MEMBERS PRESENT: ☒Cynthia Binanay, Vice-Chair, ☒Christopher Bostock, Chair, ☒George Corvin, MD, ☒Kenneth Edge (via phone), ☒James Edgerton, ☒Lodies Gloston, ☒Phillip Golden, ☒John Griffin, Ed.D (exited at 6:17 pm), ☒Curtis Massey (via phone), ☒Rev. Michael Page (via phone; entered at 4:15; exited at 4:25), ☒George Quick, ☒Vicki Shore, ☒William Stanford, Jr. (entered at 4:25 pm), ☒Caroline Sullivan, ☒Amelia Thorpe, ☒Lascel Webley, Jr., and ☐McKinley Wooten, Jr.

GUEST(S) PRESENT: Gary Bass, CEO of Pride of North Carolina, Inc.; Israel Pattison, CFAC Co-Chair

ALLIANCE STAFF PRESENT: Michael Bollini, Executive Vice-President/Chief Operating Officer (interim)/Chief Strategy Officer; Hank Debnam, Cumberland Site Director; Joey Dorsett, Senior Vice-President/CIO; Doug Fuller, Director of Communications; Kelly Goodfellow, Executive Vice-President/CFO; Amanda Graham, Senior Vice-President/Organizational Effectiveness; Carol Hammett, General Counsel; Veronica Ingram, Executive Assistant; Wes Knepper, Project Manager; Susan Knox, Senior HR Analyst; Geyer Longenecker, Quality Management Director; Ken Marsh, Medicaid Program Director; Beth Melcher, Senior Vice-President/Network Development and Evaluation; Ann Oshel, Senior Vice-President/Community Relations; Kate Peterson, Project Manager; Monica Portugal, Chief Compliance Officer; Al Ragland, Senior Vice-President/Human Resources; Rob Robinson, CEO; and Doug Wright, Director of Consumer Affairs

1. CALL TO ORDER: Chairman Christopher Bostock called the meeting to order at 4:01 p.m.

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<th>AGENDA ITEMS</th>
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<tr>
<td>2. Announcements</td>
<td>There were no announcements.</td>
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<td>3. Agenda Adjustments</td>
<td>There were no adjustments to the agenda.</td>
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<td>4. Public Comment</td>
<td>There were no public comments.</td>
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<td>5. Committee Reports</td>
<td>A. Consumer and Family Advisory Committee – page 5&lt;br&gt;The Alliance Consumer and Family Advisory Committee (CFAC) is composed of consumers and/or family members from Durham, Wake, or Cumberland counties who receive mental health, intellectual/developmental disabilities or substance use/addiction services. This month’s report included draft minutes from the August CFAC meeting. Israel Pattison, CFAC Vice-Chair, presented the report. He provided a review of Alliance CFAC meetings and county subcommittee meetings; a Quality Management update provided by Tina Howard, Quality Review Manager; a review of CFAC by-laws, and an interest in knowing more about mergers. Mr. Robinson expressed interest in attending an upcoming CFAC meeting to provide an update on mergers. B. Finance Committee – page 47&lt;br&gt;The Finance Committee’s function is to review financial statements and recommend policies/practices on fiscal matters to the Area Board. This month’s report included draft minutes from the August meeting. James Edgerton, Committee Chair, presented the report. He noted that revenue exceeded expenditures. Mr. Edgerton reviewed the State mandated ratio for expenses for services and administrative funds. He mentioned that the Alpha CM system used for claims had calculated July claims for the month of August.</td>
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### AGENDA ITEMS:

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<td>Mr. Edgerton noted that the Finance Committee would like to provide additional education for the Area Board regarding the budget process: how the agency manages funds, understanding statute requirements, staff budget/finance committee, etc. He proposed that this training occur at the November Board meeting.</td>
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<td>C. Policy Committee (10 minutes) – page 53</td>
<td>Per Alliance Behavioral Healthcare Area Board Policy “Development of Policies and Procedures”, the Board reviews all policies annually. The Policy Committee reviews a number of policies each quarter in order to meet this requirement. This month’s report included draft minutes from the August meeting, policies for continued use and policies with recommended changes.</td>
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<td>Curtis Massey, Committee Chair, presented the Policy Committee report. He mentioned that the policies were sent previously as part of the packet and noted policies that were submitted for approval with continued use: Area Board By-Laws; Area Board Code of Ethics; Area Board Conflict of Interest; Consumer, Family, Advisory Committee; Delegation of Authority to the Area Director; Strategic Planning; Guidelines for Public Comment at Area Board Meetings; Health and Safety; Emergency Management Plan; Area Board Media; Internal Control; Area Board Member Attendance Compensation; Business Continuity; Area Director Compensation; Evaluation of Area Director; and Reporting of Abuse, Neglect, Dependency and Exploitation. Additionally, Mr. Massey presented the following policies with recommended revisions: Area Authority Relations with Catchment Area Counties; Development of Policies and Procedures; Area Board Processes; Management of Service Delivery; Dispute Resolution; Pre-Review Screening for Certification; Accessibility of UR/UM Process; Utilization Review Process; Appealing Clinical UM Decisions; and Utilization Review Criteria.</td>
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<td><strong>BOARD ACTION</strong></td>
<td>A motion was made by Dr. George Corvin to approve the policies recommended for continued use and with suggested revisions; seconded by Vice-Chair Cynthia Binanay. Motion passed unanimously.</td>
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B. Executive Committee Report – page 113  
C. Human Rights Committee Report – page 116  
D. Quality Management Committee Report – page 145  
E. Proposal to Purchase and Lease 3309 Durham Drive, Raleigh – page 195  
The consent agenda was sent as part of the Board packet. Chairman Bostock mentioned that the lease was part of last month’s Board meeting. There were no comments or discussion about the consent agenda. |
| **BOARD ACTION** | A motion was made by Dr. George Corvin to adopt the consent agenda; seconded by Mr. McKinley Wooten. Motion passed unanimously. |
### AGENDA ITEMS:

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In accordance with contractual obligations and federal regulations, Alliance shall have an effective compliance program with reasonable oversight by the governing board; the governing board will have understanding of the scope and operations of the compliance program. The Board approved Corporate Compliance Plan states that a report of compliance efforts will be presented annually to the Alliance Behavioral Healthcare Area Board.  

Monica Portugal, Chief Compliance Officer, presented the annual report. She noted information from a recent compliance conference and reviewed the importance of open communication, oversight by the Compliance department and the Area Board via the Audit and Compliance Committee. Ms. Portugal reviewed the effectiveness of the compliance program; responsibilities of the governing board; internal audits, monitoring, and investigations; privacy/security incidents, special investigations; and network compliance. Mr. Webley requested providing additional information to the Board regarding how the agency handles recoupment from providers.

B. FY17 Organizational Goals – page 210  
Robert Robinson, CEO, and Amanda Graham, Senior VP/Organizational Effectiveness, presented FY17 organizational goals. Mr. Robinson provided background on how Alliance initially created its strategic plan with six strategic goals. He noted a recent review during April 2016 to evaluate current progress with the strategic plan. Ms. Graham mentioned that as a result of the April evaluation; the revised strategic plan includes four goals. Ms. Graham reviewed the four goals and objectives for each goal. The presentation of the FY17 organizational goals is attached to and made part of these minutes.

C. BECOMING Evaluation – page 224  
BECOMING is a six year, $5.4 million SAMHSA grant focused on 16-21 year olds who had become disconnected from services and supports. The grant funding ends Sept 30, 2016. Ann Oshel, Sr. VP/Community Relations, mentioned that SAMSHA requires an evaluation every two-years; she presented highlights of achievements and positive impact on persons involved in the BECOMING project. The BECOMING presentation is attached to and made part of these minutes. |

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<td>The Board received the trainings as presented. No additional action required.</td>
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| 8. Updates | There were no updates. |
| 9. Chairman’s Report | A. NEXT BOARD MEETING AT A COMMUNITY SITE  
Chairman Bostock reminded Board members that the November Board meeting is scheduled to be at the Cumberland site. This space will be undergoing renovation during this time. Additionally, he mentioned the previous decision to change the location of the August Board meeting; it was previously scheduled to be at the Durham site. |
AREA BOARD REGULAR MEETING  
4600 Emperor Boulevard, Durham, NC, 27703  
4:00-6:00 p.m.

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<td>Chairman Bostock proposed that the Board meet at the Durham site in November and schedule to meet at the Cumberland site once renovation is completed. Also, he mentioned that the Executive Committee will review the meeting location schedule and present a proposal for 2017 meeting locations at an upcoming Board meeting.</td>
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**BOARD ACTION**

A motion was made by Mr. Phillip Golden to hold the November meeting at the Durham site; seconded by Dr. George Corvin. Motion passed unanimously.

B. OPEN MEETINGS LAW

Chairman Bostock reminded Board members that, as discussed at the August meeting, the NC Open Meetings Law training was sent electronically to Board members. Currently 59% of Board members have completed the training and assessment. Chairman Bostock encouraged Board members to complete the training.

10. Closed Session

The Board entered closed session.

**BOARD ACTION**

A motion was made by Commissioner Caroline Sullivan to enter to enter closed session pursuant to NC General Statute 143-318.11 (1) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1; seconded by Dr. George Corvin. Motion passed unanimously.

The Board returned to open session.

11. Adjournment

With all business being completed the meeting adjourned at 6:27 p.m.

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**Next Board Meeting**

**Thursday, October 06, 2016**

**4:00 – 6:00**

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Robert Robinson, Chief Executive Officer  
10/6/2016  
Date Approved
ITEM: Consumer and Family Advisory Committee (CFAC) Report

DATE OF BOARD MEETING: September 1, 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 met as a whole on August 1, 2016. The minutes and accompanying documents are attached.

CEO RECOMMENDATION:
Receive the draft minutes.

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

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| 1. Welcome/Overview: | Introductions:  
  - Welcome guest Martha Brock  
  Additional handouts included:  
  - Sub-Committee Meeting Minutes from Cumberland, Durham, Wake, Executive Leadership Team  
  - Quality Improvements Project to CFAC – Tina Howard  
  Meeting Minutes from 6-6-16: Approved as Written | | |
| 2. Public Comment – Consumer/Family Challenges and Solutions: | Public Comments:  
  - Faye encouraging and inviting friends to attend CFAC  
  Consumer/Family Challenges and Solutions:  
  - Mobile Crisis Team Services concerns. David filed a complaint with Wake County liaison, had great response. Complaint still open.  
  - Martha Brock: Crystal Farrow, now Deputy Director of Wake County Human Services. She had worked on Crisis Services. | | |
| 3. Quality Improvement Projects: Tina Howard and Geyer Longenecker | Tina Howard presented an overview of the Quality Improvement Projects to CFAC (handout):  
  Quality Improvement Projects (QIP) are larger projects that meet the Federal and State and accreditation for the organization.  
  Discussion included:  
  - URAC & Federal and State Requirements  
  - Implementation  
  - Summary and success of current QIP’s, and new QIP’s for FY17 | | |
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<td>• Expanding to open another Facility Based Crisis Center in Wake County (Monarch) in 2017. Plans to extend hours until 9 pm on weeknights.</td>
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<td>• Person-Centered-Plan needing improvement – Will and continue to promote and develop.</td>
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<td>• Closing QIP’s that have met benchmarks:</td>
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<td>• Grievance/Complaint Process</td>
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<td>• Internal Processes for Care Coordination</td>
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<td>• Incoming Call Center calls are handled properly, friendly and very professional.</td>
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<td>New Projects for FY17:</td>
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<td>• Improved timeliness for individuals who received their innovation slot and are waiting for services.</td>
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<td>• Improve timeliness of Care Coordination first contact to MH/SA discharged inpatient services.</td>
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<td>• Access to Care, timeliness to receive services for urgent and routine services, and develop another project for Emergent care.</td>
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Any Questions, contact Tina Howard: thoward@alliancebhc.org

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### 4. Sub-Committee Updates:

**Rules**
- No Report

**Services**
- No Report

**Communications**
- Temporary chairperson is Caroline Ambrose. Still need to fill the Chairperson position.

**Wake**
- Dave gave a summary (Sub-Committee Minutes Handout):
  - Mobile Crisis Team Services concerns. David filed a complaint with Wake County liaison, had great response. Complaint still open.
  - Implementation of the new Innovations Waiver beginning November 1st. Training will be available at various places.
  - Elect new member to CFAC. James Eby comes from Coastal Care and Trillium CFAC. He provided a bio and history of his CFAC involvement.
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<td>Motion by Kurtis Taylor to accept James Eby as a new CFAC member, seconded by Dr. Michael McGuire, motion carried, All Ayes</td>
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<td><strong>Durham</strong> Sharon gave a summary (Sub-Committee Minutes Handout): Discussion on:</td>
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<td>• Reaching out to local congressman challenges being faced and to offer solutions for affordable housing for consumers from hospital discharge.</td>
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<td>• Durham CFAC drafting and offering comments on the By-Laws.</td>
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<td>• CFAC invited to Recovery Celebration meeting on 8-4-16 from 3-4 pm to have a booth at their upcoming September event.</td>
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<td>• Discussed the merge and how Sandhills CFAC does not want to converse with Alliance CFAC.</td>
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<td><strong>Cumberland</strong> Lotta gave a summary (Sub-Committee Minutes Handout):</td>
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<td>• Met on July 28th</td>
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<td>• Next meeting on August 25th will be held at the Godwin Town Hall, 4924 Markham Street, Godwin, NC – All the Community is Invited</td>
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<td>• Community meeting focusing on “Access to Care” with Alliance. A Q &amp; A session will follow.</td>
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<td>• Saturday, Aug 6th a booth will be set up on Cliffdale Road across from the Rec Center, come out to see Starlett Davis and Lotta Fisher.</td>
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<td><strong>Area Board</strong> Caroline provided an update:</td>
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<td>• Next meeting to be held on August 4, 2016, Caroline attending via phone.</td>
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<td><strong>Human Rights</strong> Doug <strong>Next Meeting, August 9, 2016</strong></td>
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<td><strong>Quality Management</strong> (Presentation Handout) Update presentation by Tina Howard</td>
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<td><strong>Executive Leadership Team</strong> Caroline provided feedback</td>
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<td>• Only 2 members attended, no quorum.</td>
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5. **State Updates:**

C.J. provided an update:

- Next State CFAC meeting, August 10, 2016 at Brown Building, Dix Campus. Open to the public, attendance and comments are encouraged.
- Next State Local Conference call: August 17, 2016, 7:00 pm – 8:30 pm
- November 9-11, 2016: 8th Annual NC Wide Recovery Conference, Clemens, NC. Some of the topics to be discussed:
  - Recovery Advocacy
  - Whole Health Resiliency
  - Integrated Care
  More information to come.
- November 13-16, 2016: NC TIDE Fall Conference, Greensboro, NC. Check the website [www.nctide.org](http://www.nctide.org) for more information.
- September 23, 2016: OPC CFAC, Hosting annual Peer Support Workshop at Camp New Hope, Chapel Hill, NC
- UNC-Behavioral Healthcare Program NEW name: UNC-Behavioral Health Springboard, website: [www.bhs.unc.edu](http://www.bhs.unc.edu)
  - NC First Commitment Evaluator Program. Exam and Training offered for certification.
- Consumer Engagement Empowerment Team – Beginning in September, be out in the community to provide FREE training on Mental Health First Aid.
- Dr. Cantrell has resigned, and Jason Vogler has been named Interim Director.

6. **By-Laws:**

Israel provided an Update and Discussion:

- Major changes will take effect once the merge with Sandhills happens.
- Travel, having a quorum, statutory requirements are some concerns. CFAC may have to move in different direction.
- Regional CFAC’s can be making all different recommendations to the BOD.
- Different feedback from the sub-committees may be good thing.

- Doug provide Israel with Smoky and Trillium CFAC By-Laws
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|               | • Committee members need to give thought and consideration of how your voice will be heard to the Board of Directors.  
  • See how the New MCO Administrative areas are divided. The merge plan needs to be turned in to the Secretary by 9/30/16. Committee sit tight until the plan is turned in.  
  
  Ideas:  
  • County or Community CFAC Sub-committees  
  • Shorter meetings  
  • Fewer meetings  
  • Have a smaller centralized Steering Committee.  
  • Each County/Community Sub-committee creates their own rules.  
  • Communication issues with Sandhills CFAC and Alliance CFAC.  
  • Smoky sends one Regional representative to the Local CFAC meeting.  
  • Have full CFAC events 2 times a year, more of workshop, organized event.  
  • Continue with the conference call to meet the quorum, count call-in members as attending, their voices should be heard as well.  
  
  James Eby provided Trillium CFAC is operating as 3 regions  
  • Trillium CFAC meets 2 times a year because of long distances  
  • Regional CFAC’s meet once a month  
  • Each regional CFAC has a relational agreement with Trillium CFAC |   |   | |
| 7. Announcements: | • Rules Committee needs to meet  
  • Next CFAC ELT meeting on August 22, 2016  
  • Committee members please update your contact information with Linda |   |   | |
| 8. Wrap Up & Adjourn: | Adjourned at 7:15 p.m. |   |   |
Quality Improvement Projects

Presentation to the Alliance CFAC (8/1/16)
What are Quality Improvement Projects?
Quality Improvement Projects

Definition:
- Organization-wide initiative to assess and improve the processes and outcomes of health care services and delivery

Alliance’s Requirements:
- Per URAC (accreditation): 2 QIPs per accredited module—Call Center, Health Utilization Management, and Health Network (can be combined); 1 must focus on consumer safety
- Per State Contracts: At least 3 QIPs (clinical and at least one non-clinical), reduce need for inpatient at community hospitals, reduce use of crisis & Emergency Department services
Quality Improvement Projects

Requirements (continued):

- Per CMS (federal, also called Performance Improvement Projects): Clinical or non-clinical, impact health or functional status (or impact satisfaction), reflect high-volume or high-risk populations. Examples include: access to care, grievances, appeals, and children with special health care needs.

How are They Selected?:

- Internal data (red flags), providers, consumers/family

How are They Implemented?:

- Project Lead (QM), Project Advisory Teams (subject matter experts, MD if clinical), Six Sigma process (DMAIC)
Quality Improvement Projects

Summary:
- Open/Active: 7 projects (5 continuing)
- Closed/Closing: 5 projects
- FY 17 QIPs (approved by GQMC in June): 3

Successes:
- FY 16 – First Responder QIP – Continued improvement in satisfactory calls following Compliance actions
- FY 16 – Crisis Services QIP – Decrease in ED admissions for behavioral health in Wake County
- FY 16 – Grievance QIP – 28% decrease in errors, closing due to successfully meeting benchmark
Quality Improvement Projects

Red Flags:

- Delays in FY 15 QIP –IIH data not available until late 2017 due to start of EBP models (March 2017)
- WakeBrook CAS closures - no improvement: front door closed 20% and the back door (IVC) closed 43% of the time
- Little improvement in quality of MH/SA Person-Centered Plans, particularly health/safety elements
- (For First Responder QIP): Waiting for report of consumer actual use of crisis services to compare to test results
Quality Improvement Projects

Continuations:
- FY 16 Crisis Services QIP
- FY 16 First Responder QIP
- FY 16 Mystery Shopper: Improve Person Centered Plans QIP
- FY 13-16 Intensive In Home QIP
- FY 16 Access to Care QIP

Need to Analyze:
- FY 15-16 Mystery Shopper: UM Call Monitoring (IDD)
Quality Improvement Projects

Closures:
- FY 16 Grievance QIP
- FY 16 Care Coordination (MHSA)

Conduct Post-Closure Analysis:
- UM IRR (IDD) – due in March 2017

Successful Post-Closure Analyses (no need to continue measuring performance):
- UM IRR (MH/SA)
- Access & Information Center – Call monitoring
FY 17 Quality Improvement Projects

New Projects:

- Improve timeliness of services for individuals who recently received Innovations slots (goal: 85% receive services within 45 days of plan approval)
- Improve timeliness of Care Coordination contact for individuals discharging from inpatient services
- Split Access to Care QIP into two separate projects – continue focus of one project on callers needing Urgent and Routine care, start a new project focusing on callers needing Emergent care
Detailed Results for QIPs
FY 16 Quality Improvement Projects

Reduce use of Crisis Services in Wake and Cumberland Counties

Goals:

- Reduce ED admissions of youth in best practice pilot programs (FCT and Enhanced TFC) in Cumberland County
- Increase the number of consumers utilizing Same Day Access (Tier II) after 3:00 PM by 20%
- Reduce percentage of time that WakeBrook CAS in Wake County is on diversion by 2%
FY 16 Quality Improvement Projects

Crisis Services QIP

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

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

Update:
- Promising results from Cumberland pilots (Baseline: 19%, lower ED/Crisis/Inpatient admissions post discharge)
- Wake: A provider expanded hours of Tier II on 4/18, now open until 7 PM on Mondays and Thursdays, plan to open later and more frequently in early FY 17 (Baseline: 0.24%)
FY 16 Quality Improvement Projects

Crisis Services QIP

Update: CAS closures

Baseline (Jan – June 2014): Back Door – 23%, Front Door – 15%

1st Measurement (Jan – June 2015): Back Door – 44%, Front Door – 24%

2nd Measurement (Jan – June 2016): Back Door – 43%, Front Door – 20%
FY 16 Quality Improvement Projects

Improve Person-Centered Plans

Goals:
- 85% of quality elements are met or partially met
- at least 55% of health and safety quality elements are met or partially met

Interventions:
- Feedback letters sent to providers
- Training on person-centered elements of planning and crisis plan
- Additional technical assistance to providers
- Comprehensive crisis plans are required part of request for services
FY 16 Quality Improvement Projects

Improve Person-Centered Plans

Update:

- Held training in Dec 2015 for 49 participants and in February 2016 for 58 participants
- Provided technical assistance to 6 providers

Results: (review of March 2016 authorizations)

- 89% of quality elements were met or partially met
- 53% of health and safety quality elements were met or partially met

Next Steps:

- Discuss results with Project Advisory Team, add provider representative to team
- Create new interventions
FY 16 Quality Improvement Projects

UM Call Monitoring – Improve adherence to greeting protocol

Goal:
- 85% of UM calls to providers that are sampled adhere to Alliance’s greeting protocol (name, title, and agency)

Update:
- Project continued for IDD UM staff due to goal not met:

*Continuation from FY 15 Mystery Shopper QIP*
FY 16 Quality Improvement Projects

UM Call Monitoring

Update:
- Project closed for MHSA UM staff due to goal met
UM Call Monitoring

Interventions (IDD):

- Volume of calls for staff person was noted as a barrier to meeting standards. To lessen workload, calls will be distributed among all the IDD Care Managers (effective March 1 2016).
- Supervision and coaching with staff who did not meet benchmark
- Review another sample of calls (Summer 2016)
FY 16 Quality Improvement Projects

**First Responder** – test crisis lines of providers after business hours

**Goals:** 100% of calls answered within 30 seconds and 95% of providers return calls in 1 (follow up) hour

**Interventions:**

- Providers assigned to “Tiers” based on last FY’s performance (some called more frequently, others less)
- Written feedback to all providers after calls
- Refer to Compliance the providers who continue to score “unsatisfactory”, issue Plan of Correction if poor performance continues
- Compare test results with actual data of consumers, open to enhanced services, using crisis services
FY 16 Quality Improvement Projects

First Responder QIP:

Update:

- Continued calls according to “Tier”*
- 7 providers referred to Compliance, 5 Plans of Correction (POCs) and 2 Warning Letters issued

Results:

<table>
<thead>
<tr>
<th>Satisfaction by Tier 2016</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>POC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfactory</td>
<td>87.50%</td>
<td>55.60%</td>
<td>64.10%</td>
<td>86.00%</td>
</tr>
<tr>
<td>Unsatisfactory</td>
<td>12.50%</td>
<td>44.40%</td>
<td>35.90%</td>
<td>14.00%</td>
</tr>
</tbody>
</table>

- All POCs successfully closed (and successful tests) except for one
- The agency that did not successfully close POC is now on probation for 6 months; provider subject to monthly testing, first four monthly tests have been successful

*Tier 1: Best performance, called least frequently; Tier 2: Mid performance, called more frequently than Tier 1; Tier 3: Poorest performance, called most frequently
FY 16 Quality Improvement Projects

First Responder QIP:

Results:

- Performance indicators*:

<table>
<thead>
<tr>
<th>Measure #1</th>
<th>Measure #2</th>
<th>Measure #3</th>
<th>Measure #4</th>
<th>Goal</th>
<th>Avg. FY16 (+/-) from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calls Returned Within 1 Hour</td>
<td>33%</td>
<td>36%</td>
<td>56%</td>
<td>8%</td>
<td>0%</td>
</tr>
<tr>
<td>Calls Answered Within 30 Seconds</td>
<td>92%</td>
<td>89%</td>
<td>92%</td>
<td>96%</td>
<td>95%</td>
</tr>
</tbody>
</table>

*Even though the percentage of calls returned within 1 hour has decreased from baseline in FY16, the number of calls resulting in “LIVE” answers has increased. Example: at baseline, 24/75 (32%) of completed calls resulted in a voicemail; in FY 16 Q4, only 3/19 (16%) of calls resulted in a voicemail.
FY 16 Quality Improvement Projects

First Responder QIP:

Next Steps:

- Project Advisory Team (PAT) recommended changing measure to % of satisfactory calls (call answered live or voicemail able to be left and is returned within 1 hour)
- Continue compliance actions
- Continue sending results letters to agencies, now copy CEO/owner and Clinical/QM Director along with point of contact
- Continue to offer technical assistance
FY 16 Quality Improvement Projects

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

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

**Interventions:**

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

*Continuation from FY 15 QIP*
FY 16 Quality Improvement Projects

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

**Update:**

- Evidence based practice models selected, Alliance offering subsidized trainings May -June 2016
- Implementation plans included in FY17 contracts, implementation deadline March 2017
- Collect post-intervention data late 2017
FY 16 Quality Improvement Projects

Care Coordination – *Improve Care Coordination Services*

Goals:

- MH/SA: Increase adherence to procedures (Care Coordination contact within 2 business days of assignment)
- I/DD: Reduce # of authorization requests denied/reduced due to lack of justification

Interventions:

- MH/SA: Training on Care Coordination expectations, change in procedures
- I/DD: Training/coaching of Care Coordination staff, UM training IDD Supervisors on Service Definitions, workgroup to improve ISPs
FY 16 Quality Improvement Projects

Care Coordination

Results:

  - Baseline: 43%, Post-Intervention: 87%
  - Recommendation: Continue to monitor due to possible bias in results, Focus interventions on improving contact after discharge from inpatient services

- I/DD: Reduce % of authorization requests denied/reduced due to lack of justification
  - Baseline: 78%, Post-Intervention: 82%
  - Recommendation: Close due to faulty design, refocus on meeting state performance measure of initiation of services within 45 days (85%)
FY 16 Quality Improvement Projects

Access to Care-Routine/Urgent – *Improve initiation in services for Routine & Urgent callers*

**Goals:**

- Increase consumer initiation in services based on need:

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Revised Baseline (FY15Q3)</th>
<th>Goals</th>
<th>State Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent (within 2.25 hours)</td>
<td>83%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>Urgent (within 48 hours)</td>
<td>52%</td>
<td>62%</td>
<td>82%</td>
</tr>
<tr>
<td>Routine (within 14 days)</td>
<td>53%</td>
<td>63%</td>
<td>75%</td>
</tr>
</tbody>
</table>
FY 16 Quality Improvement Projects

Access to Care

Interventions:

- Addressed technical issues of aggregating accurate data
- Identified more accurate methods of collecting valid data sources for Emergent & Urgent appointments
- Training of Call Center staff to address inconsistencies in data entry
- Break data down by provider, county, and funding source to identify root causes and in December 2015 started reminder calls to routine consumers
## FY 16 Quality Improvement Projects

### Results:

#### Overall

```
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent (within 2.25 hours)</td>
<td>83%</td>
<td>71%</td>
<td>72%</td>
<td>69%</td>
<td>75%</td>
<td>97%</td>
</tr>
<tr>
<td>Urgent (within 2 days)</td>
<td>52%</td>
<td>49%</td>
<td>48%</td>
<td>50%</td>
<td>55%</td>
<td>62%</td>
</tr>
<tr>
<td>Routine (within 14 days)</td>
<td>53%</td>
<td>47%</td>
<td>47%</td>
<td>53%</td>
<td>58%</td>
<td>63%</td>
</tr>
</tbody>
</table>
```
FY 16 Quality Improvement Projects

Results:

Impact of reminder calls:

Reminder Call-Contact Made with Consumer or Guardian, n = 76

- Attended: 70%
- No Show: 18%
- Canceled: 9%
- Other: 3%

No Reminder Call or Unable to Reach Consumer or Guardian, n = 70

- Attended: 36%
- No Show: 56%
- Canceled: 4%
- Other: 4%

Of those individuals attending their appointments, over ¾ received some kind of reminder about the appointment. Direct contact between the Access staff person and the consumer or guardian results in the highest percent showing for appointments.
FY 16 Quality Improvement Projects

Access to Care

Next Steps:

- Emergent callers now a separate, clinical-focused QIP
- Continue to evaluate impact of reminder calls
- Develop interventions for Urgent callers
FY 16 Quality Improvement Projects

Reduce Errors in Grievance Module

Description:

Alliance staff enter grievances and complaints in the Grievance Module of Alpha. In FY 15, QM staff noted a 69% rate of errors of all the data entered. QIP will focus on reducing errors in most important 16 fields. The number of grievance with errors for these 16 fields was 77%.

Goal:

- Reduce the grievance data entry error rate by 10%.
FY 16 Quality Improvement Projects

Reduce Errors in Grievance Module

Interventions:

- Revised initial interventions of Dept Supervisors providing oversight and second-level review of all complaints entered into system because it was too cumbersome

- New Interventions: simplified definition of grievance, provided training to all staff, Grievance Specialists assume responsibility of entering most fields except for critical 5 fields

- Waiting for Alpha to upgrade Grievance module to streamline and improve ease of use (date expected: unknown)
FY 16 Quality Improvement Projects

Reduce Errors in Grievance Module

Results:

Next Step:

- QIP closed, take 1 year post-closure measurement in May 2017
Successful Post-Closure Analyses (no need to continue measuring performance):

**IRR-MH/SA:**
- 1 year post-closure analysis (in June 2016): 95% agreement

**Access & Information Center:**
- 1 year post-closure analysis (in March 2016): In 100% of calls sampled, staff person informed caller of QA monitoring, in 90% of calls sampled, staff person asked applicable callers all safety questions
FY 15 QIPs – Closing Out

Conduct Post-Closure Analysis:

- UM IRR (IDD) – due in March 2017
  - Last measurement that closed project (March 2016): 88% agreement
ITEM: Finance Committee Report

DATE OF BOARD MEETING: September 1, 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. This month’s report includes draft minutes from the August 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, August 04, 2016  BOARD FINANCE COMMITTEE

APPOINTED MEMBERS PRESENT: ☑ James Edgerton, Chair; ☑ George Quick, MBA, ☑ John Griffin; ☑ Vicki Shore
BOARD MEMBERS PRESENT:
GUEST(S) PRESENT:
STAFF PRESENT: Rob Robinson, CEO; Kelly Goodfellow, CFO; Kelly Phillips, Director of Budget and Financial Analysis

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the 6/2/16 meeting were reviewed; a motion was made by John Griffin and seconded by Vicki Shore.

<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 Revenue and Expenses – Actual to Budget, Senate Bill 208 Required Ratios, and DMA Contract Ratios  
   a) Statement of Revenue and Expenses – Actual to Budget as of May 31, 2016 – Alliance currently has revenues exceeding expenses of $23,618,458. The majority of this is related to Medicaid and Medicaid risk reserve.  
   b) Senate Bill 208 Ratios - Alliance is currently meeting and exceeding all required Senate Bill 208 ratios.  
   c) DMA Contract Ratios – Alliance is currently meeting and exceeding the defensive interval ratio. Alliance feel short of the 85% Medicaid Expense Ratio by .44% for a May number of 84.56% |
| 4.            | Kelly Phillips discussed the FY16 final budget amendment. The amendment is to approve the reduction of the fund balance appropriation for state services of $2,996,001. This is due to a recent payment made by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services to satisfy the requirement of Session Law 2015-241 House Bill 97 Section 12.F.2.(d). In this bill, a portion of $30M was to be transferred to the LME/MCOs if a Medicaid budget surplus was to be achieved. A motion was made by George Quick to approve the amendment and presentation to the full board. The motion was seconded by John Griffin. |

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>The Budget Transfer policy was discussed. There was discussion regarding the authority level and to what detail.</td>
<td>Jim Edgerton will meet with Kelly Goodfellow to discuss next steps.</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 July 31, 2016*

**REVENUES**

<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>Local Grants</strong></td>
<td>$36,874,048.00</td>
<td>$3,114,917.39</td>
<td>$3,114,917.39</td>
<td>$33,759,130.61</td>
<td>8.45%</td>
</tr>
<tr>
<td><strong>State &amp; Federal Grants</strong></td>
<td>55,113,711.00</td>
<td>4,950,139.13</td>
<td>4,950,139.13</td>
<td>50,163,571.87</td>
<td>8.98%</td>
</tr>
<tr>
<td><strong>Medicaid Waiver Services</strong></td>
<td>348,220,800.00</td>
<td>30,376,588.66</td>
<td>30,376,588.66</td>
<td>317,844,211.34</td>
<td>8.72%</td>
</tr>
<tr>
<td><strong>In Kind</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>440,208,559.00</td>
<td>38,441,645.18</td>
<td>38,441,645.18</td>
<td>401,766,913.82</td>
<td>8.73%</td>
</tr>
</tbody>
</table>

**Administrative**

<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>Local Administration</strong></td>
<td>369,835.81</td>
<td>312,244.70</td>
<td>312,244.70</td>
<td>338,591.11</td>
<td>8.45%</td>
</tr>
<tr>
<td><strong>LME Administrative Grant</strong></td>
<td>4,359,385.00</td>
<td>363,282.08</td>
<td>363,282.08</td>
<td>3,996,102.92</td>
<td>8.33%</td>
</tr>
<tr>
<td><strong>Medicaid Waiver Administration</strong></td>
<td>44,330,623.20</td>
<td>3,946,661.80</td>
<td>3,946,661.80</td>
<td>40,383,961.40</td>
<td>8.90%</td>
</tr>
<tr>
<td><strong>Miscellaneous Revenue</strong></td>
<td>100,000.00</td>
<td>16,005.29</td>
<td>16,005.29</td>
<td>83,994.71</td>
<td>16.01%</td>
</tr>
<tr>
<td><strong>Total Administrative Revenue</strong></td>
<td>49,159,844.01</td>
<td>4,357,193.87</td>
<td>4,357,193.87</td>
<td>44,802,650.14</td>
<td>8.86%</td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td>489,368,403.01</td>
<td>42,798,839.05</td>
<td>42,798,839.05</td>
<td>446,569,563.96</td>
<td>8.75%</td>
</tr>
</tbody>
</table>

**EXPENSES**

<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>Local Services</strong></td>
<td>36,874,048.00</td>
<td>175,917.88</td>
<td>175,917.88</td>
<td>36,698,130.12</td>
<td>0.48%</td>
</tr>
<tr>
<td><strong>State &amp; Federal Services</strong></td>
<td>55,113,711.00</td>
<td>1,247,436.38</td>
<td>1,247,436.38</td>
<td>53,866,274.62</td>
<td>2.26%</td>
</tr>
<tr>
<td><strong>Medicaid Waiver Services</strong></td>
<td>348,220,800.00</td>
<td>15,908,780.95</td>
<td>15,908,780.95</td>
<td>332,312,019.05</td>
<td>4.57%</td>
</tr>
<tr>
<td><strong>In Kind Expenses</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Service Expenses</strong></td>
<td>440,208,559.00</td>
<td>17,332,135.21</td>
<td>17,332,135.21</td>
<td>422,876,423.79</td>
<td>3.94%</td>
</tr>
</tbody>
</table>

**Administrative**

<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>Operational</strong></td>
<td>6,749,177.51</td>
<td>324,547.68</td>
<td>324,547.68</td>
<td>6,424,629.83</td>
<td>4.81%</td>
</tr>
<tr>
<td><strong>Salaries, Benefits, and Fringe</strong></td>
<td>34,017,214.69</td>
<td>2,894,280.14</td>
<td>2,894,280.14</td>
<td>31,122,934.55</td>
<td>8.51%</td>
</tr>
<tr>
<td><strong>Professional Services</strong></td>
<td>8,293,451.81</td>
<td>145,041.29</td>
<td>145,041.29</td>
<td>8,148,410.52</td>
<td>1.75%</td>
</tr>
<tr>
<td><strong>Miscellaneous Expense</strong></td>
<td>100,000.00</td>
<td>-</td>
<td>-</td>
<td>100,000.00</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Total Administrative Expenses</strong></td>
<td>49,159,844.01</td>
<td>3,363,869.11</td>
<td>3,363,869.11</td>
<td>45,695,974.90</td>
<td>6.84%</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>489,368,403.01</td>
<td>20,696,004.32</td>
<td>20,696,004.32</td>
<td>468,572,398.69</td>
<td>4.23%</td>
</tr>
</tbody>
</table>

**CHANGE IN NET POSITION**

|                      | $22,102,834.73 | $22,102,834.73 |

*Preliminary financials subject to change.
**Senate Bill 208 Ratios - As of July 31, 2016**

---

**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%.
**DMA Ratios - As of July 31, 2016**

**DEFENSIVE INTERVAL**

**Defensive Interval** = Current assets divided by average daily operating expenses. This ratio shows how many days the organization can continue to pay expenses if no additional cash comes in. The benchmark is 30 days.

**MEDICAL LOSS RATIO**

**Medical Loss Ratio (MLR)** = Total Services Expenses plus Administrative Expenses that go towards directly improving health outcomes divided by Total Medicaid Revenue less Risk Reserve Revenue. The benchmark is 85%. This is the ratio that is currently being negotiated with DMA.
ITEM: Policy Committee Report

DATE OF BOARD MEETING: September 1, 2016

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

Policies reviewed at the August 11, 2016 Policy Committee meeting and ready for Board approval without revisions:
- Area Board By-Laws
- Area Board Conflict of Interest
- Delegation of Authority to the Area Director
- Guidelines for Public Comment at Area-Board Meetings
- Area Board Media
- Area Board Member Attendance Compensation
- Area Director Compensation
- Reporting of Abuse, Neglect, Dependency and Exploitation

Policies reviewed with suggested revisions:
- Area Authority Relations with Catchment Area Counties
- Development of Policies and Procedures
- Management of Service Delivery
- Pre-Review Screening for Certification
- Utilization Review Process

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

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

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

2. REVIEW OF THE MINUTES: The minutes from the May 12, 2016, meeting were reviewed; a motion was made by Ms. Gloston and seconded by Ms. Shore to approve the minutes. Motion passed unanimously.

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<tr>
<th>AGENDA ITEMS:</th>
<th>DISCUSSION:</th>
<th>NEXT STEPS:</th>
<th>TIME FRAME:</th>
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<tr>
<td>Announcements:</td>
<td>N/A</td>
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<td>Documents Provided:</td>
<td>May 12, 2016 Minutes; Governance and General Administrative Policies</td>
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<tr>
<td>Annual Review of Policies:</td>
<td>The Committee reviewed all Governance and General Administrative Policies. Governance Policies reviewed and considered for continued use without revisions: BL – By-Laws. A Motion was made by Mr. Golden to accept the Area Board By-Laws as presented and motion was seconded by Ms. Gloston. Motion carried. G-1-Area Board Conflict of Interest. A Motion was made by Ms. Gloston to accept Policy G-1 as presented and motion was seconded by Ms. Shore. Motion carried. G-2-Area Board Member Meeting Compensation Policy. A Motion was made by Ms. Shore to accept Policy G-2 as presented and motion was seconded by Ms. Gloston. Motion carried.</td>
<td>Draft minutes, reviewed policies and Agenda Action Form will be provided to the Board Clerk for inclusion in the September Board Packet</td>
<td>8/22/16</td>
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Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
**AGENDA ITEMS:**

| G-6-Area Director Compensation |
| G-7-Evaluation of Area Director |
| G-8-Area Board Code of Ethics |
| G-9-Consumer/Family Advisory Committee |
| G-10-Delegation of Authority to the Area Director |
| G-11-Guidelines for Public Comment at Area Board Meetings |
| G-12-Area Authority Relations with Catchment Area County Boards of Commissioners |
| G-13-Area Board Media Policy |
| G-14-Dispute Resolution |

**DISCUSSION:**

A Motion was made by Ms. Gloston to accept Governance Policies G-6 thru G-14 as presented and the motion was seconded by Ms. Shore. Motion carried.

**Governance Policies reviewed with suggested revisions:**

G-3-Area Board Processes. Non-substantive grammatical change made under Definitions. A Motion was made by Ms. Gloston to accept G-3 as revised and motion was seconded by Ms. Shore. Motion carried.

G-4-Development of Policies and Procedures. Non-substantive grammatical changes made under Section II-Definitions. Staff recommendations: Addition of clarifying language to Review Date under Definitions; changes driven by Compliance 360 and complies with URAC. Removal of language in Approval Date under Definitions regarding signature. A Motion was made by Ms. Gloston to accept G-4 as revised and motion was seconded by Ms. Shore. Motion carried.

