North Carolina Association of Local Health Directors
Full Association Meeting
Date: March 19, 2015
NC DPH, Cardinal Room, 5605 Six Forks Road, Raleigh

Minutes

Meeting Called To Order:  9:30 a.m.

Approve Minutes of Previous Meeting: Motion to approve minutes of the February 19, 2015 meeting was made and seconded; motion carried.


Get in Tune and Just Breathe – Special Guest - Victoria Baskett, Miss Goldsboro 2015, described her platform project – “Get in Tune and JUST BREATHE” in partnership with the “Speak Up” Program to encourage patients to be actively engaged in their health care decision-making.

President’s Report – Buck Wilson
- Welcomed David Jenkins as the new Carteret County Health Director.
- New Health Statistics Pocket Guides are now available.
- Reminded members to up-date the liaison list if they are serving on any state boards and committees.
- A positive meeting was held yesterday with Jamal Jones, Senior Healthcare Analyst with NC DHHS, who is working on Medicaid reform plans. Efforts are being made to make sure LHDs remain part of the discussion and play a role in the plans.
- An immunization bill (S346 - Sen. Tarte) has been introduced and a press conference will be held at 12:30 at the Legislative Building. Health Directors were encouraged to attend. The intent of the bill is to strengthen immunization requirements. Some concerns were raised about the wording of the proposed bill and how it may weaken current immunization requirements. Lynette pointed out that Sen. Tarte understands the concern and is open to revising the bill language as it moves through committee so that it does not weaken existing requirements. Danny advised caution as the bill proceeds through committee.
- A template for legislative discussion is forthcoming from Lynette to assist health directors with communication with legislators. Contact Buck if there are questions.
- Proposed change of our meeting date to the 2nd week of the month to better coincide with Social Services Directors Association to help health directors who also serve as human services directors. This will be voted on at next month’s meeting. This would go into effect next February if approved.
- Has heard positive comments concerning the new committee structure.
- Doug will be working on the policies and procedures manual as the Nominations & By-Laws committee chair.
- In the process of getting committee descriptions listed on the Association’s website.
- The three public health associations have agreed to have a presence at next year’s Commissioner’s Association Conference in Pitt County.
- There will be some abbreviated committee meetings (1-5pm) in April before the Legal Conference in Chapel Hill. Colleen is coordinating the meetings and committee chairs should contact her if they have items for discussion.

NC Division of Public Health Report - Danny Staley:
- Information will be forthcoming regarding registrar/vital records form changes or modifications resulting from the recent Same Sex Marriage ruling.
- Legislative issues: A privatization bill in Environmental Health is likely forthcoming. Working with the author of the Food stand bill on some wording changes. Coal ash ponds testing requirements—letters going to health directors in the pertinent counties; about 300 wells are scheduled to be tested.
- Working closely with DHHS Medicaid reform staff concerning public health’s role in the reform: service descriptions and what other states are doing.
- Encouraged members to review the recent Child Health Report Card and share with BOH. It points out successes and areas for improvement.
- DPH continuing to work on agreement addenda reporting compliance for Federal Funding Accountability and Transparency Act (FFATA); have made so changes to WIRM to help with data collection.
- Commended the presentations made recently to the legislative oversight committee by Dorothy Cilenti and Anna Schenck; child health issues, infant mortality and provided awareness of some gaps & concerns.
- Governor’s proposed budget recently presented – DHHS/DPH highlights: Office of Chief Medical Examiner and Vital Records are getting specific attention. Goal to establish an electronic death record system. Refinancing of the Office of Minority Health and refinancing of PAN—basically taking the state funding from the preventive health block grant. Reduction of ADAP. Switch-out of some funds for the Quitline.
- Advised LHDs to go with the budgetary estimates that they have for budgeting health promotion funding.
- State Auditor’s report – Four findings this year for DPH.
- One-time, non-re-occurring appropriations in the Governor’s budget: a few of counties getting funding for Nurse Family Partnership and high risk maternity program at ECU
- Office of Minority Health – New Director, Cornell Wright was introduced to the group. Also, 2 new regional dentists have been hired (Dr. Elizabeth Pennington and Dr. Kevin Buchholtz)
- DPH is in discussion with DMA regarding disagreements in some of their definitions used in the cost settlement process. If their “definitions” held, there would be substantial paybacks for some counties.
- Phyllis Rocco – For HIS counties, DPH is meeting with DIRM to determine when HIS counties’ first subscriber payments will be due; probably will be due in the new year.
- DPH is working on practice management training opportunities.

State Environmental Health Report – Larry Michael:
- Food Protection Branch recently added Terri Ritter to their staff. She is from Chatham County and is also a licensed soil scientist. Territory to be determined soon but will serve central NC.
- Senate Bill 7 concerning seating at food stands – they are working on some compromise language.
- Discussion regarding “Privatization” will likely be seen in the regulatory reform bill.
- Blue Bell Listeria
  - Recall initiated due to action in 3 different states.
  - Five patients who were treated in a single hospital in Kansas were infected with a rare strain of Listeria monocytogenes. Illness onset dates range from January 2014 to January 2015.
  - On Feb 12th, LM found in samples of Blue Bell Creameries products collected by the SC Department of Health & Environmental Control (DHEC) during routine product sampling at a SC distribution center. These products are manufactured at Blue Bell Creameries’ Brenham, TX facility.
  - The Texas Department of State Health Services, subsequently, collected product samples from the Blue Bell Creameries Brenham facility. These samples yielded Listeria monocytogenes from the same products tested by SC.
  - According to the Kansas Department of Health and Environment, hospital records available for four patients show that all were served ice cream from Blue Bell Creameries’ prepackaged, single-serving products and milkshakes.
  - All five case patients are adults. Three deaths have been reported.
  - In NC, product was shipped to 7 schools in Franklin Co from a Morrisville, NC distribution center. EHI is conducting effectiveness checks to ensure the products are no longer in commerce.
• NCDPH working with NCDA to ensure recalled product not shipped to other counties.

