and makes them less predictable, keeps patients in a hospital and away from the community longer. If we know why this is happening, we can put programs in place to prevent it.
Jump Shift Solution:
The objective is to understand the root cause of these extended Lengths of Stay and then implement practices and programs to decrease them.

Because there are so many potential influencers, an advanced analytics capability is needed to:

- Run pattern analysis on the impacted members and incorporate:
  - Professional, institutional and pharmaceutical data against
  - Medical history and patterns of care
  - Co-morbidities and case complexity
  - Socio-economic factors
  - Member demographics
- Compare this population against the rest of the Alliance population with similar traits, diagnoses, histories, age, etc
“You can have data without information, but you cannot have information without data.”

Daniel Keys Moran
Programmer and Science Fiction Writer
ITEM: Strategic Plan Goal #5 Update – Attract and Retain a Talented Workforce

DATE OF BOARD MEETING: April 7, 2016

BACKGROUND:
Update on work in support of Goal #5 of the Strategic Plan – Attract and Retain a Talented Workforce

REQUEST FOR AREA BOARD ACTION:
Accept the training.

CEO RECOMMENDATION:
Accept the training.

RESOURCE PERSON(S):
Al Ragland, Chief HR Officer
Our People Investment

Attract and Retain A Talented Workforce

Developing our people is our greatest investment

Building our future – being prepared for what comes next

Raising the bar on what is most important in a changing environment

Recognizing high level of performance
Performance Management

Alignment with Strategic Goals for Alliance

- Organizational
- Department
- Individual Development
- Core Responsibilities
- Values
Leadership Development Institute

- Implemented Fall of 2014
- Focus on strategic leadership learning and core management skills
- Sessions are held quarterly
- 75 participants, including supervisors, managers and executive leadership
- Topics are selected based on organizational need, current trends and by request
- Total hours facilitated: 1,575 hours
Leadership Development Institute

- Performance Management/Work Plans
- Setting goals/objectives
- Coaching for Success
- Leadership Styles
- Generations in the workplace - Traditionalist to Millennials
- Coaching for Productivity and Retention
- Change Management
- Cultural Competency
- Onboarding
- EEOC and ADA
- Internal and external education on trends and benchmarks in the healthcare industry
Employee Development

• Yearly survey to determine need and demand
• Total hours of training this past year = 8,989
  - Clinical = 2,970
  - Non Clinical = 6,019
Wellness Program

- Wellness Program Kickoff – 10/16/2015
- Wellness Committee selected, representation from each site
- Mission Statement

The Wellness Committee will provide education, resources and opportunities for employees to develop a healthy holistic lifestyle that contributes to their positive well-being.
Wellness Program

• Scheduled monthly Lunch & Learns with Nutritionist – lunch meetings occur the last week of each month at each site. Currently scheduled through June 2016

• Offer discounted gym memberships and enrollment discount for YMCA

• Vending machines companywide
  • Healthier snack options
  • Additional drinks and water options
Wellness Program

- Staff may wear athletic footwear according to established criteria
- Wellness share point page created
- Pedometers provided to staff at no cost to Alliance
- Virtual 12-week Walking Challenge began April 1, 2016, to Wrightsville Beach
Wellness Program

• The Biggest Winner 12-week weight loss challenge began April 1, 2016.

• In the works
  • Use of Wellness Codes, a program that offers discounts to employees on wellness items
  • Researching the engagement of onsite fitness instruction – desk exercise
  • American Red Cross blood drive agency-wide to occur June/July 2016
Reward and Recognition Program

What we’ve accomplished…

– Committee comprised of 11 employees from all sites selected via essay submission
– Committee delivered survey to gauge employee R&R program desires and program name
– Alliance All STARS chosen by employee vote as the program name
– Survey results used to determine how to reward employees.
Reward & Recognition Employee Survey Results

Please rank how you would like to be recognized for accomplishments at Alliance

Answered: 138  Skipped: 1

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<th>Method</th>
<th>Answered</th>
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<td>Paper Certificates</td>
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<td>Intranet</td>
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All STARS

Alliance Special Thanks and Recognition System

- Collaboration – Staff who actively develop meaningful relationships, have excellent communication and cooperation on their own and across teams
- Compassion – Staff who show dedication to the people we serve and embody community
- Accountability and Integrity – Staff who honor their commitments to stakeholders
- Dignity and Respect – Staff who value differences, seek input, strive to be inclusive and honor the culture and history of all
- Innovation – Staff who are challenging the way it’s always been done
What we are working on...

- Project Kickoff-
  - Drafting recognition criteria & procedures
  - Developing communications for program mission & benefits to share with employees
  - Determining tangible rewards
  - Implementation-Kickoff slated for June 2016
Other Notable Initiatives

• Communications Committee
  – Cross departmental, led by Communications unit
  – Implementing staff recommendations for enhancing internal communication
  – Development of Internal Communications Plan

• Social Committee
  – Uplifting, motivating, and teamwork
  – All Staff Training Day (Behavioral Health, Wellness Kick off)
  – Holiday celebration
  – Annual Alliance anniversary/Spirit Week
Gender Breakdown

- Female: 77%
- Male: 23%
Age Breakdown

- 20-29: 33.41%
- 30-39: 35.24%
- 40-49: 21.74%
- 50-59: 6.41%
- >60: 3.20%
# Turnover

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# Time to Fill

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*Online application system implemented 2014
Attracting and Retaining a Talented Workforce

THANK YOU
Senate Bill 208 Update

Presentation to the Area Board
April 7, 2016
HMS Audit – SB 208

- March 1, 2015 – August 31, 2015
- 3% of claims – 14K, $35.3M
- Claims are reviewed for:
  - Authorization, COB, correct coding, duplication, pricing, timely filing, etc.
- Requirements:
  - 90% of claims paid within 30 days
Results

• **99.96%** were found to be paid within 30 days

• 229 claims (out of 14,102) were flagged for additional review. 16 of those were found to be processed in error.

• Alliance agreed with 15 of the 16 sample findings
  • Correct coding, duplicates, and eligibility
  • Claims recouped where necessary

• Claims Processing Accuracy – **99.81%**

• Financial Accuracy – **99.96%**