**General Administrative Policies reviewed and considered for continued use without revisions:**

GA-1-Management of Service Delivery

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

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<th>DISCUSSION:</th>
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| GA-2-Strategic Planning  
GA-3-Reporting of Abuse, Neglect, Dependency and Exploitation  
GA-4-Health and Safety  
GA-5-Emergency Management Plan  
GA-6-Internal Control  
GA-7-Business Continuity Plan  
A Motion was made by Ms. Shore to accept General Administrative Policies GA-1 thru GA-7 as presented and motion was seconded by Ms. Shore. Motion carried. | | |
| **Policy reviewed with suggested revisions:**  
a. Development of Policies and Procedures. Addition of Section IV-Procedures. Last two paragraphs under Section III moved to new Sec IV. Addition of language addressing review, development and revision of all policies by Board Policy Committee before recommendation for ratification by full Area Board. For non-substantive grammatical revisions, changes may be made with approval by Board Policy Committee.  
A Motion was made by Ms. Gloston and seconded by Ms. Shore to accept policy as revised. Motion carried.  
**Policies with revised URAC reference from HUM 7.0 to HUM 7.3:**  
b. Pre-Review Screening for Certification  
c. Accessibility of Utilization Review/Utilization Management Process  
d. Utilization Review Process  
e. Appealing Clinical UM Decisions  
f. Utilization Review Criteria  
g. Dispute Resolution  
h. Management of Service Delivery | Policies with corrected reference (per URAC Standards) will be submitted to the Board. | 8/22/16 |

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
3. ADJOURNMENT: A motion was made by Ms. Gloston to adjourn at 5pm. Motion carried. The next meeting of the Board Policy Committee will be held on November 10, 2016, from 4:00 p.m. to 6:00 p.m.
The Alliance Behavioral Healthcare Board of Directors, also known as the Area Board, by virtue of powers contained in Chapter 122C of the North Carolina General Statutes is responsible for comprehensive planning, budgeting, implementing and monitoring of community based mental health, developmental disabilities and substance abuse services to meet the needs of individuals in the Durham, Wake and Cumberland County catchment area. These responsibilities shall be carried out in partnership with the Durham, Wake and Cumberland County Boards of County Commissioners hereinafter referred to as County Commissioners.

MISSION STATEMENT

The mission of the Area Board is to support and enhance the quality of life of those citizens affected by mental illness, intellectual/developmental disabilities and substance abuse.

VISION STATEMENT

The Area Board seeks to develop and maintain a network of quality providers whose services are evidence based or best practice and who embrace people with disabilities as equal partners and valued citizens. The entire community benefits when citizens with disabilities reach their full potential.

VALUES STATEMENT

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

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

ARTICLE II

STRUCTURE

A. AUTHORITY

1. The Area Board is accountable to the citizens of Durham, Wake and Cumberland Counties.
2. The authority for the Area Board derives from General Statute 122C-117.
3. General duties of the Area Board include:
   a. Defining services to meet the needs of citizens (within the parameters of the law) through an annual needs assessment.
   b. Adoption of operational policies to meet all requirements.
   c. Evaluation of quality and availability of services in meeting the needs of the population.
   d. Fiscal oversight.
   e. Hearing complaints and appeals from consumers, providers and the general public.
   f. Community education and advocacy.
   g. Appointing an area director in accordance with General Statute 122C-121 (d). The Area Director is an employee of the Area Board and shall serve at the pleasure of the Area Board.
   h. Evaluate annually the area director for performance based on criteria established by the Secretary of NCDHHS and the area board.
   i. Delegating responsibility to the Area Director who shall be responsible for the appointment of employees, the implementation of the policies and programs of the Area Board, for compliance with the rules of the North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services, and NCDHHS, supervision of all employees and management of all contract providers.
   j. Empower the Area Director to sign official contracts and agreements, where appropriate.
k. Developing plans and budgets for the area authority subject to the approval of the Secretary of NCDHHS. The area authority shall submit the approved budget to the boards of county commissioners and the county managers.

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

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

B. COMPOSITION

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

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

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

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

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

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

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

C. TERMS AND CONDITIONS OF OFFICE

1. Terms of membership shall be for three years except the terms of the County Commissioner members on the Area Board shall be concurrent with their terms of office. The initial terms of office will be staggered in accordance with General Statute 122C-118.1.d. Each of the initial staggered terms of office shall be considered a full term.

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

3. Members of the Area Board may be removed with or without cause by the appointing authority.

4. Area Board members may resign at any time, upon written notification to the Chairperson or the Executive Secretary of the Area Board.
5. Vacancies on the Area Board shall be filled by the County Commissioners before the end of the term of the vacated seat or within 90 days of the vacancy, whichever comes first. Appointments shall be for the remainder of the unexpired term.

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

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

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

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

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

D. OFFICERS

1. The officers of the Area Board shall be chosen for a one-year term at the final meeting of the fiscal year in which the Area Board is serving, and shall be as follows:
   a. Chairperson, and
   b. Vice-Chairperson.

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

3. Each Area Board member shall be eligible to serve as an officer.

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

E. COMMITTEES

1. STANDING COMMITTEES - Annually, the Area Board Chairperson shall appoint committees that are required by law, regulation, accrediting bodies or contract as well as other committees, at the discretion of the Area Board. These committees shall have the responsibility of making policy recommendations to the Area Board regarding matters within each committee’s designated area of concern. The composition of each committee shall comply with the relevant statute, regulation or contract requirements. These standing committees shall be as follows:
a. Finance Committee (NCGS 122C-119 (d))
   i. This committee shall be composed of the Finance member designees of the Area Board plus three other Area Board members. (The Finance Officers of Durham, Cumberland and Wake Counties may serve as ex-officio members)
   ii. The Committee’s functions include:
       1) Recommending policies/practices on fiscal matters to the full Area Board.
       2) Reviewing and recommending budgets to the entire Area Board.
       3) Reviewing and recommending approval of audit reports (following a meeting by a designee of this committee with the auditor and receipt of the management letter) and assure corrective actions are taken as needed.
       4) Reviewing and recommending policies and procedures for managing contracts and other purchase of service arrangements.
       5) Reviewing financial statements at least quarterly.
       6) Reviewing the financial strength of the Area Authority

b. Human Rights Committee (Contract with DMH/DD/SAS)
   i. The Human Rights Committee shall consist of 12 members and include at least 3 board members. Other members include consumers and family members representing mental health, developmental disabilities and substance abuse.
   ii. The Human Rights Committee functions include:
       1) Reviewing and evaluating the Area Authority’s Client Rights policies at least annually and recommending needed revisions to the Area Board.
       2) Overseeing the protection of client rights and identifying and reporting to the Area Board issues which negatively impact the rights of persons served.
       3) Reporting to the full Area Board at least quarterly.
       4) Submitting an annual report to the Area Board which includes, among other things, a review of the Area Authority’s compliance with NCGS 122C, Article 3, DMHDDSAS Client Rights Rules (APSM 95-2) and Confidentiality Rules (APSM 45-1).
   iii. The Human Rights Committee shall meet at least quarterly.

c. Quality Management Committee (Contract with DMHDDSAS)
   i. The Quality Management Committee shall consist of 7 members to include 3 board members, two (2) members from CFAC and 2 non-voting provider representatives. The Board QM Committee will meet at least 6 times a year.
   ii. The Committee shall review statistical data and provider monitoring reports and make recommendations to the full Area Board or other Area Board committees.
   iii. The Quality Management Committee serves as the Board’s Monitoring and Evaluation Committee charged with the review of statistical data and provider monitoring reports. The goal of the 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.

d. Executive Committee - The Area Board shall have an Executive Committee. All actions taken by the Executive Committee will be reported to the full Area Board at the next scheduled meeting.
i. The Executive Committee shall be composed of the officers of the Area Board, Chairpersons of standing committees (who are Area Board members), the past Board chairperson or at-large member.

ii. The Area Board Chairperson shall serve as the Chairperson of the Executive Committee.

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

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

e. Policy/By-Law Committee

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

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

f. County Commissioner Advisory Board

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

   a. Ad hoc committees, may be appointed by the Area Board Chair with the approval of a majority of the Area Board members who are present at the meeting during which approval is given.
   b. These committees shall carry out their duties as designated by the Area Board and shall report their findings to the Area Board or its committees.

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

ARTICLE III
MEETINGS

A. REGULAR MEETINGS

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

B. SPECIAL MEETINGS

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

C. EMERGENCY MEETINGS

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

D. NOTICE OF MEETINGS

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

E. CONDUCT OF MEETINGS

Area Board meetings shall be conducted under parliamentary procedures.

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

F. QUORUM

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

G. ABSENCES

1. Absence from three (3) consecutive meetings without notification to the Executive Secretary shall constitute resignation from the Area Board.
2. Absence from more than twenty-five percent (25%) of the meetings during a 12 month period may also constitute resignation from the Area Board.
3. In computing absences, absence from two Area Board committee meetings may constitute one absence from a regular Area Board meeting.

ARTICLE IV

GENERAL PROVISIONS

A. AMENDMENTS

1. These By-Laws may be amended or repealed as necessary.
2. New or amended By-Laws may be adopted by the affirmative vote of fifteen (15) Board members, or a corresponding majority of Board members in the event the number of Board members changes or there are vacant seats on the Board, during any regular (or other) meeting of the Area Board.
3. Notice of proposed changes must be given to the Area Board members at least thirty (30) days prior to the change.
B. SUSPENSION OF BY-LAWS

The Area Board has the authority to suspend the By-Laws by an affirmative vote of fifteen (15) Board members, or a corresponding majority of Board members in the event the number of Board members changes or there are vacant seats on the Board.

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

These By-Laws and all Area Board governance policies shall be reviewed at least annually. Approved by: Alliance Behavioral Healthcare Area Board, March 6, 2013
I. PURPOSE

The purpose of this policy is to establish standards and guidelines to prevent conflict of interest on the part of members of the Alliance Behavioral Healthcare (“Alliance”) Area Board of Directors (hereinafter “Board” or “Area Board”). The policy is intended to supplement, but not replace any applicable federal or state laws, rules and regulations governing conflict of interest. This policy is also intended to meet the requirements of the Division of Medical Assistance regarding conflict of interest under the Medicaid 1915 (b)/(c) waiver.

II. POLICY STATEMENT

It is the policy of Alliance to ensure that none of its Board members have conflicts of interest with any of the provider agencies with which Alliance has a contractual or a consumer referral relationship.

Each Area Board member shall fulfill his or her responsibilities consistent with all Federal and State laws and regulations, Area Board and Area Authority policies, and Area Board By-Laws regarding avoidance of conflict of interest. This includes the avoidance of the perception of conflict of interest which might undermine the efforts of the Area Board to maintain public confidence and trust in the Area Authority.

III. DEFINITIONS

Provider agency: Agency, organization or individual that is contracted with Alliance to deliver publicly-funded mental health, intellectual/developmental disability, substance abuse or other treatment, habilitation, rehabilitation, educational, training and/or recovery related services to consumers.

Vendor: Company or other entity that provides goods and services needed to develop, maintain or operate the corporation.
IV. RESTRICTIONS AND REPORTING

To ensure accurate disclosure and consideration of potential conflicts of interest, the following relationship of Board members are defined as a Conflict of Interest and must be reported:

A. Receiving reimbursement as consultant or employee from Alliance or being employed by Alliance during the time they serve as board member.

B. No member of the Area Board may be a ‘family member’, as defined in Section IV-E of this policy, of any employee of Alliance Behavioral Healthcare.

C. Representing him or herself to be an independent agent of the Area Board representing any potential Area Board action or position. Further, pursuant to NCGS 122C -118.1, no person registered as a lobbyist under Chapter 120C of the General Statutes shall be appointed to or serve on the Area Board.

D. Having a financial investment, an ownership interest (whether by stock ownership, partnership, or otherwise), any arrangement for the payment of any commissions, rewards, or any other financial or tangible consideration or benefit, board membership, or employment with any provider agencies with which Alliance has a current contractual or referral relationship, except that a member a Board of County Commissioners who is also a member of the Board of Directors of any nonprofit hospital due to his/her status as a County Commissioner shall not be prohibited from serving on the Area Board even if the nonprofit hospital is contracted with Alliance. Any such member must recuse themselves from any Area Board votes that may impact the nonprofit hospital, and must likewise recuse themselves from any hospital Board votes that may impact Alliance.

   1. A list of the provider agencies with which Alliance has contractual or referral relationships shall be available upon request and shall be provided to Board members annually when Board members complete updated disclosure statements.

E. Having a family member who has a financial investment, an ownership interest (whether by stock ownership, partnership, or otherwise), any arrangement for the payment of any commissions, rewards, or any other financial or tangible consideration or benefit, board membership, or employment with any provider agencies with which Alliance has a contractual or referral relationship.

For purposes of this policy, “family members” include:

   1. The Board member’s spouse;
   2. The Board member’s parents, children, and siblings;
   3. The Board member’s stepparents, stepchildren, stepbrothers, and stepsisters;
   4. The Board member’s father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law;
   5. The Board member’s grandparents and grandchildren;
   6. A spouse of any of the Board member’s grandparents or grandchildren.

F. Serving on the Consumer and Family Advisory Committee, unless as a designated liaison and reflected in the bylaws.
G. Having any interest in an Alliance vendor as follows:
   1. The Board member is a director, officer, partner, or direct or indirect owner of the beneficial interest in more than 5% of the equity in the vendor.
   2. The Board member has a family member who is a director, officer, partner, or direct or indirect owner of the beneficial interest in more than 5% of the equity in the vendor.

H. Personally having, or having a family member who has, any interest in any mortgage, deed of trust, note, or other financial interest in a vendor where the value of such interest equals more than 5% of the value of the assets of the vendor.

V. REQUIREMENTS

Certain actions are required on the part of Board members for effective implementation of this policy:

A. Board members must observe the highest moral and ethical standards in any dealings in which they represent the Area Board.

B. Board members must disclose on an ongoing basis any conflict or the appearance of a conflict of interest and depending on the circumstances, may be prohibited from serving or restricted in voting based on the disclosure.

C. All Board members are required to update the information on the disclosure form whenever a potential conflict arises.

D. Board members who are aware of any violations by any board members of this policy are required to report them to the Area Board Chair. The Board Chair shall notify the Area Director of the reported violation.

VII. CONFLICT OF INTEREST DISCLOSURE AND RESOLUTION PROCESS

A. The Conflict of Interest (COI) Disclosure form will be distributed no later than the February Board meeting.

B. Board members are required to submit COI Disclosure forms by March 31 each fiscal year.

C. Board members who do not submit COI Disclosure forms by the due date will have their membership on the Board suspended to include eligibility for stipends and financial reimbursement until such time the form is submitted. Board members who do not fully comply with the provisions in this Policy may be subject to removal from the Board.

D. Compliance Officer and Legal Counsel review forms and make recommendation to the CEO. Recommendations may include prohibition from voting to resignation from the Board.

E. Compliance Officer and Legal Counsel notifies Audit & Compliance Committee (Committee) Chair of the conflict and the recommendation to remove/avoid the conflict prior to Committee meeting.
F. Committee Chair calls Board member with identified conflict to discuss conflict and recommendation prior to the Committee meeting. Board member is offered the opportunity to remove the conflict prior to presenting to the Committee:
   1. If Board member removes the conflict, a new disclosure form is filled out reflecting no conflict
   2. If Board member does not remove conflict, it is presented to the Committee
   3. While conflict of interest issues are being reviewed, the Board member and subject of the potential conflict may be prohibited from serving or restricted from voting.

G. Committee hears the conflict and makes a final recommendation to the Board. The Committee will invite the Board member to be present when the matter is considered by the Committee.

H. Committee submits recommendation to the full Board as consent agenda item using Agenda Action Form (AAF) and a separate document identifying the Board Member, his/her conflict, and proposed solution.

I. The Area Board shall make the final decision regarding the disposition of all conflict of interest issues.
I. PURPOSE

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

II. DEFINITIONS

Area Director: The Area Director is the Area Authority’s chief executive officer. The Area Director is hired and evaluated by the Area Board and is responsible for leading and managing the Area Authority’s business and affairs.

III. POLICY STATEMENT

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

IV. PROCEDURES

A. Delegation of Authority and Responsibility to the Area Director

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

1. Hire, suspend and dismiss employees as necessary.
2. Provide the Area Board with required reports, data and information regarding programs, services, finances and any other business areas as identified by the Area Board.
3. Assume overall responsibility for implementing programs and services, including the execution of contracts pursuant thereto.
4. Develop procedures to implement the policies of the Area Board.
5. Administer and monitor the Area Authority budget and recommend changes.
6. Define duties and establish the compensation of the Area Authority employees.
7. Evaluate the Area Authority employees.
8. Serve as the primary liaison between the Area Board and the N C Department of Health and Human Services.
9. Assist the Area Board in understanding their legal responsibilities in performance of their assigned duties.
10. Meet with the Area Board or specific Area Board members, during regularly established, or impromptu, meetings as required.
11. Negotiate, approve and execute settlement agreements of provider and consumer appeals deemed necessary and in consultation with General Counsel.

B. Area Board Access to Area Authority Management and Employees

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

The purpose of this policy is to provide a framework to carry out the intent and desire of the Area Board to receive public comment at Board meetings.

II. POLICY STATEMENT

The Area Board considers public comment, within specific guidelines, an important and integral component of fulfilling its planning and decision-making responsibilities.

III. PROCEDURES

A. Persons must sign up for agenda items and identify any non-agenda items about their wish to speak as they sign up.

B. Persons may sign up prior to the meeting and during the meeting up to the point that the Board recognizes opportunity for public comment to occur.

C. Guidelines shall be posted outside the Board Room and shall be made available to persons signing up for public comment.

D. The public comment period shall be slotted into the early part of the Board’s agenda.

E. Area Board members may ask clarifying questions at any time during the public comment period and staff may be asked by the Board Chair to provide clarification.

F. No individual staff shall be named during public comment.

G. The discussion of all items is to occur only among Board members.

H. If an organization or group wishes to be heard, one person shall serve as their spokesperson.
I. Two (2) minutes per speaker is the established time limit (apart from any comment that is made in response to an Area Board member’s request for clarifying information). (Note: Any individuals/groups seeking formal inclusion on an Area Board agenda will be considered by the Executive Committee when it sets the agenda at its monthly meeting).

J. Yielding time to others is not permitted.

K. The Chairperson shall have the discretion to conduct the public comment session in a manner that maintains good order and decorum.

L. Board will acknowledge the comment but further discussion will be at the discretion of the Chair.
I. PURPOSE

The purpose of this policy is to guide board members in their relations with the news media in such a way as to ensure the effective operation of the Alliance Behavioral Healthcare Board of Directors. This policy does not seek to be comprehensive but sets out to provide guidance on how to handle issues that may arise when dealing with news media organizations.

II. DEFINITION

Media: Generally accepted organizations that publish or broadcast information aimed at informing the public.

III. POLICY STATEMENT

The Area Board is accountable to the citizens in the Alliance multi-county area. The board is committed to providing timely and accurate information to the public through all available means, including the news media. Each board member serves as an ambassador for the Area Authority and as such may be called upon by various media outlets to field questions or provide information regarding Alliance Behavioral Healthcare. Each board member shall adhere to this policy as he or she interacts with the news media regarding the affairs of the area board.

IV. PROCEDURES

A. Procedures for Dealing with the Media:

1. Board members should advise the Area Authority’s Corporate Communications Office of any planned or unplanned activities involving the news media.

2. The board shall allow all reasonable access to news media organizations and shall make every effort to respond without delay to requests for information. The board shall attend to media requests promptly and with courtesy, honesty and respect.
3. The Board shall treat all media outlets equally and shall avoid giving one outlet preferential treatment. Media releases shall be distributed to all media outlets at the same time.

4. Board members shall not disclose information that is of a confidential nature. This includes consumer information as well as information that has been discussed as confidential items on the board’s agenda.

5. The Area Board Chairperson shall serve as the official spokesperson on all matters related to the Alliance Behavioral Healthcare Board of Directors.

6. In their role as appointed representative, each board member is free to talk with the media at any time. Board members may use these opportunities to enhance the community’s understanding of the work of the Area Authority. However, if the board has not taken a position on a particular issue, the board member must make it clear that they are speaking for themselves and not for the board.

7. In responding to media inquiries, board members have an obligation to respect board policy once a decision is made. While it may be legitimate for a board member to make clear that he or she disagreed with a policy and voted against it, if the vote took place in an open session, he or she shall not seek to undermine a board decision through the news media.

8. From time to time board members may be requested to contribute material for newspaper articles or participate in a broadcast interview. The Area Authority’s Corporate Communications Office shall be available, upon request, to provide assistance.

9. From time to time it may be necessary for a Letter to the Editor or other position statement to be written as an official board communication to inform the community about a particular matter. Such letters or statements shall be issued under the signature of the Board Chairperson.
I. PURPOSE

To provide formal guidelines for compensation that Area Board Members are entitled to receive under G.S. 122C-120.

II. POLICY STATEMENT

All members of the Area Board are entitled to receive a payment of $50.00 per meeting for attendance at the following meeting(s):

Regular Monthly Area Board Meetings
Committee Meetings for appointed Committee members, or Board Members requested to attend, that occur on a day besides an Area Board Meeting

Each member has the right to decline this compensation by giving written notice to the Area Director.

Members shall be entitled to reimbursement for travel to official meetings and functions of the Area Board or Committees in excess of 40 miles round trip, at the rate established by the current IRS regulations.

III. PROCEDURES

Compensation shall be made consistent with the fiscal procedures of the Area Authority.
I. PURPOSE

The purpose of this policy is to establish a process for determining compensation for the area director.

II. DEFINITIONS

Area Director: Chief Executive Officer who is hired and evaluated by the Area Board and is responsible for leading and conducting the Area Authority’s business and affairs.

III. POLICY STATEMENT

The operational effectiveness of Alliance Behavioral Healthcare is dependent, in large part, on the leadership of its chief executive. As such, it is incumbent upon the Area Board to develop a compensation plan and process that (1) attracts and retains the best executive talent, (2) ensures compensation that is comparable to that of similar organizations and (3) is based on the area director’s performance. The Board’s compensation plan shall comply with all relevant Federal, State and local requirements.

IV. PROCEDURES

A. Total Compensation Mix

Total executive compensation shall include the following items:

1. Base pay – formal position salary structure plus any restructuring based on position reviews.
2. Benefits plan – health and medical insurance benefits, liability coverage and other benefits as approved by the board.
3. Incentives based on personal and professional performance.
B. Total Compensation References
The Area Board shall use comparability data in determining and approving an equitable compensation arrangement including:

1. Market comparator data – a review of compensation paid by other agencies of similar size and services.
2. Functionally comparable positions – a review of compensation paid to other executives of similar functions and responsibilities.
I. PURPOSE

The purpose of this policy is to ensure that all instances of alleged or suspected abuse, neglect, dependency, or exploitation of children or disabled adults, insofar as they come to the attention of the staff of Alliance Behavioral Healthcare, are reported to the County Department of Social Services in the county where the person is receiving services.

II. POLICY STATEMENT

Every employee shall immediately report to their immediate supervisor, any form of alleged or suspected abuse, neglect, dependency, or exploitation of a child or disabled adult that comes to their attention. In addition to the requirement to report to the immediate supervisor the employee shall make a report to the County Department of Social Services in the county where the child or disabled adult is receiving services.

Any employee who fails to report known or suspected abuse, neglect, dependency, or exploitation as required in this policy shall receive disciplinary action in accordance with Alliance Behavioral Healthcare policies for administering disciplinary action.

Pursuant to G.S. 7B-301 and G.S. 108A-102 the definition of duty to report and immunity shall prevail.

Aggregate data of abuse, neglect and/or exploitation reports to the Department of Social Services will be presented to the Area Board Human Rights Committee on a regular basis.

III. PROCEDURES

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

As used in this article, the following terms shall have the meaning indicated:

**Business Entity:** Any business, proprietorship, firm, partnership, person in representative or fiduciary capacity, association, venture, trust or corporation which is organized for financial gain or profit.

**Area Authority Official:** A member of the area board.

**Immediate Family:** The area board member, his/her spouse, and minor children (including stepchildren and foster children).

**Interest:** Direct or indirect pecuniary or material benefit, as a result of an official act, a contract, or transaction with Alliance Behavioral Healthcare, accruing to:

i. A board member;
ii. Any person in his/her Immediate Family;
iii. Any business entity in which the board member, member of his/her immediate family, or is about to be, an officer or director; or
iv. Any business entity in which an excess of five (05) percent of the stock, or legal or beneficial ownership of, is controlled or owned directly or indirectly by the board member, or his/her immediate family member.

For the purposes of the above paragraphs, ii, iii, and iv, a board member is presumed to have knowledge of the financial affairs of his/her immediate family members. For the purpose of this policy, the board member only has an Interest in the affairs of other immediate family members if the board member has knowledge of or should have known of the Interest of the family member.

**Official Act or Action:** Any administrative, appointive, or discretionary act of any board member.

**Confidential Information:** Any information or knowledge which has not been made public through a governmental agency or official. Information that has become public knowledge, whether or not through a governmental agency or official, is not considered confidential information.
II. POLICY STATEMENT

The Proper Operation of a public authority requires that board members of the authority and its employees be independent, impartial, and responsible to the people; that decisions and policy be made publicly; that public offices not be used for personal gain; and that the public maintain confidence in the integrity of the authority.

In recognition of these goals, a code of ethics for the Board of Directors of Alliance Behavioral Healthcare is hereby adopted. The purpose of this policy statement is to set forth guidelines for ethical standards of conduct for all such officials by setting forth acts or actions that are incompatible with the best interests of the Area Authority.

III. STANDARDS OF CONDUCT

The stability and proper operation of Alliance Behavioral Healthcare depends upon the continuing public confidence in the integrity of the Area Authority and upon responsible exercise of the trust conferred by the people. Board decisions and policy must be made and implemented through proper channels and processes of the board’s structure. The purpose of this section is to establish additional guidelines for ethical standards of conduct for board members. It should not be considered a substitute for the law or a board member’s best judgment.

Area board members must be able to act in a manner to maintain their integrity and independence, yet must be responsible to the interests and needs of those individuals served by Alliance. Board members serve in an important advocacy capacity in meeting the needs of the served communities in the Alliance Catchment Area and should recognize the legitimacy of this role as well as the importance of this function to the proper functioning of the Area Authority. At the same time, the Board must, at times, act in an administrative capacity and must, when doing so, act in a fair and impartial manner. Area board members must know how to distinguish these roles and when each role is appropriate, and they must act accordingly. Board members must be aware of their obligation to conform their behavior to standards of ethical conduct that warrant the trust of their constituents.

A. An Area Board Member Shall Obey the Law. Board members shall support the Constitution of the United States, the Constitution of North Carolina and the laws enacted by the Congress of the United States and the General Assembly pursuant thereto.

B. An Area Board Member Shall Uphold the Integrity of His or Her Office. Board members shall demonstrate the highest standards of personal integrity, truthfulness, honesty, and fortitude in all their public activities in order to inspire public confidence and trust in Alliance Behavioral Healthcare. Board members shall participate in establishing, maintaining, and enforcing, and shall themselves observe, high standards of conduct so that the integrity of their office may be preserved. The provisions of this Code should be construed and applied to further these objectives.

C. An Area Board Member Shall Avoid Impropriety and the Appearance of Impropriety in All of His or Her Activities.

1. It is essential that Alliance Behavioral Healthcare attract those citizens best qualified and willing to serve. Area Board members have legitimate interests - economic, professional and vocational - of a private nature. Board members shall not be denied, and shall not deny
to other members or citizens, the opportunity to acquire, retain and pursue private interests, economic or otherwise, except when conflicts with their responsibility to the public cannot be avoided. Area board members must exercise their best judgment to determine when this is the case and comply with the Area Board Conflict of Interest Policy.

2. Area Board members shall not allow family, social, or other relationships to unduly influence their conduct or judgment and shall not lend the prestige of the office to advance the private interests of others; nor shall they convey or permit others to convey the impression that they are in a special position to influence them.

D. An Area Board Member Shall Perform the Duties of the Office Diligently. Board members shall perform the duties of the office as prescribed by law. In the performance of these duties, the following standards shall apply:

1. Board members shall respect the legitimacy of the goals and interests of other members and shall respect the rights of others to pursue goals and policies different from their own.

2. Board members shall respect, support and abide by the decisions made by the board even in those instances when the member(s) is not on the prevailing side of an issue.

3. Board members shall demand and contribute to the maintenance of order and decorum in proceedings before the board.

4. Board members shall be honest, patient, dignified and courteous to those with whom they deal in their official capacity, and shall require similar conduct of the Area Authority’s staff.

5. Board members shall accord to every person who is legally interested in a proceeding before the board full right to be heard according to law.

E. A Board Member Shall Conduct the Affairs of the Board in an Open and Public Manner. Board members must be aware of the letter and intent of the State’s Open Meetings Law and conduct the affairs of the board consistent with the letter and spirit of that law and consistent with the need to inspire and maintain public confidence in the integrity and fairness of the Area Authority.

IV. ADDITIONAL STANDARDS OF CONDUCT

Board members shall be subject to and abide by the following standards of conduct.

A. Conflict of Interest. Board members shall comply with all provisions in the board’s policy on Conflict of Interest.

B. Use of official position. No board member shall use his/her official position or the Area Authority’s facilities for his/her private gain, or for the benefit of any individual, which benefit would not be available to any other member of the public in the same or similar circumstance.

C. Disclosure of information. No board member shall use or disclose confidential information gained in the course of or by reason of his/her official position on the board for purposes of advancing:
1. His/her financial or personal interest;

2. The interest of a business entity of which the member, an immediate family member, has an interest;

3. The financial or personal interest of a member of his/her immediate family; or

4. The financial or personal interest of any citizen beyond that which is available to every other citizen.

D. Incompatible service. No board member shall engage in, or accept private employment or render service for private interest, when such employment or service for private interest is incompatible with the proper discharge of his/her official duties with the Area Authority or would tend to impair his/her independent judgment or action in the performance of his/her official duties, unless otherwise permitted by law.

E. Gifts. No board member shall directly or indirectly solicit any gift, or accept or receive any gift, whether in the form of money, services, loan, travel, entertainment, hospitality, thing or promise, or any other form from any Alliance contractor, subcontractor, provider or supplier.

Exempted from the prohibition are reasonable honorariums for participating in meetings, advertising items or souvenirs of nominal value or meals furnished at banquets. Also exempted are customary gifts or favors between board members or officers and their friends or relatives. Board members must report in writing to the Area Director all honorariums and gifts and favors from friends and relatives if made by a covered contractor, subcontractor, or supplier.

It shall not be a violation of this policy for any board member to solicit donations, contributions or support for any charitable activity which does not result in direct pecuniary benefit to the member, a member of his immediate family, or business entity with which he is associated.

F. Area Director to Secure Advice. In any case where the circumstances make it unclear as to whether a thing constitutes a “gift” within the meaning of this provision, any board member shall consult with the Area Director who will secure an advisory opinion from General Counsel.

V. VIOLATIONS OF THE CODE OF ETHICS; SCHEDULING OF HEARING BEFORE THE AREA BOARD; RIGHTS OF ACCUSED AT HEARINGS; SANCTIONS

A. The Area Board Chairperson, after receiving an allegation of a violation of the Code of Ethics, shall refer the matter to the Area Director for further investigation and inform the Board’s Executive Committee of the alleged violation and the findings of the investigation.

B. If the Executive Committee finds sufficient evidence to believe a violation may have occurred, they shall report the matter to the full board which may schedule a hearing on the issue. The board member who is charged with the violation shall have the right to present evidence, including the testimony of witnesses, and to question witnesses, including the complainant or complainants, at the hearing.
C. The hearing shall be conducted by the Area Board in open session. Any determination resulting from said hearing shall be made in open session of the Board. The Clerk to the Board shall be authorized to swear witnesses before the presentation of their testimony.

D. If the Area Board by majority vote of the remaining members finds that a violation has occurred, they may adopt a resolution of censure which shall be placed as a matter of record in the official minutes of the Board meeting or, if warranted, refer the matter to the appointing authority.

VI. ADVISORY OPINIONS

When any board member has a doubt as to the applicability of any provision of this policy to a particular situation involving that board member or as to the definition of terms used in this policy, he/she may apply to the Area Director who shall obtain an advisory opinion from General Counsel. The board member shall have the opportunity to present his/her interpretation of the facts at issue and of the applicability of provisions of this policy before such advisory opinion is made.

CODE OF ETHICS FOR ALLIANCE BEHAVIORAL HEALTHCARE BOARD OF DIRECTORS

I, a member of the Alliance Behavioral Healthcare Board of Directors acknowledge that I have received and reviewed a copy of the Code of Ethics for the Area Board.

_________________________    ___________
Signature        Date

______________________
Printed Name
I. PURPOSE

The purpose of this policy is to ensure the ongoing and meaningful involvement of consumers and family members, through the Consumer and Family Advisory Committee (CFAC), in the planning, management and oversight of the Area Authority.

II. POLICY

It is the policy of Alliance Behavioral Healthcare that a Consumer and Family Advisory Committee (CFAC) shall be established and operational. The CFAC shall be a self-governing and self-directed organization that advises the Area Board on the planning and management of the local public mental health, intellectual/developmental disabilities and substance abuse system. The CFAC shall be actively involved in all aspects of planning, development, implementation and evaluation of the Area Authority and its providers of services.

III. PROCEDURES

A. The initial Consumer and Family Advisory Committee shall be approved by the Area Board and serve in an advisory capacity to the board.

B. The committee, upon creation, shall develop bylaws for the purpose of self-governance.

C. The membership of the committee will be 100 percent consumers and family members.

D. The Area Director shall provide support and assistance to the CFAC to ensure compliance with NCGS 122C - 170.
I. PURPOSE

The purpose of this policy is to enunciate the critical role the strategic planning process plays in guiding the Area Board as it carries out its mission of providing mental health, intellectual/developmental disabilities and substance abuse services to the residents in the Alliance multi-county area. Strategic planning is the foundation of organizational achievement and success.

II. POLICY STATEMENT

The Board shall develop a strategic plan to cover a period of no more than five years. The Board shall conduct a comprehensive review of its strategic plan every three years or more often as necessary. Annually, the board shall review the plan’s goals and objectives to adjust the plan for changes in the operational environment.

Given the importance of the strategic planning process and its outcomes, the area authority shall involve the broader catchment area community in the development of the plan. Participants shall include, but are not limited to: Area Authority staff, Area Board members, consumers, community members, advocacy groups, and funding agencies. Special effort shall be made to ensure representation from various age groups, disabilities, and cultural backgrounds representative of the catchment area demographics.

All participants in the strategic planning process shall receive an orientation to strategic planning focused on its significance to Alliance Behavioral Healthcare’s operations, and training in the specific planning process that will be utilized.

III. PROCEDURES

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

The Area Board strives to provide a healthy and safe environment for consumers, customers, staff personnel and other stakeholders who work in or visit Alliance Behavioral Healthcare facilities.

II. POLICY STATEMENT

It is the policy of the Area Board to provide services and programs in physical environments that are safe and free of health hazards. Alliance Behavioral Healthcare will comply with all Federal, state and local environmental/health and safety laws, regulations, and ordinances.
I. PURPOSE

The purpose of this policy is to set forth the requirement for the Area Authority to develop an emergency management plan to be followed in the event of an emergency, including but not limited to fire, medical, natural disaster, violent/threatening person, utility failure or bomb threat.

II. POLICY STATEMENT

It is the policy of the Area Board to have an emergency management plan to be followed by staff, consumers and visitors. Alliance Behavioral Healthcare will take every possible action to comply with all emergency regulations and protect employees, visitors and property in emergency situations.

III. PROCEDURES

The Area Director shall develop a comprehensive emergency management plan and shall conduct periodic emergency drills or simulations. The Area Director shall report to the Area Board on the results of those drills or simulations.
### I. PURPOSE

The purpose of this policy is to establish proper internal control procedures.

### II. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to establish internal control procedures to provide reasonable assurance regarding the achievement of objectives in the following categories:

1. Effectiveness and efficiency of operations
2. Reliability of financial reporting
3. Compliance with applicable laws and regulations

### III. PROCEDURES

The Area Director shall be responsible for developing internal control procedures to ensure that internal controls are established, properly documented, maintained and adhered to in each department within Alliance Behavioral Healthcare.

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<tr>
<th>TITLE:</th>
<th>Internal Control</th>
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<tr>
<td>BOARD POLICY #:</td>
<td>GA-6</td>
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<tr>
<td>LINES OF BUSINESS:</td>
<td>Business Operations, Compliance, All</td>
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<td>RESPONSIBILITY:</td>
<td>Area Board, Area Director</td>
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<td>REFERENCE(S):</td>
<td>DHHS DMA Contract</td>
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<td>URAC STANDARDS:</td>
<td>CORE, v. 3.0, Standard 4</td>
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<td>11/1/2012</td>
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<td>LATEST REVIEW DATE:</td>
<td>9/3/2015</td>
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I. PURPOSE

The purpose of this policy is to ensure that Alliance Behavioral Healthcare continue to operate during any natural and/or man-made disasters or other disruptions. The plan shall ensure minimal interruption of services to the citizens in the catchment area.

II. POLICY STATEMENT

Alliance Behavioral Healthcare shall develop a Business Continuity Plan, which shall include information and procedures for preparedness and response to natural and man-made disasters or disruptions to the daily operations. The plan shall include a Disaster Recovery Plan, to ensure timely and reliable access to critical computer systems, network services and phone system needed to support business operations. The Business Continuity Plan will be reviewed at least annually and updated as needed.

III. PROCEDURES

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

The purpose of this policy is to set forth the requirement that the Area Board conduct an annual performance evaluation of the Area Director.

II. POLICY STATEMENT

The Area Board shall complete a formal review (at least annually or more often if necessary) of the Area Director using a method that encompasses areas of operation that are important to the Area Board and required by the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (State). This method shall be used at the Board’s discretion and shall minimally include: the major categories described in the State rules for evaluating the Area Director and additional priorities as mutually agreed to by the Area Board and the Area Director. Among other things, the board shall use the performance evaluation to (1) assure that the Area Director meets performance expectations as established by the board and (2) to identify or verify information that may be used to determine or justify a change in the Area Director’s compensation package.

III. PROCEDURES

The Board Chair may appoint an ad hoc committee to conduct the annual performance evaluation. The committee shall bring its recommendation to the full board for final action.
I. PURPOSE

The Alliance Behavioral Healthcare multi-county Area Authority LME/MCO is a political subdivision of the State of North Carolina and organized under North Carolina General Statute §122C-115, to administer all publicly-funded mental health, intellectual/developmental disability, and substance abuse ("MH/I-DD/SA") services for the residents of Durham, Wake and Cumberland Counties. Alliance is also responsible for managing federal and state-funded MH/I-DD/SA services in Johnston County through an Inter-local Agreement. The purpose of this policy and accompanying procedures is to define the relationship between the Area Authority and the participating County Boards of Commissioners.

II. DEFINITIONS

Area Authority: The area mental health, developmental disabilities and substance abuse authority.
Catchment Area: The geographic part of the state served by the area authority.
Boards of County Commissioners: The participating boards of county commissioners for multicounty area authorities.

III. POLICY STATEMENT

In accordance with the “Purpose” as outlined above, the Area Authority shall develop and manage local mental health, intellectual/developmental disabilities, and substance abuse services in the multi-county area per contracts with the Department of Health and Human Services (DHHS), Inter-local Agreements and the powers and duties outlined in N.C.G.S. §122C-117. The Area Authority shall collaborate with all relevant local governmental agencies in the catchment area to coordinate and advance the development of mental health, intellectual/developmental disabilities and substance abuse services. The Area Authority shall also operate in accordance with all applicable federal and state laws, rules, regulations, executed contracts, agreements, and resolutions as promulgated by the Alliance Behavioral Healthcare Board of Directors.
IV. PROCEDURES

A. Alliance Behavioral Healthcare shall create and manage the provision of high quality cost-effective mental health, intellectual/developmental disabilities, and substance abuse services to residents of the catchment area.

B. Alliance Behavioral Healthcare shall adhere to the requirements of applicable Federal and State laws, rules and regulations including but not limited to Chapters 108A 108D and 122C of the North Carolina General Statutes, the NC State Plan for Medical Assistance, the 1915 b/c Medicaid Waivers, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services’ (DMH/DD/SAS) State Plan, Clinical Coverage Policies, State Service Definitions, executed contracts with the NC Department of Health and Human Services, agreements with catchment area counties or other funding sources, all as may be amended, updated or supplemented from time to time.

C. Annually, the Area Director/CEO shall negotiate and sign a Funding Agreement with the Board of Commissioners of each county in the catchment area. County funding allocated for local services annually shall be conveyed through this Agreement between the funding County and the Area Authority. The terms of the Agreement shall be mutually developed and in compliance with applicable County, State and Federal requirements.

D. The Area Director/CEO or designee may attend catchment area County Department Head meetings and provide information and reports as specified in the Agreement between the Area Authority and the respective county government.

E. Alliance Behavioral Healthcare shall provide a status report on operations and service delivery to the catchment area County Boards of Commissioners at least annually, or more often if specified in the County Agreement or if circumstances dictate. The report shall be presented in a format as agreed upon by each County and the Area Authority and shall include, but not be limited to the following:
   1. Financial report
   2. Risk-management report
   3. Service planning and delivery activities
   4. Quality improvement activities including program audits, surveys, and reports
   5. Provider network management activities
   6. Consumer activities including complaints and grievances
   7. Other reports as identified
I. PURPOSE

To provide a process for the Alliance Behavioral Healthcare Board of Directors (Area Board) to develop, revise, review, approve and monitor policies and procedures that govern the core business of the Area Authority.

II. DEFINITIONS

Approval authority: The party or parties authorized to approve Area Board and Area Authority policies and procedures. The Area Board approves Area Board policies and procedures and the Area Director approves Area Authority operational procedures.

Approval date: The date on which the policy or procedures has been approved by all applicable parties and becomes effective for use. This approval date shall appear on all policies and procedures accompanied by the signature of the approval authority.

Policy: Documents developed and approved by the Area Board that provide direction to guide the Area Authority’s decision making including the development of operating procedures.

Procedures: Documents developed and approved by the Area Director that provide steps for employees to follow when performing a particular function.