- BETS
• In production with PayPoint, so that establishments can now pay online. This will significantly increase efficiency so that EH Section is no longer processing and depositing 30,000+/- checks by hand.

- EH Aid-to-County Funds
• The overall gross reimbursement to counties is up approximately 10% (~1.6M-1.8M).
• Actual will vary by county since the formula is based on percent compliance. Adjustments are also made to account for supplies, etc.

Executive Director’s Report – Lynette Tolson
- Website revision is ready and hopes to be live within the next few days. Encouraged members to check their information listed on the website and let her know if county information is correct needs to be changed.
- Future information concerning association agendas, committee agendas, materials, meeting schedules, etc. will be posted on the website. Lynette and staff will no longer send this information out by emails.
- Freshmen Legislator Educational Luncheon will be held on March 26 and the topic will be the County Health Rankings. Health Director’s with freshmen legislators will receive an invitation to participate.
- Reminder for LHDs to pay their dues if they have not done so. All but one county has paid accreditation dues.
- Talking points are forthcoming concerning the use of block grant funds to fund Office of Minority Health and PAN.

Partner Reports
NCAPHA Report – Jerry Parks
- Invited members to stay for lunch and the board meeting today.

NCPHA – Lisa Harrison
- Busy planning for the spring combination meeting with Eastern District May 6-8 in New Bern.
- Encouraged support and participation in the FAMI Section of NCPHA (Finance, Administration, Management Support and IT). The section needs more participation from LHDs to expand educational opportunities.
- Advocacy Agenda – Participated in a press conference last Tuesday on a bill to help address “food deserts.”

Action/Information Items - Committee Reports

Core Public Health – Denise Michaud:
Action/Motion: None
Information:
1. OBCM/CC4C – Vienna Barger and Cheryl Lowe
   - Vienna Barger presented an overview of PCM (see attachment for presentation); priority to prevent pre-term birth; services are targeted to priority population: patients at elevated risk of pre-term birth; data dashboard developed as a QI tool
   - Cheryl Lowe presented an overview of CC4C (see attachment for presentation); majority of contract performance measures are from claims data; environmental factors can impact performance measures; some data “stalled out” with loss of claims data due to NC Tracks though has begun to improve; data dashboard measures only available quarterly due to Medicaid eligibility information takes 3 months to “cycle through” (used to calculate percentages); results are only available in table format at this time; can also view results from other LHDs to compare

2. FP Annual Report – Sydney Atkinson
   - See attachment; reporting issues are the biggest concern especially with batch counties (questionable data reliability); working with John Bryant to improve this; Anna Austin is
working on a project to determine why numbers are decreasing and will be conducting interviews with select health department personnel; most numbers are declining in the Southeastern family planning Title X clinics; may be due to increased access of care (ACA)

3. Monitoring Medicaid billing – Carol Tant and Marshall Tyson
   • Concerns related to CH program monitoring; Health Check billing guide is detailed and if the visit is not properly documented, the whole payment must be refunded; example: if 10 medical records are reviewed in the program audit and 5 of those are non-compliant, 50% of the money received for that visit code must be refunded; if errors are identified, additional records will be reviewed; in 2014, 29 programs were reviewed and 15 were in payback status (5 with 25% of records, 2 with 26-50%, 5 with more than 50% and 2-3 with 90-100%); regular self-audits are highly encouraged especially when any changes occur that affect how documentation is done (including the adoption of EHR as does not necessarily include all required components of the visit); CH AA require at least one self-audit per year; trend data has been provided to LHDs (will resend); staff welcome suggestions to provide better outreach and consultation as they are trying to prevent payback; no “hold harmless”; good news: 2013-2014 91% did not meet monitoring requirement but has decreased to 52% at present; Danny stated that DPH must recoup the funds if there is a finding; health directors should make sure they are aware of AA requirements;
   concern re: licensing issues for staff signing off on encounters (specific parts done by different providers); standing orders need to be up to date; December 2 memo from Phyllis re: CAPs (will resend); for the first time, DMA is requiring DPH to report results of monitoring; let RN consultant know if assistance is needed

Public Health Promotion & Prevention – Janet Clayton:
   Action/Motion: None
   Information:
   • Tara McAdoo, Task Lead-Population Health with Alliant Quality, presented an overview of QIN-QIO Population Health- Quality Initiatives. The services that are offered are grant funded through July 2019. Alliant Quality is concentrating efforts in North Carolina and Georgia. There are four key roles of this initiative:
      o Results Oriented- Serve as a multi-state and local change agent champion
      o Learning & Action Networks- A facilitator of learning and action
      o Technical Assistance- a teacher and advisor
      o Communication- highly effective communicator and trusted partner
   She provided insight on the Million Hearts Advisory Board and the implementation goal for North Carolina. There are meetings scheduled with the AHECs in North Carolina and with the North Carolina Home Care Association. For more information visit the website: http://qiosprogram.org.
   She shared with the group the participation agreement as well.

Technology – Beth Lovette:
   Action/Motion: None
   Information:
   1. Cancer Program Updates : Debi Nelson and Terence Tumenta Shendeh reminded the health directors that the BCCCP branch sends monthly reports to each BCCCP program coordinator in the LHDs. Terence provided a presentation, attached. Batch reporting errors are improving, but do need the attention of the local coordinators and may require involving vendors for understanding of resolution of errors.

   2. HIS Update:
      a. Batch Interface Update: John Bryant updated the group that batch error report percentages are syncing better and error rates are steadily improving with all vendors. Reminder: Every batch
reporting health department should be running Batch County Edit Errors Report (Avatar) and BL201 (which can be run out of Avatar, but can more easily be scheduled in BOXI monthly which allows the report to run in the background and will not “time out.” The Batch County Edit report gives an overview of errors. The BL201 gives patient level information which allows the errors to be corrected at the patient level. Staff should also reference the Batch Error document available on the HIS website under Batch Resources. This document helps the end user understand what the error message means and how it might be corrected.

b. Program specific requirements and report dates: John is still working on this document and vetting it with the DPH Program staff. But John does plan to have this document with program specific requirements and dates for routine state/federal reporting as soon as possible.

c. HIS Meaningful Use: Phyllis Rocco offered a brief update on the new HIS modules scheduled for roll-out. Order Connect will go live in June, with Care Connect and My Patient Portal rolling out over the summer. HIS online counties will receive specific details from DPH. She also mentioned that NC HIE connection for HIS users will be free, but the annual fee for 1 physician per Health Department ($175) will be required.

d. Pregnancy Medical Home Billing Update: John reported that some claims are being paid. He and Dennis Williams continue to work toward final resolution with NC DMA for denials that will not require too much work at the LHD level.

e. Progress on Netsmart fix: Beth Lovette noted that we are now waiting for Netsmart to provide a specific price so that Danny Staley can move ahead with a work order. This fix will improve the error rates for all batch counties, regardless of vendor.

3. NC Health Care Information and Communications Alliance (NCHICA): Update on opportunity to participate on committees. After the Committee meeting, Beth Lovette and Lynette Tolson had a call with Jennifer at NCHICA. Clarification is that the LHD must be a member of NCHICA to have staff participate on committees.

4. Risk and Liability with Electronic Health Records: Terrie Snowden with The Snowden Company discussed several points of concern with uptake of electronic health records. She is working with Colleen Canning, ACE, to provide audits as requested at LHDs. In particular, she plans to audit a few LHDs with the various vendors as well as HIS. The points of concern that LHDs should consider with their clinical staff:

a. Is there an ability to sign-off and date entries or specific components by the staff member that worked with the patient?

b. Do you have policies about timeliness of the encounter sign-off? If so, are you enforcing the policy?

c. Do you regularly audit records for logical documentation? Does the visit tell the story? Can you identify why the patient is in the clinic and does the documentation address the original issue as well as a plan for any issues that may have been identified in the actual visit. Beth asked Terrie if there are any audit tools available. Also, if you provide primary care, remember that DPH does not audit or support this program, so we are on our own for assuring that we are providing this service with the least liability possible.

d. Terrie stated that Phyllis Rocco provided an excellent memo regarding these issues to LHDs in the Fall. She will re-send this to the LHDs.

e. This should be an ongoing discussion with plans for training, audit tools, etc., forthcoming. Beth will work with Terrie and Phyllis on these issues.

Beth noted she is trying to get the NC HIE to present at a meeting soon.

Policy and Finance – Lisa Harrison
**Action/Motion:** Concerning the draft Senate Bill from Senator Tarte to Enact Stricter Immunization Requirements, motion made to send Lisa Harrison suggestions, comments and concerns about the Bill so we can offer feedback; and to support Senator Tarte’s efforts & intent and watch how the Bill evolves. Motion carried.

**Information:**

1. **Medicaid Reform** – The Public Health Position
   One-pager on public health funding option was shared.

   On the topic of Medicaid reform, Colleen Bridger provided an update of an earlier meeting on March 18th with Jamal Jones of the Office of the Secretary of Health and Human Services. Jamal is a new research analyst who is working on the Department’s Medicaid Reform details. Colleen reported that the meeting was very good and Jamal has a clear grasp of public health, of how public health can fit into the Medicaid System, and is focused on the data surrounding public health contributions in North Carolina.

   It’s important for everyone to know and share that “the Association is working together with the department on core local public health services and prevention activities related to Medicaid reform.” We continue to work with Danny and Dennis Williams and Jamal well and appreciate their efforts on our behalf. Ongoing conversations are welcome.

   Marlon Hunter asked about a Plan B. After some discussion, Colleen offered that first we have to clearly define Plan A…but a Plan B is also good to think about. Marilyn added that she has attended meetings where discussions are taking place around measures/metrics for quality in Medicaid ACOs.

   Chris Hoke brought up that we need to be aware that Plan A looks good but so far, remember that Plan B is that we could lose our ability in local health departments to compete as a valid partner in an ACO.

   A question was asked about clarity on Jamal Jones’ role again – He works directly for Secretary Wos to craft what Medicaid looks like and present to the House and Senate a plan.

2. **Tobacco Branch Updates** – Summary of Strategic Planning
   Sally and Jim were present to offer updates about the latest visits across each region in NC to discuss strategic planning for the CDC grant related to Tobacco Prevention and Control. Sally announced they should hear about that grant the end of March. TP&C Branch staff are learning lots about local personalities and policies and where to maintain or begin new focus for Military families, understanding better the education variation, and regional history. Sally thanked the group for the time they are dedicating to this effort.

3. **Effective advocacy for public health in 2015** – Paying close attention
   Reviewed the DRAFT Bill from Senator Tarte to Enact Stricter Immunization Requirements in NC. Lynette provided an overview of the genesis of this bill and intentions we understand to date behind it. Senator Tarte is asking for our opinions and feedback on wording and is ready to hold a press conference in support of stricter requirements for childhood immunization.
   In discussion, Marlon raised the issue that the HPV vaccine was removed as a required vaccine and that perhaps there is opportunity for us to make a suggestion that local health departments can provide education and vaccination for HPV to prevent cancer.

   Continuing discussion around new legislation to watch, the committee reviewed Lynette’s summary from last Friday outlining public health related bills. Senate Bill 231 and 235 are Senator Hartsell’s
Bills that we have seen before – one is calling for a study commission to explore a unified public health system. The second is establishing regional authorities. After discussion about both of these bills, Chris Hoke suggested the state DPH leaders will meet with Hartsell to discuss the intentions behind these Bills this year and to talk about potential consequences. It was pointed out that in the past, these Bills have not made it far in the process toward becoming legislation.

With regard to a bill discussed last month concerning school based health clinics and related opportunity to offer more complete family planning services and birth control methods in the school based health clinics, Senator McKissick presented the language change and made it a local Bill only affecting Durham County for now. So far, that Bill is not moving and McKissick has offered to take up that charge when the timing is right within the process.