Review date: The date the policy or procedures were reviewed and approved for continued use. Procedure review date is the date Alliance initiates the review of a procedure. Policies and procedures shall be reviewed at least annually (month year to month year) and revised as necessary.

Revision date: The date on which the policy or procedures were revised to reflect required changes in the organization’s decision making process. Revisions may be effected at any time and it is not necessary to await the scheduled review date.

III. POLICY STATEMENT

The Area Board shall be responsible for the development, revision, approval, and monitoring of Area Authority policies that govern the operation of the Area Authority’s programs and services. Among other things, these policies may relate to Federal or State statutes, NC DHHS rules or other regulatory or
accreditation requirements affecting the provision of mental health, intellectual/developmental
disabilities and substance abuse services.

Policies for inclusion in the policy manual require Area Board action. Annually, the Area Board shall
review its policies. These reviews may occur more often if required by rules, statutes, or outside
accrediting bodies.

The Area Director (or designee) is responsible for developing a process for revising, approving and
monitoring all procedures associated with the implementation of Board policies.

IV. PROCEDURES

Policies for inclusion in the policy manual require Area Board action. Annually, the Area Board shall
review its policies. These reviews may occur more often if required by rules, statutes, or outside
accrediting bodies.

The Board Policy Committee shall develop, review and revise all Area Board policies before submission
to the full Area Board for review and approval. Non-substantive, grammatical revisions may be made
with the approval of the Board Policy Committee.

The Area Director (or designee) is responsible for developing a process for revising, approving and
monitoring all procedures associated with the implementation of Board policies.
TITLE: Management of Service Delivery  
BOARD POLICY #: GA-1  
LINES OF BUSINESS: All  
RESPONSIBILITY: Area Board, Area Director  
REFERENCE(S): G.S. 122C-115.4  
URAC STANDARDS: CORE, v. 3.0, Standards 4, 6-9, 31, 34, 36 & 38; HUM, v. 7.03, Standards 1-38; N-NM, v. 7.0, Standards 1-3 & 5, 7-17; N-CR Standards 1-17  
APPROVAL DATE: 5/3/2013  
LATEST REVISION DATE: 9/3/2015  
LATEST REVIEW DATE: 9/3/2015

I. PURPOSE

To set forth policy that guides and directs the management and provision of public mental health, intellectual and developmental disabilities and substance abuse services in Alliance Behavioral Healthcare’s catchment area.

II. POLICY STATEMENT

Alliance Behavioral Healthcare (Alliance) is charged with management and oversight responsibility for the public mental health, intellectual and developmental disabilities and substance abuse service system in a multi-county area. It is the intent of the Board of Alliance Behavioral Healthcare that the service delivery system will be managed in a manner that is consistent and accountable to the citizens of the catchment area.

This policy will guide the Board as it carries out its responsibilities outlined in North Carolina General Statutes 122C-115.4 which assigns the following functions to the LME:

1. Access to services 24/7/365 basis;
2. Provider endorsement, monitoring, technical assistance, capacity development and quality control;
3. Authorization of services, utilization review and management;
4. Authorization of the utilization of state psychiatric hospitals, three-party contracted local hospitals and other state facilities;
5. Care coordination and quality management;
6. Community collaboration and consumer affairs;
7. Financial management and accountability; and
8. Management of waiting lists for consumers with intellectual and developmental disabilities.
III. PROCEDURES

Annually, the Board will review and approve the plan for managing and delivering services in the catchment area. The plan shall be presented to the Board as part of the budget development process and shall outline the process for assuring a consistent clinical model and best practices across the catchment area.
I. PURPOSE

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

II. DEFINITIONS

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

III. POLICY STATEMENT

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

IV. PROCEDURES

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

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

II. POLICY STATEMENT

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

III. PROCEDURES

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

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

II. DEFINITIONS

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

III. POLICY STATEMENT

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

IV. PROCEDURES

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

To identify activities necessary for the orderly planning and implementation of Area Board processes.

II. DEFINITIONS

Processes: Activities associated with Area Board meetings including agenda planning, developing and distributing meeting materials, overseeing committee work, compiling meeting minutes, etc.

III. POLICY STATEMENT

The Area Board shall utilize processes required for effective and efficient meetings, to execute Board business and to carry out Area Authority responsibilities for service delivery and operations.

IV. PROCEDURES

A. Agenda Planning

Each Area Board meeting shall utilize an agenda developed by the Area Board Executive Committee with assistance from the Area Director. Meeting agendas shall conform to the following principles:

1. The agenda shall have continuity from the previous meeting.
2. Agenda items may sometimes include special issues such as election of new members, attention to crisis situations, goal setting, etc.
3. The agenda shall indicate the beginning and ending times for each Board meeting.
4. The agenda shall be sent to Area Board members at least five (5) working days prior to each meeting.

B. Developing and Distributing Meeting Materials

The Area Director is responsible for the following:
1. Sending notices to Area Board members regarding meetings
2. Preparing “Board Packets” to be available to Board members five (5) working days prior to each regularly scheduled board meeting. The packets shall include:
   a. The meeting agenda
   b. Agenda Action Form
   c. Minutes from the previous Area Board meeting
   d. Minutes from committee meetings, as applicable
3. Post agenda on website
I. PURPOSE

The purpose of this policy is to provide guidance to the Board and consumers, enrollees, providers, vendors, stakeholders, or other persons or entities that have a contractual or business relationship with Alliance Behavioral Healthcare (“Alliance”), as to how to resolve disputes concerning Alliance contract actions, service authorization decisions or other matters, including applicable appeal rights.

II. DEFINITIONS

**Consumer:** Means any consumer of mental health, intellectual/ developmental disability, and/or substance abuse (“MH/I-DD/SA”) services who is enrolled with Alliance, regardless of funding source.

**Enrollee:** Means any Medicaid-eligible beneficiary whose Medicaid eligibility is based in any of the counties included within the Alliance catchment area and who is enrolled in the Alliance Medicaid Prepaid Inpatient Health Plan.

**Network Provider:** Means as defined in N.C.G.S. §108D-1(13), i.e. an appropriately credentialed provider of MH/I-DD/SA services that has entered into a contract for participation in the Alliance Closed Network.

**Out of Network provider:** Means any provider who has entered into an Out of Network Single Case Agreement in order to provide services to an Alliance Enrollee.

**Provider:** Means any provider who has a contract or agreement with Alliance for the delivery or reimbursement of publicly-funded MH/I-DD/SA services, regardless of funding source or type, and includes all Network Providers, Out of Network providers, and providers of emergency services.

**Provider of emergency services:** Means as defined in N.C.G.S. §108D-1(18), i.e. A provider that is qualified to furnish emergency services to evaluate or stabilize an enrollee’s emergency medical condition, and has submitted claims to or been reimbursed by Alliance for such services.

**Vendor:** Means any individual or entity contracted with Alliance to furnish goods or services to the organization, but does not include Providers.
III. POLICY STATEMENT

It is the policy of Alliance Behavioral Healthcare to resolve disputes that arise over decisions made by the Area Board at the lowest level and in accordance with all applicable Federal and State laws, rules and regulations and accreditation requirements, including but not limited to Chapter 108D of the North Carolina General Statutes (for Medicaid enrollee appeals) and 10A NCAC Subchapter 27G (for State-funded service appeals). Alliance will attempt to informally resolve any and all disputes with consumers, enrollees, providers or vendors and will establish dispute resolution procedures. It is the position of Alliance that the NC Office of Administrative Hearings lacks jurisdiction over Alliance (a local unit of government) except for timely petitions contesting service authorization decisions filed by Medicaid enrollees or duly authorized representatives, as set forth in N.C.G.S. §150B-23(a3). Any formal action alleging breach of contract by Alliance should be filed in accordance with the terms and conditions of the provider’s or vendor’s contract and all applicable laws, rules and regulations, including but not limited to N.C.G.S. §1-52.

IV. PROCEDURES

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

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

II. POLICY STATEMENT

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

III. PROCEDURES

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

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

II. POLICY STATEMENT

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

III. PROCEDURES

The Area Director shall develop procedures to implement this policy.
ITEM: Draft Minutes from the August 4, 2016, Regular Board Meeting

DATE OF BOARD MEETING: September 1, 2016

REQUEST FOR BOARD ACTION: Approve the draft minutes from the August 4, 2016, Regular Board Meeting.

CEO RECOMMENDATION: Approve the minutes.

RESOURCE PERSON(S): Robert Robinson, CEO; Veronica Ingram, Executive Assistant
MEMBERS PRESENT: Cynthia Binanay, Vice-Chair, Christopher Bostock, Chair, George Corvin, MD, Kenneth Edge (exited at 6:25 pm), James Edgerton, Lodies Gloston, Phillip Golden, John Griffin, Ed.D (exited at 6:08 pm), Curtis Massey (via phone), Rev. Michael Page (exited at 6:16 pm), George Quick (exited at 5:55 pm), Vicki Shore, William Stanford, Jr. (via phone), Caroline Sullivan, Amelia Thorpe (exited at 5:55 pm), Lascel Webley, Jr. (exited at 5:55 pm), and McKinley Wooten, Jr. (via phone)

GUEST(S) PRESENT: Gary Bass, CEO of Pride of North Carolina, Inc.

ALLIANCE STAFF PRESENT: Michael Bollini, Executive Vice-President Operations/Chief Operating Officer; Dr. Tedra Anderson-Brown, Chief Medical Officer; Joey Dorsett, Senior Vice-President/Chief Information Officer; Cathy Estes, Director of Provider Networks Operations; Amanda Graham, Senior Vice-President/Chief of Organizational Effectiveness; Carol Hammett, General Counsel; Veronica Ingram, Executive Assistant; Geyer Longenecker, Director of Quality Management; Beth Melcher, Senior Vice-President/Network Development and Evaluation Officer; Kelly Phillips, Director of Budget and Financial Analysis; Monica Portugal, Chief Compliance Officer; Al Ragland, Senior Vice-President/Human Resources; Rob Robinson, CEO; Matt Ruppel, Director of Program Integrity; Sean Schreiber, Executive Vice-President/Clinical Operations; and Doug Wright, Director of Consumer Affairs

1. CALL TO ORDER: Chairman Christopher Bostock called the meeting to order at 4:05 p.m.

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<tr>
<td>2. Announcements</td>
<td>A. FUTURE DEVELOPMENT WORKGROUP: Chairman Bostock mentioned that this staff workgroup meets monthly and is open to Board members. The next meeting will be Tuesday, September 06, 2016 at 4:00 pm. Board members may contact Ms. Ingram if they are interested in attending.</td>
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<td>B. NC OPEN MEETINGS LAW TRAINING: Chairman Bostock stated that Alliance annually provides this training for staff. The Executive Committee decided to offer this training for all Board members and have set a goal of 100% compliance. The training will be sent electronically. Board members were asked to complete the training before the September Board meeting.</td>
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<td>C. NC Council Award: Mr. Robinson shared that on June 20, 2016, Alliance and UNC Health Care received the 2016 Provider Partner Leadership Award for their partnership with Alliance in implementing a continuum of care to meet the needs of individuals with serious and potentially debilitating behavioral health issues.</td>
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<td>3. Agenda Adjustments</td>
<td>There were no adjustments to the agenda.</td>
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4. Public Comment
Gary Bass, CEO of Pride of North Carolina, mentioned that his agency is new to Alliance’s network of providers and has merged with Carolina Support Services. Mr. Bass shared that Pride of NC is part of multiple NC LME/MCO networks. He stated that he looked forward to a successful partnership with Alliance.

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 Cumberland, Durham and Wake CFAC subcommittees.

Doug Wright, Director of Consumer Affairs, presented the CFAC report. He noted that CFAC’s annual report was included in the packet and shared CFAC’s concerns/goals: need for Medicaid expansion, continued State budget cuts and impact on behavioral health services, potential mergers, transportation and housing needs, and increased advocacy and utilization of available resources.

B. Finance Committee (10 minutes) – page 44
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 June meeting.

James Edgerton, Committee Chair, presented the report. Mr. Edgerton stated that the revenues exceeded expenditures and Alliance met State mandated rations. He also requested a budget amendment as included in the packet previously sent to the Board; this adjusts the fund balance appropriation as Alliance was refunded a portion of the single stream cuts.

BOARD ACTION
A motion was made by Mr. James Edgerton to amend the FY16 budget by 2,996,001; seconded by Dr. John Griffin. Motion passed unanimously.

6. Consent Agenda
A. Draft Minutes from June 2, 2016, Regular Board Meeting – page 53
B. Draft Minutes from June 21, 2016, Special Board Meeting – page 58
C. County Commissioner Advisory Committee Report – page 60
D. Executive Committee Report – page 63
E. Network Development and Services Committee Report – page 68
F. Quality Management Committee Report – page 80
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<td>The consent agenda was sent as part of the Board packet. There were no comments or discussion about the consent agenda.</td>
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**BOARD ACTION**

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

7. Recommendations for Reappointment – page 89

In accordance with NC General Statute 122C-118.1.d and the By-Laws of the Alliance Board the initial terms of Alliance original Board members were staggered with each initial term being considered a full term. NC Senate Bill 191 revised G.S. 122C-118.1.d to allow members to be reappointed for two additional three-year terms.

The terms of Christopher Bostock, Kenneth Edge, and Lodies Gloston expire on September 30, 2016; recommendation for their reappointment was presented.

**BOARD ACTION**

A motion was made by Vice-Chair Cynthia Binanay to recommend to the Cumberland Board of County Commissioners the reappointment of Kenneth Edge and Lodies Gloston; seconded by Mr. James Edgerton. Motion passed unanimously.

A motion was made by Commissioner Kenneth Edge to recommend to the Cumberland Board of County Commissioners the reappointment of Christopher Bostock; seconded by Ms. Lodies Gloston. Motion passed unanimously.

8. Updates

A. Consumer Perception of Care Survey – page 90

Geyer Longenecker, Quality Management Director, presented an overview of survey results. Mr. Longenecker mentioned that this annual survey is self-administered by consumers through randomly selected providers. The results were compiled and analyzed by Carolinas Center for Medical Excellence. Mr. Longenecker shared the domains asked of the survey takers (i.e. access to services, cultural sensitivity, outcomes) and an overview of the survey results. The consumer perception of care survey is attached to and made part of these minutes.

B. Staff Benefits Savings – page 102

Al Ragland, Chief HR Officer, provided an update on recent negotiations for staff benefits and subsequent savings. Mr. Ragland provided background information and shared how the decision to be self-funded has produced considerable savings of over $700,000. The staff benefits saving presentation is attached to and made part of these minutes.
AGENDA ITEMS:                                      DISCUSSION:
  9. Chairman’s Report  Chairman Bostock reminded Board members that the September 1, 2016, Board meeting is the day before Labor Day weekend. He requested that Board members confirm their attendance to determine we would have quorum for this meeting.
  10. Closed Sessions  The Board entered closed session.

**BOARD ACTION**

A motion was made by Mr. Phillip Golden to enter closed session pursuant to NC General Statute 143-318.11(A) (5) to instruct staff concerning the price and other material terms of a proposed contract for the acquisition of real property and pursuant to NC General Statute 143-318.11 (1) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1.; 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 6:29 p.m.

Next Board Meeting
Thursday, September 01, 2016
4:00 – 6:00
ITEM: Executive Committee Report

DATE OF BOARD MEETING: September 1, 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 August 16, 2016, meeting.

REQUEST FOR AREA BOARD ACTION:
Accept the report.

CEO RECOMMENDATION:
Accept the report.

RESOURCE PERSON(S):
Christopher Bostock, Area Board Chair; Robert Robinson, CEO
APPOINTED MEMBERS PRESENT: ☒Cynthia Binanay, Board Vice-Chair, B.S.N, M.A.; ☒Christopher Bostock, Board Chair, B.S.I.M.; ☒George Corvin, Quality Management Committee Chair, M.D. (exited at 4:50 pm); ☒James Edgerton, Finance Committee Chair, B.S.; ☒Lodies Gloston, Human Rights Committee Chair, B.A., M.A.; ☒Curtis Massey, Policy Committee Chair, B.A., J.D.; ☒William Stanford, Previous Board Chair, B.A., J.D.; and ☐Lascel Webley, Audit and Compliance Committee Chair, B.S., M.B.A., M.H.A.

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

1. WELCOME AND INTRODUCTIONS

2. REVIEW OF THE MINUTES – The minutes from the July 19, 2016, Executive Committee meeting were reviewed; a motion was made by Vice-Chair Binanay to approve the minutes; seconded by Ms. Gloston. Motion passed unanimously.

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<td>3. Updates</td>
<td>a) NEXT FUTURE DEVELOPMENT WORKGROUP MEETING: Chairman Bostock mentioned that the next staff workgroup is Tuesday, September 06, 2016, at 4:00 PM. Board members are invited to be part of this meeting. b) SEPTEMBER EXECUTIVE COMMITTEE MEETING: Chairman Bostock reminded Committee members that next month’s meeting is the second Tuesday, September 13, 2016, at 8:00 am. A call-in number will be available. c) BOARD TRAINING - NC OPEN MEETINGS LAW: Chairman Bostock provided an update on the number of Board members who have completed the mandatory training. d) FACILITIES COMMITTEE ACTION: A motion was made by Dr. Corvin to recommend that the Finance Committee and Area Board approve the acquisition and lease of the facility at 3309 Durham Drive in Raleigh; seconded by Mr. Stanford. Motion passed unanimously. e) BOARD COMMITTEES COMMITTEE ACTION: A motion was made by Mr. Stanford to create a subcommittee to review the by-laws; seconded by Mr. Massey. Motion passed unanimously.</td>
<td>a) Committee members will contact Ms. Ingram if they need a call-in number. b) Committee members will contact Ms. Ingram if they need a call-in number. c) Ms. Ingram will send a reminder to Board members. d) Committee’s recommendation will be forwarded to the Area Board. e) Mr. Robinson and Ms. Hammett will staff the ad hoc committee and coordinate committee meetings.</td>
<td>a) 9/6/2016 b) 9/13/2016 c) 8/19/2016 d) 9/1/2016 e) None specified.</td>
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The members of the subcommittee will be William Stanford, subcommittee Chair; Curtis Massey, Lodies Gloston and Cynthia Binanay.

Draft minutes may be submitted with the monthly Board packet. Minutes will be approved by this Committee at a later date.
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<tr>
<td>4. September 1, 2016, Area Board Draft Agenda</td>
<td>Committee reviewed proposed agenda and provided input.</td>
<td>Ms. Ingram will forward agenda to staff.</td>
<td>8/17/2016</td>
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<td>5. Closed Session</td>
<td>COMMITTEE ACTION</td>
<td>None specified.</td>
<td>N/A</td>
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<td>A motion was made by Ms. Gloston to enter closed session pursuant to NC General Statute 143-318.11 (1) to prevent the disclosure of information that is confidential and not a public record under NCGS 122C-126.1; seconded by Mr. Edgerton. Motion passed unanimously.</td>
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<td>Committee returned to open session.</td>
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6. **ADJOURNMENT**: the next Committee meeting will be September 13, 2016, at 8:00 a.m.

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

DATE OF BOARD MEETING: September 1, 2016

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

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

The Human Rights Committee shall meet at least quarterly.

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

The Human Rights Committee is a Board Committee with at least 50% of its membership being either consumers or family members that are not Board Members. All members and the chair are appointed by the Chair of the Alliance Board of Directors. The Committee is currently chaired by Ms. Lodies Gloston. Draft minutes and attachments for August 9, 2016, meeting are attached.

REQUEST FOR AREA BOARD ACTION:
Accept the report.

CEO RECOMMENDATION:
Accept the report.

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

APPOINTED, NON-VOTING MEMBERS PRESENT:

BOARD MEMBERS PRESENT:

GUEST(S) PRESENT: Ira B. Wolfe

STAFF PRESENT: Doug Wright, Director of Consumer Affairs, Yancee Perez, Starlett Davis, Linda Losiniecki

1. WELCOME AND INTRODUCTIONS

   - Additional Handouts Included:
     Human Rights Committee Membership Application, Submitted by Ira B. Wolfe
     Alliance Operational Procedure: Provider Dispute Resolution

2. REVIEW OF THE MINUTES - The minutes from the April 14, 2016, meeting were reviewed; a motion was made by McKinley Wooten and seconded by William Stanford to approve the minutes. Motion passed.

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| **Introduction of Potential New Member:** Ira B. Wolfe | Ira presented her bio and a background history of her employment, community, education and affiliation with children and young adults with disabilities and their families (Application Handout):  
Recommendation to the Board Chair, Motion was made by William Stanford and seconded by McKinley Wooten to recommend Ira B. Wolfe to become a member of the Board of Human Rights Committee. Motion passed. | Lodies Gloston to make recommendation to board chair for appointment of Ira Wolfe. | 9/1/2016    |
| **Incidents – May Alexander**     | On behalf of May Alexander, Doug Wright presented and reviewed the Incidents data (Excel Presentation):  
Sources include: Consumers, Parents/Guardian, Providers, Family Members, Attorney, Consumer Advocate/Rep, Anonymous, & Other. |                                                                           |             |
### AGENDA ITEMS:

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- There are 64 complaints against Alliance for FY16, of which 62 relate to LME/MCO functions, and 2 is categorized as Client Rights.
- 23 of 64 were External Stakeholders concerns, 39 were Grievances, and 2 were Internal Employee Concerns.
- Data represents a drop in March, and then an increase again in May. No specific reason was given.

Doug presented the Level III (High Level) Incident Data:
Important that the incident is categorized properly and proper agency has been reported.
- April had 13 Level III reports, May had 12 Level III reports, and June had 13 Level III reports.

Doug presented the Abuse and Neglect Data:
- April had 43 reported abuse and neglect cases, May had 30 reported abuse and neglect cases, and June had 25 reported abuse and neglect cases.
- Abuse and neglect reports filed with DHSR; DSS the information provided to Alliance is delayed.

Doug presented the Incidents by County:
The report showed consistency over April, May and June. The highest reported incidents are Unknown Deaths with 8 and Neglect and Abuse at 11. Some data is re-categorized once an autopsy report is completed.

Doug summarized the Rights and Confidentiality Concerns:
- 52 concerns regarding Clients Rights or HIPAA/Confidentiality in FY16
- 35 were Clients Rights, 17 were HIPAA/Confidentiality
- 11 of 52 were initiated by an Alliance employee
Data did not include June, 2016

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

### DISCUSSION:

**Grievances – May Alexander**

Not Discussed

**Provider Dispute Resolution Procedure:**

Doug read the Provider Dispute Resolution Operational Procedure (Handout):

Committee questions the reasoning why Board of Human Rights Committee

approves this procedure.

Motion was made by McKinley Wooten and seconded by Dan Shaw to

approve the Operational Procedure, motion passed.

**Announcements:**

- Resignation of Marie Dodson from the Board of Human Rights Committee. She has become an Alliance employee, as a TCL In-Reach Peer Support Specialist at the Cumberland office.
- Continue to search the community for individuals to become members.
- Policy Committee has requested the Human Rights Committee review their Client Rights Policies and have any revisions submitted back to the Policy Committee by 1/15/17.

**Adjournment:**

Next meeting scheduled for October 13, 2016

Meeting was adjourned at 5:20 p.m.

### NEXT STEPS:

- Doug reach out to May/Monica to get an explanation of this committee’s approval.
- Report to 10/13/16 Board of HRC meeting.
- Doug reach out to Johnston County CFAC to solicit for membership.
- Doug to send out the Clients Rights Policies to the committee.

### TIME FRAME:

- Review the CR policies at 10/13/16 meeting.
Human Rights Committee Membership Application

Please note: this is a public document.

Name: __Ira B. Wolfe
Address: _P.O. Box 42933
City, Zip: __Fayetteville, NC 28309

Phone: __910.916.9996
Email: __iwolfe@nct.rr.com
Date: __April 4, 2016

What disability/disabilities do you represent?
Mental Health: _X__ Substance Abuse: __ Intellectual/Developmental: __

Are you willing to commit two years to the Committee? Yes: _X__ No: __

Are you an employee, owner, or director of any provider contracted with Alliance Behavioral Healthcare? Yes: ___ No: _X_

Please attach a brief resume to the application.

Briefly explain why you are interested in participating on the Alliance Behavioral Healthcare Human Rights Committee:
The majority of my professional career has been dedicated to working with and for children and young adults with disabilities and their families. Having recently retired from public service, there is a void in this aspect of my life. I believe that serving on this board would give me the opportunity to give back to the community as well as fill this personal void.

Thank you for your interest!
Someone from Alliance Behavioral Healthcare will contact you regarding next steps.
IRA LEA BURKS WOLFE  
P.O. Box 42933  
Fayetteville, North Carolina 28309  
(910)867-2541 (H) (910) 916-9996 (C)  
RESUME ADDENDUM  

EDUCATION  

2014-2015  
Institute for Community Leadership, Fayetteville North Carolina  
2008-2009  
Education Policy Fellowship Program, Raleigh, North Carolina  

EMPLOYMENT  

2005-2014  
Chief Consultant; Policy, Monitoring and Audit Section; Exceptional Children Division; Department of Public Instruction; Raleigh, North Carolina. Served as Team Leader (Section Chief) for Dispute Resolution Consultants, Monitoring Consultants, and Regional Consultants. The section provided special education policy interpretation, investigated formal complaints, collaborated with the Office of Administrative Hearings regarding the special education due process hearings, monitored school systems for compliance and continuous improvement, and provided training and technical assistance to parents and school systems.  

COMMUNITY AFFILIATION  

2016  
Volunteer, Anne Chesnut Middle School, Fayetteville, North Carolina  
2014-2015  
Served as Proctor for End-of-Grade/End-of-Course Tests  
Cumberland County Schools
IRA LEA BURKS WOLFE
7716 Kennybunk Drive
Fayetteville, North Carolina 28304
(910) 867-2541 (H) (919) 807-3977 (W)

PERSONAL

Born April 30, 1949, Camden, Arkansas; married to Retired Lieutenant Colonel William L. Wolfe, United States Army; three sons, William, Christopher and Michael

EDUCATION

1966  Lincoln High School, Camden, Arkansas
1970  Arkansas A.M. & N. College, Pine Bluff, Arkansas; B.S. Secondary Education
1974  Kansas State University, Manhattan Kansas; M.S. Special Education, Learning Disabilities
1981- Present  Continuing Education Credits; National and State Conferences

EMPLOYMENT

6/1999- Present  Consultant, Policy, Monitoring and Audit Section; Exceptional Children Division; North Carolina Department of Public Instruction; Raleigh, North Carolina. Provide technical assistance, staff training, and support to LEAs state operated programs, and charter schools. Coordinate all monitoring activities for all districts in the Northeast and Southeast Regions. Provide leadership and training about the monitoring/audit process to Exceptional Children Division staff and other educators. Complete other duties as assigned.

1998-1999  Supervisor for Compliance/Preschool; Cumberland County Schools; Fayetteville, North Carolina. Provided leadership for the compliance component of the Exceptional Children's Program. Organized and conducted training for LEA Representatives/Case Managers and Administrators. Provided central services support for preschool program. Coordinated Surrogate Parent and Child Find activities.

1997-1998  Program Specialist; Cumberland County Schools; Fayetteville, North Carolina. Served eleven elementary schools lending technical assistance in the areas of compliance and instruction. Functioned as liaison between Office of Program Director and school and/or parents.

1995-1997  Compliance/Case Monitor; Cumberland County Schools; Fayetteville, North Carolina. Responsible for review of Exceptional Children's records before presentation to APC. Assisted schools in the area of compliance and procedures.
Ira Lea Burks Wolfe

-2-  

Resume

1994-1995  Consultant Teacher; Exceptional Children's Program; Cumberland County Schools. Served four schools lending technical assistance to school-based committees. Consulted with regular education and exceptional teachers regarding needs of students.

1988-1994  Educational Diagnostician; Exceptional Children's Programs; Cumberland County Schools; Fayetteville, NC. Member of Diagnostic Team which evaluated students referred for special education services. Administered Educational Evaluations. Interpreted test data for SBC's and/or parents. Developed draft IEP's.


1980-1981  Teacher; Adult Education Center; Illasheim, Germany. Program was administered by Temple University. Taught basic skills to soldiers. Developed Individualized Training Programs.

1975-1976  Teacher, Exceptional Children's Program, Junction City, Kansas; Taught children with learning disabilities. Served two junior high schools and one high school.

1974-1975  Teacher, Junction City High School, Junction City, Kansas; Taught students in self-contained EMH Class.


COMMITTEES/RELATED ACTIVITIES

11/2003  Member, State Team; Regional Summit to Address the Disproportionate Representation of Minority Students in Special Education; Baltimore, Maryland. Summit was sponsored by the National Center for Culturally Responsive Educational System.

6/2001-10/2003  Coordinator, Revision of the EC Division's document, Questions and Answers Related to Policy Issues about Students with Disabilities. Responsibilities included gathering and organizing input from LEA and Division personnel and collaborating with other DPI staff regarding the production of the document.
Nov 1996  Team Member, Program Compliance Audit, Public School of Robeson County. Responsibilities included review of students' records and interviews with teachers, principals and parents.

Dec 1995  Team Member, Program Compliance Audit, Brunswick County Schools. Responsibilities included review of students' records and interviews with teachers, principals and parents.

1993-1995  Presenter, Staff Development, "Serving the Learning Disabled Students in Regular Classroom." Provided regular and exceptional teachers with methods, strategies, modifications and materials for use with learning disabled students. Course included overview of definition and characteristics of learning disabilities.

1995-Present  Presenter, Case Management/Compliance Monitoring Training. Sessions consist of techniques and methods for organizing and conducting SBC meeting and training in use of compliance checklist. An overview of state and federal procedures and regulations was also included.

1994  Member, IEP Workshop Committee; Developed and organized course content and materials for System Wide IEP Workshop.

CHURCH AND COMMUNITY AFFILIATIONS

Member, Lewis Chapel Baptist Church, Fayetteville, NC

Past Advisor, Senior High Voices Choir, Lewis Chapel Baptist Church, Fayetteville, NC

Past Musician/Director - Youth for Christ and Senior High Voices Choirs, Lewis Chapel Baptist Church, Fayetteville, NC

Tutor/Consultant, After School Tutorial Program, Lewis Chapel Baptist Church, Fayetteville, NC

Past Member, Board of Directors, Day Care Program, Lewis Chapel Baptist Church, Fayetteville, NC

Past Second Vice-President, Senior Missionary Department, Lewis Chapel Baptist Church, Fayetteville, NC
<table>
<thead>
<tr>
<th>Categories Receiving “No”s by Month</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriately Categorized</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Notified Proper Agency</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Reported Within Timeline</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Effective Intervention and Protection</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>0</td>
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<td>2</td>
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<tr>
<td>Report Accurate and Complete</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

**Non-Compliance by Category by Month - FY16**

- **Report Accurate and Complete**
  - July: 1
  - August: 2
  - September: 2
  - October: 3
  - November: 2
  - December: 1
  - January: 0
  - February: 2
  - March: 0
  - April: 3
  - May: 2
  - June: 1

- **Effective Intervention and Protection**
  - July: 2
  - August: 2
  - September: 1
  - October: 2
  - November: 5
  - December: 2
  - January: 0
  - February: 3
  - March: 2
  - April: 5
  - May: 1
  - June: 2

- **Reported Within Timeline**
  - July: 1
  - August: 3
  - September: 2
  - October: 3
  - November: 2
  - December: 1
  - January: 2
  - February: 2
  - March: 3
  - April: 1
  - May: 2
  - June: 1

- **Notified Proper Agency**
  - July: 1
  - August: 3
  - September: 1
  - October: 1
  - November: 5
  - December: 1
  - January: 5
  - February: 5
  - March: 1
  - April: 1
  - May: 2
  - June: 1

- ** Appropriately Categorized**
  - July: 1
  - August: 1
  - September: 1
  - October: 1
  - November: 1
  - December: 1
  - January: 1
  - February: 1
  - March: 3
  - April: 1
  - May: 1
  - June: 1

**Combined Compliance for Level 3s - FY16**

- ** Appropriately Categorized**
  - Yes: 136
  - No: 12
  - % No: 9%

- ** Notified Proper Agency**
  - Yes: 130
  - No: 18
  - % No: 14%

- ** Reported Within Timeline**
  - Yes: 125
  - No: 23
  - % No: 18%

- ** Effective Intervention and Protection**
  - Yes: 134
  - No: 14
  - % No: 10%

- ** Report Accurate and Complete**
  - Yes: 135
  - No: 13
  - % No: 10%
## JULY

<table>
<thead>
<tr>
<th>Incident</th>
<th># of Reports</th>
<th>Level</th>
<th># Not Reported to DSS</th>
<th>Reason Not Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse Alleged</td>
<td>4</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregive Abuse</td>
<td>6</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregive Neglect</td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Assault</td>
<td>8</td>
<td>3</td>
<td>6</td>
<td>Police were contacted in 5 of the incidents. It was not necessary to contact DSS. In 1 of the incidents, the member declined police involvement.</td>
</tr>
<tr>
<td>Staff Abuse</td>
<td>4</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Neglect</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>29</strong></td>
<td></td>
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</table>

## AUGUST

<table>
<thead>
<tr>
<th>Incident</th>
<th># of Reports</th>
<th>Level</th>
<th># Not Reported to DSS</th>
<th>Reason Not Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse Alleged</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregive Abuse</td>
<td>6</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregive Neglect</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exploitation</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>In this incident, staff did not complete the Authorities Contacted section. Alliance incident staff has followed up with them twice to complete this section of the report.</td>
</tr>
<tr>
<td>Sexual Assault</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>This is an incident involving the same member as in previous months. Provider is working with member around issues involving accuracy of allegations and contacting the appropriate agencies regarding the allegations.</td>
</tr>
<tr>
<td>Staff Abuse</td>
<td>6</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Neglect</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>HCPR was notified and staff was terminated. It was not necessary to call DSS.</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>32</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>

## SEPTEMBER

<table>
<thead>
<tr>
<th>Incident</th>
<th># of Reports</th>
<th>Level</th>
<th># Not Reported to DSS</th>
<th>Reason Not Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse Alleged</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>Police were notified, an arrest was made, and a protective order was filed. DSS contact was not necessary.</td>
</tr>
<tr>
<td>Caregive Abuse</td>
<td>10</td>
<td>2, 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregive Neglect</td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Both were incidents involving the same member as in previous months. Provider is working with member around issues involving accuracy of allegations and contacting the appropriate agencies regarding the allegations.

HCPR was contacted; allegation was not substantiated.

Staff Abuse was contacted; allegation was not substantiated.

<table>
<thead>
<tr>
<th>Incident</th>
<th># of Reports</th>
<th>Level</th>
<th># Not Reported to DSS</th>
<th>Reason Not Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Assault</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>Both were incidents involving the same member as in previous months. Provider is working with member around issues involving accuracy of allegations and contacting the appropriate agencies regarding the allegations.</td>
</tr>
<tr>
<td>Staff Abuse</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>HCPR was contacted; allegation was not substantiated.</td>
</tr>
<tr>
<td>Staff Neglect</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incident</th>
<th># of Reports</th>
<th>Level</th>
<th># Not Reported to DSS</th>
<th>Reason Not Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse Alleged</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregive Abuse</td>
<td>7</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregive Neglect</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exploitation</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Assault</td>
<td>7</td>
<td>3</td>
<td>5</td>
<td>3 were incidents involving the same member as in previous months. Provider is working with member around issues involving accuracy of allegations and contacting the appropriate agencies regarding the allegations. 1 was an incident where the member refused to call the police. In the other incident, the police were contacted but the member refused to disclose details.</td>
</tr>
<tr>
<td>Staff Abuse</td>
<td>9</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Neglect</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incident</th>
<th># of Reports</th>
<th>Level</th>
<th># Not Reported to DSS</th>
<th>Reason Not Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse Alleged</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregive Abuse</td>
<td>7</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregive Neglect</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neglect Alleged</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Assault</td>
<td>10</td>
<td>3</td>
<td>3</td>
<td>1 incident involved the same member as in previous months. Provider is working with member around issues involving accuracy of allegations and contacting the appropriate agencies regarding the allegations. 1 incident is being investigated by the police. In the third incident, the school is involved, and the parents are deciding whether or not they want to involve the police.</td>
</tr>
<tr>
<td>Staff Abuse</td>
<td>4</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incident</td>
<td># of Reports</td>
<td>Level</td>
<td># Not Reported to DSS</td>
<td>Reason Not Reported</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------</td>
<td>-------</td>
<td>-----------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Abuse Alleged</td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregive Abuse</td>
<td>8</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregive Neglect</td>
<td>4</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exploitation</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neglect Alleged</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Assault</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>For one incident, member did not want to press charges. In the other incident, police were contacted; DSS contact was not applicable.</td>
</tr>
<tr>
<td>Staff Abuse</td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Neglect</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>30</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DECEMBER**

- **Abuse Alleged**: 5 incidents, 2 not reported to DSS
- **Caregive Abuse**: 8 incidents, 2 not reported to DSS
- **Caregive Neglect**: 4 incidents, 2 not reported to DSS
- **Exploitation**: 1 incident, 2 not reported to DSS
- **Neglect Alleged**: 1 incident, 2 not reported to DSS
- **Sexual Assault**: 3 incidents, 3 not reported to DSS, 2 not applicable
- **Staff Abuse**: 5 incidents, 2 not reported to DSS
- **Staff Neglect**: 3 incidents, 2 not reported to DSS

**JANUARY**

- **Abuse Alleged**: 1 incident, 2 not reported to DSS, 1 not applicable
- **Caregive Abuse**: 8 incidents, 2 not reported to DSS
- **Caregive Neglect**: 3 incidents, 2 not reported to DSS
- **Exploitation**: 2 incidents, 2 not reported to DSS
- **Sexual Assault**: 5 incidents, 3 not reported to DSS, 1 not applicable
- **Staff Abuse**: 6 incidents, 2 not reported to DSS
- **Staff Neglect**: 2 incidents, 2 not reported to DSS

**Total:** 27

**FEBRUARY**

- **Abuse Alleged**: 8 incidents, 2 not reported to DSS
- **Caregive Abuse**: 7 incidents, 2 not reported to DSS
<table>
<thead>
<tr>
<th>Incident</th>
<th># of Reports</th>
<th>Level</th>
<th># Not Reported to DSS</th>
<th>Reason Not Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse Alleged</td>
<td>9</td>
<td>2</td>
<td>5</td>
<td>3 were domestic violence; DSS contact not necessary. 1 incident had police contact; DSS not necessary. 1 did not meet criteria for DSS contact.</td>
</tr>
<tr>
<td>Caregive Abuse</td>
<td>13</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregive Neglect</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exploitation</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>Police were contacted; DSS contact not necessary.</td>
</tr>
<tr>
<td>Neglect Alleged</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Assault</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>The incident had police contact.</td>
</tr>
<tr>
<td>Staff Abuse</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>HCPR was contacted; waiting to hear back about DSS involvement and additional incident details.</td>
</tr>
<tr>
<td>Staff Neglect</td>
<td>7</td>
<td>2</td>
<td>2</td>
<td>2 reports filed with DHSR; DSS contact has not been confirmed in either case.</td>
</tr>
<tr>
<td>Total</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incident</td>
<td># of Reports</td>
<td>Level</td>
<td># Not Reported to DSS</td>
<td>Reason Not Reported</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------</td>
<td>-------</td>
<td>-----------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Abuse Alleged</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>In one incident, police were contacted. The second was domestic and police were not contacted. It was not necessary to contact DSS.</td>
</tr>
<tr>
<td>Caregive Abuse</td>
<td>8</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregive Neglect</td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exploitation</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>Police involved due to illegal activity; DSS contact not necessary.</td>
</tr>
<tr>
<td>Sexual Assault</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>In one incident, the member declined any police involvement; DSS contact not necessary. In the other, incident occurred at school and police were involved.</td>
</tr>
<tr>
<td>Staff Abuse</td>
<td>8</td>
<td>2</td>
<td>1</td>
<td>HCPR was contacted; agency was instructed to contact DSS but has yet to update report in IRIS.</td>
</tr>
<tr>
<td>Staff Neglect</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>30</strong></td>
<td></td>
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</tr>
</tbody>
</table>

**JUNE**

<table>
<thead>
<tr>
<th>Incident</th>
<th># of Reports</th>
<th>Level</th>
<th># Not Reported to DSS</th>
<th>Reason Not Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse Alleged</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>Police were involved; DSS contact not necessary.</td>
</tr>
<tr>
<td>Caregive Abuse</td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exploitation</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>HCPR notified</td>
</tr>
<tr>
<td>Sexual Assault</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>In both incidents, police were involved; DSS contact not necessary.</td>
</tr>
<tr>
<td>Staff Abuse</td>
<td>7</td>
<td>2,3</td>
<td>1</td>
<td>HCPR was contacted; Incident Specialist contactede provider for DSS info but has not yet heard back.</td>
</tr>
<tr>
<td>Staff Neglect</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>HCPR notified; out of county report</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>25</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type</td>
<td>July</td>
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<td></td>
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**FY2016 Summary:**

- 52 concerns regarding Clients Rights or HIPAA/Confidentiality in FY16
- 35 were Clients Rights, 17 were HIPAA/Confidentiality
- 11 of 52 were initiated by an Alliance employee

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**Breakdown of Clients Rights & HIPAA/Confidentiality Concerns - FY16**

![Bar chart showing the breakdown of clients rights and HIPAA/Confidentiality concerns by month for FY16.](chart.png)
Summary of Concerns Against Alliance - FY16

64 complaints against Alliance in FY 2016

62 LME/MCO Functions. 2 Clients Rights

8 different sources (Consumer, Parent/Guardian, Provider, Family Member, Attorney, Consumer Advocate/Rep., Anonymous, Other) submitted complaints.