Planning and Innovation – Colleen Bridger
Action/Motion:
Information:
1. Medicare
   Jeanie Schepsi spoke to the group about the NC State Health Insurance Program for Medicare called SHIIP (State Health Insurance and Information Program) run out of the Department of Insurance. She walked us through their website: www.necshiip.com and the Medicare website: www.medicare.gov There is a lot of good information for our clients (and our parents and in the near future ourselves) on these two websites and there is a SHIIP office in most counties where people can go for help.

2. Accreditation and Institute Update
   Dorothy Cilenti spoke about our Association’s request that the contract between the Association and the Institute for Public Health be modified to reflect the action taken months ago requiring a county’s accreditation dues be paid in full before they are eligible for accreditation. If Chris Hoke agrees there is nothing in the Accreditation legislation that would prevent this, Dorothy will work with Lynette to modify the contract. If a county’s accreditation dues are delinquent, when they receive their “90 day letter” informing them of their accreditation timeline, it will simply say the county will not receive any accreditation work from the Institute until the accreditation dues are paid in full.
   Dorothy also talked about an article available on the Institute’s website that examines the impact of the recession on public health outcomes. Click here for more info: http://sph.unc.edu/sph-news/local-health-department-staffing-services-contribute-to-reduction-in-infant-mortality-rate-study-finds/

3. EBI 2.0
   Avia Manor from the Institute presented information about the next iteration of the Evidence Based Intervention training called “EBI 2.0”. This training will be more hands on and address EBIs specific to obesity prevention. It will be a two day training with technical assistance and following up available via webinars for 3 months post training. There will also be a mini-grant of $1,000 available to a few lucky participants. The training will be held in Hickory in September, look for more info soon.

PBRN Update- NCPHA conference in September – Will be having a one hour session including “speed presentations” (5 minutes each). This will be in addition to the student and practitioner sessions. Information for presentation submissions has been emailed to LHDs.

Education & Awards – Dave Jenkins:
   Action/Motion: None
   Information: None

Nominations & Bylaws – Doug Urland:
## Action/Information Items - Public Health Regions

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## Liaison Reports

**NC Institute of Government – Jill Moore**  
Reminded members of the April 22-23 Legal Conference in Chapel Hill and thanks members for support in assisting with development of the conference.

**PHLP – Anna Schenck**  
Congratulations to Rebecca McCleod and Burke County for recent PHAB Accreditation.

**ANCPH – Barbara Ann Hughes**  
Discussing the process of accreditation and the involvement of Boards of Health. The Vaughn Upshaw Scholarship will be presented to Maria Victoria Howard-Williams, a graduate student in the UNC Public Health Leadership program, April 16, prior to Ford Lecture at the School of Public Health. Four $500 scholarships are available for NALBOH Conference in Louisville in August. Encouraged submission of NC stories for quarterly NEWSBRIEF newsletter from NALBOH.

**Meeting Adjourned:** 11:23 a.m.

**Next Meeting:** April 23, 2015 2:30pm (In conjunction with Health Directors’ Legal Conference)  
**Location:** Chapel Hill, NC – UNC School of Government
To ensure that children have healthier outcomes and that measures are met, consider the following during EVERY client contact:

- **Is the work/intervention I’m doing with this client meaningful? Will this work/intervention positively improve the child’s health, as well as the CC4C measures?**
- **Are the children on my caseload part of the CC4C Target Population?**
- **Am I continuing to positively impact this child/family or am I simply “monitoring” the situation? Is it time to move on to try to impact another child/family? Am I continuing to work with this family simply because I am concerned about case numbers?**
- **Am I expressing interest and concern to the family using Motivational Interviewing and/or other techniques, which can have a more positive impact on engagement?**
- **Did I share with families that I am a care manager working with their child's primary care provider to ensure that they receive the best quality of care possible and that this is a benefit of their Medicaid coverage? Did I explain that I will be following up on their child’s progress through phone calls and contacts? Or did I reference enrolling the child in the CC4C Program OR ask them if they are interested in receiving this service, which may be not be as successful?**
- **Did I use all possible resources in ensure healthy outcomes for children, including:***
  - Children with Special Health Care Needs Help Line at 1-800-737-3028 or CYSHCN_Helpline@dhhs.nc.gov,
  - QuitlineNC at [http://quitlinenc.com/](http://quitlinenc.com/) to support parents in smoking cessation, and
  - Local resources.

To ensure the appropriate identification of children in the CC4C Target Population:

- **Develop strong relationships with all PCPs, or at least those who are serving the largest number of children in the county, so that the PCPs can appropriately refer children who are in the CC4C Target Population.**
- **Provide PCPs with and discuss resource information such as food referrals, housing, etc. (this may help to reduce the number of referrals you get only for these specific reasons).**
- **Partner with the OBCM to identify children in the CC4C Target Population; OBCMs may assist the CC4C CMs to identify children in the CC4C Target Population using a standardized referral process; once the referral is made, the child's record would be added per network policy, as a record for the child more than likely has not yet been created.**
- **Utilize Informatics Center Lists and/or lists generated by the local network to ID children who meet target population criteria or have a utilization history that warrants follow-up; don't wait for referrals - pursue them proactively.**

On the following pages is a list of the CC4C Measures (Contract Performance Measures & Data Dashboard Measures) with a **MENU of possible strategies** to positively impact each measure. The intent is that each agency will prioritize the measure(s) to be addressed and then **CHOOSE FROM THE MENU** the strategy that would most likely be successful in your area, with input from DPH consultants & network CC4C lead staff. There is **NO** way that one agency can successfully implement or focus on all the strategies listed below at one time. Also, agencies will need to constantly reassess and refocus priorities for continued progress.
1. **Contract Performance Measures:** Results are available in the Informatics Center using the following path: Home > Local Health Department Standard Reports > CountyName > CC4C Reports > Key Performance Indicators and NICU Graduates.

   a. **Measure #1 – NICU**

   i. Use any of the following resources to identify hospitals that may be providing NICU services to children in your county, and try to develop relationships with those hospitals that are not referring NICU babies: NC Hospital Association website, claims data provided by network/CCNC, info provided by tracking referrals, and knowledge of network and LHD staff.; inquire about the hospital’s current referral process and discuss possible ways to revise the process to ensure that NICU grads are effectively and quickly referred to CC4C.

   ii. Identify NICUs who are confused about which programs are most appropriate for families (CDSA, CC4C, etc.) and facilitate discussions to ensure the needs of families are met.

   iii. Collaborate with the OBCMs and/or LHD staff providing Post-Partum and Newborn Home Visiting services, as these staff may become aware of NICU admits/discharges in timely manner.

   iv. Coordinate with appropriate partners (CCNC, CHACC CM, Family Support Network, etc.) to establish/strengthen linkages with NICU hospitals. Share CC4C Referral Directory with NICU hospitals so that referrals are made to all CC4Cs, not just your county.

   v. Identify and work with the local Family Support Network serving NICU families in your area, if applicable. Check out local affiliates at [http://www.fsncc.org/findlocal](http://www.fsncc.org/findlocal).

   vi. Collaborate with other programs supporting the NICU grads (i.e. CDSAs, NICU Follow Up Clinics) to ensure that the system of care is efficient and effective.

   vii. Review Birth Certificates to identify NICU babies. (Note: there may be a delay in the BCs for children born Out of County/Out of State.); review slides 23-34 from the July 2014 CC4C Webinar, which are available in the CC4C Tool Kit, for info about utilizing electronic birth certificates.

   viii. Consult with local health department & CCNC network Privacy Officer if hospital is concerned about making a referral without a signed consent. Note: The guidance posted in CMIS under Resources → Privacy → CCNC/CC4C/OBCM Confidentiality Guidance” should be helpful to these discussions.

   ix. Identify the best contact person at each NICU (discharge planner, transition coordinator, CHACC CM, etc.) with whom to develop a relationship to ensure comprehensive and timely referrals.

   x. Ask the person making NICU Referrals to fax the discharge summary with the referral to the CC4C staff, when appropriate, a copy could be given to the LHD Child Health Clinic charge nurse (if the LHD is the primary care provider) so she can be sure that the child sees a provider within the desired time frame.

   xi. To prevent missing any potential referrals, ask that all children be referred from L&D and NICU, and then the CC4C staff will assess to determine if they need care management; work closely with staff in L&D and NICU staff, who can help distribute CC4C information to parents, to ensure they understand the CC4C target population. **NOTE:** This strategy may
only be appropriate in areas where a small number of children could be referred from the L&D, thus ensuring that the CC4C program is not overloaded with referrals.

xii. Consider visiting the NICU (if possible) multiple times weekly to gather info on all NICU babies so that contact can be made to ensure they have a follow up appt.

xiii. If possible, consider contacting NICU families while they are still in the hospital (ideally just a few days before the baby is due to be discharged) to discuss the importance of a timely PCP visit.

xiv. Consider whether a care manager can be placed within the hospital/NICU, particularly hospitals who serve children from multiple counties, so that this CM could identify and contact families while in the hospital, and then make referrals to the outlying counties when the child is discharged; this approach may require a partnership between the hospital, multiple LHDs, local CCNC network, etc., in order to identify the resources needed to support this project.

xv. When contacting the family of a NICU grad, be sure to assess and address any barriers to making that first appointment, i.e. transportation, insurance coverage, etc.

b. Measure #2 – Hospital Admissions

i. Effectively target outreach to children on the Priority Population Report, particularly those with a high risk for admission in the next 12 months as indicated by a higher percentage in this column of the report.

ii. Effectively work the Current ADT List, if the hospitals in your area participate in the Live Data Feed.

iii. Strategize with CCNC network & other CC4C colleagues on ways to partner to reduce county Admission Rates.

iv. Develop strong relationships with PCPs to ensure children are well-linked.

v. Review Birth Certificates, if applicable, to identify CSHCNs & ensuring they are well-linked to a PCP.

vi. Use the Priority Population Report to identify CSHCNs & Foster Care Children in order to ensure they are well-linked to a PCP. Note: you can sort to identify specific dx (asthma) and ID those who are not well linked and/or those that are not receiving appropriate treatment (using inhaler).

vii. Identify CSHCNs who would benefit from the flu vaccine and consider best method(s) to communicate the benefit, such as letters, involvement of the Health Check Coordinators, automated messaging systems, etc.

viii. Implement actions that will help keep children as healthy as possible, which in turn would help them stay out of the hospital; Possible action steps could include:

1. Consider incorporating a reminder of the importance of getting the flu vaccine into every conversation with parents of children using information from the CDC available at [http://www.cdc.gov/flu/protect/children.htm](http://www.cdc.gov/flu/protect/children.htm); also share the importance of caregivers receiving the flu vaccine based on the CDC recommendations found at [http://www.cdc.gov/flu/protect/infantcare.htm](http://www.cdc.gov/flu/protect/infantcare.htm).

2. To protect the health of NICU grads, CSHCNs and all children, CC4C CMs should consider obtaining the flu vaccine based on the CDC recommendations for
healthcare workers found at [http://www.cdc.gov/flu/healthcareworkers.htm](http://www.cdc.gov/flu/healthcareworkers.htm), as well as ensuring that all vaccines (including whooping cough) for CC4C CMs are up-to-date per the CDC recommendations for healthcare professionals found at [http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html](http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html).

3. Outreach to child care providers, including posters and flyers, regarding flu prevention may be helpful; a partnership may be needed to accomplish this action, which could include the local Partnership for Children, Child Care Consultant, etc.; this approach could ensure that every family with a child in licensed child care receives information on how to prevent the spread of the flu and the importance of the flu vaccine.