23 of 64 were External Stakeholder concerns; 39 were Grievances; 2 were Internal Employee Concerns

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Number of Concerns Against Alliance by Month - FY16

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The purpose of this procedure is to ensure Alliance Behavioral Healthcare implements a fair, consistent, respectful, timely and impartial process for Network Providers to appeal contract disputes, credentialing actions, administrative actions or sanctions. Alliance must ensure that provider dispute mechanisms are implemented consistent with its written agreements to address alleged violations by Network Providers. These mechanisms must include the following: Disputes Concerning Professional Competence or Conduct; Disputes that Impact the Provider’s Status within the Closed Network; Disputes Involving Other Contract or Compliance Actions; and Network Provider Suspension Mechanism for Patient Safety. Consumer appeals of medical necessity determinations are not included within the scope of this procedure and are addressed in the Alliance Due Process – Appeals of Medical Necessity Determinations Procedure. This procedure outlines the process for resolving disputes with Network Providers, sets forth a clear description of the dispute resolution process, and defines explicit time frames from initiation of the dispute resolution mechanism through a written notification of the outcome to the Network Provider.

DEFINITIONS

Administrative Action means an action taken against a Network Provider that does not impact the Network Provider’s status within the Closed Network.

Applicant means as defined in N.C.G.S. §108D-1(1), i.e. a provider of MH/I-DD/SA services who is seeking to participate in the Alliance Closed Network.

Closed Network means as defined in N.C.G.S. §108D-1(2), i.e. the network of providers that have contracted with Alliance to furnish MH/I-DD/SA services to Alliance consumers.
First level panel means a panel consisting of three individuals who were not involved in the original decision, one of whom must be a Network Provider randomly selected by or from the Alliance Provider Advisory Committee who is not otherwise involved in network management and who is a clinical peer of the provider that filed the dispute.

Network Provider means as defined in N.C.G.S. §108D-1(13), i.e. an appropriately credentialed provider of MH/I-DD/SA services that has entered into a contract for participation in the Alliance Closed Network.

Sanction means an action taken against a Network Provider that impacts the Network Provider’s status within the Closed Network.

Second level panel means a panel consisting of three individuals who were not involved in the original decision or first level panel decision, one of whom must be a Network Provider randomly selected by or from the Alliance Provider Advisory Committee who is not otherwise involved in network management and who is a clinical peer of the provider that filed the dispute.

Written Agreement or Network Contract means the document signed by all Parties in accordance with the Alliance Network Contract Procedure that specifies the terms and conditions of a relationship between Alliance and a Network Provider. This term may include a contract or agreement and any attachments or addenda.

Note: All timelines in this procedure refer to calendar days unless otherwise noted. “Working day” or “business day” means a day on which Alliance is officially open to conduct its affairs.

PROcedures

Provider dispute mechanisms apply to Alliance Network Providers and Applicants who are denied participation in the Closed Network. Not all Network Provider disputes are subject to the dispute process. Network Providers may not appeal a decision by Alliance not to renew or extend a Network Contract beyond its original term, and may not appeal contract termination or suspension based on the following: notification to Alliance of exclusion from participation in federally-funded health care programs by the U.S. HHS Office of Inspector General, Immediate Jeopardy finding issued by the Centers for Medicare and Medicaid Services, action taken by the NC Department of Health and Human Services or any of its Divisions, loss of required facility or professional licensure, accreditation or certification, Provider is excluded from participation in any other North Carolina State health care program, such as Health Choice or another LME-MCO, or Federal, State or local funds allocated to Alliance are revoked or terminated in a manner beyond the control of Alliance for any part of the Contract period.

A. Types of Sanctions, Actions, and Disputes

The Alliance Corporate Compliance Committee has the authority to take a variety of Administrative Actions and Sanctions against Network Providers, which are more fully described in the Alliance Provider Sanctions, Administrative Actions, and Suspensions to Ensure Patient Safety Procedure. The Alliance Medical Director and Chief Clinical Officer also have the authority to take emergency suspension actions against a Network Provider to protect the life, health, safety or welfare of any consumer. Other Departments may also take Administrative Actions against Network Providers, such as
Claims Denials. Network Providers have the opportunity to request reconsideration of any of the following actions or sanctions, subject to the limitations discussed above.

1. **Sanctions that Impact Network Participation**
   - Limiting Referrals
   - Suspension of Referrals
   - Payment Suspension
   - Suspension from Closed Network (including Emergency Suspension to Protect Consumer)
   - Site or Service Specific Termination
   - Termination from Closed Network
   - Exclusion from Participation in Closed Network
   - Denied Credentialing and/or Enrollment

2. **Administrative Actions that do not Impact Network Participation**
   - Moratorium on Expansion of Sites or Services
   - Warning/ Educational letter
   - Plan of Correction
   - Probation (increased monitoring)
   - Identification, Recovery or Recoupment of overpayments

3. **Actions or Disputes Related to the Network Provider’s Professional Competence or Conduct**

   Examples of Actions or Disputes Related to the Network Provider’s Professional Competence or Conduct include but are not limited to those disputes or actions based on: actions by the Network Provider’s licensure board, ethics, clinical boundaries, dual relationships, quality of care, professional competence to perform contracted services, or a determination by the Alliance Medical Director or Chief Clinical Officer that a Network Provider is engaged in behavior or practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of any consumer.

**B. General Requirements**

1. The Alliance appeal process is available to any Network Provider who wishes to initiate it in response to an Alliance notification of Administrative Action or Sanction. Any notification of Administrative Action or Sanction to a Network Provider will include the basis for the Alliance decision, an explanation of how to request reconsideration and how to submit additional information, and the timelines for doing so. A Reconsideration Request Form is available on the Alliance website.

2. A Network Provider has twenty-one (21) days to request reconsideration from receipt or attempted first delivery of the Alliance notification of Administrative Action or Sanction. Network Providers must submit a formal written request via certified mail, return receipt requested, using the Reconsideration Request Form, signed by the sole practitioner or an Owner/ Operator/ Managing Employee of a provider organized as a corporation, partnership or limited liability company. Formal Requests must be sent to:
The Alliance Behavioral Healthcare
ATTN: COMPLIANCE – PROVIDER RECONSIDERATIONS
4600 Emperor Boulevard, Suite 200
Durham, NC 27703

The Alliance decision shall be considered final if a reconsideration request is not received within twenty-one (21) days from the receipt or first attempted delivery of the notification of Administrative Action or Sanction. The Network Provider must provide any additional information on four (4) duplicate paper copies at the time the Request for Reconsideration is filed via USPS certified mail.

3. Alliance provides written notification to the Network Provider of all Administrative Actions, Sanctions, and Reconsideration Outcomes. All notifications are sent via email. If the Network Provider does not signify acceptance of the email within one (1) business day, the notification is sent via trackable mail. The trackable mail receipt will be maintained as part of the file. The timeframe for requesting reconsideration begins upon the provider’s acknowledgement of email receipt or first attempted mail delivery.

4. There are two tracks for provider dispute resolution. One track is for disputes involving professional competence/conduct or Sanctions that impact the Network Provider’s status in the Closed Network. The other track is for Administrative Actions that do not involve professional competence/conduct or impact the Network Provider’s status in the Closed Network.

5. Reimbursement may continue during the Reconsideration Process except in the following circumstances:
   a. The provider is cited for gross negligence or serious quality of care concerns; or
   b. The provider is suspected of committing fraud or abuse; or
   c. Alliance believes continued reimbursement is likely to increase any overpayment amount due.

C. Corporate Compliance Committee Process

The Alliance Corporate Compliance Committee is responsible for making decisions and recommendations about Administrative Actions and Sanctions against Network Providers in accordance with the Alliance Provider Sanctions, Administrative Actions, and Suspensions to Ensure Patient Safety Procedure. Administrative Actions and most Sanctions are considered final upon issuance by the Compliance Committee, and the Network Provider may initiate the dispute resolution process upon receipt of a Notice of Administrative Action. The Notice will include instructions for how to initiate the dispute resolution process.

D. Reconsideration Process for Sanctions or Other Actions Related to the Network Provider’s Professional Competence or Conduct

1. Upon receipt of a timely request for reconsideration of a sanction or action related to the Network Provider’s Professional Competence or Conduct, Alliance will convene a first level panel. If the Network Provider does not request a reconsideration review within twenty-one (21) days from receipt of the final notification of Administrative Action or Sanction, the decision shall become final.
2. A first level panel meeting will be scheduled at the Alliance Headquarters no later than fourteen (14) days from the receipt of the request for reconsideration. The Corporate Compliance Committee designee will provide each panel member with a summary of the dispute/problem; identification of panel members, including indication of which member of the panel is the clinical peer of the Network provider who is the subject of the dispute; and the supporting documentation submitted by the Network Provider.

3. The Network Provider is informed of the date, time and place of the meeting at least three (3) days in advance and invited to appear in person or by telephone and to present arguments and documentation to the first level panel. The Network Provider must notify Alliance in advance if they intend to bring legal counsel to the panel meeting. The Network Provider must provide any additional written documentation to be considered during the Reconsideration Process at the time the Request for Reconsideration is filed.

4. The first level panel will notify the Compliance Department of their decision no later than seven (7) days following the panel meeting. The Compliance Department will issue a written decision to the Network Provider no later than seven (7) days following the panel decision.

5. If not satisfied with the first level panel decision, the Network Provider may request reconsideration by a second level panel within seven (7) days from receipt or attempted first delivery of the first level panel decision as set forth in D.2. above. If the Network Provider does not request a second level panel review within seven (7) days from receipt of the first level panel decision, the decision shall become final.

6. The second level panel will conduct a Desk Review of the first level panel decision within fourteen (14) days of receipt of the request for a second level review, and may consider any additional documentation submitted by the Network Provider along with the second request for reconsideration.

7. The second level panel will notify the Compliance Department of their decision no later than seven (7) days from completion of the Desk Review. The Compliance Department will issue a final written decision to the Network Provider no later than seven (7) days following the panel decision. The second level panel decision is final and there is no right to appeal beyond the second level panel.

8. If the Network Provider challenges the final Alliance decision in any administrative, State or federal court, Legal Counsel will contract with outside counsel or begin preparing a defense of the case. In the event of an appeal, the Compliance Department will be required to prepare a case summary and gather relevant documents, and Alliance staff involved in the audit, review, investigation or sanction determination will participate at all levels of the appeal process as deemed necessary by Legal Counsel.

E. Reconsideration Process for Administrative Actions

1. Upon receipt of a request for timely reconsideration of an Administrative Action, Alliance will convene a reconsideration panel consisting of three Alliance employees who were not involved in the original decision. If the Network Provider does not request a reconsideration review within twenty-one (21) days from receipt or attempted delivery of the Alliance final notification of Administrative Action or Sanction, the decision shall become final.

2. The reconsideration panel meeting will be scheduled at the Alliance Headquarters no later than fourteen (14) days from the receipt of the request for reconsideration. The Network Provider will be invited to appear in person or by telephone and to present arguments and documentation to the
reconsideration panel. The Network Provider must provide any additional written documentation to be considered during the Reconsideration Process at the time the Request for Reconsideration is filed.

3. The reconsideration panel will notify the Compliance Department of their decision no later than seven (7) days following the panel meeting. The Compliance Department will issue a final written decision to the Network Provider no later than seven (7) days following the panel decision. This decision is final and there is no right to appeal beyond the reconsideration panel.

4. If the Network Provider challenges the final Alliance decision in any administrative, State or federal court, Legal Counsel will contract with outside counsel or begin preparing a defense of the case. In the event of an appeal, the Compliance Department will be required to prepare a case summary and gather relevant documents, and Alliance staff involved in the audit, review, investigation or sanction determination will participate at all levels of the appeal process as deemed necessary by Legal Counsel.

F. Reconsideration Process for Claims Denials or Other Provider Disputes

Requests for reconsideration of a claim denial must be submitted as set forth in Section D., above, within twenty-one (21) days of the date the Remittance Advice was posted in the AlphaMCS Provider Portal, and shall be considered by the Alliance Chief Financial Officer or designee. The CFO or designee will notify the Network Provider of the final decision within thirty (30) days of receipt of the request for reconsideration. Alliance will consider requests for reconsideration submitted by Network Providers concerning other disputes on a case-by-case basis. If the request for reconsideration is accepted, the review will be conducted in accordance with Section E., Reconsideration Process for Administrative Actions.

G. Approval of these procedures

The Alliance Behavioral Healthcare Human Rights Committee shall approve these procedures and any subsequent revisions which alter the content related to the reconsideration review panels. The approval shall be documented in the Human Rights Committee minutes. All operational procedures are approved by the Alliance Behavioral Healthcare CEO per the Alliance Policy on Development of Policies and Procedures.
ITEM: Global Quality Management Committee Report

DATE OF BOARD MEETING: September 1, 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. Currently, the committee consists of two provider representatives—one from an agency primarily serving individuals with I/DD and another from an agency primarily serving individuals with MH/SA. The MCO employees typically assigned are the Director of the Quality Management (QM) Department who has the responsibility for overall operation of the Quality Management Program; the MCO Medical Director, who has ultimate responsibility of oversight of quality management; the Quality Review Manager, who staffs the committee; the Quality Management Data Manager; and other staff as designated.

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

The draft minutes from the meeting in August are attached. The committee received an update on the draft Quality Management Plan and Evaluation, items that are required for URAC. Both will be finalized and ready for a vote next month. The committee also received an update on Board surveys and Quality Improvement Projects. Quality Management received only a 67% response rate to the Board surveys, whereas, last year, there was a 100% response rate. Hard copies of the surveys were distributed at the August Board meeting, although no additional, completed surveys were received. QM will analyze data and make recommendations for the September meeting.

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: ☐ George Corvin, MD, Chair (Area Board); ☑ Cynthia Binanay, MA, BSN (Area Board); ☑ Phillip Golden, BA, Co-Chair (Area Board); ☑ Joe Kilsheimer, MBA (CFAC); ☑ Amelia Thorpe, BA/CFAC (Area Board); ☑ Lascel Webley, Jr., BS, MBA, MHA (Area Board)

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

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

GUEST(S) PRESENT: Christ Bostock, Alliance Board Chairman; Andrea Kinnaugh, Quality Review Coordinator I

WELCOME AND INTRODUCTIONS: Philip Golden, BA (Chairing meeting in Dr. Corvin’s absence)


REVIEW OF THE MINUTES: GQMC Special Meeting Minutes of June 20, 2016 were read and a motion to approve was made by Joe Kilsheimer to approve and seconded Phillip Golden. The minutes were approved unanimously.

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<td>OLD BUSINESS: Area Board and Committee Survey Results/Follow-up: Tina Howard</td>
<td>• Tina Howard presented the 2016 Board Survey results which showed that only 12 total or 67% of members responded to the survey.&lt;br&gt;• The condensed version was sent to non-board members who are on Alliance Board committees.&lt;br&gt;• Tina recommended seeking additional responses before finalizing analysis, seeking a 100% response rate.&lt;br&gt;• Tina will distribute hard copies to the Board members today to acquire additional responses.&lt;br&gt;• Update on last year’s survey: Created Provider Services Committee to more closely monitor provider needs/gaps/issues and review provider performance; Improved sharing of financial information with Board through more detailed presentations and creation of a financial audit process that involved Board.</td>
<td>• Chris Bostock will announce survey at Board meeting to increase response rate.</td>
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<td>NEW BUSINESS:</td>
<td><strong>Sign Confidentiality Statements:</strong> Confidentiality statements were given to voting and representative individuals for completion and returned to Tina.</td>
<td>None</td>
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| QM Evaluation and QM Description – Updates (Geyer): | - Geyer stated he was just notified by the State that this report is due by the end of August and there are a few outstanding issues that need completion.  
- In the process of completing reporting, evaluating QIPs, and addressing outstanding elements.  
- Reorganization is underway at Alliance.  
- Looking for information about our contract with the State particularly about reporting. We already self-report; however, the State will begin using NC Tracks data to run data. Alliance is responsible for reviewing data and notifying them when we find errors.  
- URAC will be back at Alliance on September 20-21, 2016 to conduct reaccreditation on-site visit.  
- EQRO is scheduled for January 2017. | Email Tina at thoward@alliancebhc.org if you have questions, concerns, or comments about the QIPs. | |
| QIP Updates (Tina): | - Tina presented the updated Quality Improvement Projects with a focus on the first 9-10 slides as a summary, the rest of the slides go into details.  
- Alliance continues to use the Six Sigma method to conduct the projects. Project teams are called Project Advisory Teams and will (shortly) involved provider representatives in those projects that are provider-focused.  
- Seven projects are open and active.  
- Five projects will be continued and three new projects will start in FY 17, as approved by this committee.  
- Five projects are in the process of being closed or have been closed because all measures are exhausted and have sustained for one year. | | |
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| • Tina noted success in several projects, such as First Responder in which test calls of provider’s crisis lines continue to show improvement and the Grievance project that resulted in a 28% decrease in errors  
• Three new projects were approved in June:  
  o Improve timeliness of services for individuals who recently received Innovations slots (goal: 85% receive services within 45 days of plan approval)  
  o Improve timeliness of Care Coordination contact for individuals discharging from inpatient services  
  o Split Access to Care QIP into two separate projects – continue focus of one project on callers needing Urgent and Routine care, start a new project focusing on callers needing Emergent care | | | |
| Red Flags:  
• Delays in FY 15 QIP –IIH data not available until late 2017 due to start of EBP models (March 2017)  
• WakeBrook CAS closures - no improvement: front door closed 20% and the back door (IVC) closed 43% of the time  
• Little improvement in quality of MH/SA Person-Centered Plans, particularly health/safety elements  
• (For First Responder QIP): Waiting for report of consumer actual use of crisis services to compare to test results | | | |
| CFAC Feedback:  
• QM (Tina & Geyer) presented findings and new projects to CFAC at their August 1, 2016 meeting  
• We received no feedback directly related to the QIPs  
• We did receive a comment about the long amount of time that individuals, who request services, wait for therapy and prescriber appointments | | | |
| Performance Standards Dashboard (Geyer):  
Geyer presented the dashboard results to the committee, focusing on those areas in need of improvement or have seen success: | | | |
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<td>TCLI standard:</td>
<td>The team is in the process of hiring more people.</td>
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<td>This is the first time in two years we are meeting CDW standards.</td>
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<td>Access to Care standards: we are still not meeting standards (as members can see from Tina’s QIP report). The state has discussed revising the standards due to feedback from LME/MCOs, but has not moved forward yet. The report is not working properly, resulting in inaccurate data for 4Q 2016. Tina’s team is manually reviewing data to feedback to Alpha, who created report.</td>
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<td>We are now in compliance with NC-TOPPS! NCTOPPS has been out of compliance for a long time; Alliance issued Plans of Correction for providers not submitting interviews on time.</td>
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**Primary Care Data & Service Patterns of High Risk/Cost – MicroStrategy Implementation:**

Alliance has struggled to get this data due to the limitations with our existing IT system (Alpha). We purchased a new business intelligence software, called MicroStrategy, which will allow us to analyze very large data sets in a much more user-friendly way. It is currently being implemented at Alliance. Several reports have been created and are in the process of being tested. We expect this data to be one of the reports created shortly.

**Upcoming Meetings:**

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

- September 1, 2016 (location: Corporate) – Topics: Complaints/Incidents annual report, QIP Updates, URAC updates, and vote on QM Plan & QM Evaluation
- October 6, 2016 (location: Cumberland site, 711 Executive Place, Fayetteville) – TBD
- November 3, 2016 (location: Corporate) – TBD
- December 1, 2016 (location: Corporate) – TBD
- January 2017 – Meeting canceled, Winter break

**Adjournment:**

Meeting adjourned at 3:55pm

When the report is created and validated, the data will be reported to this committee.
Quality Improvement Projects

Presentation to the
Alliance Global Quality Management Committee
(8/4/16)
What are Quality Improvement Projects?
Quality Improvement Projects

Definition:

- Organization-wide initiative to assess and improve the processes and outcomes of health care services and delivery

Alliance’s Requirements:

- Per URAC (accreditation): 2 QIPs per accredited module—Call Center, Health Utilization Management, and Health Network (can be combined); 1 must focus on consumer safety
- Per State Contracts: At least 3 QIPs (clinical and at least one non-clinical), reduce need for inpatient at community hospitals, reduce use of crisis & Emergency Department services
Quality Improvement Projects

Requirements (continued):

- Per CMS (federal, also called Performance Improvement Projects): Clinical or non-clinical, impact health or functional status (or impact satisfaction), reflect high-volume or high-risk populations. Examples include: access to care, grievances, appeals, and children with special health care needs.

How are They Selected?:

- Internal data (red flags), providers, consumers/family

How are They Implemented?:

- Project Lead (QM), Project Advisory Teams (subject matter experts, MD if clinical), Six Sigma process (DMAIC)
Quality Improvement Projects

Summary:

- Open/Active: 7 projects (5 continuing)
- Closed/Closing: 5 projects
- FY 17 QIPs (approved by GQMC in June): 3

Successes:

- FY 16 – First Responder QIP – Continued improvement in satisfactory calls following Compliance actions
- FY 16 – Crisis Services QIP – Decrease in ED admissions for behavioral health in Wake County
- FY 16 – Grievance QIP – 28% decrease in errors, closing due to successfully meeting benchmark
Quality Improvement Projects

Red Flags:

- Delays in FY 15 QIP –IIH data not available until late 2017 due to start of EBP models (March 2017)
- WakeBrook CAS closures - no improvement: front door closed 20% and the back door (IVC) closed 43% of the time
- Little improvement in quality of MH/SA Person-Centered Plans, particularly health/safety elements
- (For First Responder QIP): Waiting for report of consumer actual use of crisis services to compare to test results
Quality Improvement Projects

Continuations:

- FY 16 Crisis Services QIP
- FY 16 First Responder QIP
- FY 16 Mystery Shopper: Improve Person Centered Plans QIP
- FY 13-16 Intensive In Home QIP
- FY 16 Access to Care QIP

Need to Analyze:

- FY 15-16 Mystery Shopper: UM Call Monitoring (IDD)
Quality Improvement Projects

Closures:
- FY 16 Grievance QIP
- FY 16 Care Coordination (MHSA)

Conduct Post-Closure Analysis:
- UM IRR (IDD) – due in March 2017

Successful Post-Closure Analyses (no need to continue measuring performance):
- UM IRR (MH/SA)
- Access & Information Center – Call monitoring
FY 17 Quality Improvement Projects

New Projects:

- Improve timeliness of services for individuals who recently received Innovations slots (goal: 85% receive services within 45 days of plan approval)
- Improve timeliness of Care Coordination contact for individuals discharging from inpatient services
- Split Access to Care QIP into two separate projects – continue focus of one project on callers needing Urgent and Routine care, start a new project focusing on callers needing Emergent care
Quality Improvement Projects

CFAC Feedback:

- QM (Tina & Geyer) presented findings and new projects to CFAC at their August 1, 2016 meeting
- We received no feedback directly related to the QIPs
- We did receive a comment about the long amount of time that individuals, who request services, wait for therapy and prescriber appointments
Detailed Results for QIPs
FY 16 Quality Improvement Projects

Reduce use of Crisis Services in Wake and Cumberland Counties

Goals:

- Reduce ED admissions of youth in best practice pilot programs (FCT and Enhanced TFC) in Cumberland County
- Increase the number of consumers utilizing Same Day Access (Tier II) after 3:00 PM by 20%
- Reduce percentage of time that WakeBrook CAS in Wake County is on diversion by 2%
FY 16 Quality Improvement Projects

Crisis Services QIP

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

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

Update:
- Promising results from Cumberland pilots (Baseline: 19%, lower ED/Crisis/Inpatient admissions post discharge)
- Wake: A provider expanded hours of Tier II on 4/18, now open until 7 PM on Mondays and Thursdays, plan to open later and more frequently in early FY 17 (Baseline: 0.24%)
FY 16 Quality Improvement Projects

Crisis Services QIP

Update: CAS closures

Baseline (Jan – June 2014): Back Door – 23%, Front Door – 15%

1st Measurement (Jan – June 2015): Back Door – 44%, Front Door – 24%

2nd Measurement (Jan – June 2016): Back Door – 43%, Front Door – 20%
FY 16 Quality Improvement Projects

Improve Person-Centered Plans

Goals:

- 85% of quality elements are met or partially met
- at least 55% of health and safety quality elements are met or partially met

Interventions:

- Feedback letters sent to providers
- Training on person-centered elements of planning and crisis plan
- Additional technical assistance to providers
- Comprehensive crisis plans are required part of request for services
FY 16 Quality Improvement Projects

Improve Person-Centered Plans

Update:

- Held training in Dec 2015 for 49 participants and in February 2016 for 58 participants
- Provided technical assistance to 6 providers

Results: (review of March 2016 authorizations)

- 89% of quality elements were met or partially met
- 53% of health and safety quality elements were met or partially met

Next Steps:

- Discuss results with Project Advisory Team, add provider representative to team
- Create new interventions
FY 16 Quality Improvement Projects

UM Call Monitoring – Improve adherence to greeting protocol

Goal:
- 85% of UM calls to providers that are sampled adhere to Alliance’s greeting protocol (name, title, and agency)

Update:
- Project continued for IDD UM staff due to goal not met:
  * Continuation from FY 15 Mystery Shopper QIP
FY 16 Quality Improvement Projects

UM Call Monitoring

Update:
- Project closed for MHSA UM staff due to goal met
FY 16 Quality Improvement Projects

UM Call Monitoring

Interventions (IDD):

- Volume of calls for staff person was noted as a barrier to meeting standards. To lessen workload, calls will be distributed among all the IDD Care Managers (effective March 1, 2016).
- Supervision and coaching with staff who did not meet benchmark
- Review another sample of calls (Summer 2016)
FY 16 Quality Improvement Projects

**First Responder** – test crisis lines of providers after business hours

**Goals:** 100% of calls answered within 30 seconds and 95% of providers return calls in 1 (follow up) hour

**Interventions:**

- Providers assigned to “Tiers” based on last FY’s performance (some called more frequently, others less)
- Written feedback to all providers after calls
- Refer to Compliance the providers who continue to score “unsatisfactory”, issue Plan of Correction if poor performance continues
- Compare test results with actual data of consumers, open to enhanced services, using crisis services
FY 16 Quality Improvement Projects

First Responder QIP:

Update:

- Continued calls according to “Tier”*
- 7 providers referred to Compliance, 5 Plans of Correction (POCs) and 2 Warning Letters issued

Results:

<table>
<thead>
<tr>
<th>Satisfaction by Tier 2016</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>POC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfactory</td>
<td>87.50%</td>
<td>55.60%</td>
<td>64.10%</td>
<td>86.00%</td>
</tr>
<tr>
<td>Unsatisfactory</td>
<td>12.50%</td>
<td>44.40%</td>
<td>35.90%</td>
<td>14.00%</td>
</tr>
</tbody>
</table>

- All POCs successfully closed (and successful tests) except for one
- The agency that did not successfully close POC is now on probation for 6 months; provider subject to monthly testing, first four monthly tests have been successful

*Tier 1: Best performance, called least frequently; Tier 2: Mid performance, called more frequently than Tier 1; Tier 3: Poorest performance, called most frequently
FY 16 Quality Improvement Projects

First Responder QIP:

Results:

- Performance indicators*:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline FY15</th>
<th>Measure #1</th>
<th>Measure #2</th>
<th>Measure #3</th>
<th>Measure #4</th>
<th>Goal</th>
<th>Avg. FY16 (+/-)from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calls Returned Within 1 Hour</td>
<td>33%</td>
<td>36%</td>
<td>56%</td>
<td>8%</td>
<td>0%</td>
<td>95%</td>
<td>26% (-7)</td>
</tr>
<tr>
<td>Calls Answered Within 30 Seconds</td>
<td>92%</td>
<td>89%</td>
<td>92%</td>
<td>96%</td>
<td>95%</td>
<td>100%</td>
<td>93% (+1)</td>
</tr>
</tbody>
</table>

*Even though the percentage of calls returned within 1 hour has decreased from baseline in FY16, the number of calls resulting in “LIVE” answers has increased. Example: at baseline, 24/75 (32%) of completed calls resulted in a voicemail; in FY 16 Q4, only 3/19 (16%) of calls resulted in a voicemail.
FY 16 Quality Improvement Projects

First Responder QIP:

Next Steps:

- Project Advisory Team (PAT) recommended changing measure to % of satisfactory calls (call answered live or voicemail able to be left and is returned within 1 hour)
- Continue compliance actions
- Continue sending results letters to agencies, now copy CEO/owner and Clinical/QM Director along with point of contact
- Continue to offer technical assistance
FY 16 Quality Improvement Projects

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

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

**Interventions:**

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

*Continuation from FY 15 QIP*
FY 16 Quality Improvement Projects

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

**Update:**

- Evidence based practice models selected, Alliance offering subsidized trainings May - June 2016
- Implementation plans included in FY17 contracts, implementation deadline March 2017
- Collect post-intervention data late 2017
FY 16 Quality Improvement Projects

Care Coordination – *Improve Care Coordination Services*

**Goals:**

- MH/SA: Increase adherence to procedures (Care Coordination contact within 2 business days of assignment)
- I/DD: Reduce # of authorization requests denied/reduced due to lack of justification

**Interventions:**

- MH/SA: Training on Care Coordination expectations, change in procedures
- I/DD: Training/coaching of Care Coordination staff, UM training IDD Supervisors on Service Definitions, workgroup to improve ISPs
FY 16 Quality Improvement Projects

Care Coordination

Results:

  - Baseline: 43%, Post-Intervention: 87%
  - Recommendation: Continue to monitor due to possible bias in results, focus interventions on improving contact after discharge from inpatient services

- I/DD: Reduce % of authorization requests denied/reduced due to lack of justification
  - Baseline: 78%, Post-Intervention: 82%
  - Recommendation: Close due to faulty design, refocus on meeting state performance measure of initiation of services within 45 days (85%)
FY 16 Quality Improvement Projects

Access to Care-Routine/Urgent – *Improve initiation in services for Routine & Urgent callers*

**Goals:**

- Increase consumer initiation in services based on need:

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Revised Baseline (FY15Q3)</th>
<th>Goals</th>
<th>State Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent (within 2.25 hours)</td>
<td>83%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>Urgent (within 48 hours)</td>
<td>52%</td>
<td>62%</td>
<td>82%</td>
</tr>
<tr>
<td>Routine (within 14 days)</td>
<td>53%</td>
<td>63%</td>
<td>75%</td>
</tr>
</tbody>
</table>
FY 16 Quality Improvement Projects

Access to Care

Interventions:

- Addressed technical issues of aggregating accurate data
- Identified more accurate methods of collecting valid data sources for Emergent & Urgent appointments
- Training of Call Center staff to address inconsistencies in data entry
- Break data down by provider, county, and funding source to identify root causes and in December 2015 started reminder calls to routine consumers
## FY 16 Quality Improvement Projects

### Results:

**Overall**

<table>
<thead>
<tr>
<th></th>
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<td>47%</td>
<td>47%</td>
<td>53%</td>
<td>58%</td>
<td>63%</td>
</tr>
</tbody>
</table>
FY 16 Quality Improvement Projects

Results:

Impact of reminder calls:

Reminder Call-Contact Made with Consumer or Guardian, n = 76

No Reminder Call or Unable to Reach Consumer or Guardian, n = 70

Of those individuals attending their appointments, over ¾ received some kind of reminder about the appointment. Direct contact between the Access staff person and the consumer or guardian results in the highest percent showing for appointments.
FY 16 Quality Improvement Projects

Access to Care

Next Steps:

- Emergent callers now a separate, clinical-focused QIP
- Continue to evaluate impact of reminder calls
- Develop interventions for Urgent callers
FY 16 Quality Improvement Projects

Reduce Errors in Grievance Module

Description:
Alliance staff enter grievances and complaints in the Grievance Module of Alpha. In FY 15, QM staff noted a 69% rate of errors of all the data entered. QIP will focus on reducing errors in most important 16 fields. The number of grievance with errors for these 16 fields was 77%.

Goal:
- Reduce the grievance data entry error rate by 10%. 
FY 16 Quality Improvement Projects

Reduce Errors in Grievance Module

Interventions:

- Revised initial interventions of Dept Supervisors providing oversight and second-level review of all complaints entered into system because it was too cumbersome

- New Interventions: simplified definition of grievance, provided training to all staff, Grievance Specialists assume responsibility of entering most fields except for critical 5 fields

- Waiting for Alpha to upgrade Grievance module to streamline and improve ease of use (date expected: unknown)
FY 16 Quality Improvement Projects

Reduce Errors in Grievance Module

Results:

Next Step:

- QIP closed, take 1 year post-closure measurement in May 2017
Successful Post-Closure Analyses (no need to continue measuring performance):

**IRR-MH/SA:**
- 1 year post-closure analysis (in June 2016): 95% agreement

**Access & Information Center:**
- 1 year post-closure analysis (in March 2016): In 100% of calls sampled, staff person informed caller of QA monitoring, in 90% of calls sampled, staff person asked applicable callers all safety questions
FY 15 QIPs – Closing Out

Conduct Post-Closure Analysis:

- UM IRR (IDD) – due in March 2017
  - Last measurement that closed project (March 2016): 88% agreement
### Monthly LME-MCO Report

<table>
<thead>
<tr>
<th>Category</th>
<th>Standard</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
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</thead>
<tbody>
<tr>
<td>Medicaid/State - % Calls Abandoned</td>
<td>&lt; 5%</td>
<td>1.5%</td>
<td>0.6%</td>
<td>1.2%</td>
<td>1.2%</td>
<td>1.5%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Medicaid/State - % Calls Answered Within 30 Seconds</td>
<td>95%</td>
<td>98.5%</td>
<td>99.4%</td>
<td>99.8%</td>
<td>98.8%</td>
<td>98.5%</td>
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</tr>
<tr>
<td>DOJ - Percent of funded in-reach positions that are filled</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
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<tr>
<td>Medicaid - % Expedited Auths Processed in 3 Days</td>
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<td>Medicaid - Total % Processed in Required Timeframes</td>
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### DMH Data Submissions Reports

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<thead>
<tr>
<th>Report</th>
<th>Standard</th>
<th>FY16 Q1</th>
<th>FY16 Q2</th>
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</thead>
<tbody>
<tr>
<td>Monthly Financial Reports</td>
<td>Timely/Complete</td>
<td>Not Met</td>
<td>Met</td>
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<tr>
<td>Substance Abuse/Juvenile Justice Initiative Quarterly Report</td>
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<td>National Core Indicators (NCI) Consents, Pre-Surveys, and Mail Surveys</td>
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<td>Client Data Warehouse (CDW) - Screening Record</td>
<td>Timely/Complete/90%</td>
<td>Disc</td>
<td>Disc</td>
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<tr>
<td>Client Data Warehouse (CDW) - ICD-9 Diagnosis</td>
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</tr>
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<td>Client Data Warehouse (CDW) - Unknown Data (Admissions)</td>
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</table>
### Alliance Behavioral Healthcare

**Performance Standards Compliance Dashboard - FY 2015 - FY 2016**

**Updated 08-03-2016**

<table>
<thead>
<tr>
<th>Monthly LME-MCO Report</th>
<th>Standard</th>
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<th>May</th>
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<table>
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</table>
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<thead>
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<th>Standard</th>
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<th>FY16 Q2</th>
</tr>
</thead>
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<tr>
<td>Emergent - Medicaid (2 hours)</td>
<td>97%</td>
<td>67%</td>
<td>69%</td>
</tr>
<tr>
<td>Emergent - Non-Medicaid</td>
<td>97%</td>
<td>75%</td>
<td>68%</td>
</tr>
<tr>
<td>Emergent - Combined</td>
<td>97%</td>
<td>72%</td>
<td>69%</td>
</tr>
<tr>
<td>Urgent - Medicaid (48 hours)</td>
<td>82%</td>
<td>51%</td>
<td>47%</td>
</tr>
<tr>
<td>Urgent - Non-Medicaid (48 hours)</td>
<td>82%</td>
<td>47%</td>
<td>52%</td>
</tr>
<tr>
<td>Urgent - Combined (48 hours)</td>
<td>82%</td>
<td>48%</td>
<td>50%</td>
</tr>
<tr>
<td>Routine - Medicaid (14 days)</td>
<td>75%</td>
<td>52%</td>
<td>51%</td>
</tr>
<tr>
<td>Routine - Non-Medicaid (14 days)</td>
<td>75%</td>
<td>41%</td>
<td>54%</td>
</tr>
<tr>
<td>Routine - Combined (14 days)</td>
<td>75%</td>
<td>47%</td>
<td>53%</td>
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### Quarterly Innovations Reports

<table>
<thead>
<tr>
<th>Category</th>
<th>Standard</th>
<th>FY16 Q1</th>
<th>FY16 Q2</th>
</tr>
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<tbody>
<tr>
<td>Proportion of new waiver participants receiving service within 45 days of ISP approval.</td>
<td>85%</td>
<td>68.8%</td>
<td>75.0%</td>
</tr>
<tr>
<td>Percent of Actions Taken to Protect the Consumer</td>
<td>85%</td>
<td>87.1%</td>
<td>95.2%</td>
</tr>
<tr>
<td>Proportion of Level 2/3 incidents reported within required timeframes.</td>
<td>85%</td>
<td>75.8%</td>
<td>79.5%</td>
</tr>
<tr>
<td>Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation.</td>
<td>85%</td>
<td>Disc</td>
<td>Disc</td>
</tr>
<tr>
<td>Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.</td>
<td>85%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of Level 2 or 3 incidents where required LME/MCO follow-up interventions were completed as required.</td>
<td>85%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of medication errors resulting in medical treatment.</td>
<td>&lt;15%</td>
<td>100%</td>
<td>100%</td>
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<td>Percentage of beneficiaries who did not receive medication as prescribed</td>
<td>&lt;15%</td>
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<td>Percentage of restrictive interventions resulting in medical treatment.</td>
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<td>0.0%</td>
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### Semi-Annual Innovations Reports

<table>
<thead>
<tr>
<th>Category</th>
<th>Standard</th>
<th>FY16 Q1-Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of Level of Care evaluations completed at least annually for enrolled</td>
<td>85%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
### Client Data Warehouse (CDW) - Identifying and Demographic Records
- Timely/Complete/90%
  - Met

### Client Data Warehouse (CDW) - Drug of Choice
- Timely/Complete/90%
  - Met

### Client Data Warehouse (CDW) - Episode Completion Record (SA Clients)
- Timely/Complete/90%
  - Not Met
  - Met

### NC Treatment Outcomes and Program Performance System (NC-TOPPS)
- 90% submitted

### NC Support Needs Assessment Profile (NC-SNAP)
- 90% updated

### Quarterly Access to Care Report
<table>
<thead>
<tr>
<th></th>
<th>Standard</th>
<th>FY16 Q3</th>
<th>FY16 Q4</th>
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<td>Emergent - Medicaid (2 hours)</td>
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<tr>
<td>Emergent - Non-Medicaid</td>
<td>97%</td>
<td>68%</td>
<td></td>
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<tr>
<td>Emergent - Combined</td>
<td>97%</td>
<td>75%</td>
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<tr>
<td>Urgent - Medicaid (48 hours)</td>
<td>82%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
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<td>82%</td>
<td>51%</td>
<td></td>
</tr>
<tr>
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<td>82%</td>
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<td>75%</td>
<td>60%</td>
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<td>Routine - Non-Medicaid (14 days)</td>
<td>75%</td>
<td>56%</td>
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<td>Routine - Combined (14 days)</td>
<td>75%</td>
<td>58%</td>
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<td>87.9%</td>
<td>85.7%</td>
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<th></th>
<th>Standard</th>
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<tr>
<td>Proportion of Level of Care evaluations completed at least annually for enrolled</td>
<td>85%</td>
<td>98.9%</td>
</tr>
<tr>
<td>Measure</td>
<td>Standard</td>
<td>FY16 Q1</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Proportion of Level of Care evaluations completed using approved processes</td>
<td>85%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Proportion of New Level of Care evaluations completed using approved processes</td>
<td>85%</td>
<td>99.1%</td>
</tr>
<tr>
<td>Proportion of Individual Support Plans that address identified health and safety risk factors</td>
<td>85%</td>
<td>94.8%</td>
</tr>
<tr>
<td>Proportion of PCPs that are completed in accordance with DMA requirements.</td>
<td>85%</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Quarterly NC-TOPPS Report</strong></td>
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</tr>
<tr>
<td>% Received</td>
<td>90%</td>
<td>93.0%</td>
</tr>
<tr>
<td>% Received On-Time</td>
<td>90%</td>
<td>85.0%</td>
</tr>
<tr>
<td>Proportion of Level of Care evaluations completed using approved processes and instrument</td>
<td>85%</td>
<td>100.0%</td>
</tr>
<tr>
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<tr>
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<td>88.9%</td>
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</tr>
</tbody>
</table>
ITEM: Purchase and Lease of 3309 Durham Drive, Raleigh

DATE OF BOARD MEETING: September 1, 2016

BACKGROUND:
Alliance has identified the need for an additional crisis facility in Wake County. Last year, a service contract was awarded to Monarch through a competitive bid for the operation of a crisis facility, the location of which was still to be determined. Over the course of the past several months, Alliance has worked diligently with Monarch to identify a location that would be appropriate for a crisis facility. A location was recently identified. While it will need up-fitting to meet Alliance’s needs, the purchase price of the facility was financially preferable than a lease for the property. Alliance made an offer to purchase the property located at 3309 Durham Dr. in Raleigh for $1.6 million dollars, which offer was accepted. There is a due diligence period in which Alliance is investigating the property, including procuring a survey and a Phase 1 environmental evaluation. Barring any substantive issues arising from the due diligence, the CEO requests Board approval to move forward with the purchase of the property for the offered price, which closing shall take place on or before September 26, 2016.

Once this property is purchased, Alliance will lease the property to Monarch to manage the construction process and operation of the facility once complete. The lease agreement terms are as follows:
1. The term of the lease will run concurrent with Monarch’s Provider contract for operation of the Wake Crisis Facility located at 3309 Durham Dr.
2. The lease rate is $1 per year.
3. Maintenance will be shared with the Tenant.
4. Utilities will be paid by Monarch.
5. There will be a termination provision that will allow Alliance to terminate the lease in the event funding for the facility is no longer available.
6. There will be a construction rider that will contain the terms of the construction period.