4. Assess which providers, including PCPs, LHD and other entities in your community, are providing flu clinics, so that this information may be shared with families.

5. Ensure that initial contact with children diagnosed with asthma occur by home visit, when possible, in order to effectively identify possible environmental triggers and assess medication usage.

6. Use the Priority Population Report to identify children with an asthma or COPD indicator or Care Alert for Beta Agonist; contact them (letter or phone call) to ensure: 1) they receive a flu vaccine, 2) are well linked to a PCP, AND 3) that they have an effective Asthma Action Plan; a copy of an Asthma Action Plan template could be shared with the family.

ix. Send the list of patients being actively care managed by practice to the primary care provider (PCP) monthly so the provider is aware of the involvement of the CC4C CM, in order to improve collaboration and coordination of care, particularly for CSHCNs; consider occasionally including brief updates on each child to keep the PCP informed and involved.

c. **Measure #3 – Hospital Re-Admissions**

i. Collaborate with CCNC staff (TC staff & PCMs providing TC) to ensure effective and efficient service delivery to children ages 0-5 who have been hospitalized.

ii. Ensure that hospitalized CC4C children are well-linked to PCP upon discharge.

iii. Effectively work the Current ADT List based on guidance/expectations of the local network, if the hospitals in your area participate in the Live Data Feed.

iv. Send the list of patients being actively care managed by practice to the PCP monthly so the provider is aware of the involvement of the CC4C CM, in order to improve collaboration and coordination of care, particularly for CSHCNs; consider occasionally including brief updates on each child to keep the PCP informed and involved.

d. **Measure #4 – Non-Emergent ED Use**

i. Family Level

1. Effectively target outreach to children on the following lists: Priority Population Report, ADT, &/or ED Visits.

2. Filter the Priority Population Report for those children who:

   a. Have no history of PCM or CC4C engagement, then sort by # of ED visits, in order to identify children who have a high number of ED visits
b. May benefit from CM services, based on specific criteria, such as identifying children with a high number of ED visits who also have no PCP visits listed.

3. In talking with families, assess why the family went to the ED, in order to effectively address non-emergent use.

4. Share specific, standardized information/resources with families once they are engaged.

5. Compile the following info related to PCPs in your community, which then can be shared as a helpful resource for CC4C CMs to reference in working with individual families:
   a. After-hours policies, including contact phone number; consider methods to assess ease of after-hours access (request feedback from families, personally calling the number, etc.)
   b. Open access scheduling (same day appointments)
   c. Extended hours of service

Determine whether to include Urgent Care clinics, including location and hours, in this resource; consider collaborating with your network to incorporate this compiled information into the Community Resources Tab in CMIS for quick access to this information.

6. Review the list of top 25 ED Users (possibly from the ED Visit Report based on claims), identify those children from the top 25 ED User who have an Asthma Indicators on the Priority Population report, and then one CM could call to: 1) evaluate ED usage, 2) assess if Asthma Action Plan is in place, and 3) encourage flu shot.

7. Consider implementing a “Fever Initiative” that was an idea that came from local pediatrician that is Access Care Medical Director; a high school student raised money as part of her senior project to buy some thermometers; the OBCMs are giving them to their patients and providing education on how to use them and when to call the doctor; they also start education at that time about PCP vs ED.

8. Use the ED Visit Report (based on claims) to identify children who have accessed the ED multiple times recently and who had a primary or secondary diagnosis of asthma for the ED visit; this list of children could be “worked” in a manner similar to the Priority Population Report, and interventions could be implemented to ensure that the asthma is well controlled, thus keeping them from returning to the ED.


10. Think prevention, and talk with the parents about after-hours procedures at their practice as well as strategies to avoid non-emergent use of the ED (THIS IS FOR EVERY CLIENT IDENTIFIED).

11. If a pattern of ED usage is identified for a particular client, strategize with the PCP and/or family on how to impact that pattern.
12. If a parent is told by the PCP to go the ED because there are no open
appointments for a problem visit, explore if there are any alternatives, particularly
for Children with Special Health Care Needs, such as a designated PCP staff
member who is knowledgeable about the needs of the child and may have the
ability obtain an appointment for the child.

ii. Systems Level

1. Consider with network & LHD staff if there are systems barriers to reducing non-
emergent ED use & develop strategies to successfully intervene; for example, a
PCP may be sending patients to the ED because their appointment schedule is full.
2. Collaborate with Health Check Coordinators to see if they can remind families
about the PCP’s after-hours policies.
3. Discuss with the local network CC4C Lead staff the possibility of collaborating with
the network QI Team to address the issue of non-emergent ED use.
4. Consider asking the PCP to post their after-hours policies in the waiting room as
well as the exam rooms, including hours of special after-hours clinics (nights, early
morning, and weekends).
5. Determine if the local network has designated staff members embedded within
the ED (i.e. ED Navigators) who are available to strategize with the CC4C CMs on
decreasing inappropriate ED use.
6. Educate the local ED staff about the CC4C Program so that they may refer families
who are frequently utilizing ED services inappropriately; Provide the local ED staff
with written info to share with families about the prevention of fall and winter
illnesses that may result in healthier outcomes for children.

7.