The Board is requested to approve the lease to Monarch for 3309 Durham Dr. upon the terms and conditions set forth therein, subject to changes approved by General Counsel and the CEO.

REQUEST FOR AREA BOARD ACTION:
Consider and approve the purchase of 3309 Durham Dr., Raleigh and the lease of said property to Monarch for the construction and operation of a crisis facility.

CEO RECOMMENDATION:
The CEO recommends that the Board approve the purchase and lease of 3309 Durham Dr., Raleigh subject to changes approved by General Counsel and the CEO and delegate to the CEO the authority to execute the lease.

RESOURCE PERSON(S):
Robert Robinson, CEO, Carol Hammett, General Counsel
AGREEMENT FOR PURCHASE AND SALE OF REAL PROPERTY

THIS AGREEMENT, including any and all addenda attached hereto ("Agreement"), is by and between

Alliance Behavioral Healthcare

a(n) a political subdivision of NC ("Buyer"), and
(individual or State of formation and type of entity)

Randy Dickens, LLC

a(n) LLC ("Seller"),
(individual or State of formation and type of entity)

FOR AND IN CONSIDERATION OF THE MUTUAL PROMISES SET FORTH HEREIN AND OTHER GOOD AND VALUABLE CONSIDERATION, THE RECEPt AND SUFFICIENCY OF WHICH ARE HEREBY ACKNOWLEDGED, THE PARTIES HERETO AGREE AS FOLLOWS:

Section 1. Terms and Definitions: The terms listed below shall have the respective meaning given them as set forth adjacent to each term.

(a) "Property"; (Address) 3309 Durham Drive, Raleigh, NC 27603

Plat Reference: Lot(s) , Block or Section , as shown on Plat Book or Slide 10506 at Page(s) 0080 , Wake County, consisting of 1.09 acres.

☐ If this box is checked, "Property" shall mean that property described on Exhibit A attached hereto and incorporated herewith by reference,

(For information purposes: (i) the tax parcel number of the Property is: ; and, (ii) some or all of the Property, consisting of approximately acres, is described in Deed Book , Page No. , Wake County.)

together with all buildings and improvements thereon and all fixtures and appurtenances thereto and all personal property, if any, itemized on Exhibit A.

$1,600,000.00 (b) "Purchase Price" shall mean the sum of One Million, Six Hundred Thousand Dollars, payable on the following terms:

$25,000.00 (i) "Earnest Money" shall mean Twenty-Five Thousand Dollars or terms as follows: delivered within 48 hours of fully executed PSA of Real Property or the next business day, whichever comes last.

Upon this Agreement becoming a contract in accordance with Section 14, the Earnest Money shall be promptly deposited in escrow with Harris & Hilton P.A. (name of person/entity with whom deposited), to be applied as part payment of the Purchase Price of the Property at Closing, or disbursed as agreed upon under the provisions of Section 10 herein.

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STANDARD FORM 580-T
Revised 7/2013
© 7/2016
- ANY EARNEST MONEY DEPOSITED BY BUYER IN A TRUST ACCOUNT MAY BE PLACED IN AN INTEREST BEARING TRUST ACCOUNT, AND: (check only ONE box)

- ANY INTEREST EARNED THEREON SHALL BE APPLIED AS PART PAYMENT OF THE PURCHASE PRICE OF THE PROPERTY AT CLOSING, OR DISBURSED AS AGREED UPON UNDER THE PROVISIONS OF SECTION 10 HEREIN. (Buyer's Taxpayer Identification Number is: ______________________)

- ANY INTEREST EARNED THEREON SHALL BELONG TO THE ACCOUNT HOLDER IN CONSIDERATION OF THE EXPENSES INCURRED BY MAINTAINING SUCH ACCOUNT AND RECORDS ASSOCIATED THEREWITH.

$ ______________________ N/A (ii) Proceeds of a new loan in the amount of ______________________ Dollars for a term of ______ years, with an amortization period not to exceed ______ years, at an interest rate not to exceed ______ % per annum with mortgage loan discount points not to exceed ______ % of the loan amount, or such other terms as may be set forth on Exhibit B. Buyer shall pay all costs associated with any such loan.

$ ______________________ N/A (iii) Delivery of a promissory note secured by a deed of trust, said promissory note in the amount of ______________________ Dollars being payable over a term of ______ years, with an amortization period of ______ years, payable in monthly installments of principal, together with accrued interest on the outstanding principal balance at the rate of ______________________ percent (_______ %) per annum in the amount of $____________________, with the first principal payment beginning on the first day of the month next succeeding the date of Closing, or such other terms as may be set forth on Exhibit B. At any time, the promissory note may be prepaid in whole or in part without penalty and without further interest on the amounts prepaid from the date of such prepayment. (NOTE: In the event of Buyer’s subsequent default upon a promissory note and deed of trust given hereunder, Seller’s remedies may be limited to foreclosure of the Property. If the deed of trust given hereunder is subordinated to senior financing, the material terms of such financing must be set forth on Exhibit B. If such senior financing is subsequently foreclosed, the Seller may have no remedy to recover under the note.)

$ ______________________ N/A (iv) Assumption of that unpaid obligation of Seller secured by a deed of trust on the Property, such obligation having an outstanding principal balance of $ ______________________ and evidenced by a note bearing interest at the rate of ______________________ percent (_______ %) per annum, and a current payment amount of $____________________. The obligations of Buyer under this Agreement are conditioned upon Buyer being able to assume the existing loan described above. If such assumption requires the lender’s approval, Buyer agrees to use its best efforts to secure such approval and to advise Seller immediately upon receipt of the lender’s decision. Approval must be granted on or before ______________________. On or before this date, Buyer has the right to terminate this Agreement for failure to be able to assume the loan described above by delivering to Seller written notice of termination by the above date, time being of the essence. If Buyer delivers such notice, this Agreement shall be null and void and Earnest Money shall be refunded to Buyer. If Buyer fails to deliver such notice, then Buyer will be deemed to have waived the loan condition. Unless provided otherwise in Section 3 hereof, Buyer shall pay all fees and costs associated with any such assumption, including any assumption fee charged by the lender. At or before Closing, Seller shall assign to Buyer all interest of Seller in any current reserves or escrows held by the lender, any property management company and/or Seller, including but not limited to any tenant improvement reserves, leasing commission reserves, security deposits and operating or capital reserves for which Seller shall be credited said amounts at Closing.

$ 1,575,000.00 (v) Cash, balance of Purchase Price, at Closing in the amount of One Million, Five Hundred Seventy-Five Thousand Dollars.

Buyer Initials ____________________ Seller Initials ____________________
"Closing" shall mean the date and time of recording of the deed. Closing shall occur on or before fifteen (15) days from end of due diligence.

"Contract Date" means the date this Agreement has been fully executed by both Buyer and Seller.

"Examination Period" shall mean the period beginning on the first day after the Contract Date and extending through 11:59pm (based upon time at the locale of the Property) on forty five (45) days from fully executed contract.

TIME IS OF THE ESSENCE AS TO THE EXAMINATION PERIOD.

"Broker(s)" shall mean:

Brown Commercial Realty, LLC
Colin C Brown
(Listing Agency)
acting as: X Seller's Agent; [] Dual Agent

Rich Commercial Realty, LLC
E Street Jones, IV
(Selling Agency)
acting as: X Buyer's Agent; [] Seller's (Sub) Agent; [] Dual Agent

"Seller's Notice Address" shall be as follows:
6500 Dornoch Place
Froshy Varina, NC 27526
except as same may be changed pursuant to Section 12.

"Buyer's Notice Address" shall be as follows:
4600 Emperor Blvd. Suite 200
Durham, NC 27703
except as same may be changed pursuant to Section 12.

If this block is marked, additional terms of this Agreement are set forth on Exhibit B attached hereto and incorporated herein by reference. (Note: Under North Carolina law, real estate agents are not permitted to draft conditions or contingencies to this Agreement.)

Section 2. Sale of Property and Payment of Purchase Price: Seller agrees to sell and Buyer agrees to buy the Property for the Purchase Price.

Section 3. Proration of Expenses and Payment of Costs: Seller and Buyer agree that all property taxes (on a calendar year basis), leases, rents, mortgage payments and utilities or any other assumed liabilities as detailed on attached Exhibit B, if any, shall be prorated as of the date of Closing. Seller shall pay for preparation of a deed and all other documents necessary to perform Seller's obligations under this Agreement, excise tax (revenue stamps), any deferred or rollback taxes, and other conveyance fees or taxes required by law, and the following:

Buyer Initials [PP]
Seller Initials [RO]

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Revised 7/2013
© 7/2016
Durham Drive
Buyer shall pay recording costs, costs of any title search, title insurance, survey, the cost of any inspections or investigations undertaken by Buyer under this Agreement and the following:

Each party shall pay its own attorney's fees.

Section 4. Deliveries: Seller agrees to use best efforts to deliver to Buyer as soon as reasonably possible after the Contract Date copies of all information relating to the Property in possession of or available to Seller, including but not limited to: title insurance policies (and copies of any documents referenced therein), surveys, soil test reports, environmental surveys or reports, site plans, civil drawings, building plans, maintenance records and copies of all presently effective warranties or service contracts related to the Property. Seller authorizes (1) any attorney presently or previously representing Seller to release and disclose any title insurance policy in such attorney's file to Buyer and both Buyer's and Seller's agents and attorneys; and (2) the Property's title insurer or its agent to release and disclose all materials in the Property's title insurer's (or title insurer's agent's) file to Buyer and both Buyer's and Seller's agents and attorneys. If Buyer does not consummate the Closing for any reason other than Seller default, then Buyer shall return to Seller all materials delivered by Seller to Buyer pursuant to this Section 4 (or Section 7, if applicable), if any, and, shall, upon Seller's request, provide to Seller copies of (subject to the ownership and copyright interests of the preparer thereof) any and all studies, reports, surveys and other information relating directly to the Property prepared by or at the request of Buyer, its employees and agents, and shall deliver to Seller, upon the release of the Earnest Money, copies of all of the foregoing without any warranty or representation by Buyer as to the contents, accuracy or correctness thereof.

Section 5. Evidence of Title: Seller agrees to convey free simple marketable and insurable title to the Property without exception for mechanics' liens, free and clear of all liens, encumbrances and defects of title other than: (a) zoning ordinances affecting the Property, (b) Liens (if applicable) and (c) matters of record existing at the Contract Date that are not objected to by Buyer prior to the end of the Examination Period ("Permitted Exceptions"); provided that Seller shall be required to satisfy, at or prior to Closing, any encumbrances that may be satisfied by the payment of a fixed sum of money, such as deeds of trust, mortgages or statutory liens. Seller shall not enter into or record any instrument that affects the Property (or any personal property listed on Exhibit A) after the Contract Date without the prior written consent of Buyer, which consent shall not be unreasonably withheld, conditioned or delayed.

Section 6. Conditions: This Agreement and the rights and obligations of the parties under this Agreement are hereby made expressly conditioned upon fulfillment (or waiver by Buyer, whether explicit or implied) of the following conditions:

(a) New Loan: The Buyer must be able to obtain the loan, if any, referenced in Section 1(b)(ii). Buyer must be able to obtain a firm commitment for this loan on or before N/A , effective through the date of Closing. Buyer agrees to use its best efforts to secure such commitment and to advise Seller immediately upon receipt of lender's decision. On or before the above date, Buyer has the right to terminate this Agreement for failure to obtain the loan referenced in Section 1(b)(ii) by delivering to Seller written notice of termination of the above date, time being of the essence. If Buyer delivers such notice, this Agreement shall be null and void and Earnest Money shall be refunded to Buyer. If Buyer fails to deliver such notice, then Buyer will be deemed to have waived the loan condition. Notwithstanding the foregoing, after the above date, Seller may request in writing from Buyer a copy of the commitment letter. If Buyer fails to provide Seller a copy of the commitment letter within five (5) days of receipt of Seller's request, then Seller may terminate this Agreement by written notice to Buyer at any time thereafter, provided Seller has not then received a copy of the commitment letter, and Buyer shall receive a return of Earnest Money.

(b) Qualification for Financing: If Buyer is to assume any indebtedness in connection with payment of the Purchase Price, Buyer agrees to use its best efforts to qualify for the assumption. Should Buyer fail to qualify, Buyer shall notify Seller in writing immediately upon lender's decision, whereupon this Agreement shall terminate, and Buyer shall receive a return of Earnest Money.

(c) Title Examination: After the Contract Date, Buyer shall, at Buyer's expense, cause a title examination to be made of the Property before the end of the Examination Period. In the event that such title examination shall show that Seller's title is not free simple marketable and insurable, subject only to Permitted Exceptions, then Buyer shall promptly notify Seller in writing of all such title defects and exceptions, in no case later than the end of the Examination Period, and Seller shall have thirty (30) days to cure said noticed defects. If Seller does not cure the defects or objections within thirty (30) days of notice thereof, then Buyer may terminate this Agreement and receive a return of Earnest Money (notwithstanding that the Examination Period may have expired). If Buyer is to purchase title insurance, the insurance company must be licensed to do business in the state in which the Property is located. Title to the Property must be insurable at regular rates, subject only to standard exceptions and Permitted Exceptions.

(d) Same Condition: If the Property is not in substantially the same condition at Closing as of the date of the offer, reasonable wear and tear excepted, then the Buyer may (i) terminate this Agreement and receive a return of the Earnest Money or (ii) proceed to Closing whereupon Buyer shall be entitled to receive, in addition to the Property, any of the Seller's insurance proceeds payable on account of the damage or destruction applicable to the Property.

Buyer Initials: Seller Initials: Page 4 of 8

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(e) **Inspections:** Buyer, its agents or representatives, at Buyer's expense and at reasonable times during normal business hours, shall have the right to enter upon the Property for the purpose of inspecting, examining, performing soil boring and other testing, conducting timber cruises, and surveying the Property. Buyer shall conduct all such on-site inspections, examinations, soil boring and other testing, timber cruises and surveying of the Property in a good and workmanlike manner, shall repair any damage to the Property caused by Buyer's entry and on-site inspections and shall conduct same in a manner that does not unreasonably interfere with Seller's or any tenant's use and enjoyment of the Property. In that respect, Buyer shall make reasonable efforts to undertake on-site inspections outside of the hours any tenant's business is open to the public and shall give prior notice to any tenants of any entry onto any tenant's portion of the Property for the purpose of conducting inspections. Upon Seller's request, Buyer shall provide to Seller evidence of general liability insurance. Buyer shall also have a right to review and inspect all contracts or other agreements affecting or related directly to the Property and shall be entitled to review such books and records of Seller that relate directly to the operation and maintenance of the Property, provided, however, that Buyer shall not disclose any information regarding this Property (or any tenant therein) unless required by law and the same shall be regarded as confidential, to any person, except to its attorneys, accountants, lenders and other professional advisors, in which case Buyer shall obtain their agreement to maintain such confidentiality. Buyer assumes all responsibility for the acts of itself, its agents or representatives in exercising its rights under this Section 6(e) and agrees to indemnify and hold Seller harmless from any damages resulting therefrom. This indemnification obligation of Buyer shall survive the Closing or earlier termination of this Agreement. Buyer shall, at Buyer's expense, promptly repair any damage to the Property caused by Buyer's entry and on-site inspections. Except as provided in Section 6(e) above, Buyer shall have from the Contract Date through the end of the Examination Period to perform the above inspections, examinations and testing. **IF BUYER CHOOSES NOT TO PURCHASE THE PROPERTY, FOR ANY REASON OR NO REASON, AND PROVIDES WRITTEN NOTICE TO SELLER THEREOF PRIOR TO THE EXPIRATION OF THE EXAMINATION PERIOD, THEN THIS AGREEMENT SHALL TERMINATE, AND BUYER SHALL RECEIVE A RETURN OF THE EARNEST MONEY.**

Section 7. Leases (Check one of the following, as applicable):

☐ If this box is checked, Seller affirmatively represents and warrants that there are no Leases (as hereinafter defined) affecting the Property.

☐ If this box is checked, Seller discloses that there are one or more leases affecting the Property (oral or written, recorded or not - "Leases") and the following provisions are hereby made a part of this Agreement.

(a) A list of all Leases shall be set forth on Exhibit B;

(b) Seller shall deliver copies of any Leases to Buyer pursuant to Section 4 as if the Leases were listed therein;

(c) Seller represents and warrants that as of the Contract Date there are no current defaults (or any existing situation which, with the passage of time, or the giving of notice, or both, or at the election of either landlord or tenant could constitute a default) either by Seller, as landlord, or by any tenant under any Lease ("Lease Default"). In the event there is any Lease Default as of the Contract Date, Seller agrees to provide Buyer with a detailed description of the situation in accordance with Section 4. Seller agrees not to commit a Lease Default as Landlord after the Contract Date, and agrees further to notify Buyer immediately in the event a Lease Default arises or is claimed, asserted or threatened to be asserted by either Seller or a tenant under the Lease.

(d) In addition to the conditions provided in Section 6 of this Agreement, this Agreement and the rights and obligations of the parties under this Agreement are hereby made expressly conditioned upon the assignment of Seller's interest in any Lease to Buyer in form and content acceptable to Buyer (with tenant's written consent and acknowledgment, if required under the Lease), and Seller agrees to use its best efforts to effect such assignment. Any assignment required under this Section 7 shall be required to be delivered at or before Closing by Seller in addition to those deliveries required under Section 11 of this Agreement.

(e) Seller agrees to deliver an assignment of any Lease at or before Closing, with any security deposits held by Seller under any Leases to be transferred or credited to Buyer at or before Closing. Seller also agrees to execute and deliver (and work diligently to obtain any tenant signatures necessary for same) any estoppel certificates and subordination, non-disturbance and attainment agreements in such form as Buyer may reasonably request.

Section 8. Environmental: Seller represents and warrants that it has no actual knowledge of the presence or disposal, except as in accordance with applicable law, within the buildings or on the Property of hazardous or toxic waste or substances, which are defined as those substances, materials, and wastes, including, but not limited to, those substances, materials and wastes listed in the United States Department of Transportation Hazardous Materials Table (49 CFR Part 172.101) or by the Environmental Protection Agency as hazardous substances (40 CFR Part 302.4) and amendments thereto, or such substances, materials and wastes, which are or become regulated under any applicable local, state or federal law, including, without limitation, any material, waste or substance which is (i) petroleum, (ii) asbestos, (iii) polychlorinated biphenyls, (iv) designated as a Hazardous Substance pursuant to Section 311 of the
Clean Water Act of 1977 (33 U.S.C. §1321) or listed pursuant to Section 307 of the Clean Water Act of 1977 (33 U.S.C. §1317), (v) defined as a hazardous waste pursuant to Section 1004 of the Resource Conservation and Recovery Act of 1976 (42 U.S.C. §6903) or (vi) defined as a hazardous substance pursuant to Section 101 of the Comprehensive Environmental Response, Compensation and Liability Act of 1980 (42 U.S.C. §9601). Seller has no actual knowledge of any contamination of the Property from such substances as may have been disposed of or stored on neighboring tracts.

Section 9. Risk of Loss/Damage/Repair: Until Closing, the risk of loss or damage to the Property, except as otherwise provided herein, shall be borne by Seller. Except as to maintaining the Property in its same condition, Seller shall have no responsibility for the repair of the Property, including any improvements, unless the parties hereto agree in writing.

Section 10. Earnest Money Disbursement: In the event that any of the conditions hereto are not satisfied, or in the event of a breach of this Agreement by Seller, then the Earnest Money shall be returned to Buyer, but such return shall not affect any other remedies available to Buyer for such breach. In the event this offer is accepted and Buyer breaches this Agreement, then the Earnest Money shall be forfeited, but such forfeiture shall not affect any other remedies available to Seller for such breach. NOTE: In the event of a dispute between Seller and Buyer over the return or forfeiture of Earnest Money held in escrow by a licensed real estate broker, the broker is required by state law to retain said Earnest Money in its trust or escrow account until it has obtained a written release from the parties consents to its disposition or until disbursement is ordered by a court of competent jurisdiction, or alternatively, the party holding the Earnest Money may deposit the disputed monies with the appropriate clerk of court in accordance with the provisions of N.C.G.S. §93A-12.

Section 11. Closing: At or before Closing, Seller shall deliver to Buyer a general warranty deed unless otherwise specified on Exhibit B and other documents customarily executed or delivered by a seller in similar transactions, including without limitation, a bill of sale for any personality listed on Exhibit A, an owner's affidavit, lien waiver forms (and such other lien related documentation as shall permit the Property to be conveyed free and clear of any claim for mechanics' liens) and a non-foreign status affidavit (pursuant to the Foreign Investment in Real Property Tax Act), and Buyer shall pay to Seller the Purchase Price. At Closing, the Earnest Money shall be applied as part of the Purchase Price. The Closing shall be conducted by Buyer's attorney or handled in such other manner as the parties hereto may mutually agree in writing. Possession shall be delivered at Closing, unless otherwise agreed herein. The Purchase Price and other funds to be disbursed pursuant to this Agreement shall not be disbursed until Closing has taken place.

Section 12. Notices: Unless otherwise provided herein, all notices and other communications which may be or are required to be given or made by any party to the other in connection herewith shall be in writing and shall be deemed to have been properly given and received on the date delivered in person or deposited in the United States mail, registered or certified, return receipt requested, to the addresses set out in Section 1(g) as to Seller and in Section 1(h) as to Buyer, or at such other addresses as specified by written notice delivered in accordance herewith.

Section 13. Entire Agreement: This Agreement constitutes the sole and entire agreement among the parties hereto and no modification of this Agreement shall be binding unless in writing and signed by all parties hereto. The invalidity of one or more provisions of this Agreement shall not affect the validity of any other provisions hereof and this Agreement shall be construed and enforced as if such invalid provisions were not included.

Section 14. Enforceability: This Agreement shall become a contract when signed by both Buyer and Seller and such signing is communicated to both parties; it being expressly agreed that the notice described in Section 12 is not required for effective communication for the purposes of this Section 14. The parties acknowledge and agree that: (i) the initials at the bottom of each page of this Agreement are merely evidence of their having reviewed the terms of each page, and (ii) the complete execution of such initials lines shall not be a condition of the effectiveness of this Agreement. This Agreement shall be binding upon and inure to the benefit of the parties, their heirs, successors and assigns and their personal representatives.

Section 15. Adverse Information and Compliance with Laws:

(a) Seller Knowledge: Seller has no actual knowledge of (i) condemnation(s) affecting or contemplated with respect to the Property; (ii) actions, suits or proceedings pending or threatened against the Property; (iii) changes contemplated in any applicable laws, ordinances or restrictions affecting the Property; or (iv) governmental special assessments, either pending or confirmed, for sidewalk, paving, water, sewer, or other improvements on or adjoining the Property, and no pending or confirmed owners' association special assessments, except as follows (Insert "None" or the identification of any matters relating to (i) through (iv) above, if any):

________________________________________  Buyer Initials

________________________________________  Seller Initials

Buyer 6 of 8

STANDARD FORM 590-T
Revised 7/2013
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Note: For purposes of this Agreement, a "confirmed" special assessment is defined as an assessment that has been approved by a governmental agency or an owners' association for the purpose(s) stated, whether or not it is fully payable at time of closing. A "pending" special assessment is defined as an assessment that is under formal consideration by a governing body. Seller shall pay all owners' association assessments and all governmental assessments confirmed as of the date of Closing, if any, and Buyer shall take title subject to all pending assessments disclosed by Seller herein, if any.

Seller represents that the regular owners' association dues, if any, are $_________________________ per _____________.

(b) Compliance: To Seller's actual knowledge, (i) Seller has complied with all applicable laws, ordinances, regulations, statutes, rules and restrictions pertaining to or affecting the Property; (ii) performance of the Agreement will not result in the breach of, constitute any default under or result in the imposition of any lien or encumbrance upon the Property under any agreement or other instrument to which Seller is a party or by which Seller or the Property is bound; and (iii) there are no legal actions, suits or other legal or administrative proceedings pending or threatened against the Property, and Seller is not aware of any facts which might result in any such action, suit or other proceeding.

Section 16. Survival of Representations and Warranties: All representations, warranties, covenants and agreements made by the parties hereto shall survive the Closing and delivery of the deed. Seller shall, at or within six (6) months after the Closing, and without further consideration, execute, acknowledge and deliver to Buyer such other documents and instruments, and take such other action as Buyer may reasonably request or as may be necessary to more effectively transfer to Buyer the Property described herein in accordance with this Agreement.

Section 17. Applicable Law: This Agreement shall be construed under the laws of the state in which the Property is located. This form has only been approved for use in North Carolina.

Section 18. Assignment: This Agreement is freely assignable unless otherwise expressly provided on Exhibit B.

Section 19. Tax-Deferred Exchange: In the event Buyer or Seller desires to effect a tax-deferred exchange in connection with the conveyance of the Property, Buyer and Seller agree to cooperate in effecting such exchange; provided, however, that the exchanging party shall be responsible for all additional costs associated with such exchange, and provided further, that a non-exchanging party shall not assume any additional liability with respect to such tax-deferred exchange. Seller and Buyer shall execute such additional documents, at no cost to the non-exchanging party, as shall be required to give effect to this provision.

Section 20. Memorandum of Contract: Upon request by either party, the parties hereto shall execute a memorandum of contract in recordable form setting forth such provisions hereof (other than the Purchase Price and other sums due) as either party may wish to incorporate. Such memorandum of contract shall contain a statement that it automatically terminates and the Property is released from any effect thereby as of a specific date to be stated in the memorandum (which specific date shall be no later than the date of Closing). The cost of recording such memorandum of contract shall be borne by the party requesting execution of same.

Section 21. Authority: Each signatory to this Agreement represents and warrants that he or she has full authority to sign this Agreement and such instruments as may be necessary to effectuate any transaction contemplated by this Agreement on behalf of the party for whom he or she signs and that his or her signature binds such party.

Section 22. Brokers: Except as expressly provided herein, Buyer and Seller agree to indemnify and hold each other harmless from any and all claims of brokers, Consultants or real estate agents by, through or under the indemnifying party for fees or commissions arising out of the sale of the Property to Buyer. Buyer and Seller represent and warrant to each other that: (i) except as to the Brokers designated under Section 1(f) of this Agreement, they have not employed nor engaged any brokers, Consultants or real estate agents to be involved in this transaction and (ii) that the compensation of the Brokers is established by and shall be governed by separate agreements entered into as amongst the Brokers, the Buyer and/or the Seller.

Section 23. Attorneys Fees: If legal proceedings are instituted to enforce any provision of this Agreement, the prevailing party in the proceeding shall be entitled to recover from the non-prevailing party reasonable attorneys fees and court costs incurred in connection with the proceeding.

☐ EIFS/SYNTHETIC STUCCO: If the adjacent box is checked, Seller discloses that the Property has been clad previously (either in whole or in part) with an "exterior insulating and finishing system" commonly known as "EIFS" or "synthetic stucco". Seller makes no representations or warranties regarding such system and Buyer is advised to make its own independent determinations with respect to conditions related to or occasioned by the existence of such materials at the Property.
THE NORTH CAROLINA ASSOCIATION OF REALTORS®, INC. AND THE NORTH CAROLINA BAR ASSOCIATION MAKE NO REPRESENTATION AS TO THE LEGAL VALIDITY OR ADEQUACY OF ANY PROVISION OF THIS FORM IN ANY SPECIFIC TRANSACTION. IF YOU DO NOT UNDERSTAND THIS FORM OR FEEL THAT IT DOES NOT PROVIDE FOR YOUR LEGAL NEEDS, YOU SHOULD CONSULT A NORTH CAROLINA REAL ESTATE ATTORNEY BEFORE YOU SIGN IT.

BUYER:

Individual

__________________________________________
Date: ________________

__________________________________________
Date: ________________

__________________________________________
Date: ________________

Business Entity

Alliance Behavioral Healthcare
By: ________________
Name: ________________
Title: ________________
Date: ________________

SELLER:

Individual

__________________________________________
Date: ________________

__________________________________________
Date: ________________

__________________________________________
Date: ________________

Business Entity

Randy Dickens, LLC
By: ________________
Name: ________________
Title: ________________
Date: ________________

The undersigned hereby acknowledges receipt of the Earnest Money set forth herein and agrees to hold said Earnest Money in accordance with the terms hereof.

Harris & Hilton P.A.
(Name of Firm)

__________________________________________
Date: ________________

This Instrument has been pre-audited in the manner required by the Local Government and Fiscal Control Act.

Sara Pacholke
Alliance Behavioral Healthcare
Finance Officer
EXHIBIT B
ADDENDUM TO AGREEMENT FOR PURCHASE AND SALE OF REAL PROPERTY

The following terms and conditions contained in this Addendum To Agreement For Purchase And Sale Of Real Property ("Addendum") have been negotiated and approved by the undersigned parties and are incorporated into the Agreement For Purchase and Sale of Real Property ("Agreement") of even date herewith. If the terms of the Agreement and this Addendum conflict, the terms of this Addendum shall govern and control. Capitalized terms in the Addendum not defined herein shall have the meaning as provided in the Agreement.

1. Seller Deliverables. In addition to the items set forth in paragraph 4 of the Agreement titled "Seller Deliverables", Seller shall deliver the items identified on Exhibit B-1 which as attached to this Addendum and incorporated by reference.

2. Assignment. Buyer may assign all of its rights and obligations hereunder without the Seller's consent without the written consent of Seller; provided, however, that any assignee of Buyer will assume all of the obligations of Buyer hereunder.

3. Conditions To Closing. The obligations of Buyer hereunder shall be in all respects conditioned upon satisfaction of each of the following conditions precedent (the "Conditions Precedent") on or prior to Closing. If any of the Conditions Precedent have not been satisfied on or as of the Closing Date (or such other time as may be specified herein), then Buyer (without waiving any of its rights or electing any of its remedies hereunder or otherwise) shall be entitled to terminate this Agreement upon written notice to Seller, and receive an immediate and full refund of the Earnest Money.

   a. Seller shall deliver unencumbered, fee simple marketable, and insurable title at closing.

   b. Buyer receives evidence satisfactory to it (in its sole and absolute discretion) that no material or adverse developments or changes have occurred with respect to the Property or the development thereof since the date of this Agreement, to include without limitation, no casualty loss, no moratoria or restriction on the issuance of building permits or on the allocation of water or sewer permits or use.

   c. There are no leases, tenants, occupants or parties in possession of the Property.

4. Additional Seller Representations And Warranties. In addition to the representation and warranties set forth in the Agreement, Seller provides the following to Buyer:

   a. Seller warrants that to the best of Seller's knowledge the Property shall be delivered to Buyer without encroachments of the buildings or other improvements on adjacent property or streets or rights-of-way or easements, and without violation of any zoning regulations, municipal ordinances, regulations and easements.

   b. To the best of Seller's knowledge: (a) all buildings and improvements (including all streets, curbs, sidewalks, sewers and other utilities) have been completed and installed in accordance with the plans and specifications approved by the various governmental authorities having jurisdiction and meet the requirements of all tenant leases at the time they were completed, and (b) permanent certificates of occupancy, all licenses, permits, authorizations and approvals required by all governmental authorities having jurisdiction over the Property (including, but not by way of limitation, those having jurisdiction by virtue of its use by any tenant), have been issued for the construction, use, and occupancy of the buildings and improvements and, as of the Closing date, all of the same will be in full force and effect.

- 1 -
5. **Risk of Loss.** Notwithstanding anything in this Agreement to the contrary, if after the end of the Examination Period but prior to Closing any material part of the Property is damaged in any material manner by fire, casualty or otherwise, through no fault of Buyer, Seller shall notify Buyer of such damage within five (5) days. After receipt of such notice from Seller, Buyer may terminate this Agreement, in which case Buyer shall receive a return of the Earnest Money deposit. For the purposes of this section the term “material manner” shall mean any damage or loss in excess of Ten Thousand and No/100 Dollars ($10,000.00).

6. **Default and Remedies.**

   a. **Buyer Default.** If, after the expiration of the Examination Period, Buyer will fail or refuse to purchase the Property in violation of Buyer’s obligations hereunder for any reason other than a default by Seller under this Agreement or a failure of any condition precedent to Closing, and provided that Seller is then ready, willing and able to proceed to Closing, has performed all of its obligations hereunder and all conditions precedent to Closing hereunder have been satisfied, Seller will have as its sole remedy the right to terminate this Agreement, after giving Buyer thirty (30) days prior written notice and the opportunity to cure such default, and receive the full amount of the Earnest Money as a full and final settlement of any damages to Seller.

   b. **Seller Default.** In the event Seller defaults under any of the terms of this Agreement on or prior to the Closing Date (including without limitation, Seller’s material failure or refusal to deliver any items required to be delivered pursuant to this Addendum or the Agreement or Seller’s material breach of a representation and warranty set forth in this Addendum or this Agreement, Buyer will have the right, after giving Seller thirty (30) days prior written notice and the opportunity to cure such default, to exercise one or more of the following remedies: (i) seek specific performance of this Agreement; (ii) declare this Agreement to be null and void and demand and receive the return of the Deposit. In the event of a Seller default, in addition to the remedies set forth above, Seller will reimburse to Buyer an amount equal to Buyer’s actual, out-of-pocket expenses incurred in respect of the Property and this Agreement limited to $10,000.

7. **OFAC Representations.** Seller is not a “Prohibited Person”, which term is defined as follows: (i) a person or entity that is listed in the Annex to, or is otherwise subject to the provisions of, Executive Order No. 13224 on Terrorist Financing (effective September 24, 2001) (the “Executive Order”); (ii) a person or entity owned or controlled by, or acting for or on behalf of any person or entity that is listed in the Annex to, or is otherwise subject to the provisions of, the Executive Order; (iii) a person or entity that is named as a “specially designated national” or “blocked person” on the most current list published by the U.S. Treasury Department’s Office of Foreign Assets Control (“OFAC”) at its official website, http://www.ustreas.gov/offices/enforcement/ofac/ sdn/, or any replacement website or other replacement official publication of such list; (iv) a person or entity that is otherwise the target of any economic sanctions program currently administered by OFAC; or (v) a person or entity that is affiliated with any person or entity identified in clause (i), (ii), (iii) and/or (iv) above. Seller represents and warrants that (x) none of Buyer’s affiliates, principals or parent entities is a Prohibited Person.

8. **SECTION 1031 EXCHANGE:** Buyer agrees (at no expense or liability to Buyer) to reasonably assist Seller in effecting a tax deferred exchange of the Property under Section 1031 of the Internal Revenue Code. The parties agree, however, that the effectiveness of this Transaction shall not be contingent upon the availability or completion of such an exchange.

(SIGNATURE PAGE ATTACHED)
Entered into by the undersigned parties on July 26, 2016.

BUYER:
ALLIANCE BEHAVIORAL HEALTHCARE

By: __________________________ (SEAL)
Name: Rob Robinson
Title: CEO

SELLER:
RANDY DICKENS, LLC

By: __________________________ (SEAL)
Name: RANDY L. DICKENS
Title: Member
EXHIBIT B-1

1. **Leases.** Copies of all existing or pending Leases for the Property and all guaranties of the tenants' obligations under the existing Leases;

2. **Contracts, Licenses, Permits.** Copies of any service contracts, all building permits, certificates of occupancy, and insurance policies applicable to the Property;

3. **Three Years' Maintenance Expenses.** Information concerning maintenance and utility costs of the Property for the past three years, or such lesser period that Seller has owned the Property;

4. **Three Years' Tax Bills.** A copy of tax bills (i) for the current year, and (ii) if available, for the preceding two years;

5. **Expenses.** Copies of the expenses directly related to operating and maintaining the property provided to the buyer for the past three years, or such lesser period as Seller has owned the Property, together with the operating expenses for the current year provided to the buyer.

6. **Schedule of Violations.** A schedule setting forth all violations of any law, ordinance, regulation, rule or requirement of any governmental body having jurisdiction, whether existing or prospective, of which Seller has received written notice, issued or noted by any governmental body during the past three years, and copies of any notices, terminations or correspondence relating thereto;

7. **Schedule of Notices.** A schedule of any written demands, requests, requirements or recommendations regarding the operation, maintenance, repair or replacement of the Property or any portion thereof of which Seller has received notice during the past three years from the holder of any mortgage or deed of trust or any insurance company or any board of fire underwriters or real estate association or like body;

8. **Schedule of Replacements and Repairs.** All documentation in Seller's possession regarding replacements and repairs to the Property;

9. **Zoning, Site Plan, Subdivision Plan or Plat.** All conditional and permanent zoning, site plan, subdivision, building, housing, safety, fire and health approvals, including, without limitation, the local governmental applications, resolutions and approvals supporting the same which are in Seller's possession or otherwise reasonably obtainable by Seller;

10. **Takings or Changes.** Copies of all written notices to Seller of proposed or threatened takings or changes with respect to the Property or major access roads within a reasonable radius which would affect access to the Property, or any portion thereof, by prospective occupants;

11. **Tax Assessments, Appeals and Increases.** Copies of all written notices to Seller of all filed, proposed or threatened tax assessment appeals or tax assessment increases related to the Property;

12. **Litigation.** Copies of all written notices to Seller of pending and threatened litigation affecting the Property or this transaction;

13. **Insurance Policies.** Copies of all insurance policies of Seller related to the Property;
14. **Environmental and Engineering Reports.** Copies of any material environmental, engineering or soils reports prepared for Seller or otherwise in Seller's possession with respect to the Property to the extent not privileged;

15. **Title Information.** Copies of Seller's most recent title commitment, title policy and survey respecting the Real Property;

16. **Covenants.** Copies of any and all restrictive covenants that encumber the Property;

17. **Condominium Documents.** Confirmation that there are no condominium interests within the Property. Or, if condominium interests exist, copies of all documents pertaining to the condominium regime that governs the Property, including all exhibits to the documents and condominium plats;

18. **Condominium Records.** Copies of all Condominium Board meeting minutes for the past three years and three years of financial statements (if applicable);

19. **Capital Improvements.** Schedule of capital improvements that have been performed within the past five years.
ITEM: Annual Compliance Report FY16

DATE OF BOARD MEETING: September 1, 2016

BACKGROUND:
Alliance’s compliance program is designed to deter and mitigate risk to the organization through prevention, detection and remediation activities. It is intended that the scope of all compliance activities promotes integrity, ensures objectivity, fosters trust and supports the stated values of Alliance Behavioral Healthcare. In accordance with contractual obligations and federal regulations, Alliance shall have an effective compliance program with reasonable oversight by the governing board; understanding the scope and operations of the compliance program. The Board approved Corporate Compliance Plan states that a report of compliance efforts will be presented annually to the Alliance Behavioral Healthcare Area Board.

REQUEST FOR AREA BOARD ACTION:
Accept the report.

CEO RECOMMENDATION:
Accept the report.

RESOURCE PERSON(S):
Robert Robinson, CEO; Monica Portugal, Chief Compliance Officer
ITEM: FY17 Organizational Goals

DATE OF BOARD MEETING: September 1, 2016

BACKGROUND:
In April 2016 the Executive Leadership Team and senior management completed a two day, intensive strategy session to review the current Strategic Plan, evaluate progress, and make changes that reflect the current needs of the organization and the future landscape of Medicaid transformation. This presentation is a high level report of notable outcomes from FY16 Strategic Plan initiatives and an introduction to the new Strategic Plan goals and objectives.

REQUEST FOR AREA BOARD ACTION:
Accept the training.

CEO RECOMMENDATION:
Accept the training.

RESOURCE PERSON(S):
Robert Robinson, CEO; Amanda Graham, Senior Vice President, Organizational Effectiveness
FY17 Organizational Goals

Presentation to the Alliance Board of Directors
September 1, 2016
Working Towards Our Mission

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

Objectives

Initiatives

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

- Served 10% more Medicaid members than previous year while saving 31 million Medicaid dollars
- One of the highest LME/MCO penetration rates in North Carolina
- One of the lowest LME/MCO rates of ED admissions of individuals with BH diagnosis
- Ranked #1 among LME/MCOs for overall provider satisfaction for second year in a row
Meeting Contractual Requirements

- Financial audit without findings
- Legislative requirements of SB208
- EQRO
- URAC
Alliance Strategic Plan
Evolution
Our organizational Vision shapes the way we conduct our business…

“To be a leader in transforming the delivery of whole person care in the public sector”
Working Towards Our Mission

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

**GOALS**

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

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

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

**PERSON-DIRECTED HEALTH**
Advance person-directed health.

**Objectives**

**Initiatives**
Optimize our business performance to meet today’s needs and prepare for the future

**OBJECTIVES**

- Continuously improve and align business processes and operations to meet organizational needs and the healthcare system of the future
- Deliver information-driven and technologically-innovative services and solutions to enhance our business performance
- Be a financially-sound organization while identifying and implementing innovative and strategic investments
- Recruit, develop and retain a talented, diverse workforce to meet the changing environment
Influence the future policy direction related to Medicaid reform

**OBJECTIVES**

- Align and leverage strategic collaborative partnerships
- Anticipate and understand the Medicaid reform and policy direction
- Actively participate in the external reform and policy dialogue
- Strategically communicate our successes and value to a broad external audience
HEALTH OUTCOMES

**GOAL**
Improve health outcomes of the people we serve

**OBJECTIVES**

1. Align our departmental operations and workflows with the future healthcare system
2. Deliver information-driven and technologically-innovative services and solutions
3. Align and leverage strategic collaborative partnerships
4. Strengthen and support a high-quality provider network
PERSON-DIRECTED HEALTH

GOAL

Advance person-directed health

OBJECTIVES

1. Align our internal policies, procedures and manuals with the philosophy of person-directed health
2. Educate our system and members to promote wellness and prevention
3. Promote self-management strategies through technology and innovative solutions
Some Things are Still the Same

• Our *mission, vision and values* guide us

• We will always value our greatest strengths: our high-quality staff and relationships with external stakeholders

• Our focus on data, financial performance, providers and the people we serve is more important than ever

• Involvement and participation from staff across the organization is vital
Some Things Have Changed

• Our *goals* are more externally focused

• Some *objectives* are “cross cutting”
  o For example, information and partnerships

• *Initiatives* are managed by various groups

• Many of our *initiatives* are broader and include several projects beneath them

• *Initiatives* already underway or have been in the planning stages for several months
ITEM: BECOMING Evaluation and Sustainability

DATE OF BOARD MEETING: September 1, 2016

BACKGROUND:
BECOMING was a six year, $5.4 million SAMHSA grant focused on 16-21 year olds who had become disconnected from services and supports. The grant funding ends Sept 30, 2016, and we will discuss some of the accomplishments of the grant and plans for sustainability.

REQUEST FOR AREA BOARD ACTION:
Accept the training.

CEO RECOMMENDATION:
Accept the training.

RESOURCE PERSON(S):
Ann Oshel, Sr. VP, Community Relations Officer
BECOMING
Year 3 Evaluation Report to
Alliance Behavioral Healthcare

February 2016
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Introduction

Purpose
This report presents youth progress evaluation findings through the third full year of program implementation (October 2011-December 2014) for the BECOMING (Building Every Chance of Making it now and Grown-up) program. BECOMING is supported by a six year, $5.4 million dollar SAMHSA grant, which was awarded to Alliance Behavioral Healthcare (formerly The Durham Center) in October of 2010.1 The first year of the grant was mandated to be a planning year with full implementation beginning in earnest on October 1, 20112.

The program has three overarching goals: 1) to bridge the child and adult service systems with a more effective and comprehensive approach inclusive of all life domain areas, 2) to develop a system equipped to address the clinical, developmental and social needs of high-risk Transition Age Youth, including educational attainment and workforce connections, and 3) to address service system and policy barriers with statewide dissemination. Specifically, BECOMING has worked to build upon the existing System of Care by ensuring that youth are interfacing with a highly trained workforce across service systems, that youth and their families are engaged as partners both at the programmatic and systems levels, and that there is “no wrong door” to accessing services.

BECOMING targets Durham youth ages 16 to 21 with serious mental illness or serious emotional disturbance3, who also have one or more of the following risk factors: 1) no diploma or not in school, 2) pregnant or parenting, 3) criminal justice encounter(s), 4) exiting foster care or other institutional placement, 5) long-term unemployment or underemployment, and 6) homelessness. The program aims to promote the development of healthy, capable and contributing adults. The following strategies outlined in the program logic model are designed to achieve this goal:

- Increase levels of educational attainment
- Build workforce connections for in and out of school youth
- Promote individualized supported housing
- Support youth who are involved in the criminal justice system
- Improve physical health and well-being
- Enhance meaningful youth and family support and involvement
- Build capacity and expertise to deliver clinically and developmentally appropriate mental health services
- Develop a sustainable system of care for transition-aged youth

---

1 Durham County was the initial recipient of the award, with The Durham Center serving as the contractor to run the program.
2 The first participant was not enrolled until November 2011.
3 SAMHSA requires that CMHS System of Care grantees target the following children/youth for inclusion in the program: “The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the DSM-IV or its ICD-9-CM equivalents, or subsequent revisions (with the exception of DSM -IV A V codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder).”
This evaluation report specifically focuses on collective information about youth enrolled in BECOMING, and does not focus on other key aspects of the program related to the broader goals of the grant around systemic change in Durham (e.g., training and TA initiatives, development of cultural and linguistic competency (CLC) capacity, development of youth and family voice in the community, campaigns and events to promote community wellness, and enhancements to Durham’s SOC that serves transition age youth [TAY]). Evaluative efforts around these areas are largely conducted by SAMHSA during their bi-annual site review, and the national evaluators for these grants (ICF/MACRO) during their bi-annual site review focused on evaluating key SOC goals.⁴

**Outreach and Engagement-Level 1 and Level 2**

In October of 2013 (the third year of implementation) BECOMING leadership determined that an adjustment to the model was necessary to better meet the needs of Durham’s youth. As such, a two-tiered system was developed that would allow youth with greater needs to receive more intensive one-to-one supports from BECOMING staff. At screening and enrollment, Care Coordinators determined whether a youth qualified for placement on level 1 (more intensive supports for up to 6 months) or would be better served on level 2. Level 1 youth received ongoing case management and supports in addition to participation in BECOMING groups, activities and events. Level 2 youth received ongoing interaction with BECOMING staff primarily through groups, activities and events. Further, Alliance Behavioral Healthcare expanded the number of mental health providers serving BECOMING youth from 2 to 12 allowing youth a greater number of options in choosing mental health treatment.

**Workforce Connections**

The program also partnered with the City of Durham, Office of Economic and Workforce Development to provide individualized employment support for youth interested in both immediate employment opportunities as well as long-term career planning support. BECOMING youth were referred to this resource by care coordinators before intake with one of the mental health providers or by outreach coordinators and therapists after clinical services began.

**Youth and Family Support and Involvement**

In order to address the goal associated with increased youth and family engagement, the program has a full time youth coordinator as well as a full time family coordinator. The primary role of these positions is to provide direct one-to-one support to youth and families. Additionally, these positions are intended to work systemically to build a foundation for the inclusion of youth and family voice/advocacy across agencies in Durham.

**Training and Technical Assistance**

The training and technical assistance coordinator works directly with community-based organizations and mental health provider agencies to provide training and build capacity to provide evidence-based practices, develop a trauma informed system, and promote the use of developmentally appropriate services for transition-age youth.

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⁴ Reports from both of these site visits have been produced and are publicly available.
**Other**
Flexible funds are available through SAMHSA grant dollars to provide BECOMING youth with financial support that may be utilized for various expenses such as transportation, recreation, and education.

**Evaluator**
The Center for Child and Family Policy (CCFP) at Duke University is contracted to conduct the national and local evaluation of BECOMING. CCFP brings together scholars, policy makers, and practitioners to solve problems facing children in contemporary society by undertaking rigorous social science research and then translating important findings into policy and practice. Drs. Nicole Lawrence and Elizabeth Snyder lead the evaluation with support provided by Sonya Fischer, Willie Burt, and student research assistants.

**Data Sources**
CCFP partners with the Duke University Medical Center, Division of Community Health to utilize their existing COACH database as the primary management information system for BECOMING. COACH is a comprehensive case management, data warehouse and communication system that has been utilized in Durham for more than ten years. This secure, HIPAA-compliant and web-based system enables BECOMING to collect data from multiple agencies and service providers required as part of SAMHSA’s national evaluation protocol. The system also tracks key implementation measures, which allows evaluators to provide rapid-time feedback to stakeholders to help guide programmatic decisions.

The measures administered and stored in COACH include the National Outcomes Measure Survey (NOMS; a data collection tool required for all SAMHSA funded grants), Enrollment and Demographics Information Form (EDIF), Traumatic Events Screening Inventory (TESI), and the Strengths and Difficulties Questionnaire (SDQ); see Appendix A for a description of all instruments). Contact forms and goal plan forms designed to track direct service provided to youth by BECOMING staff are also housed within the COACH database system. Other data are collected for the Longitudinal Outcomes Study (LOS) and the Costs and Services Study but these data are not stored within the COACH system.

This evaluation report focuses on answering the following evaluation questions for the first three full years of implementation:

1. Who are the youth that are referred, screened, and enrolled in BECOMING? To answer this question, data were extracted from COACH for all youth screened for BECOMING between November 1, 2011 and December 31, 2014. Data from various measures and sources were utilized to answer this question including: EDIF, NOMs, TESI, the North Carolina Division of Social Services, and the North Carolina Corrections Department.

2. What BECOMING-specific services and supports did these youth receive while enrolled in BECOMING, and what impact did these program interventions have on Medicaid costs, retention in services, and types of services received? Data were extracted from
multiple sources to examine the types of services youth enrolled in BECOMING received, how long they received those services and the associated costs.

- First, data from the NOMS follow-up and clinical discharge assessments were examined to identify what mental health and support services youth received from mental health providers and how long youth were in services.
- Medicaid data were also examined to determine patterns of use and the associated costs of mental health services.
- Next, data regarding SAMHSA flexible funds were examined to ascertain the use of these funds to pay for educational expenses, recreational activities, transportation, clothing, household furnishings/supplies, and utilities.
- Additionally, BECOMING youth were split into three distinct groups and compared based on the level of BECOMING services received.
  - Group 1 was comprised of youth who had meaningful interaction with BECOMING staff as evidenced by the development of goal plans and/or contacts with care coordinators/youth resource specialists.
  - Group 2 included youth who had contacts with other BECOMING staff but no goal plans.
  - Group 3 included all other youth who enrolled in the project, but did not have any interaction with BECOMING staff after initial enrollment.

3. What happened to youth as a result of participating in BECOMING? To answer this question data collected from LOS study participants with one or more follow-up interviews were analyzed to measure change over time. Additionally, administrative data from various sources (e.g., Medicaid, Durham Police Department, Durham Sherriff’s Office, Durham Public Schools, Durham Technical Community College) was examined for this subset of youth. Analyses were conducted to explore what factors may be associated with the length of time youth remain in mental health services as well as the factors associated with law enforcement encounters and educational attainment after enrolling in BECOMING.

I. Who Are the Youth Referred, Screened, and Enrolled in BECOMING?

**Demographics – All Referred Youth**

BECOMING staff routinely conducts outreach with youth referred to BECOMING by community-based organizations. As would be expected, some of these youth opt not to sign a consent form for screening and enrollment into the program. However, staff still collect basic information from the referral such as gender, race/ethnicity, referral sources, and the risk factors qualifying them for potential enrollment (e.g., no diploma/not in school, pregnant/parenting, criminal justice involvement, exiting foster care, un-employed, homeless). Table 1 provides information on the universe of youth with whom outreach was conducted based on a referral. It is important to note that this does not include all youth. For example, some youth were considered internal referrals because they were directly enrolled by virtue of the fact that they were already engaged with a BECOMING mental health provider. Likewise, staff engaged in
outreach efforts with youth who were not formally referred to the program by partnering agencies; therefore these youth are also not reflected in these numbers.

Table 1. Demographics- Outreach

<table>
<thead>
<tr>
<th>Demographics for Referred Youth (N=878)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>51%</td>
</tr>
<tr>
<td>Female</td>
<td>49%</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>African American or Black</td>
<td>78%</td>
</tr>
<tr>
<td>Caucasian or White</td>
<td>10%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>8%</td>
</tr>
<tr>
<td>Multi-racial</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
</tr>
<tr>
<td>(includes American Indian, Alaskan Native, Asian, Pacific Islander)</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>15 yrs.</td>
<td>2%</td>
</tr>
<tr>
<td>16 yrs.</td>
<td>20%</td>
</tr>
<tr>
<td>17 yrs.</td>
<td>23%</td>
</tr>
<tr>
<td>18 yrs.</td>
<td>18%</td>
</tr>
<tr>
<td>19 yrs.</td>
<td>18%</td>
</tr>
<tr>
<td>20 yrs.</td>
<td>12%</td>
</tr>
<tr>
<td>21 yrs.</td>
<td>7%</td>
</tr>
</tbody>
</table>

The majority of youth (49%) were referred to BECOMING from the criminal justice system (e.g., law enforcement, courts, corrections, etc.). Approximately 21% were referred from mental health providers or agencies. Very few youth were referred from educational institutions (7%), family/friends (4%), or the Durham Department of Social Services (2%). The category of “other” captured 17% of referral sources. BECOMING identified six risk factors that, in addition to a diagnosed mental health condition, qualify youth for enrollment into the program. These risk factors include: no diploma/not in school, pregnant or parenting, criminal justice involvement, exiting from foster care, un-employed and homelessness. The risk factor most commonly associated with youth referred to BECOMING was involvement in the criminal justice system.
(n = 627). A large number of youth had risk factors associated with low educational attainment (n=267) and/or were un-employed (n=257). Figure 1 below highlights the number of youth presenting with these key risk factors.

**Figure 1. Risk Factors**

![Risk Factors Chart]

---

**Demographics – All Screened Youth**

The section below highlights demographic information for all youth who consented to be screened for BECOMING from November 2011 through December 2014 (N=434). Table 2 highlights information on gender, race and age. During each of the three years of program implementation, the majority of youth screened were African American or Black. Slightly more females than males were screened, and the highest percentage of youth fell between the age of 17 and 19 years old. It is important to note that while more males are referred to BECOMING, fewer consent to screening/enrollment than their female counterparts. The racial/ethnic make-up of those referred, versus those who consent, reflects that slightly more Hispanics and slightly fewer African-Americans consent to screening and/or enrollment. Of the youth screened for the program, 314 (72%) officially enrolled in the program as evidenced by attending at least an intake appointment with a mental health provider after enrolling in BECOMING.
Table 2. Demographics-Screening/Enrollment

Demographics for Youth Screened for BECOMING (N=434)

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>47%</td>
</tr>
<tr>
<td>Female</td>
<td>53%</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
</tr>
<tr>
<td>African American or Black</td>
<td>72%</td>
</tr>
<tr>
<td>Caucasian or White</td>
<td>8%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>10%</td>
</tr>
<tr>
<td>Multi-racial</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
</tr>
<tr>
<td>(includes American Indian, Alaskan Native, Asian, unknown)</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>16 yrs.</td>
<td>15%</td>
</tr>
<tr>
<td>17 yrs.</td>
<td>23%</td>
</tr>
<tr>
<td>18 yrs.</td>
<td>22%</td>
</tr>
<tr>
<td>19 yrs.</td>
<td>19%</td>
</tr>
<tr>
<td>20 yrs.</td>
<td>15%</td>
</tr>
<tr>
<td>21 yrs.</td>
<td>6%</td>
</tr>
</tbody>
</table>

Referral Sources/Agency Involvement

As part of the enrollment process, additional data are collected regarding the sources of referrals to BECOMING, and the agencies with which the youth are involved. Figure 2\(^5\) shows the referral sources for all youth who were screened for BECOMING. The majority of youth were referred by mental health agencies, followed by schools, and family members or friends. Although each agency referred a small number of youth, the combined referrals from corrections, probation, police and courts account for just over 20% of the referrals.

---

\(^5\) The “School” category includes traditional schools and community colleges, as well as alternative programs such as Bridgescapes, EDGE, Gateway, Achievement Academy and Performance Learning Center. The “Early Childhood” category includes Baby Love, Healthy Families of Durham and other early childhood programs. Most “Early Childhood” referrals were for pregnant or parenting individuals.
Figure 2. Referral Sources for all Screened Youth

Note. Many youth reported involvement with more than one agency, thus total percentages exceed 100%.

Figure 3 depicts the types of agencies with which the youth reported to be involved. Just under half of all youth reported involvement with the school system at the time of their screening. Other agencies for which youth often reported involvement included physical health, corrections and probation. These percentages have remained stable over the course of program enrollment. Awareness of referral sources and agency involvement of enrolled youth is important as this information can allow BECOMING personnel to target their recruitment and outreach efforts more effectively; particularly for partners with low referral rates.
Diagnostic Information

Clinicians report mental health diagnoses for BECOMING youth after they attend an intake and clinical assessment appointment with a mental health provider. Seventy percent of the screened youth had Axis I diagnoses (see Figure 4). As individuals can be diagnosed with more than one Axis I diagnosis, the total percentages exceed 100%. Over half of the youth were diagnosed with mood disorders. Just under half were diagnosed with ADHD, Conduct Disorder or Oppositional Defiant Disorder. Almost 30% were diagnosed with a type of substance use disorder and 26% received a diagnosis of Post-Traumatic Stress Disorder.

---

6 Diagnoses are defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria. Some diagnoses were grouped together for reporting purposes. “ADHD/Conduct Disorder/ODD” includes all varieties of attention deficit disorders or behavioral disorders such as disruptive behavior, conduct disorder and oppositional defiant disorder. “Mood Disorders” includes depression, dysthymia, and other mood-based disorders. “Bipolar Disorder” was considered its own category and thus not included in the “Mood Disorder” category. “Substance Use Disorders” includes all types of substances such as alcohol, opioids, cannabis and nicotine. “Other” includes diagnoses that were reported in a very low number of individuals such as autism and dysomnia.
Figure 4. Axis 1 Diagnoses for Enrolled Youth

Note. Diagnoses were only reported for those youth who ultimately attended an intake appointment with a provider, thus the sample size of 307 in this chart is less than the total number of youth who enrolled in BECOMING (434).

National Outcomes Measure (NOMS; Baseline)

Self-report data collected from youth using the NOMs at the time of initial screening for the program were examined specific to measures of functioning, education, criminal justice involvement, and social connectedness. The following analyses represent data collected for 463 youth screened for BECOMING between October of 2011 and December 2014. A small number of these youth had been screened for or enrolled in BECOMING previously and therefore are represented in these data more than once (which is why the sample size for this data is larger than the sample of 434 youth screened for BECOMING).

Health and Substance Use
Youth were asked to rate their overall health at the time of screening using a five-point response scale ranging from excellent to poor. Most youth (68%) rated their current health as excellent, very good, or good. However, nearly one-third (30%) of the youth indicated their overall health
as fair or poor. A small number of youth (2%) did not provide a response or did not know the status of their health.

Youth were asked about their use of alcohol, cigarettes, and other drugs in the past 30 days. The measure lists various substances, and respondents are directed to specify their level of use, if applicable. The response options offered included: never, once or twice, weekly, and daily/almost daily.

- Slightly more than half (52%) responded that they had used tobacco products in the past 30 days.
  - Almost 32% indicated that they used tobacco products daily, with fewer (11%) noting more sporadic use such as at least once a week or 1 or 2 times over the past 30 days.
- The vast majority (68%) indicated that they had not used alcohol; however 25% had used it 1 or 2 times, and 6% noted weekly or daily use.
- Likewise, 64% indicated that they had not used cannabis; however 13% responded that they had used it 1 or 2 times, and 17% reported using it weekly or daily.
- The other substances listed received almost no affirmative responses with the exception of prescription opioids. Fifteen youth (3%) responded that they had used prescription opioids 1 or 2 times in the past 30 days.

These percentages have not changed considerably from those presented in the last evaluation report. However, it is important to note that it is not uncommon for people, regardless of age, to under-report substance use when surveyed. It is likely that use of drugs and alcohol among the youth screened is much higher in reality.

**Functioning**

Youth were asked to rate how they had handled daily life in the past 30 days. The question offers a five-point Likert scale; with response options ranging from strongly disagree to strongly agree. As shown in Table 3, at the time of initial screening for the program the majority of youth agreed that they were:

- Handling daily life (83%)
- Getting along with family (60%)
- Getting along with friends (84%)
- Coping when things go wrong (58%)

Conversely, the responses related to levels of satisfaction with family life were split, with 40% of youth indicating satisfaction and 41% indicating dissatisfaction, and 17% undecided.

Similarly, youth were asked to rate statements about their feelings of nervousness, hopelessness, restlessness, and depression in the past 30 days. Youth rated each statement, using a 5-point Likert scale with response options ranging from “all the time” to “none of the time.” These numbers have remained stable and have not changed substantially from the last evaluation report. As shown in Table 3:

- More youth responded that they felt restless or fidgety all of the time or most of the time than they did for any other statement (33%).
Conversely, youth were least likely to report that they felt worthless all of the time or most of the time (13%).

Table 3. Functioning

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Refused/ Don’t know</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am handling daily life.</td>
<td>1%</td>
<td>8%</td>
<td>9%</td>
<td>53%</td>
<td>30%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>I get along with my family members.</td>
<td>8%</td>
<td>19%</td>
<td>12%</td>
<td>42%</td>
<td>18%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>I get along with friends and other people.</td>
<td>2%</td>
<td>4%</td>
<td>9%</td>
<td>62%</td>
<td>22%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>I am able to cope when things go wrong.</td>
<td>5%</td>
<td>18%</td>
<td>19%</td>
<td>47%</td>
<td>11%</td>
<td>&lt;1%</td>
<td>-</td>
</tr>
<tr>
<td>I am satisfied with our family life right now.</td>
<td>17%</td>
<td>23%</td>
<td>17%</td>
<td>30%</td>
<td>10%</td>
<td>1.94%</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In the last 30 days how often did you feel….</th>
<th>All the time</th>
<th>Most the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
<th>Refused</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nervous?</td>
<td>7%</td>
<td>15%</td>
<td>29%</td>
<td>25%</td>
<td>23%</td>
<td>-</td>
<td>1%</td>
</tr>
<tr>
<td>Hopeless?</td>
<td>7%</td>
<td>11%</td>
<td>22%</td>
<td>16%</td>
<td>42%</td>
<td>-</td>
<td>2%</td>
</tr>
<tr>
<td>Restless or Fidgety?</td>
<td>15%</td>
<td>18%</td>
<td>21%</td>
<td>17%</td>
<td>28%</td>
<td>-</td>
<td>1%</td>
</tr>
<tr>
<td>That everything was an effort?</td>
<td>13%</td>
<td>16%</td>
<td>29%</td>
<td>14%</td>
<td>26%</td>
<td>-</td>
<td>2%</td>
</tr>
<tr>
<td>Worthless?</td>
<td>4%</td>
<td>8%</td>
<td>17%</td>
<td>14%</td>
<td>55%</td>
<td>&lt;1%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Education

Responses for the statement “I am doing well in school and/or work” brought mixed results.

- Nearly one-third (32%) of youth marked not applicable for this statement, indicating they were neither employed nor enrolled in school at baseline.
- A total of 23% indicated that they disagreed, strongly disagreed or were unsure as to whether they were doing well in work/school.
- Just under half (45%) agreed or strongly agreed that they were doing well.

As shown in Figure 5, the vast majority of BECOMING youth (76%) had not completed high school upon enrollment in the program. This is a discouraging number because the majority of youth (62%) screened for the program are 18 or older. Only 16% had completed 12th grade, while
7% had either vocational training or some college. This finding underscores the high need among these youth with regard to educational planning and linkage to appropriate resources to ensure success.

**Figure 5. Educational Attainment**

![Educational Attainment Chart]

**Social Connectedness**

In exploring social connectedness, BECOMING youth were asked to indicate their level of agreement with statements using a 5-point Likert-scale ranging from strongly agree to strongly disagree. As Table 4 shows, the vast majority of youth agreed or strongly agreed that they had social supports in place, including someone to listen and understand them, someone to talk about their problems with, supports if needed during a crisis, and people with whom they could spend leisure time. Approximately 16% of youth reported not having a reliable support network (up slightly from 14% in the previous report). Supportive networks are critical for people of all ages, but transition-age youth are at a developmental stage marked by increasing independence from family which intensifies the need for other social supports.
Table 4. Social Connectedness

<table>
<thead>
<tr>
<th>Statement</th>
<th>Response Options (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I know people who will listen and understand me when I need to talk</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
</tr>
<tr>
<td></td>
<td>Undecided</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
</tr>
<tr>
<td></td>
<td>Strongly Agree</td>
</tr>
<tr>
<td></td>
<td>Refused</td>
</tr>
<tr>
<td>I have people that I am comfortable talking with about my problems</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>52%</td>
</tr>
<tr>
<td></td>
<td>29%</td>
</tr>
<tr>
<td></td>
<td>&lt;1%</td>
</tr>
<tr>
<td>In a crisis, I would have the support I need from family/friends</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td>51%</td>
</tr>
<tr>
<td></td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>&lt;1%</td>
</tr>
<tr>
<td>I have people with whom I can do enjoyable things</td>
<td>&lt;1%</td>
</tr>
<tr>
<td></td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

**Criminal Justice**

The NOMs also collects information about involvement with the criminal justice system. The vast majority of youth (92%) reported at baseline that in the previous 30 days they had no arrests on record. A relatively small number (7%) indicated that they had been arrested one time during this period, and one youth reported two arrests. These percentages have remained stable over the course of program enrollment.

**Traumatic Events Screening Inventory (TESI)**

The TESI is typically completed by a clinician within 30 days of intake and is intended to inform and shape a youth’s plan of care as well as measure the level and scope of trauma experienced by BECOMING youth. Clinicians were asked to administer this instrument with all youth, either as part of their mental health intake appointment or during their first few counseling sessions, as long as they did not have clinical reasons not to administer the instrument. Between January 2012 and May 2015, 100 TESIs were administered to 98 individuals (n=67 females; n=31 males)7.

The results show a high level of exposure to potentially traumatic events. Of those youth that were screened, the average number of traumatic events reported was 9.78 out of 24 possible. The range reported was between 0-21 traumatic events. Exposure rates associated with various other potentially traumatic events were reported as follows.

---

7 The TESI was administered twice to two individuals, thus there are data for 100 TESIs given to 98 youth. Additionally, some TESI items had missing data, thus the sample size for each item presented varies.
• 63% (58/92) indicated they had seen family members physically fighting; shooting a gun, or involved in a stabbing.
• 62% (56/91) indicated they had seen non family members fighting, hitting, beating, shooting, or attacking others in school and/or within their community.
• 60% (56/94) had known or seen that a family member was arrested, jailed, imprisoned, or taken away by police.
• 59% (51/87) had watched other people use drugs.
• 58% (55/95) indicated someone close to them had died, not from natural causes.
• 56% (52/92) had seen someone badly injured.
• 52% (49/95) have been separated from someone they depend on for love and security for more than a few days (like going to a foster home or detention center).
• 49% (44/90) have been physically attacked (hitting, pushing, choking, shaking, biting, or burning); punished so badly they were badly hurt or bruised; or attacked with a weapon (e.g., gun or knife).
• 46% (42/91) indicated someone had said they were going to hurt them really badly or kill them.
• 31% (27/87) indicated someone had ever made them see or do something sexual.
• 31% (27/88) indicated someone close to them had ever tried to kill or hurt themselves really badly on purpose.
• 28% (26/93) said someone had mugged or attacked them in order to steal money from them.

Prior Experience with Child Protective Services

Child maltreatment and interactions with child protective services staff can be significant traumatic events for children and youth. In an effort to gain a more complete picture of the various types and severity of prior traumatic events experienced by youth screened for BECOMING, data from the North Carolina Division of Social Services (NCDSS) were examined for 434 youth.

Quantitative data drawn from administrative sources, including Child Protective Service reports and Services Information System data, were examined for potential matches with youth screened for BECOMING. The North Carolina Department of Health and Human Services (DHHS) collects data regarding accepted CPS reports of child maltreatment from each county. The data from these reports are entered into the Central Registry and stored in the Client Services Data Warehouse. Like the CPS reports, DHHS provides SIS data via the Client Services Data Warehouse. These data include information about the type of social service provided for each case, as well as the dates the service was provided. Data for youth screened for BECOMING (names, birthdates, gender and race/ethnicity) were used to examine for possible matches within the Client Services Data Warehouse. Where matches were found, data were extracted from the Data Warehouse, proving information on individual report and assessment dates, the type of maltreatment reported, the case finding, and dates of service for children with 109 services (i.e., foster care services; see Appendix B for a detailed description of the CPS report and SIS data used in this evaluation).
Child Protective Services (CPS) is designed to protect children from further harm and to support and improve parental abilities in order to assure a safe home for each child. In North Carolina, when a valid CPS report is received, it is assigned to a social worker for an assessment/investigation. The goal of the assessment is to determine if a child is abused, neglected, or dependent and to assure safety. Of the 434 youth included in this analysis, 269 (62%) had been involved in at least one accepted child maltreatment report by the time they were screened for BECOMING. Of the 62% with at least one accepted report, the range was between one and thirty-two reports.

- Nearly three-quarters (72%; n=193) had between one and five reports;
- 21% (n=56) had between six and 10 reports, and
- 7% (n=20) had between 11 and 32 accepted reports.

Similar to the entire population screened for BECOMING to date, the majority of youth with one or more CPS reports were female, and African-American (see Table 5). Only 10% of the youth in this sample were Hispanic.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>56%</td>
</tr>
<tr>
<td>Male</td>
<td>44%</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>73%</td>
</tr>
<tr>
<td>White</td>
<td>11%</td>
</tr>
<tr>
<td>Other or Mixed Race</td>
<td>16%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>10%</td>
</tr>
</tbody>
</table>

Prior to 2002, all accepted maltreatment reports in North Carolina could have one of two findings: substantiated or unsubstantiated. Beginning in 2002, however, this process changed with the implementation of the reform initiative Multiple Response System (MRS); consequently accepted maltreatment reports are now assigned to one of two tracks for assessment or investigation. Depending on which track the report is assigned to, findings from the assessment/investigation can differ. Because many youth screened for BECOMING were born prior to 2002, they could have some reports that occurred prior to MRS reform, and some reports that occurred after.

For those on an investigative track, findings include: substantiated abuse, substantiated abuse and neglect, substantiated neglect, or unsubstantiated. Substantiated findings result in mandatory in-
home services and/or possible placement in foster care. As shown in Table 6, only 12 youth screened for BECOMING had at least one substantiated report of abuse and neglect. However, one youth had four such severe occurrences by the time the youth was screened for BECOMING. A substantially higher number (n=136) of youth had at least one substantiated report of neglect by the time they were screened for BECOMING. Lastly, 189 youth had at least one maltreatment report that was found to be unsubstantiated.

Table 6. CPS Investigation Findings

<table>
<thead>
<tr>
<th>Investigative Track Findings</th>
<th># of Reports Range</th>
<th># of Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantiated Abuse and Neglect</td>
<td>1-4</td>
<td>12</td>
</tr>
<tr>
<td>Neglect Substantiated</td>
<td>1-8</td>
<td>136</td>
</tr>
<tr>
<td>Unsubstantiated</td>
<td>1-18</td>
<td>189</td>
</tr>
</tbody>
</table>

For those reports assigned to the family assessment track, findings include: services needed, services provided – no longer needed, services recommended, and services not recommended. As shown in Table 7, only 36 youth had one or more reports for which the finding was “services needed.” As with substantiated cases, this finding also results in mandatory in-home services and/or possible foster care placement. A very small number of youth had findings of “services provided, no longer needed.” This finding is used when child protective services staff was able to provide services during the assessment period that reduced the child maltreatment risk enough to avoid a finding of services needed. The majority of youth with an accepted report that was assigned to the family assessment track had findings of either “services recommended” or “services not recommended.” Similar to unsubstantiated cases, CPS staff close the case at the conclusion of their work with either of these findings.

Table 7. CPS Family Assessment Findings

<table>
<thead>
<tr>
<th>Family Assessment Track Finding</th>
<th># of Reports Range</th>
<th># of Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services Needed</td>
<td>1-3</td>
<td>36</td>
</tr>
<tr>
<td>Services Provided – No Longer Needed</td>
<td>1-2</td>
<td>18</td>
</tr>
<tr>
<td>Services Recommended</td>
<td>1-4</td>
<td>86</td>
</tr>
<tr>
<td>Services Not Recommended</td>
<td>1-4</td>
<td>106</td>
</tr>
</tbody>
</table>
With respect to placement in foster care, data indicated that only 43 youth (10%) had at least one placement in foster care ever. Of those, 40 were in foster care at some point before being screened for BECOMING.

Analyses were performed to explore possible relationships between demographic variables (i.e., gender, race, and ethnicity) and the occurrence of the most common child maltreatment reports; substantiated neglect and unsubstantiated neglect. Significant differences were not found related to any of these demographic variables.

**Department of Corrections Data**

Department of Public Safety records are accessible to the public and include youth 16 and older because they are considered adults within the criminal justice system in the state of North Carolina. These records provide information on offense dates, offense types, and sentencing types and duration for all individuals convicted of a felony or misdemeanor. Of the youth screened for BECOMING, 88 (20%) of those individuals had convictions that were included in the database at the time of data retrieval. This is similar to the percentage from the 2014 Report. Table 8 highlights information about the number and types of offenses of which these individuals were convicted.

- 34% of the youth with reports of involvement with the Department of Public Safety had one reported offense
- 33% had two offenses
- 33% had 3 or more offenses
- 41% of the youth were convicted of misdemeanors only
- 32% of the youth were convicted of felonies
- 27% of the youth were convicted of both felonies and misdemeanors.

Fifty-three (60%) of the youth with convictions who were screened for BECOMING also enrolled in BECOMING; the other 35 individuals (40%) either chose not to enroll or did not qualify for enrollment. Table 8 shows the number and percent of youth who had reported convictions prior to and after enrolling in BECOMING. For the youth who ultimately enrolled in BECOMING:

- 37 individuals (70%) committed their first offense prior to enrolling in BECOMING
- 16 individuals (30%) committed their first offense after enrolling in BECOMING
- 31 (58% of enrolled youth with convictions) of the youth enrolled in BECOMING did not commit another offense after enrolling in BECOMING
- 6 individuals (11% of enrolled youth with convictions) committed at least one other offense after enrolling in BECOMING.

Thirty-five of the youth with convictions did not enroll in BECOMING. For those youth:

- 29 individuals (83%) committed their first offense prior to screening
- 6 individuals (17%) committed their first offense after screening
- 21 (72% of screened youth with convictions) of the youth screened for BECOMING did not commit another offense after screening
- 8 individuals (28% of enrolled youth with convictions) committed at least one other offense after screening.
Table 8. Criminal Records Information

<table>
<thead>
<tr>
<th>All BECOMING Screened Youth (n=88)</th>
<th>Number</th>
<th>Percent (out of total with offenses)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Offense</td>
<td>30</td>
<td>34%</td>
</tr>
<tr>
<td>Two Offenses</td>
<td>29</td>
<td>33%</td>
</tr>
<tr>
<td>Three or more Offenses</td>
<td>29</td>
<td>33%</td>
</tr>
<tr>
<td>Youth reported to be involved in misdemeanors only</td>
<td>36</td>
<td>41%</td>
</tr>
<tr>
<td>Youth reported to be involved in felonies only</td>
<td>28</td>
<td>32%</td>
</tr>
<tr>
<td>Youth reported to be involved in both felonies and misdemeanors</td>
<td>24</td>
<td>27%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All BECOMING Enrolled Youth (n=53)</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Offense Occurred Before Enrollment</td>
<td>37</td>
<td>70%</td>
</tr>
<tr>
<td>First Offense After Enrollment</td>
<td>16</td>
<td>30%</td>
</tr>
<tr>
<td>No Re-offense After Enrollment</td>
<td>31</td>
<td>84%*</td>
</tr>
<tr>
<td>Re-offense After Enrollment</td>
<td>6</td>
<td>16%*</td>
</tr>
</tbody>
</table>

*percent is out of the 37 youth whose first offense was committed before enrollment

<table>
<thead>
<tr>
<th>All BECOMING Screened Youth, But Not Enrolled Youth (n=35)</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Offense Occurred Before Screening</td>
<td>29</td>
<td>83%</td>
</tr>
<tr>
<td>First Offense After Screening</td>
<td>6</td>
<td>17%</td>
</tr>
<tr>
<td>No Re-offense After Screening</td>
<td>21</td>
<td>72%*</td>
</tr>
<tr>
<td>Re-offense After Screening</td>
<td>8</td>
<td>28%*</td>
</tr>
</tbody>
</table>

*percent is out of the 29 youth whose first offense was committed before screening

Section 1: Summary of Findings
The demographic characteristics of the youth screened for and/or enrolled in BECOMING have remained consistent since the inception of program enrollment. While there are no differences with respect to gender for youth referred to BECOMING, a higher proportion of females ultimately consent to be screened and enrolled in BECOMING as compared to their male counterparts (53% and 47%, respectively). The majority (62%) of youth are 18 years or older and identify as African American (72%). The largest source of referrals continues to be from community-based mental health providers (31%), followed by educational institutions (17%). The breakdown of mental health diagnoses has not changed dramatically from the last reporting period with the highest percentages of Axis 1 mental health diagnoses falling into the categories of Mood Disorders (52%), ADHD/Conduct/OCD (46%), substance abuse (28%), and Post-
traumatic Stress Disorder (PTSD) (26%). These percentages reflect very small increases in mood disorder, PTSD, learning disorder and psychotic disorder, and small decreases in anxiety, ADHD, substance use disorder and bipolar disorder, as compared to numbers presented in the 2014 evaluation report.

Basic measures of functioning, as captured by the NOMs at baseline, suggest that the majority of youth believe they are managing daily life, getting along with family and friends, and coping during difficult circumstances. Nearly one third of youth (32%) reported that they were neither in school nor working at the time of screening for BECOMING. This is an important finding because it further highlights the high degree of need BECOMING youth have related to education and employment. Likewise, other data collected through the NOMs showed that most youth (76%) had not completed high school at the time of screening/enrollment, underscoring this problem and likely contributing to high levels of unemployment.

The numbers of youth who have been administered the TESI by their clinician remains small. Through May of 2015, 100 youth were administered the TESI. Thus, providers are only completing this measure to help them implement trauma informed care with a small proportion of the BECOMING youth who have received clinical services. Despite the relatively small numbers of measures completed, the findings clearly show that youth enrolled in BECOMING have experienced a significant number of traumatic events in their lifetime.

Data from the North Carolina Division of Social Services were also examined to provide a more complete picture of the types of prior traumatic events experienced by the youth screened or enrolled in BECOMING. The majority (62%) had at least one accepted CPS report prior to enrolling in BECOMING. A smaller number (9%) had experienced foster care placement. Relatedly, only 6% of youth reported current involvement with Durham County DSS at the time of enrollment and less than 1% of youth had been referred by DCDSS. This indicates that BECOMING youth have had high levels of involvement with CPS early in life but not necessarily as young adults.

Information on criminal activity (i.e., felony and/or misdemeanor convictions) was collected from criminal records from the Department of Public Safety, Division of Adult Corrections. Of the youth screened for BECOMING 20% (n=88) had convictions at the time of data retrieval (these could have occurred prior to and/or after enrollment). Importantly, the majority (70%) of offenses occurred prior to enrollment in the program and few youth had additional convictions after enrollment in BECOMING (N = 6 out of 37).

II. What Services and Supports Did Youth Receive While Enrolled in BECOMING?

Contacts with BECOMING Staff

Contact forms were designed to allow BECOMING staff to track various aspects of their work with youth (and their families, as applicable) after initial screening for the program. Information such as the number of contacts, the types of contact (i.e., in person or phone), and the services or supports provided are entered and stored within the COACH database. The form also allows
program staff to store case notes that could be referred to at a later date to ensure follow-up items were addressed or to note other significant issues related to a specific youth. These contacts also include group activities such as youth resource groups, leadership/advisory council, etc. For all youth enrolled before January 2015, BECOMING staff recorded 5,252 contacts with 231 individual youth. The types of contacts are broken down as follows:

- Phone (17%)
- Email (17%)
- In person (60%)
- Mail (<1%)
- Attempted but not completed (5%)

The number of contacts per youth ranged from a minimum value of 1 to a maximum of 324 contacts. The mean number of contacts was 22 but the range is large and the data indicate that the majority of cases had relatively low numbers of contacts. As shown in Table 9, 53% of youth had 7 or fewer contacts.

Table 9. Number of Contacts

<table>
<thead>
<tr>
<th>Total Number of Contacts</th>
<th>Number of Youth (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 2</td>
<td>64 (28%)</td>
</tr>
<tr>
<td>3 to 7</td>
<td>58 (25%)</td>
</tr>
<tr>
<td>8 to 25</td>
<td>50 (22%)</td>
</tr>
<tr>
<td>26 or more</td>
<td>59 (25%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>231</strong></td>
</tr>
</tbody>
</table>

Contacts can be further divided both by the types of staff members conducting them, and the types of activities involved in the contacts. Contacts were broken up into two groups: 1) those contacts associated with more intensive case management services (e.g., contacts provided by care coordinators and youth resource specialists), and 2) those related to other more informal supports or group activities (e.g., contacts provided by youth and family coordinators, outreach coordinators, or associated with various group activities). The majority of contacts (57%) were associated with the latter group (informal supports or group activities). More intensive contacts (i.e., group 1) made up 43% of all contacts. The mean number of contacts for group 1 was 10 (range=1 to 103) with the mean for group 2 slightly higher at 13 (range=1 to 279) contacts.

The elapsed time from the first contact to the last is one indicator of the length of time BECOMING staff were actively working with youth. The mean number of days from the first contact to the last, regardless of grouping, was 250 days, or about 8 months. Because of the large range in the data (1 to 1,348 days) the median is helpful in describing the distribution. The median was 106 days; meaning that 50% of youth had an engagement window shorter than 106 days. Table 10 below highlights the length of contact in days and the number of associated youth.
Table 10. Contact Length

<table>
<thead>
<tr>
<th>Contact Length</th>
<th>Number of Youth (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Contact</td>
<td>42 (18%)</td>
</tr>
<tr>
<td>1 to 30 days</td>
<td>30 (13%)</td>
</tr>
<tr>
<td>31 to 90 days</td>
<td>29 (13%)</td>
</tr>
<tr>
<td>91 to 150 days</td>
<td>22 (9%)</td>
</tr>
<tr>
<td>151 to 210 days</td>
<td>13 (6%)</td>
</tr>
<tr>
<td>More than 210 days</td>
<td>95 (41%)</td>
</tr>
<tr>
<td>Total</td>
<td>231</td>
</tr>
</tbody>
</table>

Importantly, there appears to be few cases with an extended length of time between first and last contacts and high numbers of total contacts. As would be expected, some youth have a lower number of contacts occurring over a longer time frame and others have a higher number of contacts occurring within a relatively short timeframe. The scatterplot (Figure 6 below) shows this relationship. Plots in the upper right quadrant would reflect the ideal scenario; cases with both extended length of contact and high numbers of total contacts. The figure illustrates that the opposite is true, as the data cluster in the lower left quadrant, meaning that most youth received few contacts over a relatively brief time.

Figure 6. Total Contacts by Length of Contacts
In total, 5,252 contacts were made for 231 unique individuals. This indicates that at least one contact was made with approximately 53% of all youth who had been screened for BECOMING by December 2014 (N=434), and 74% of all youth who had officially enrolled in the program by that time (n=314).