2. Data Dashboard Measures: Results are available in the Informatics Center using the following path: Home
> Local Health Department Standard Reports > CountyName > CC4C Reports.

a. Measure #1: % of Medicaid Children Contacted

i. Effectively work all applicable lists/reports: Priority Population Report, ADT, and/or ED
Visits; explore ways to manipulate the reports to identify those children most in need of
care management services; for example, the Priority Population Report can be used to
identify the children in your county diagnosed with asthma or those children who have
the highest Medicaid costs.

ii. Develop strong relationships with PCPs to effectively identify children in the Target
Population.

iii. Foster a relationship with the NICU hospital serving the community.

iv. Develop relationships with other local, applicable partners to ensure the CC4C Target
Population is identified.

v. Consider routine, formalized case reviews with OBCMs to identify children in the CC4C
Target Population, and document these reviews.
b. Measure #2: % of Medicaid Children Engaged in H & M Case Status
   ii. When engaged in H & M Case Status, the CMIS documentation should indicate that appropriate interventions are taken to reach stated goals. If progress is not being made (despite the CM’s best efforts to engage/impact the child) or if the goals are met, the CM should defer the case in order to engage others in H & M Case Status.
   iii. Review the case status with each goal update and then update the case status at least every 90 days; be sure the needs of the child determine the case status and that the appropriate case status is assigned; for example, if the needs of child require you to contact the family at least weekly, then the HEAVY case status should be chosen; don’t hesitate to assign the HEAVY case status, as the case status can easily be changed if/when the child’s needs change; be sure to give yourself credit for the work you are doing by choosing the appropriate case status.
   iv. When initially engaging the client, ensure the case status assigned accurately reflects the intensity of services that are needed; moving forward, the case status can be adjusted accordingly as needed; this approach will ensure that the needs of the patient are promptly and fully assessed and addressed.

c. Measure #3: % of Deferred d/t Unable to Contact
   i. Use strategies to effectively locate families (top of page 3, CC4C WG Priority Population Report BP document).
   ii. Appropriately choose reasons for deferrals based on deferral definitions in the Standardized Plan. Example: If the CC4C is certain the family has moved out of state, some staff may choose “Unable to Contact”, when, based on the definitions, “Does Not Qualify for CM at this Time” is the most appropriate deferral reason.
   iii. Consider whether CC4C CMs can be granted access to PCP EMR, which could provide the CMs with the following opportunities to:
      1. Have the most current contact information
      2. Remind families of upcoming appointments
      3. Identify and address barriers to keeping appointments
      4. Meet the family at the appointment

d. Measure #4: % of Deferred d/t Refused Services
   i. Effectively share the benefit of program services.
   ii. Incorporate MI techniques into attempts to engage families in CC4C services.
   iii. Use all possible strategies to effectively engage families (bottom of page 3, CC4C WG Priority Population BP document).
   iv. Be able to verbalize the benefit of program services for families – if the staff do not understand the benefits of program services for families, it will be difficult for the families to understand and value the services.
   v. Appropriately choose reasons for deferrals based on deferral definitions in the Standardized Plan. Example: If upon offering CC4C services, the family says “we are fine
right now", some staff may be choose “Refused Services”, when the family was actually “Well-Linked”.

Additional References/Guidance related to Performance Improvement Strategies developed by the CC4C Workgroup:

2. CC4C Best Practices for Reducing Non-Emergent ED Use
3. CC4C Best Practice “Lite” Series for Care Managers:
   a. Priority Population Report
   b. Non-Emergent ED Use
Pregnancy Care Management Data Dashboard: Using data to improve care management and outcomes among pregnant Medicaid patients

North Carolina Association of Local Health Directors meeting
February 18, 2015
Pregnancy Care Management (OBCM)

- Population-based care management approach to improving birth outcomes in the pregnant Medicaid population
  - All pregnant Medicaid patients are in the population
  - Integral component of larger Pregnancy Medical Home initiative
  - Primary focus is on preterm birth prevention

- Care management services are targeted to the “priority OB population”: patients at elevated risk of preterm birth

- Pregnant Medicaid patients with priority risk factors should be engaged in active care management to promote an optimal pregnancy outcome
  - Identified from the Pregnancy Medical Home risk screening form, hospital utilization data, referral from other agency, or self-referral
Priority risk factors include:

- A history of preterm birth
- A history of low birth weight
- Multiple gestation
- Fetal complications
- Chronic conditions which may complicate pregnancy
- Unsafe living environment (homelessness, inadequate housing, violence or abuse)
- Substance use
- Tobacco use
- Missing two or more prenatal appointments without rescheduling
- Antenatal hospital utilization
Population Identification

Data & All Other Community Agencies/Services
- Hospital Reports
- WIC
- School System
- Faith Community Based Organizations

Non-PMH OB Providers
- Private OB Providers
- Local Health Departments
- FQHCs

Pregnancy Medical Homes (Risk Screening Forms)
- Private OB Providers
- Local Health Departments
- FQHCs
OBCM Dashboard Measures - Rationale

• Need for process measures to inform performance improvement
  • Outcome measures for OBCM are far downstream

• OBCM dashboard measures selected as indicators of performance of core OBCM program activities
  • Need to identify best practice sites to share strategies statewide and identify

• Indicators reflect fundamental OBCM expectations
  • No guarantee that outcomes will be achieved even with high scores on all dashboard measures
  • Reasonable assumption that outcomes will not be achieved if scores on dashboard measures are low
OBCM Dashboard Measures

1. Proportion of priority patients (based on risk screening form data) that had **ANY contact** with an OBCM

2. Proportion of priority patients with an **assessment documented** within 30 days of being identified

3. Proportion of priority patients **deferred** from OBCM within 60 days of being identified
   a. Proportion of priority patients deferred for “unable to contact”
   b. Proportion of priority patients deferred for “refused services”

4. Proportion of estimated pregnant Medicaid population in each county actively **engaged** in OBCM
Measuring Missed Opportunities for Pregnancy Care Management

- “Priority OB Patients Contacted” measure reflects OBCM contact or attempted contact with priority patients identified by risk screening form

- Three possibilities for patient contact within 30 days of being screened:
  - Successful contact with patient (CONTACTED) ✓
  - Attempt contact with patient (ATTEMPTED)
  - No contact or attempted contact with patient (NONE) ✗
Missed Opportunities
No attempted or completed contact

- Jul-Dec 2012
- Jan-Jun 2013
- Jul-Dec 2013
- Jul-Jun 2014
**OBCM Data Dashboard**

**Measure 3 – Deferral-Any Reason (State)**

- Jul-Dec 2012: 18.2%
- Jan-Jun 2013: 18.9%
- Jul-Dec 2013: 17.2%
- Jul-Jun 2014: 14.2%
OBCM Data Dashboard
Measure 3b - Deferral-Refused Services (State)