**Goal Planning**

Youth receiving more intensive case management services and supports from Care Coordinators/Youth Resource Specialists typically work with BECOMING staff to develop goal plans for needs related to education, employment, stable housing, transportation, childcare/parenting, etc. A total of 426 goals were developed in collaboration with 76 unique youth (see Figure 7). Education (28%), employment (22%), mental health (14%) and shelter (12%) were the area of greatest need for enrolled youth as evidenced by the goal plans.

**Figure 7. Goal Categories**

These goals are classified as either immediate need goals or long-term goals. Immediate need goals are those that can be addressed relatively quickly, whereas long-terms goals may require many months or even years to achieve. It is important to note that goal setting with youth is a dynamic process and changes over time as the needs of youth change or as specific objectives are met. For example, a youth can have multiple educational goals in the system; some that are completed, some that no longer applicable, and some that are new. In total there were 238 immediate need goals and 188 long-term goals developed. With respect to immediate need goals 57 out of the 76 youth had such goals:

- 26 youth had between 1-3 immediate needs goals,
- 24 youth had between 4-6 immediate needs goals,
- 7 youth had more than 6 immediate needs goals.
With respect to long-term goals 47 youth had such goals:

- 24 youth had between 1-3 long-term goals,
- 16 youth had between 4-6 long-term goals,
- 7 youth had more than 6 long-term goals.

Of the 76 youth with established goals of either type, 42 (55%) had not successfully met any of their goals, 20 (26%) had met between 1 and 3 goals, and 14 (18%) had met 4 or more. It is possible that some youth may have successfully completed additional goals at a point when they were no longer actively working with BECOMING staff and thus that information would not be available for this report.

**NOMs - Services Received**

The types of mental health services received are collected from providers through the NOMS at six-month intervals and/or at clinical discharge. Follow-up and/or discharge data collected through the NOMs was available on 313 youth. The majority (73%) of these data came from clinical discharges rather than follow-up assessments. Figure 8 shows the specific evidence-based practices received by youth, as reported by mental health providers. In many cases, youth received multiple interventions, including: Cognitive Behavioral Therapy (CBT), Cognitive Processing Therapy (CPT), Seeking Safety (SS), Seven Challenges, Dialectic Behavior Therapy (DBT), and Motivational Interviewing (MI). As such, the percentages across categories exceed 100. MI, CBT and SS were the most commonly reported evidence-based practices utilized with BECOMING youth. In fact, these three interventions in combination were the most frequently reported, with a total of 87 (28%) youth receiving all three. Nearly as many (83; 27%) received a combination of CBT and MI only.

**Figure 8. Evidence-based Clinical Practices**

![Diagram showing the percentage of youth receiving different evidence-based practices. The most common practices are MI (66%), CBT (78%) and SS (36%). Other practices include CPT (2%), 7 Challenges (2%) and DPT (6%).]
Core and Support Services

BECOMING youth received a number of both core and support services from mental health providers as part of their overall treatment. These data are reported at different points in time including at follow-up (6-month, 12-month, 18-month, and 24-month) or at clinical discharge. Figure 9 highlights data collected from mental health clinicians regarding the core services provided to youth. The NOMs measure requires providers to indicate whether or not a youth received various specific services. As would be expected, the majority of youth received screening, assessment, treatment planning and mental health services.
The most common support services reported were transportation, educational, employment, and social/recreational services. These activities are consistent with the priorities outlined in the program logic model and help support the overall goals of the program to help transition-age youth increase educational or vocational achievement, obtain greater stability in their life, and decrease involvement with the criminal justice system (see Figure 10).

Service Frequency/Duration

Data on the levels of service authorized, or the frequency of mental health services provided, as reported at follow-up or at clinical discharge by mental health providers are presented in Figure 11. The data indicate that 46% of youth were receiving mental health services with relatively low frequency (i.e., one 50-minute session per week). Approximately one-third received two or three
sessions per week, with very few youth receiving more intensive services characterized by four or more sessions per week.

**Figure 11. Clinical Service Frequency**

Data regarding the last date of service for youth who were discharged from services were available for 292 individual youth corresponding to 310 completed records. There are more completed sets of records than there are youth because some youth had more than one episode of care (e.g., they were enrolled and discharged more than once).

- The mean number of days from baseline to discharge was 209 days; while the median was 167 days.
- Youth were engaged in mental health services anywhere from 1 to 1,127 days.

It is important to note that while these numbers provide a sense of the length of time in mental health services, the data may reflect discharge dates that are up to 90 days longer than the last time clinicians saw the youth. This is supported by the fact that only 3% of discharge interviews were completed in-person with the youth. Most likely, clinicians complete a discharge at a point when they are fairly certain that the youth is unlikely to continue mental health services, and after multiple outreach attempts over time to encourage continued engagement.

This is further highlighted in Figure 12 which depicts the reasons that youth were discharged, as reported by mental health providers. Nearly one-quarter of youth withdrew or refused further mental health treatment and 49% reportedly dropped out of services with no contact for 90 days or more. Overall, 73% either withdrew or ceased contact with their provider, suggesting the need for improved strategies aimed at better engagement of youth to ensure that they remain enrolled in the program for a longer period of time (i.e., six months or more) and can benefit from the other programmatic aspects and opportunities associated with BECOMING. Longer engagement in the program will likely result in better long-term program outcomes such as increased educational attainment and workforce connections and decreased criminal justice involvement.
Flexible Spending Funds

Flex funds are available to assist youth who officially enroll in BECOMING (i.e., attend an intake appointment with a mental health provider) with educational, recreational, and employment related expenses, among other things. Flex funds may be requested by care coordinators, youth resource specialists, outreach coordinators or mental health clinicians working with BECOMING youth, as needs and priorities are identified. As shown in Table 11, the majority of these requests were for transportation costs (e.g., bus passes), but the largest dollar amount was spent on educational support (e.g., tuition, lab fees, or computers). Clearly lack of transportation is a limiting factor in the lives of BECOMING youth. Hopefully increased access to transportation will allow these individuals to attend school or find employment in locations that might otherwise be inaccessible due to limited transportation. A high percentage of requests were also for items such as clothing or funding related to housing or other supplies.

As of December 2015, 202 (47%) BECOMING youth had received support through flexible funds totaling approximately $65,000. On average, individual youth received $319 in Flex Funds (median $152, range $2-$2,150). The mean number of funded requests per youth was five and the median was three (range 1 to 21 requests).

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8 Flex Funds data are recorded in two files by BECOMING staff (one for checks and one for cash). Until this year, the CCFP evaluation team only received data from one of these sources, thus data included in reports in prior years does not reflect the amount that was actually spent on Flex Funds. The data reported in this report reflects the most up to date and comprehensive accounting of these funds.
Table 11. Flexible Funds Requests

<table>
<thead>
<tr>
<th>Flexible Funds Category</th>
<th># of Funded Requests Nov 2011 – Dec 2015</th>
<th>Total (%) by Category</th>
<th>Total $ Spent by Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities</td>
<td>54</td>
<td>5.4%</td>
<td>$6,194</td>
</tr>
<tr>
<td>Clothing</td>
<td>98</td>
<td>9.9%</td>
<td>$7,930</td>
</tr>
<tr>
<td>Daycare</td>
<td>1</td>
<td>0.001%</td>
<td>$300</td>
</tr>
<tr>
<td>Educational Support</td>
<td>118</td>
<td>11.9%</td>
<td>$17,940</td>
</tr>
<tr>
<td>Housing/Furnishings/Supplies</td>
<td>90</td>
<td>9.1%</td>
<td>$8,160</td>
</tr>
<tr>
<td>Groceries</td>
<td>26</td>
<td>2.6%</td>
<td>$1,391</td>
</tr>
<tr>
<td>Legal</td>
<td>27</td>
<td>2.7%</td>
<td>$1,580</td>
</tr>
<tr>
<td>Medical</td>
<td>9</td>
<td>0.9%</td>
<td>$834</td>
</tr>
<tr>
<td>Transportation</td>
<td>462</td>
<td>46.5%</td>
<td>$13,137</td>
</tr>
<tr>
<td>Utilities</td>
<td>108</td>
<td>10.9%</td>
<td>$6,783</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>993</strong></td>
<td><strong>100%</strong></td>
<td><strong>$64,249</strong></td>
</tr>
</tbody>
</table>

Flex funds are an important aspect of the program because they provide financial support in areas of high need and where there are typically no other funding sources. Flex funds are used to support and assist youth in reaching educational or employment goals, as well as assisting with housing and transportation needs. The data suggests that the number of flex funds requests has risen steadily since the beginning of the program, with 993 requests funded through December 2015. The majority of these requests were for transportation assistance, which suggests that lack of access to transportation is a limiting factor in these youths’ lives.

**Medicaid Data**

In an effort to quantify the mental health services received by youth and their associated costs, Medicaid data were secured from Alliance Behavioral Healthcare (ABH). However, because ABH transitioned to a new Medicaid Claims database system in mid-2012, retrieval of most archived data prior to this time is not possible. Consequently, data for youth who enrolled in BECOMING from November 2011 through at least mid-2012 were not available to evaluators. The approximate number of BECOMING youth who would be expected to have had at least one claim for an intake appointment within the data set is 252, however there are only claims for 158. It is unclear as to why there are no Medicaid claims for these youth. It is possible for example, that providers aren’t billing for intake appointments for youths that only attend an intake and do not return for therapy. It may also be true that some of these youth are participating in group therapy sessions and again, providers are not billing for every individual participant. In any case, it will be important to explore these and other possible causes to ensure that the data are accurately capturing all of the services provided to youth.
In order to understand what Medicaid-billed mental health services youth received while they were enrolled in BECOMING, evaluators established a BECOMING episode of care. This was initially operationalized as the period of time from initial enrollment in the program (i.e., date of screening for BECOMING) to either the last known date of service (as reported by providers) or the discharge date (also reported by providers). This process yielded only 20 youth who had Medicaid claims fitting within a BECOMING episode of care. As such, the parameters were expanded to include claims that fell six-months prior to and six-months after the BECOMING episode of care. This allowed evaluators to match most claims provided by ABH to a BECOMING episode of care; this included 4,933 claims for 158 youth.

The mean number of claims per youth while in BECOMING was 31 (range 1- 606). The total amount expended for these youth while in BECOMING was $2,319,047. The average expenditure was $14,677, however the range was very large ($303.00 - $697,742). Examination of the data revealed that the mean is quite skewed as a result of one youth for which nearly $700,000 in claims was paid. Figure 13 below highlights the relationship between costs and number of claims. As shown, the data cluster in the lower left quadrant of the scatter plot suggesting the vast majority of youth had few claims.

**Figure 13. Costs vs. Claims**
The histogram (Figure 14) below further highlights the frequency of youth by the total number of paid claims. The distribution of the data reflects that most youth had a relatively small number of claims. When these numbers are further broken down we see that 66% of youth had 20 or fewer claims.

Of the 158 youth:
- 104 youth had between 1-20 claims
- 18 youth had between 21-40 claims
- 14 youth had between 41-60 claims
- 5 youth had between 61-80 claims
- 8 youth had between 81-100 claims
- 9 youth had more than 100 claims

The types of services, as defined by procedure codes, were collapsed into three broad categories in order to make analyses more manageable. The categories included: intensive outpatient services (e.g. MST, IIHS, ACTT, community support), other intensive services (e.g. BH LT residential treatment, psych. rehabilitation, PRTF, crisis services, psychiatry, 1915 B3 Services), and non-intensive outpatient services. As shown in Table 12, the vast majority of youth (n=141) had claims associated with non-intensive outpatient services.
Table 12. Medicaid Services

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Mean # of Claims</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-intensive Outpatient (n= 141)</td>
<td>10</td>
<td>1-175</td>
</tr>
<tr>
<td>Intensive Outpatient (n= 53)</td>
<td>16</td>
<td>11-398</td>
</tr>
<tr>
<td>Other Intensive (n=46)</td>
<td>4</td>
<td>1-150</td>
</tr>
</tbody>
</table>

*The number of youth exceeds 158 because some youth received services within more than one category.

Two sample t-tests were used to examine the differences in means for total Medicaid claims, type of service claim, gender and race. Significant differences were not found for gender and type of service claim or total claims. However, while the difference in means for total cost of claims and gender was significant, this finding is likely a result of the outlier with claims totaling $700,000. No significant differences were found for race and total claims, total cost, or type of service. Table 13 below highlights the average total cost of claims and average number of claims by gender and race. African-Americans and females had the highest number of claims. Males appear to have a higher average cost but as noted an outlier affects this number.

Table 13. Medicaid Demographics

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Mean # of Claims</th>
<th>Mean Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female (n= 92)</td>
<td>40</td>
<td>$7,356</td>
</tr>
<tr>
<td>Male (n=66)</td>
<td>25</td>
<td>$24,881</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black (n=126)</td>
<td>33</td>
<td>$16,039</td>
</tr>
<tr>
<td>Other (n=32)</td>
<td>26</td>
<td>$9,315</td>
</tr>
</tbody>
</table>

BECOMING Interventions

Youths who were screened for and/or ultimately enrolled in BECOMING have received varying degrees of interventions and supports from BECOMING staff members, as well as private mental health providers. When the program was first implemented with only two private mental health providers, BECOMING funds were utilized to employ two peer-support specialists at each respective provider entity. These staff members provided outreach, support, and transportation, among other services, to many (but not all) of the BECOMING youths who engaged with one of the two mental health providers. These staff members entered their contacts in COACH in an effort to document and track their interactions with youths.

However, beginning in the third year of program implementation, these positions were no longer funded and BECOMING Youth Resource Specialist positions were created and housed at ABH to work in tandem with existing BECOMING Care Coordinators instead. Since BECOMING began implementation, BECOMING Care Coordinators have screened and enrolled youth and assisted in ensuring they attend an initial intake appointment with a mental health provider. However, during the first two years of
implementation, once these intake appointments had occurred, Care Coordinators rarely continued contact with BECOMING youths. When the BECOMING peer-support specialist positions were eliminated, the newly hired BECOMING Youth Resource Specialists and ABH-housed BECOMING staff members worked as teams to provide more in-depth support to youths while they received mental health services. This has included the creation of goal plans, and ongoing support to youths to help them achieve their goals related to education, employment, mental health, housing, etc. In order to track these activities, BECOMING Care Coordinators and Youth Resource Specialists enter these contacts and goals in COACH.

Other support that BECOMING youth have received are through the BECOMING Youth Coordinator. The coordinator is responsible for leading the Youth Leadership Council, support groups, trainings, and individual support and consultation. All of these contacts are also entered in COACH in an effort to document and track these types of interactions with youths.

In an effort to understand differences in the levels of BECOMING services youths received, evaluators grouped youths into one of three service categories:

1. **Intensive:** Youth who have at least one goal plan. All of these youths would also have varying levels of contacts with BECOMING staff. \( n=76 \) (18% of all youths screened for BECOMING\(^9\)).
   a. 4 of these youths did not ever engage with a mental health provider.

2. **Intermediate:** Youth who have at least one contact with BECOMING staff. \( n=155 \) (36% of all youths screened for BECOMING).
   a. 31 of these youths did not ever engage with a mental health provider.

3. **Low:** Youth who have no goal plans or contacts with BECOMING staff. \( n=204 \) (47% of all youths screened for BECOMING).
   a. 84 of these youths did not ever engage with a mental health provider.

\(^9\) 434 youths were screened for BECOMING.
Level of Service by Demographics

Figure 15 displays level of service by gender. Females were significantly more likely to receive intensive BECOMING interventions.

As shown in Figures 16 and 17 below, no significant associations based on race were found for level of BECOMING service. In large part, these findings reflect the fact that the overwhelming majority of BECOMING participants are African-American.
Level of Service and Medicaid Costs and Total Number of Claims

Figures 18 and 19 below display data for the 158 youths for whom Medicaid claims occurred while enrolled in BECOMING. Overall, youths who received the lowest level of BECOMING service (i.e., mental health services from a provider only) incurred the highest total Medicaid costs. However, statistically significant differences in Medicaid costs were not found among the three groups. Additionally, while not statistically significant, youth receiving an intermediate level of BECOMING service incurred the highest number of Medicaid claims, on average.\(^\text{10}\)

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\(^{10}\) Sample sizes for each group were as follows: intensive (n=43), intermediate (n=64), and low (n=51).
Figure 18. Level of Service by Medicaid Claim Costs Incurred While Enrolled in BECOMING

![Bar chart showing total cost of claims by level of service: Intensive (7848), Intermediate (16550), Low (19991).]

Figure 19. Level of Service by Average Number of Medicaid Claims Incurred While Enrolled in BECOMING

![Bar chart showing average number of claims by level of service: Intensive (32), Intermediate (36), Low (25).]
With respect to the types of mental health services these three groups of youth received (i.e., intensive outpatient services, other intensive services, or outpatient group/individual therapy), significant differences were not found (see Figure 20 below). A total of 53 youths for whom we received Medicaid claims for, across the three BECOMING level of service groups, received intensive outpatient services (e.g., MST, ACTT, IIHS, CST, etc.), and the average number of these claims did not differ by level of BECOMING service. Similarly, while 141 youths received non-intensive outpatient services, and 46 youths received other intensive services, significant differences in the average number of these claims did not differ by level of BECOMING service.

**Figure 20. Type of Mental Health Service Received by Level of BECOMING Service**

Differences in the number of contacts with BECOMING staff members was examined for youths who received either intensive or intermediate levels of BECOMING service. Those receiving intensive BECOMING services (e.g., had goal plans and contacts) had significantly more contacts with BECOMING staff members than did those youth with no goal plans (see Figure 21). In addition, youths with goal plans (i.e., intensive) were significantly more likely to have contacts with BECOMING staff over a longer period of time (see Figure 22).
Lastly, differences in the number of flex funds received by levels of BECOMING service were examined. Those receiving intensive BECOMING services (e.g., had goal plans and contacts), or intermediate BECOMING services (contacts only) had significantly more flex fund requests than did those youths with no goal plans or contacts (see Figure 23). Relatedly, youths in the intensive service level group received significantly more flex fund dollars than did those youths with no goal plans or contacts (see Figure 24).
Case Study Example

A brief phone interview was conducted with a 20 year-old Hispanic male who had been enrolled in BECOMING for approximately 8 months. The youth had an Axis 1a diagnosis of Post-Traumatic Stress Disorder and an Axis 1b diagnosis of Attention-Deficit/Hyperactivity Disorder. He had been served by BECOMING on Level 2, meaning that he received less intensive services and thus represents a typical youth served by the program. He was referred to BECOMING through his clinician at Carolina Outreach with whom he had been working with for some time.
He initially became involved in services with Carolina Outreach when he and his two siblings were placed in foster care after the death of their mother. At the time of the interview, he had been receiving outpatient services approximately 1 time per week. In speaking with this young man about his experiences with mental health services, he indicated a high level of satisfaction. He reported feeling that his therapist was effective and that “she helps me to talk through my feelings, plan for what I need to do in my life and maintain focus on those things.”

When asked why he chose to enroll in BECOMING, he indicated that he was having difficulty finding employment and was not performing well in school. His therapist referred him to the BECOMING program to help him address his challenges in those key areas.

Based on records in the COACH database system, the youth had roughly 15 contacts with the youth coordinator over a 5-month period. The youth indicated a high degree of satisfaction related to his interaction with the youth coordinator and the supports received. Specifically, he reported that “Garron is great, a great guy. He has given me really good advice, helped me to decide what to put on job applications and sent me information about job opportunities. He helped me find a job.”

When asked about other kinds of activities or services he received from BECOMING staff directly, he indicated that he had participated in BECOMING leadership/advisory meetings and retreats. He also received flex funds for tuition costs and bus passes.

When asked if there were things he needed that the program was not able to help him with, he said “none that I can think of.” Overall, this young man reported that the program had provided appropriate supports in the areas of need that he identified. He said that “BECOMING has helped me to advance my skills in leadership and in education.” This example shows how BECOMING supports in conjunction with mental health services can work together to truly improve the lives of these youth across multiple life domains.

**Locations and Types of Services Received**

When youth are interviewed for the Longitudinal Outcomes Study (LOS), they are asked about the kinds of mental health services they have received in the six months prior to the interview. Because the primary interest is in understanding the types of services these youth received, and their opinions about those services, the data presented are for all youth who responded that they had received services in the six months prior to the interview. The majority of youth engage in services within the first six months after enrollment, so data presented are for all individuals who responded that they received services during their six-month interview. The following section highlights information about the types of services the youth reported having received and their opinions about those services.
The vast majority of youth that had follow-up interviews reported that they had received some type of mental health services in the preceding six months (84%). Of those youth, 72% reported that they would probably, or absolutely, come back to the system of care for services if they needed them again. Figure 25 shows the percentage of youth who reported that they had received services in each location specified. Just over half (55%) of the youth reported receiving services in a mental health clinic, 24% reported receiving services in school, and 18% percent reported receiving services at home.

**Figure 25. Service Locations**

![Service Locations Graph](image)

Figures 26 and 27 show the types of therapeutic and support services these 49 youth reported receiving at the time of their six-month interview. Importantly, 69% of the youth reported receiving individual therapy, 24% reported receiving case management services, and 41% reported attending group therapy. Almost a quarter of the youth reported receiving services for independent living. The percentage of youth who reported receiving Flexible Funds is lower than the actual number of youth receiving Flex Funds. This is likely due to a confusion of terminology. Interviewers have found that youth do not always know the source of the funds or supplies they receive. Flex funds data described earlier in this report are based on funds actually distributed and are therefore more accurate.

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11 It should be noted that the percentage of youth receiving services might be higher than reported. Some youth may not remember or know the terms for all the services they received and therefore indicate that he or she is not receiving services. If a youth reports that he or she has not received services, the interviewer will provide more specific details and descriptions of different types of services in order to ensure that the individual understands the terms. However, it is still possible that services received are underreported by the youth.
Figure 26. Types of Therapeutic Services Received

- Assessment/Evaluation: 63% (n=49)
- Individual Therapy: 69%
- Group Therapy: 41%
- Family Therapy: 10%
- Crisis Stabilization: 6%

Figure 27. Types of Support Services Received

- Transportation: 20%
- Case Management: 24%
- Independent Living: 22%
- Flexible Funds: 10%
- Family Preservation: 4%
- Family Support: 4%
- Behavioral Aide: 2%
- School-based: 6%
Satisfaction with Services Received

At the six-month follow-up interview participants are given a questionnaire designed to assess their overall satisfaction with the services they have received. This survey measures satisfaction across seven domains, six of which are presented in this report.\(^\text{12}\)

- **Access to Services** measures how convenient the location and times of services were.
- **Participation in Treatment** reflects how involved the individual was in the development and planning of the treatment plan.
- **Cultural Sensitivity** measures whether the individual believed that the treatment staff interacted with him or her in a culturally sensitive manner.
- **Satisfaction with Services** is assessed by questions relating to the youth’s overall perception of services received (e.g., the extent to which they received the help they wanted, felt that the people helping them would stick by them no matter what happened, and that they had someone to talk to when needed).
- **The Outcomes domain** measures how well the individual is functioning at school and home.
- **Social Connectedness** refers to how well the youth seeks out and accepts support from people other than service providers.

The overall majority of individuals reported receiving some type of services in the six months since enrolling in BECOMING (87%). Figure 28 shows the percent of individuals who reported feeling satisfied or very satisfied in response to questions related to each of the above-mentioned domains. At the six-month follow-up interview, three-quarters or more of the youth reported feeling satisfied in all areas assessed. These percentages are slightly higher than last year and represent more youth who have received services. These are encouraging data and indicate that youth who engage are feeling positive about the services they have received.

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\(^{12}\) The seventh domain, Functioning, is identical to Outcomes with the exception of one question. Thus the scores are very similar for both domains. Given the similarity between the scores and the fact that reliability analyses have been conducted for all domains except Functioning, we decided not to present the Functioning domain.
Cultural and Linguistic Competence

Youth were also asked about the importance of cultural competence in the provision of services (i.e., the degree to which support providers respect and are sensitive to cultural traditions and beliefs and/or are of the same racial or ethnic group as the child). These questions are first asked at the six-month interview after the individuals have had time to establish relationships with a service provider and have a sense of what they feel is important in a provider. Table 14 shows the percent of youth who responded that specific culturally related items were extremely important or very important to them. The majority of youth reported that having a service provider who understands their customs, practices and cultural traditions was very important and about half reported that it was important to include their cultural beliefs, traditions and heritage in service planning and provision. However, only 28% of the youth surveyed felt it was important that the service provider they see most often share the same cultural heritage as the youth and 35% reported that the provider they see most often did in fact share the same cultural heritage as the individual.
Table 14. Cultural Competence

<table>
<thead>
<tr>
<th>Statement</th>
<th>Percent indicating extremely or very important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Provider who understand my customs, practices, and traditions</td>
<td>60%</td>
</tr>
<tr>
<td>Inclusion of beliefs, traditions, &amp; practices in service planning/provision</td>
<td>46%</td>
</tr>
<tr>
<td>Provider seen most often is of the same cultural heritage</td>
<td>28%</td>
</tr>
</tbody>
</table>

If youth have received services in the six months prior to the follow-up interview they are also asked questions about the understanding, knowledge and inclusion of their culture in the services they received from their primary provider. Table 15 highlights the percent of youth who responded positively to questions about the service provider they have seen most often. All of these percentages have improved over the past year, which is a positive sign that more youth feel comfortable with their provider’s cultural sensitivity. Approximately half of the youth reported that their providers asked about their traditions, beliefs and values when planning services; and two-thirds reported that their provider attends to their cultural needs. It is also worth noting that only 18% of the youth felt other people have access to better services than they do. Given that these youth come from low-income families where they may not have access to as many types of programs as they would like, it is encouraging that most of them do not feel that other people have access to better services than they do.

Table 15. Cultural Competence of Service Providers

<table>
<thead>
<tr>
<th>Statement</th>
<th>Percent indicating most or all the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>My provider understands my beliefs about mental health</td>
<td>82%</td>
</tr>
<tr>
<td>My provider speaks the same language as me</td>
<td>90%</td>
</tr>
<tr>
<td>I am comfortable discussing alternative therapies/strategies</td>
<td>67%</td>
</tr>
<tr>
<td>My provider asks about my traditions, beliefs &amp; values when planning/providing services</td>
<td>51%</td>
</tr>
<tr>
<td>Other people have access to better services than me</td>
<td>18%</td>
</tr>
<tr>
<td>Materials provided are easy to understand</td>
<td>77%</td>
</tr>
<tr>
<td>Provider attends to my cultural needs</td>
<td>67%</td>
</tr>
<tr>
<td>Provider is comfortable interacting with me</td>
<td>90%</td>
</tr>
</tbody>
</table>

Section 2: Summary of Findings

In total, 5,252 contacts were made for 231 unique individuals. This indicates that at least one contact was made with approximately 53% of all youth who had been screened for BECOMING
by December 2014 (N=434), and 74% of all youth who had officially enrolled in the program by that time (n=314). The majority of these contacts (60%) were made in person. While many youth had some contact with BECOMING staff, it appears that the elapsed time from the first contact to the last was relatively short, as about half of youth had an engagement window of 100 days or less. Roughly three months of interaction is likely not sufficient to impact the other intended goals of the program such as increased educational attainment, employment, housing stability, etc.

All youth receiving more intensive case management services on Level 1 are encouraged to work with staff to develop goals that guide service planning and supports. A total of 426 goals were developed for 76 youth. The most frequent types of goals were associated with educational pursuits (n=118) and employment (n=94). Of the 76 youth with established goals, 55% had not successfully met any of their goals, 26% had met between 1-3 goals, and 18% had met 4 or more. It may be helpful for staff to consider the scope of the goals being set with youth. Specifically, it may be prudent to set smaller, more attainable goals such as enrolling in a specific number of classes that could lead toward a longer-term goal such as completing a degree program.

Data collected on the services received by youth revealed that clinicians provided multiple interventions to youth in their care with Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT), and Seeking Safety (SS) reported most often. These three interventions in combination were provided for 28% of youth. Another 27% received a combination of CBT and MI only. In sum, youth received various clinical services from mental health clinicians including; screening (70%), assessment (73%), treatment planning (81%), medication management (39%), and mental health services (84%). Other core support services most frequently provided included: transportation (45%), employment (41%), education (40%) and social/recreational (40%). Data on the frequency of mental health services suggests that the majority (64%) of youth were receiving less intensive services characterized as sessions occurring 1 to 2 times per week. Nearly 75% of youth withdrew from services or had not had contact with their provider for 90 days or more.

Flex funds are an important aspect of the program because they provide financial support in areas of high need and where there are typically no other funding sources. Flex funds are used to support youth in reaching educational, employment and recreational goals. The data suggest that the number of flex funds requests have increased steadily since the beginning of the program, with 993 requests funded totaling $64,249. Just over 200 youth have received support through flex funds, with an average of five funded requests each. The category with the largest total expenditures was education ($17,940) followed by transportation ($13,137).

In an effort to more precisely quantify the mental services received, analyses of Medicaid data were conducted on a subset of BECOMING youth enrolled after mid-2012 but before January 2015. Nearly 5,000 claims were identified for 158 youth while they were enrolled in BECOMING. The mean number of claims per youth was 31 (range 1-606). The total cost of billed claims for this group was $2,319,047, with an average expenditure per youth of $14,677. It is important to note that the mean is somewhat skewed due to one youth who had claims
representing about 30% of the total Medicaid claims paid. The majority of youth had claims associated with non-intensive outpatient services.

In order to examine differences in the level of direct services received from BECOMING staff, youth were divided into groups; intensive, intermediate and low. Females were more likely to be in the intensive group than were their male counterparts. No significant differences were found for level of BECOMING service and race due to the fact that the majority of youth served are African-American. Overall, youth receiving the lowest level of BECOMING services had the highest total cost and youth in the intermediate group had the highest number of claims. These differences were not statistically significant. As would be expected, youth receiving more intensive services (goal plans and contacts) had significantly more contact with BECOMING staff than did those in the intermediate group. These youth were also significantly more likely to have contact with staff over a longer period of time. Lastly, those receiving intensive or intermediate services had significantly more flex fund requests awarded than youth within the low level of services category. These findings support the notion that when youth are offered higher intensity supports they may be more likely to engage with BECOMING staff over time and utilize other associated resources designed to help them progress across multiple life domains.

A brief phone interview was conducted with a typical BECOMING youth to provide additional perspective in understanding how youth may view the services received through the program. While the youth of focus had particularly difficult childhood circumstances and exposure to trauma, the 20-year old male was receiving outpatient therapy one time per week with Carolina Outreach. The youth indicated very high levels of satisfaction with the mental health services received through the provider, as well as those provided by the BECOMING Youth Coordinator. He offered that he had received flex funds to support school tuition and bus passes. He also participated in youth leadership activities and retreats.

As part of the Longitudinal Outcomes Study youth are asked questions about the kinds of mental health services they received and their level of satisfaction with those services. Eighty-four percent of youth with a follow-up interview reported that they had received some type of mental health services in the preceding six months; and of those, 72% indicated that they would return if they needed services again in the future. The majority (69%) reported receiving individual therapy, 24% reportedly received case management and 41% attended group therapy sessions. When asked about the level of satisfaction with services the majority (75% or more) reported being “satisfied” or “very satisfied” in response to questions covering six domains including: access to services, participation in treatment, cultural sensitivity, satisfaction with services, outcomes and social connectedness. Youth were also asked about the importance of cultural competence in the provision of services and the majority (60%) responded that it is extremely important or very important that the service provider understands their customs, practices and traditions. Additional questions were asked about the understanding, knowledge and inclusion of their culture in the services received from their mental health provider. The majority of youth reported that their provider understands their beliefs about mental health, speaks the same language, asks about traditions/beliefs/values, provides easy to understand materials, attends to cultural needs, and is comfortable interacting with the youth.
III. What Happened to Youth as a Result of Participating in BECOMING?

Longitudinal Outcomes Study (LOS)

It is important to consider the outcomes for youth highlighted in this section in the context of the BECOMING services they received apart from formal mental health treatment. The improvements in functioning highlighted below include many youth who had considerable interaction with BECOMING staff through contacts, goal planning and flexible funds support.

As of December 2014, 116 youth had participated in a baseline interview, 57 had also participated in a 6-month interview and 46 had participated in a 12-month interview. Of those with a 12-month interview:

- 49% had worked with either a BECOMING Care Coordinator or Youth Resource Specialist;
- 48% had at least one immediate or long-term goal plan developed with a BECOMING Care Coordinator or Youth Resource Specialist;
- 78% had at least one contact with a BECOMING staff member after their initial screening; and
- 69% had received at least one flex fund request.

Life Skills and Knowledge of Youth Enrolled in the LOS

As part of the longitudinal study, participants are asked specific questions about life experiences and living situations. These data provide background information and help paint a clearer picture of what life is like for these individuals. For instance, feeling safe in one’s environment is a basic need, yet almost 30% of the youth enrolled in the LOS report that they do not feel safe in their neighborhoods, 45% report having seen a violent crime in their neighborhood, and 12% report having been a victim of a violent crime their neighborhood in the six months prior to the first interview. These percentages do not change much during the 6- and 12-month interviews. Participating in BECOMING will not change the nature of the neighborhoods in which these youths reside, but it may provide them with tools to better cope with challenges in their lives and assist them in taking steps to improve the trajectories of their lives (e.g., increased employment opportunities, independent living skills, and increased participation in education). This section of the report highlights the living status, employment status, educational status and life skills of the youth enrolled in the LOS.

Living Situations of Youth Enrolled in the LOS

Youth are asked where they have lived and with whom in the six months prior to the interview. The majority of youth (between 88% and 93%) reported living in a home or apartment in the six months prior to all interviews. A small percentage (between 4% and 7%) of the youth interviewed reported being homeless or living in a shelter. However, given how hard it is to

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13 Baseline data for the entire group of youth were compared with baseline data for youth with two interviews and those with all three interviews; significant differences among the three groups at baseline on all LOS measures were not found.
locate youth who are homeless, the actual number of youth experiencing homelessness may be higher. Figure 29 highlights with whom the youth have reported living during the 6 months prior to the interview. As shown, the percentage of youth who reported living with friends increased, suggesting a slight increase in the percent of youth moving out of their caregiver’s homes.

**Figure 29. Living Situations of Youth in the LOS**

![Living Situations of Youth](chart)

*Employment and Volunteer Experiences*

Table 16 shows the percent of youth who reported having worked or done volunteer work in the six months prior to each interview. The percent of youth reporting having been employed in the past six months increased from 38% at baseline to 52% at the 12-month interview. The percent of youth who participated in volunteer work did not change. The primary reasons youth gave for not working were that they were trying, but had not yet found a job, or that they were in school.

**Table 16. Employment and Volunteer Work**

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>6-months</th>
<th>12-months</th>
</tr>
</thead>
<tbody>
<tr>
<td>% employed in the past 6 months</td>
<td>43%</td>
<td>40%</td>
<td>52%</td>
</tr>
<tr>
<td>% who participated in volunteer work in the past 6 months</td>
<td>30%</td>
<td>25%</td>
<td>30%</td>
</tr>
</tbody>
</table>
Table 17 shows the percentage of youth who responded affirmatively to questions about their competence with life skills. Almost all of the youth reported having basic knowledge of food preparation, pregnancy and STD prevention, and physical consequences of drug or alcohol use. At baseline, slightly more than half reported an understanding of how to set up new living arrangements, complete rental agreement or arrange for utilities. Importantly, the percentage of youth reporting an understanding of these independent living skills increased from the first interview through the 6- and 12-month interviews; by the 12-month interview, almost all youth endorsed being able to calculate start-up costs for a new living arrangement, arrange for utilities and services, and complete a rental agreement. Many youth attend an independent living skills support group and BECOMING resource groups, and thus it is possible that the skills they are learning in these groups translate into increased skills and confidence regarding their ability to care for themselves.
Table 17. Life Skills and Knowledge

<table>
<thead>
<tr>
<th>Skill or Knowledge</th>
<th>% “Very much or somewhat like me”</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline (n=117)</td>
</tr>
<tr>
<td>Arrange for new telephone service and utilities</td>
<td>61%</td>
</tr>
<tr>
<td>Complete a rental agreement or lease</td>
<td>62%</td>
</tr>
<tr>
<td>Calculate start-up costs for new living arrangement</td>
<td>69%</td>
</tr>
<tr>
<td>Use kitchen appliances</td>
<td>98%</td>
</tr>
<tr>
<td>Fix meals on my own</td>
<td>97%</td>
</tr>
<tr>
<td>Store food so it doesn’t spoil</td>
<td>96%</td>
</tr>
<tr>
<td>Explain how to prevent pregnancy</td>
<td>97%</td>
</tr>
<tr>
<td>Explain 2 ways to prevent STDs</td>
<td>97%</td>
</tr>
<tr>
<td>Explain what happens to your body if you smoke, drink alcohol or use illegal drugs</td>
<td>97%</td>
</tr>
</tbody>
</table>

Educational Information

When youth are interviewed they are asked whether or not they have attended school in the six months prior to the interview. During the baseline interview, 54% of the youth reported attending school. During the 6- and 12-month interviews, this percentage decreased to 47% and 33%, respectively. Figure 30 shows the types of school programs the youth reported attending at all time points. The percentages shown are taken out of the total number of youth who reported attending school. Not surprisingly with youth ages 16-21, the percentage of youth attending regular public school decreased over time and the percentage of youth attending alternative public school or postsecondary school increased.14

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14 Over the course of the three interviews, 14 youth reported attending more than one type of school over the preceding 6 months. Two youth also attended home-based school (e.g., online GED programs), 8 youth also attended an alternative public school and 3 attended other types of schools.
Youth are also asked about school attendance and disciplinary actions. Table 18 shows the attendance rates and disciplinary actions taken for youth who reported attending school. Attendance is reported out of the total number of youth who reported missing any school at all. Significant changes were not found for attendance rates or disciplinary actions, though it is worth noting that percentages of suspensions and expulsions decreased from the baseline interview to the 12-month interview.

Table 18. School Attendance and Disciplinary Actions

<table>
<thead>
<tr>
<th>Attendance Description</th>
<th>Baseline (n=54)</th>
<th>6-month (n=22)</th>
<th>12-month (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missed More than 1 Day per Month</td>
<td>48%</td>
<td>55%</td>
<td>46%</td>
</tr>
<tr>
<td>Missed ≤1 Day per Month</td>
<td>52%</td>
<td>45%</td>
<td>54%</td>
</tr>
<tr>
<td>Suspended</td>
<td>31%</td>
<td>22%</td>
<td>10%</td>
</tr>
<tr>
<td>Expelled</td>
<td>8%</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>Suspended and Expelled</td>
<td>4%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Delinquency Survey, Revised (DS-R)

The Delinquency Survey, Revised (DS-R) asks individuals about their involvement in various illegal or problem behaviors (e.g., stealing, fighting, carrying weapons) and details about any contact with law enforcement. Table 19 shows the percent of individuals who reported...
involvement in various criminal activities in the six months prior to the baseline, 6- and 12-month interviews. The percent of youth who reported being so out of control that their caregivers called the police, or selling, distributing or making illegal drugs, decreased from the first interview to the 12-month interview. This change was statistically significant. However, the increase in the percent of youth who reported buying, receiving or possessing stolen goods from the baseline to 12-month interview was also statistically significant. This is concerning and it is unclear what factors may have contributed to this increase. While the sample size is small, this is an area to continue to monitor and track in the event that this trend continues.

Table 19. Self-Reported Criminal Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percent who Participated in Past 6 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline Interview (n=116)</td>
</tr>
<tr>
<td>Physical Fight</td>
<td>38%</td>
</tr>
<tr>
<td>Out of Control and Caregiver Called Police</td>
<td>19%</td>
</tr>
<tr>
<td>Carried a Weapon</td>
<td>23%</td>
</tr>
<tr>
<td>Sold, Distributed or Made Illegal Drugs</td>
<td>14%</td>
</tr>
<tr>
<td>Illegal Gang Activities</td>
<td>12%</td>
</tr>
<tr>
<td>Broken Into House or Building</td>
<td>5%</td>
</tr>
<tr>
<td>Bought, Received or Possessed Stolen Goods</td>
<td>5%</td>
</tr>
</tbody>
</table>

Table 20. Self-Reported Criminal Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number of Youth who Participated in Past 6 Months*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline Interview</td>
</tr>
<tr>
<td>Been stopped or questioned by police</td>
<td>13 (n=26)</td>
</tr>
<tr>
<td>Been arrested</td>
<td>9 (n=21)</td>
</tr>
</tbody>
</table>

*Not all youth have ever been stopped by the police or arrested so the number of youth responding to these questions is much lower than the others. Thus, actual numbers are presented instead of percentages. The n’s represent the number of youth who reported having *ever* been stopped by the police or arrested.
**GAIN Quick-R**

The GAIN Quick-R is used to identify whether an individual has a problem with drugs or alcohol.

- Individuals are asked whether they have ever used a particular substance and if so, they are asked follow-up questions about the frequency and amount of use.
- Results are grouped into a Substance Use and Abuse scale and a Substance Dependence scale and the severity or urgency of the score is rated according to risk level (i.e., low urgency, moderate urgency or high urgency).

According to the results of the GAIN Quick-R:

- At baseline 56% of youth indicated that they had used alcohol or drugs (excluding nicotine) in the six months prior to the interview;
- At six months that percentage decreased to 39%; and
- At 12 months that percentage increased back to the baseline rate of 58%.

For youth who indicated they had used substances in the past six months prior to their interviews, GAIN scores fall into one of the three risk categories on the Substance Use and Abuse, Substance Dependence, and Substance Problem Scales (see Figures 31, 32, and 33). The percent of youth whose scores were in the No/Low Urgency range increased from the baseline to 12-month interview for all scales. In fact, by the 12-month interview, none of the youth interviewed scored in the High Urgency range at all. Though this finding is encouraging, due to the small sample size, these changes were not statistically significant.

**Figure 31. GAIN Quick-R: Substance Use and Abuse Scale**

![Figure 31: GAIN Quick-R: Substance Use and Abuse Scale](image)
Clinical Data for Youth Enrolled in the LOS

Many of the longitudinal study instruments assess how the youth perceive themselves and the degree to which they exhibit any behavior challenges, depression, or anxiety. Youth who struggle with low self-esteem, depression or anxiety are at-risk for substance use, criminal behavior and educational challenges. The following section describes the clinical instruments used in the longitudinal study and highlights the baseline and follow-up clinical data for youth involved in the LOS. As mentioned earlier, this year’s report will focus on outcome data for the youth for whom we have up to a year’s worth of data. Data for the larger group of youth for
whom we only have baseline and 6-month interviews are very similar to the group for whom we have more data and are presented in Appendix C for reference.

**Child Behavior Checklist (CBCL)**

The CBCL is a 117-question interview administered to the caregiver that measures social competence and behavioral and emotional difficulties in children and adolescents. The CBCL is normed and validated for youth 6-18 years old. However some of the youth in the LOS are over 18 years old and living with a caregiver. In these cases, if the caregiver participates in an interview then the caregiver also completes the CBCL, regardless of the age of the youth. Caregivers rate statements on a 3-point scale indicating the extent to which a statement is very true, somewhat true, or not true. The results can be grouped into two broad categories, Internalizing and Externalizing Behaviors, a Total Problem scale and eight subscales.

The **Internalizing Behavior** scale is comprised of the Anxious/Depressed subscale, the Withdrawn/Depressed subscale and the Somatic Complaints subscale. The **Externalizing Behavior** scale is comprised of the Rule-Breaking Behavior subscale and the Aggressive Behavior subscale. The remaining 3 subscales are Social Problems, Thought Problems, and Attention Problems.

The Anxious/Depressed subscale measures anxiety and depression and includes items such as “worries,” “self-conscious or easily embarrassed,” and “feels worthless or inferior.” The Withdrawn/Depressed subscale measures social isolation and depression. It includes items such as “there is very little he/she enjoys,” “would rather be alone than with others,” and “unhappy, sad, or depressed.” The Somatic Complaints subscale measures physical symptoms that may reflect underlying emotional problems or challenges. Items include “feels dizzy or lightheaded,” “overtired without a good reason,” and “physical problems without known medical cause.”

The Rule Breaking subscale measures the extent to which the individual engages in rule-breaking or rebellious behavior. Items in this scale include “doesn’t seem to feel guilty after misbehaving,” “lying or cheating,” and “steals outside of the home.” The Aggressive behavior subscale measures the extent to which the individual displays physically or emotionally aggressive behavior. Items in this scale include “argues a lot,” “destroys his or her own things,” and “gets in many fights.”

The Social Problem subscale measures social interaction challenges the individual has with peers. Items include “complains of loneliness,” doesn’t get along with other kids,” and “easily jealous.” The Thought Problem subscale measures challenges the individual has with intrusive or obsessive thought patterns or behaviors. This scale includes items such as “can’t get his/her mind off certain thoughts; obsessions,” “deliberately harms self or attempts suicide,” and “repeats certain acts over and over; compulsions.” The Attention Problem subscale measures whether the individual has challenges with distractibility or impulsivity. Items in this scale include “can’t concentrate, can’t pay attention for long,” “daydreams or gets lost in his/her thoughts,” and “impulsive or acts without thinking.”
The CBCL is given to caregivers and typically caregivers are only interviewed at baseline. Thus we do not have enough follow-up data to show changes over time for the CBCL. Nevertheless, the CBCL provides information describing these youth from the caregiver’s perspective and is worth reviewing. Caregivers for 24 individuals completed the CBCL during the baseline interview. Figures 34 and 35 illustrate the percent of youth scoring in the clinical range across categories and indicating a need for intervention. Almost half of all youth scored in the clinical range on the Externalizing Behavior scale and just over a third scored in the clinical range on the Internalizing Behavior scale. On the subscales, the highest percentages of youth scored in the clinical ranges on the Aggressive Behavior, Rule-Breaking Behavior and Thought Problems subscales.15

Figure 34. CBCL Broad Scales at Baseline (n=24)

A higher percentage of youth can score in the clinical range on the broad scales than on the individual subscales because clinical ranges for the Internalizing and Externalizing scales start lower levels than the clinical ranges for the subscales.

15 A higher percentage of youth can score in the clinical range on the broad scales than on the individual subscales because clinical ranges for the Internalizing and Externalizing scales start lower levels than the clinical ranges for the subscales.
The BERS-2Y is a 57 item assessments completed by the youth. The BERS measures an individual’s strengths in six areas. Higher scores indicate greater strengths in each area assessed:

- **Interpersonal Strength**: focuses on an individual’s ability to control his or her behavior and emotions in social situations (e.g., loses a game gracefully, reacts to disappointment in a calm manner).
- **Family Involvement**: assesses the individual’s relationship and involvement with his or her family (e.g., demonstrates a sense of belonging to family, maintains positive family relationships).
- **Intrapersonal Strength**: measures the youth’s view of his or her competence and accomplishments (e.g., is enthusiastic about life, talks about positive aspects of life).
- **School Functioning**: focuses on competence at school (e.g., pays attention in class, attends school regularly). Affective Strength
- **Affective Strength**: evaluates an individual’s ability to express feelings and accept affection from others (e.g., expresses affection for others, shows concern for the feelings of others).
- **Career Strength**: measures a youth’s interest in and aptitude for career development.
Figure 36 shows the average standard scores for youth interviewed at baseline, 6 and 12-months. Standard scores on the BERS range from 1-20 with a mean of 10 and standard deviation of 3. Average scores increased on all scales except Family Involvement. Statistically significant changes were found from baseline to 12-month on the Interpersonal Strength scale, the Intrapersonal Strength scale and the Affective Strength scale. These increases indicate that youth are feeling more positive about themselves and their strengths. The BERS is designed for youth up to age 18, so decreases in Family Involvement scale are not surprising. The questions asked pertain more to younger youth living at home, so a decrease as the youth get older is not unexpected.

Figure 36. BERS Scores

Reynolds Adolescent Depression Scale, Second Edition (RADS-2)

The RADS-2 is a 30-item self-report measure that assesses adolescent depression. Each item describes a feeling, and youth use a 4-point scale to rate how often each statement describes how they feel (e.g., “hardly ever,” “sometimes,” “most of the time” and “almost never”). The RADS-2 measures depression across 4 domains or subscales:

- **Dysphoric mood**: measures symptoms of depression such as sadness, loneliness, worrying, self-pity and crying behavior.
- **Anhedonia/Negative Affect**: measures symptoms that indicate a lack of engagement in pleasant activities such as disinterest in having fun, disinterest in engaging in activities with other people, or disinterest in eating meals.
- **Negative Self-Evaluation**: measures negative feelings about oneself such as low self-esteem, feeling that one’s parents or other people do not care about you, and thoughts about harming oneself.
• **Somatic Complaints:** measures physical manifestations of depressions such as stomachaches, sleep difficulties and feeling tired.

All scales are combined to yield a Total Depression score. Items in each subscale are summed and converted to standard score for each scale. A standard score about 65 is considered elevated.

Figure 37 shows the average standard scores for each time frame youth were interviewed. Statistically significant decreases from the baseline to 12-month interview were found for the Dysmorphic Mood, Negative Self-Evaluation, and Total Depression scales. These are positive changes indicating that youth are reporting fewer symptoms of depression than they were when they first enrolled in BECOMING.

**Figure 37. RADS-2 Scores**

![Figure 37. RADS-2 Scores](image)

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**Revised Children’s Manifest Anxiety Scale, Second Edition (RCMAS-2)**

The RADS-2 is a 30-item self-report measure that assesses adolescent depression. Each item describes a feeling, and youth use a 4-point scale to rate how often each statement describes how they feel (e.g., “hardly ever,” “sometimes,” “most of the time” and “almost never”). The RADS-2 measures depression across 4 domains or subscales:

- **Dysphoric mood:** measures symptoms of depression such as sadness, loneliness, worrying, self-pity and crying behavior.
- **Anhedonia/Negative Affect:** measures symptoms that indicate a lack of engagement in pleasant activities such as disinterest in having fun, disinterest in engaging in activities with other people, or disinterest in eating meals.
• **Negative Self-Evaluation**: measures negative feelings about oneself such as low self-esteem, feeling that one’s parents or other people do not care about you, and thoughts about harming oneself.

• **Somatic Complaints**: measures physical manifestations of depressions such as stomachaches, sleep difficulties and feeling tired.

All scales are combined to yield a Total Depression score. Items in each subscale are summed and converted to standard score for each scale. A standard score about 65 is considered elevated.

Figure 38 shows the average standard scores for each time frame youth were interviewed. Statistically significant decreases from the baseline to 12-month interview were found for the physiological, worry, social and total anxiety scales. These are positive changes indicating that youth are reporting fewer symptoms of anxiety than they were when they first enrolled in BECOMING.

**Figure 38. RCMAS-2 Scores**

![Average Standard Scores on the RCMAS-2](image)

**LOS Participants and Administrative Data**

Administrative data from various sources (e.g., Medicaid, Durham Police Department, Durham Sherriff’s Office, Durham Technical Community College) were examined for a subset of 69 youth who participated in the LOS study and for whom data from at least two time periods (baseline plus 6- months or 12- months) was available. Pearson chi- square tests of association were conducted to explore a possible relationship between contact with law enforcement or enrollment at Durham Technical Community College and level of BECOMING services, gender, race/ethnicity, and age. No associations were found based on the presence/absence of incidents with Durham Police Department/Durham Sheriff’s Department or enrollment at Durham Technical Community College and these factors. Likewise, two-sample t-test revealed no significant differences in means for Medicaid claims/costs, goal plans, contacts or flexible funds.
and involvement with any of these agencies. As data collection is ongoing, a larger sample size may allow evaluators to detect relationships among these variables in future reports.
Section 3: Summary of Findings

The LOS collects data using multiple measures allowing evaluators to examine changes across a number of life domains. However these data are collected on a smaller number of youth enrolled in BECOMING. At 6-month follow-up, the percentage of youth reporting competencies related to key independent living skills such as arranging for home services/utilities, entering a rental or lease agreement, and calculating the costs associated with new living arrangements had increased from baseline; at 12-months nearly all youth endorsed their abilities in these key areas. With regard to educational placements, fewer youth reported attending a school at the 6- and 12-month interviews (47% and 33% respectively) as compared to baseline (54%). Youth reported significant positive directional changes specific to criminal activities including being so out of control that a caregiver had to call the police and selling or distributing illegal drugs from baseline to 12-months. Conversely, youth also reported increased activity related to buying receiving or possessing stolen goods.

Improvements in risk level for substance use, dependence, or problems improved as the percent of youth whose scores on the GAIN Quick-R were in the No/Low Urgency range increased from baseline to 12-months for all scales. Due to a small sample size this finding was not statistically significant. Findings from the BERS showed that average scores increased on all scales except family involvement. Statistically significant improvements from baseline to 12-months were found on interpersonal strength, intrapersonal strength, and affective strength scales.

Analyses of the RADS data showed statistically significant improvements from baseline to 12-months for items related to dysphoric mood, negative self-evaluation and total depression scales. Collectively, these findings suggest decreased physical manifestations of depression and positive changes in overall mood for this group of youth. Lastly, data from the RCMAS measuring levels of anxiety showed that youth made statistically significant improvements from baseline to 12-months on all four scales including physiological anxiety, worry, social anxiety, and total anxiety indicating that youth reported lower levels of anxiety after enrolling in BECOMING.

Analyses conducted to examine possible relationships between administrative data (e.g. Durham Police Department/Durham Sheriff’s Office and Durham Technical Community College) and level of BECOMING service, gender, race/ethnicity, and age revealed no association for a subset of 69 BECOMING youth. Similarly, no significant differences were found for those with records (verses those without) within the administrative data and Medicaid claims/cost, goal plans, contacts or flexible funds.

Conclusions and Recommendations

Overall, more than 434 youth were screened, in-person by BECOMING staff from October 2011 through December 2014. The majority (72%) ultimately enrolled in the program, which for most also included participating in mental health treatment services. BECOMING staff members made at least one contact (after initial screening) with 53% of all youth screened and 74% of those youth who enrolled. Of the 314 who enrolled, 76 worked with a Care Coordinator or Youth Resource Specialist to develop over 400 immediate and long-term goals primarily related to
education and employment aspirations. Youth received multiple interventions from community-based providers with a combination of Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT) and Seeking Safety (SS) most often reported by clinicians. Two-hundred youth received flexible funds totaling $64,249 to support educational pursuits, transportation, employment and social/recreational activities.

In examining the differences in the level of direct services received from BECOMING staff, findings suggest that while relatively few youth (18%) received intensive supports, those that did, engaged with staff over a longer period of time and utilized flexible funds and/or other program resources designed to help them progress across multiple life domains.

The majority (75% or more) of youth participating in the LOS reported being “satisfied” or “very satisfied” in response to questions covering satisfaction with services across six domains; access to services, participation in treatment, cultural sensitivity, satisfaction with services, outcomes and social connectedness. A youth selected as a sample case study provided similar feedback on both mental health services received as well as support services provided directly by BECOMING staff. This typical BECOMING youth indicated very high levels of satisfaction with the services provided by the youth coordinator offering that he had participated in numerous activities/events as well as been the recipient of flexible funds.

Findings from the LOS showed that youth reported increased competencies related to independent living skills and improvement in risk levels for substance abuse, dependence and problems. Clinical measures indicated improvements over time in individual strengths, decreased physical manifestations of depression, positive changes in overall mood, and reduced anxiety after enrolling in the program. Importantly, while the sample size of youth interviewed at 12-month follow-up was relatively small, many of these youth with improved outcomes had considerable interaction with BECOMING staff through contacts, goal planning and flexible funds support. Of the 46 youth with a 12-month interview 49% had worked with either a BECOMING Care Coordinator or Youth Resource Specialist, 48% had at least one immediate or long-term goal plan developed with a BECOMING Care Coordinator or Youth Resource Specialist, 78% had at least one contact with a BECOMING staff member after their initial screening and 69% had received at least one flex fund request.

While these findings are encouraging, data presented within this report also suggests that ongoing engagement of this population continues to be a challenge for the program. For example, while many youth had some contacts with BECOMING staff, the elapsed time from the first contact to the last was relatively short for half of all those with contacts. Ideally, youth would have a greater number of contacts over a longer time period given that the program aims to assist youth in working toward longer-term life goals (e.g. increased educational attainment, employment, housing stability, etc.). This is further highlighted by the NOMs clinical discharge data which indicated that nearly 75% of youth withdrew from services or had no contact with their provider for 90 days or more. Analyses of Medicaid data also suggests that most youth are not engaging in mental health services at intensive levels and/or for long periods as 66% of youth had 20 claims or less.
It is important to note that transition age youth are a notoriously difficult population to engage and grant funding from SAMHSA continues to provide the opportunity to refine strategies aimed at informing and improving practices overall. With this in mind the following recommendations have emerged both through the analyses of the data collected and from internal conversations with BECOMING staff and leadership.

- Continue to enhance and refine screening and enrollment processes to ensure that only youth with significant mental health needs (with an expected duration of treatment to meet or exceed 6 months) and appropriate levels of motivation for engagement in the entire BECOMING initiative are enrolled regardless of whether they are assigned to Level 1 or 2.
- Program level incentives that encourage ongoing participation in activities/events and regular contact with staff. Other programs have effectively utilized disposable cell phones and/or monthly minutes/data allotments as incentives for this population.
- Stronger collaboration with mental health providers so that BECOMING staff are aware when a youth has disengaged from mental health services. This would provide an opportunity for staff to assist providers in reaching out to youth and encouraging them to remain in treatment or identifying other options for ongoing treatment.
- Development of goals for level 1 youth that are more readily attainable providing an opportunity to build upon small successes and achieve more of the goals set. For example, for a youth who dropped out of high school but wants to complete his/her education, creating a goal of exploring programs available to complete a GED followed by the goal of enrolling in a GED program, etc.

Through the implementation of these recommendations, there is a stronger likelihood that youth will remain engaged in services for a longer duration, which would allow evaluators to measure impacts and assess whether the program is moving toward its intended goals. While no relationships between administrative data and the other variables explored were identified for a subset of BECOMING youth, data collection efforts are ongoing and larger sample sizes may allow evaluators to detect relationships among these variables in future reports.
Appendix A: Data Sources

Description of Data Sources

1. The National Outcomes Measure Survey (NOMS) collects data related to participant demographics, functioning, housing stability, education, crime and criminal justice involvement, social connectedness, services received, and satisfaction with those services. Data are collected at baseline and every six months thereafter until the youth is discharged from services.

2. The Enrollment and Demographics Information Form (EDIF) is administered at enrollment and collects data regarding involvement with various agencies, referral source, demographics, diagnostic assessment, and service plan development.

3. The Traumatic Events Screening Inventory (TESI) is a 15-item clinician-administered interview that assesses a youth’s experience related to a variety of potentially traumatic events including: 1) current and previous injuries, 2) hospitalizations, 3) domestic violence, 4) community violence, 5) disasters, 6) accidents, 7) physical abuse, and 8) sexual abuse. Follow-up questions assess Post-traumatic Stress Disorder criterion A and other additional information about the specifics of the event(s).

4. Contact forms and goal plan forms stored in COACH for purposes of tracking direct services provided to youth by key BECOMING staff such as Care Coordinators/Youth Resource Specialist and the Youth Coordinator.

5. The Longitudinal Outcomes Study (LOS) tracks youth for 24 months by collecting data via personal interviews at baseline and every 6-months thereafter for a total of 5 interviews. There are 17 instruments associated with the LOS interview: 1) Child Information Update Form (the follow-up form of the EDIF), 2) Caregiver Information Questionnaire, 3) Caregiver Strain Questionnaire, 4) Living Situations Questionnaire, 5) Education Questionnaire, Revision 2, 6) Child Behavior Checklist, 7) Columbia Impairment Scale, 8) Behavioral and Emotional Rating Scale- 2nd Edition, 9) Multi-Sector Services Contacts Questionnaire, 10) Youth Services Survey, 11) Cultural Competence and Services Provision Questionnaire, 12) Youth Information Questionnaire, 13) Delinquency Survey- Revised, 14) GAIN Substance Problem Scale, 15) Reynold’s Adolescent Depression Scale, 16) Revised Children’s Manifest Anxiety Scale- 2nd Edition, and 17) Substance Use Survey.

6. Administrative data collected as part of the Costs and Services Study for the purposes of assessing the types of services used by youth enrolled in BECOMING, the patterns of service use, and the associated costs. These data are collected directly from agencies and/or service providers including mental health, child welfare, and corrections/law enforcement for youth/caregivers who have consented to share this information.
Appendix B: Data Processing & Statistical Analyses

**Child protective services (CPS) assessments**

**Source**
Data provided in the Central Registry records of the Client Services Data Warehouse are from the DSS-5104 form. These data include records for all CPS assessments. For this evaluation, data were extracted with the following parameters:

- **Date of Download** – 8/6/2013
- **Time Period** – Records from 1/1/1990 to 12/31/2012 (inclusive) were selected based on the Assessment End Date.
- **County** – County Name was used to select data for Durham County.
- **View** – All fields were selected from the Central Registry with an Individual Type of “Victim.”
- **Fields** – The following fields were included:

  - Initial Report Date
  - Investigation Initiated Date
  - Investigation Completed Date
  - County Case Number
  - Form Number
  - County Name
  - First Name
  - Middle Initial
  - Last Name
  - Race
  - Race Code
  - Sex
  - SIS Client ID
  - Social Security Number
  - Type Reported
  - Type Reported Code
  - Type Found
  - Type Found Code
  - Primary Maltreatment Type Found
  - Perpetrator Relationship
  - Caretaker Contributory Factor
  - Child Contributory Factor
  - Household Contributory Factor
  - Social Worker First Initial
  - Social Worker Middle Initial
  - Social Worker Last Name

**Initial Processing**
The data file was downloaded from the Data Warehouse, and converted into a SAS® dataset16. This process included re-naming variables, converting dates, converting “#EMPTY” values to blanks, and other non-substantive changes. Records with a Perpetrator Relation of “Female Employee of Institution/Group Home,” “Female Employee of a Day Care Facility/Plan,” “Male Employee of Institution/Group Home,” or “Male Employee of a Day Care Facility/Plan” were deleted, as were records with any variation of “Delete,” “Do Not Use,” “Invalid,” or “Duplicate” for the First Name or Last Name. Following this, a unique ID was assigned to all records for each child according to the following rules:

1. Records with the same SIS # were assigned the same ID, AND

---

16 All data processing was done with the SAS® statistical package, version 9.2.
2. Records with the same Last Name, First Name, Birth Date, and Sex (where all values for these fields are non-missing) were assigned the same ID.

There were a total of 71,321 records for Durham County.

“Fuzzy” Matching
The data were further processed to assign the same unique ID to records with slight variations in the First Name, Last Name, Birth Date, or Sex fields. In all cases, the identifying fields were required to be non-missing. In some cases, SSN, SIS Number, Case Number, or Form Number were used to verify whether variations in the identifying variables indicated the records were for different children.

Children with Duplicate Records Except Form Number
For these, only one record was kept since all other information is the same, and the Form Number was not used in analyses.

Records with Missing Finding
These records were deleted.

Multiple Overlapping Assessments
Records showing multiple overlapping assessments for the same child exist in the CPS data. These records were combined if they had the same Investigation Completed Date. When combining, each field was looked at separately and the worst case for the field was kept in the combined record.

Becoming Specific Processing
After processing all records for Durham County, these data were “fuzzy” matched to data for Becoming children using First Name, Last Name, Birth Date, and Sex. These data, including records for the Becoming children only, were transposed to one record per child.

Final Data Files
The final data file for all of Durham County contains 68,867 records. The final data file for Becoming children only contains 235 records after being transposed to one record per child. The final SAS® programs to process these data are as follows:

```
ReadCPS_S12  08/09/2013 at 11:09:07 AM
ID1_Init_S12  08/09/2013 at 11:22:07 AM
ID2_FName_S12  08/09/2013 at 3:26:10 PM
ID3_LName_S12  08/09/2013 at 5:14:40 PM
ID4_BDate_S12  08/12/2013 at 1:12:09 PM
ID5_Sex_S12  08/12/2013 at 1:49:19 PM
CrMastCPS_S_9012  08/12/2013 at 4:18:10 PM
CleanCPS_S_9012  09/03/2013 at 4:21:06 PM
ReadNames_Becoming12  12/10/2013 at 2:31:52 PM
CrMastCPS_Becoming12  12/10/2013 at 2:32:34 PM
CrMastCPSSIS_Becoming12  12/24/2013 at 2:44:50 PM
```
**Services information system (SIS) data**

**Source**
Data provided in the SIS Daily records of the Client Services Data Warehouse are from the DSS-5027 form. For this evaluation, data were extracted with the following parameters:

- **Date of Download** – 11/11/2013
- **Time Period** – Records from 1/1/1990 to 12/31/2012 (inclusive) were selected based on the Service Begin Date.
- **County** – County Name was used to select data for Durham County.
- **Service Code** – Records with Service Codes of 109 were selected.
- **Fields** – The following fields were included:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIS Client ID</td>
<td>Service Begin Date</td>
</tr>
<tr>
<td>Client First Name</td>
<td>Service Terminated Date</td>
</tr>
<tr>
<td>Birth Date</td>
<td>Client Middle Initial</td>
</tr>
<tr>
<td>Race</td>
<td>Client Last Name</td>
</tr>
<tr>
<td>Client Social Security Number</td>
<td>County Case Number</td>
</tr>
<tr>
<td>Service Name</td>
<td>Service Code</td>
</tr>
<tr>
<td>Social Worker First Initial</td>
<td>Service Reason Code</td>
</tr>
<tr>
<td>Social Worker Middle Initial</td>
<td>Service Reason Description</td>
</tr>
<tr>
<td>Social Worker Last Name</td>
<td></td>
</tr>
</tbody>
</table>

**Initial Processing**
The data file was downloaded from the Data Warehouse, and converted into a SAS® dataset. This process included re-naming variables, converting dates, converting “#EMPTY” values to blanks, and other non-substantive changes. Records with any variation of “Delete,” “Do Not Use,” “Invalid,” or “Duplicate” for the First Name or Last Name were deleted. Following this, a unique ID was assigned to all records for a child after matching to the CPS records according to the following rules:

**Becoming Specific Processing**
After processing all records for Durham County, these data were “fuzzy” matched to data for Becoming children using First Name, Last Name, Birth Date, and Sex. These data, including records for the Becoming children only, were then transposed to one record per child.

**Final Data Files**
The final data file for all of Durham County contains 1,555 records. The final data file for Becoming children only contains 235 records after being transposed to one record per child. The final SAS® programs to process these data are as follows:

<table>
<thead>
<tr>
<th>Program</th>
<th>Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>ReadSIS_Becoming12</td>
<td>12/10/2013 at 2:39:02 PM</td>
</tr>
<tr>
<td>CrMastSIS_Becoming12</td>
<td>12/24/2013 at 2:23:03 PM</td>
</tr>
<tr>
<td>CrMastCPSSIS_Becoming12</td>
<td>12/24/2013 at 2:44:50 PM</td>
</tr>
</tbody>
</table>
**Statistical Analyses: Medicaid Data**
Two-sample t-tests were conducted to examine the difference in means for total Medicaid claims, type of service claim, gender and race. Results showed that males (M= $24,881, SD=$11,675) had significantly higher total cost of claims than did females (M=$7,356, SD=$1,664); t(156)= 1.74, p=.04. No significant differences were found for race and total claims, total cost or type of service.

**Statistical Analyses: Youth Grouped by Service Level**

**Statistical Analyses: DSR LOS 6-Month Follow-Up**
Wilcoxon signed-ranks tests were conducted to examine possible changes in youths’ self-reported criminal activities as a result of participating in BECOMING. Significant differences were not found.

**Statistical Analyses: GAIN, BERS, RADS-2, AND RCMAS-2 LOS 6 Month Follow-Up**
Wilcoxon signed-ranks tests were conducted to examine possible changes in youths’ substance use as a result of participating in BECOMING. Significant differences were not found. To examine whether there were statistically significant changes for behaviors and emotion ratings, and depression and anxiety from baseline to six month follow-up, paired sample t-tests were performed. Significant increases were found for three BERS domains: interpersonal strength, t (39) = -3.31, p = .002, family involvement, t (39) = -2.80, p = .008, intrapersonal strength, t (39) = -2.77, p = .008, school functioning, t (39) = -2.80, p = .008, affective strength, t (39) = -1.88, p = .067, and career strength, t (39) = -3.65, p = .001. A significant decrease was found for the RADS domains of negative items, t (40) = 2.28, p = .028, and somatic items, t (40) = 2.60, p = .013. A moderately significant decrease was found for the dysphoric mood domain, t (40) = 1.78, p = .082. Lastly, significant decreases were found for three RCMAS anxiety domains, and total anxiety: psychological anxiety, t (24) = 2.46, p = .021, worry, t (25) = 2.95, p = .007, social anxiety, t (24) = 3.08, p = .005, and total anxiety, t (24) = 3.14, p = .004.
Appendix C: Additional Tables and Figures for Youth Involved in the LOS

This appendix contains tables and graphs comparing results from LOS assessments over time. Results presented in the body of the report compared all youth who had participated in the LOS interviews (i.e., results for the 116 youth who had baseline interviews, the 57 who had 6-month interviews and the 46 who had 12-month interviews). Another way to view the data would be to compare only the kids who were interviewed at Baseline and 6-months or only the youth who were interviewed at Baseline, 6- and 12-months. There were 55 youth who had Baseline and 6-month interviews and 33 who had Baseline, 6- and 12-month interviews. The outcomes for those groups look similar to the outcomes for the larger groups that were reported in the body of the report. We are presenting these outcome data for these smaller groups for reference. The tables and graphs are presented in the order in which they appear in the report and are numbered according to the corresponding table or graph in the report. For example, Figure 29 in this appendix corresponds to Figure 29 in the report.

Figure 29. Living Situations of Youth in the LOS (n=55)

![Living Situations of Youth in the LOS](image)
Figure 29. Living Situations of Youth in the LOS (n=33)

Table 16. Employment and Volunteer Work

<table>
<thead>
<tr>
<th>Employment and Volunteer Work (n=55)</th>
<th>Baseline</th>
<th>6-months</th>
</tr>
</thead>
<tbody>
<tr>
<td>% employed in the past 6 months</td>
<td>36%</td>
<td>42%</td>
</tr>
<tr>
<td>% who participated in volunteer work in the past 6 months</td>
<td>24%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Table 16. Employment and Volunteer Work

<table>
<thead>
<tr>
<th>Employment and Volunteer Work (n=33)</th>
<th>Baseline</th>
<th>6-months</th>
<th>12-months</th>
</tr>
</thead>
<tbody>
<tr>
<td>% employed in the past 6 months</td>
<td>38%</td>
<td>41%</td>
<td>53%</td>
</tr>
<tr>
<td>% who participated in volunteer work in the past 6 months</td>
<td>16%</td>
<td>22%</td>
<td>25%</td>
</tr>
<tr>
<td>Skill or Knowledge</td>
<td>% “Very much or somewhat like me” (n=55)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Baseline</td>
<td>6-month</td>
<td></td>
</tr>
<tr>
<td>Arrange for new telephone service and utilities</td>
<td>58%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Complete a rental agreement or lease</td>
<td>64%</td>
<td>66%</td>
<td></td>
</tr>
<tr>
<td>Calculate start-up costs for new living arrangement</td>
<td>69%</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td>Use kitchen appliances</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Fix meals on my own</td>
<td>98%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Store food so it doesn’t spoil</td>
<td>98%</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td>Explain how to prevent pregnancy</td>
<td>95%</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td>Explain 2 ways to prevent STDs</td>
<td>98%</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td>Explain what happens to your body if you smoke, drink alcohol or use illegal drugs</td>
<td>98%</td>
<td>98%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skill or Knowledge</th>
<th>% “Very much or somewhat like me” (n=33)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
</tr>
<tr>
<td>Arrange for new telephone service and utilities</td>
<td>59%</td>
</tr>
<tr>
<td>Complete a rental agreement or lease</td>
<td>59%</td>
</tr>
<tr>
<td>Calculate start-up costs for new living arrangement</td>
<td>62%</td>
</tr>
<tr>
<td>Use kitchen appliances</td>
<td>100%</td>
</tr>
<tr>
<td>Fix meals on my own</td>
<td>97%</td>
</tr>
<tr>
<td>Store food so it doesn’t spoil</td>
<td>100%</td>
</tr>
<tr>
<td>Explain how to prevent pregnancy</td>
<td>94%</td>
</tr>
<tr>
<td>Explain 2 ways to prevent STDs</td>
<td>97%</td>
</tr>
<tr>
<td>Explain what happens to your body if you smoke, drink alcohol or use illegal drugs</td>
<td>100%</td>
</tr>
</tbody>
</table>
### Table 19. Self-Reported Criminal Activities (n=55)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percent who Participated in Past 6 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline Interview</td>
</tr>
<tr>
<td>Physical Fight</td>
<td>34%</td>
</tr>
<tr>
<td>Out of Control and Caregiver Called Police</td>
<td>24%</td>
</tr>
<tr>
<td>Carried a Weapon</td>
<td>23%</td>
</tr>
<tr>
<td>Sold, Distributed or Made Illegal Drugs</td>
<td>5%</td>
</tr>
<tr>
<td>Illegal Gang Activities</td>
<td>9%</td>
</tr>
<tr>
<td>Broken Into House or Building</td>
<td>7%</td>
</tr>
<tr>
<td>Bought, Received or Possessed Stolen Goods</td>
<td>9%</td>
</tr>
</tbody>
</table>

### Table 19. Self-Reported Criminal Activities (n=33)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percent who Participated in Past 6 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline Interview</td>
</tr>
<tr>
<td>Physical Fight</td>
<td>45%</td>
</tr>
<tr>
<td>Out of Control and Caregiver Called Police</td>
<td>25%</td>
</tr>
<tr>
<td>Carried a Weapon</td>
<td>27%</td>
</tr>
<tr>
<td>Sold, Distributed or Made Illegal Drugs*</td>
<td>6%</td>
</tr>
<tr>
<td>Illegal Gang Activities</td>
<td>6%</td>
</tr>
<tr>
<td>Broken Into House or Building</td>
<td>6%</td>
</tr>
<tr>
<td>Bought, Received or Possessed Stolen Goods</td>
<td>6%</td>
</tr>
</tbody>
</table>

*Many youth opted not to respond to this question so these numbers may not be representative of the entire group.
Figure 36. Percent of Youth Scoring in the Average or Above Range on the BERS (n=55)
Figure 36. Percent of Youth Scoring in the Average or Above Range on the BERS (n=33)
Figure 37. Percent of Youth Scoring in the Normal Range on the RADS-2 (n=55)

The bar chart shows the percent of youth scoring in the normal range on the RADS-2 (n=55). The following data is provided:

- Dysthmic Mood: Baseline 89%, 6-month 91%
- Anhedonia/Negative Affect: Baseline 98%, 6-month 100%
- Negative Self-Evaluation: Baseline 80%, 6-month 88%
- Somatic Complaints: Baseline 84%, 6-month 89%
- Total Depression: Baseline 88%, 6-month 88%
Figure 37. Percent of Youth Scoring in the Normal Range on the RADS-2 (n=33)

Figure 38. Percent of Youth Scoring in the Typical Range on the RCMAS-2 (n=55)
Figure 38. Percent of Youth Scoring in the Typical Range on the RCMAS-2 (n=33)
BECOMING Overview

- Six year SAMHSA funded System of Care grant
  - Implementation began in Year 2
  - Currently in Year 6
- $5.4 million federal award
- $6 million local match
- Focus on 16-21 year transition age youth
  - Primary mental health diagnosis
  - Disconnected from services and supports
BECOMING Overview

- Bridge adult and child service system chasm with a more effective and comprehensive approach inclusive of all life domain areas

- Develop a system to address high-risk Transition Age Youths’ clinical, developmental and social needs including educational attainment and workforce connections

- Address service system and policy barriers with statewide dissemination
2016 evaluation report addresses 3 key questions for the first 3 full years of program implementation:

1. Who are the youth that are referred, screened, and enrolled in BECOMING?

2. What BECOMING-specific services and supports did these youth receive while enrolled in BECOMING?

3. What happened to youth as a result of participating in BECOMING?

- Youth provided outreach by BECOMING staff: 878
- Youth that agreed to BECOMING screening: 434
- Youth that officially enrolled: 314 (72% of those screened)

- Demographics have remained largely unchanged since the inception of the program:
  - Females = 53%, Males = 47%
  - African American = 72%
  - Hispanic = 10%
  - 18 years or older = 62%
Mental Health Diagnoses - Enrolled Youth

- Highest % of youth diagnosed with Mood Disorders and ADHD/Conduct/ODD
Other Characteristics

Prior to BECOMING screening:

- 76% of youth had not graduated from high school
- 72% had between 1 and 5 prior reports for child abuse and/or neglect
- High rates of prior exposure to traumatic events
- 15% had been convicted of a felony or misdemeanor at the time of screening
BECOMING Interventions

- Connections to MH providers for youth less likely to engage
- Intensive one-to-one supports from BECOMING staff for selected youth
  - Case management and other supportive services
- Youth leadership groups and opportunities
- Youth resource groups
- Flexible funds to support education, transportation, recreational activities, etc.
- Trauma-informed training and TA provided to select MH providers
BECOMING Services & Supports

- BECOMING staff made 5,252 contacts with 231 unique youth
- 53% of all screened youth had at least one contact beyond initial screening
- 74% of all enrolled youth had at least one contact beyond initial screening
- Elapsed time from 1st to last contact relatively short for most youth (~<100 days)

Scatterplot: Total contacts by length of contact
426 Goals were developed for 76 unique youth on Level 1
- Indicates high levels of need: ~6 goals per youth
- Most frequent types of goals were associated with educational pursuits (n=118) and employment (n=94)
- Of the 76 youth, 26% met between 1-3 goals, 18% met 4 or more
SAMHSA flexible funding expenditures have increased steadily: 993 funded requests totaling $64,249
202 youth received flex funds; ~5 requests per youth

<table>
<thead>
<tr>
<th>Flexible Funds Category</th>
<th># of Funded Requests Nov 2011 – Dec 2015</th>
<th>Total (%) by Category</th>
<th>Total $ Spent by Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities</td>
<td>54</td>
<td>5.4%</td>
<td>$6,194</td>
</tr>
<tr>
<td>Clothing</td>
<td>98</td>
<td>9.9%</td>
<td>$7,930</td>
</tr>
<tr>
<td>Daycare</td>
<td>1</td>
<td>0.001%</td>
<td>$300</td>
</tr>
<tr>
<td>Educational Support</td>
<td>118</td>
<td>11.9%</td>
<td>$17,940</td>
</tr>
<tr>
<td>Housing/Furnishings/Supplies</td>
<td>90</td>
<td>9.1%</td>
<td>$8,160</td>
</tr>
<tr>
<td>Groceries</td>
<td>26</td>
<td>2.6%</td>
<td>$1,391</td>
</tr>
<tr>
<td>Legal</td>
<td>27</td>
<td>2.7%</td>
<td>$1,580</td>
</tr>
<tr>
<td>Medical</td>
<td>9</td>
<td>0.9%</td>
<td>$834</td>
</tr>
<tr>
<td>Transportation</td>
<td>462</td>
<td>46.5%</td>
<td>$13,137</td>
</tr>
<tr>
<td>Utilities</td>
<td>108</td>
<td>10.9%</td>
<td>$6,783</td>
</tr>
<tr>
<td>Total</td>
<td>993</td>
<td>100%</td>
<td>$64,249</td>
</tr>
</tbody>
</table>
BECOMING Services & Supports

- 5,000 Medicaid claims were matched for 158 youth during enrollment in BECOMING
- 66% had ≤ 20 claims
- Total expenditures= $2,319,047
- Average expenditure= $14,677 (inflated due to outlier)

<table>
<thead>
<tr>
<th>Range in # of Claims</th>
<th># of Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-20</td>
<td>104</td>
</tr>
<tr>
<td>21-40</td>
<td>18</td>
</tr>
<tr>
<td>41-60</td>
<td>14</td>
</tr>
<tr>
<td>61-80</td>
<td>5</td>
</tr>
<tr>
<td>81-100</td>
<td>8</td>
</tr>
<tr>
<td>More than 100</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>158</td>
</tr>
</tbody>
</table>

Challenges associated with Alliance’s transition to a new database system in mid-2012 accounts for low numbers of youth included in analyses.
As of December 2014:
- 116 youth had enrolled in the LOS
- 57 had 6-month interviews
- 46 had 12-month interviews

Many of the youth in the LOS received higher levels of BECOMING interventions:
- 49% worked with a care coordinator
- 48% had a goal plan
- 78% had 1 or more contacts with staff after initial screening
- 69% had 1 or more flex funds requests
Delinquency Survey: Significant, positive directional changes specific to some criminal activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>In the Past 6 Months...</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline Interview</td>
</tr>
<tr>
<td>Physical Fight</td>
<td>38%</td>
</tr>
<tr>
<td>Out of Control and Caregiver Called Police</td>
<td>19%</td>
</tr>
<tr>
<td>Carried a Weapon</td>
<td>23%</td>
</tr>
<tr>
<td>Sold, Distributed or Made Illegal Drugs</td>
<td>14%</td>
</tr>
<tr>
<td>Illegal Gang Activities</td>
<td>12%</td>
</tr>
<tr>
<td>Broken Into House or Building</td>
<td>5%</td>
</tr>
<tr>
<td>Bought, Received or Possessed Stolen Goods</td>
<td>5%</td>
</tr>
</tbody>
</table>
**GAIN-Substance Use**: Significant improvements in risk level for all 3 scales (substance use and abuse presented below) from baseline to 6 and 12 months.

- **No/Low Urgency**
  - Baseline: 58%
  - 6-month: 59%
  - 12-month: 77%

- **Moderate Urgency**
  - Baseline: 35%
  - 6-month: 36%
  - 12-month: 23%

- **High Urgency**
  - Baseline: 8%
  - 6-month: 5%
  - 12-month: 0%
Behavioral & Emotional Rating Scale (BERS): Significant improvements from baseline to 12-months on all scales except family involvement.
Longitudinal Outcomes Study (LOS)

- Reynolds Adolescent Depression Scale (RADS): Significant improvements from baseline to 12-months for dysphoric mood, negative self-evaluation, and total depression scales.

- Revised Children’s Manifest Anxiety Scale (RCMAS): Significant improvements from baseline to 12-months on all four scales.

![Average Standard Scores on the RCMAS-2](chart.png)
# Longitudinal Outcomes Study (LOS)

## Employment and Volunteer Work

<table>
<thead>
<tr>
<th>Employment and Volunteer Work</th>
<th>Baseline</th>
<th>6-months</th>
<th>12-months</th>
</tr>
</thead>
<tbody>
<tr>
<td>% employed in the past 6 months</td>
<td>43%</td>
<td>40%</td>
<td>52%</td>
</tr>
<tr>
<td>% who participated in volunteer work in the past 6 months</td>
<td>30%</td>
<td>25%</td>
<td>30%</td>
</tr>
</tbody>
</table>
# Outcomes: Department of Corrections

<table>
<thead>
<tr>
<th>First Conviction Before Screening</th>
<th>70%</th>
<th>83%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Convictions After Screening</td>
<td>16%*</td>
<td>28%**</td>
</tr>
</tbody>
</table>

*percent is out of the 37 youth whose first offense was committed *before* enrollment

**percent is out of the 29 youth whose first offense was committed *before* screening
Questions?