Jul-Dec 2012: 8.0%
Jan-Jun 2013: 8.2%
Jul-Dec 2013: 6.3%
Jul-Jun 2014: 5.8%
OBCM Data Dashboard
Measure 4 - Active Care Management (State)

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<tr>
<th>Year</th>
<th>Percentage</th>
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</thead>
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<tr>
<td>Jul-Dec 2012</td>
<td>53.9%</td>
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<tr>
<td>Jan-Jun 2013</td>
<td>56.3%</td>
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<td>Jul-Dec 2013</td>
<td>55.0%</td>
</tr>
<tr>
<td>Jul-Jun 2014</td>
<td>58.6%</td>
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</tbody>
</table>
Potential Action Steps

Meet as local staff (CMs, supervisor, local QI staff, etc.) to:

- Identify undesired trends
- Prioritize the measure that should be addressed first
- Discuss local situations that may have negatively impacted results and strategize on how to minimize the impact
- Develop a plan to address the identified measure that:
  - Contains goal(s) written in SMART format
  - Includes a short time frame for assessing impact
  - Uses available data to assess impact
Available Resources

- DPH Regional Social Work Consultant
- Local CCNC network OB Coordinator
- OBCM Performance Improvement Strategies
  (Coming Soon)
Moving the OBCM Data Dashboard measures in the desired direction can assist you with:

- Working to improve the birth outcomes in your county

  AND

- Meeting the Performance Measures in the contract with the local network
Participation Agreement

(Organization) and Alliant Quality, the QIN-QIO (Quality Innovation Network – Quality Improvement Organization) for Georgia and North Carolina, agree to collaborate between the present date and July 31, 2019, on the following initiatives(s) sponsored by the Centers for Medicare & Medicaid Services (CMS). Please indicate your intent to participate with Alliant Quality by checking the box below for your chosen initiative(s).

Goal: Healthy People, Healthy Communities: Improving the Health Status of Communities

☐ Improving Cardiac Health and Reducing Cardiac Healthcare Disparities: The QIN QIO will convene medical practices, patients, community partners, and medical associations to join a learning and action network (LAN) called, The Cardiac Health and Disparities Learning and Action Network. The collaborative endeavor will engage participants in testing interventions to improve management of the Million Hearts Initiative measures and identify health disparities: aspirin therapy, blood pressure control, cholesterol control, and smoking cessation counseling. Medical practices participating in the cardiac quality improvement will submit ABCS via a PQRS aligned EHR.

Participants may join as a ☐ Network Participant OR ☐ Cardiac Improvement and Network Participant

☐ Improving Prevention Coordination through Meaningful Use of HIT and Collaborating with Regional Extension Centers: The QIN-QIO will facilitate a Preventive Health and HIT Learning and Action Network (LAN) for eligible professionals, eligible hospitals, and critical access hospitals challenged in meeting the EHR Incentive Program requirements due to HIT disparities in their community. The LAN will support organizations in effective use of clinical decision support, meeting meaningful use clinical quality measures reporting requirements, promoting patient and family engagement through use of patient portals, and provide technical assistance on strategies to optimization of the EHR to track and improve cardiac population health and preventive health screenings.

Participants may join as a ☐ Network Participant OR ☐ CQM Improvement and Network Participant

Goal: Make Care More Affordable

☐ Quality improvement through Value-Based Payment, Quality Reporting, and the Physician Feedback Reporting Program: The QIN-QIO will assist organizations in successfully reporting to Physician Quality Reporting System (PQRS), Value Based Modifier Program (VM), and the Value Based Purchasing program (VBP). Eligible professionals, eligible hospitals, critical access hospitals, Inpatient Psychiatric Facilities, PPS-exempt cancer hospitals, and ambulatory surgical centers challenged in meeting quality data reporting requirements will receive technical assistance in Improving VBP measures, best practices on how to avoid PQRS and VM payment adjustments, and assistance with Quality and Resource Use Reports (QRUR) analysis and interpretation.

Confidentiality

A healthcare quality improvement project is considered a quality review study, defined in 42 CFR Section 480.101(b) of federal regulations as being "an assessment, conducted by or for the QIO, for the purpose of improving patient care through peer analysis, intervention, resolution of the problem and follow-up." Federal regulations at 42 CFR Section 480.140 protect the identities of individual patients, practitioners, and institutions that participate in such studies, and prohibit, with few exceptions, Alliant Quality from disclosing any specific information about their work on quality review studies.

Consent to Share Data

This consent to share data does not cover patient-identifiable information or information that implicitly or explicitly identifies a patient. Patient information should not be transmitted to Alliant Quality for any reason.

The Organization hereby acknowledges and consents to

• Release of the Organization’s name to other affiliated participants in the quality improvement project
• Alliant Quality’s sharing of aggregate performance data with all participants in the quality initiatives stated above to facilitate sharing, learning, and improvement of patient care

Acceptance

We understand this is a non-binding agreement that may be amended by mutual written consent and may be terminated at any time by either party.

The executive leadership of our organizations has reviewed this agreement and expectations to ensure that we are able to make an ongoing commitment throughout the course of the project. Please sign and return all pages of the Participation Agreement by fax to: Elisabeth Klemis at (678) 527-3030 or (678)-527-3025.
## Roles and Responsibilities

<table>
<thead>
<tr>
<th>Organization commitments</th>
<th>Alliant Quality commitments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff resource allocation and participation</strong></td>
<td><strong>Communications/primary contact</strong></td>
</tr>
<tr>
<td>- Identify and allocate staff, taking into consideration practice organizational regulations, policy, and clinical impact on site.</td>
<td>- Designate an individual to be the primary Alliant Quality point of contact for the quality initiative.</td>
</tr>
<tr>
<td>- Develop a detailed statement of needs and establish a project plan in collaboration with Alliant Quality.</td>
<td><strong>Technical assistance</strong></td>
</tr>
<tr>
<td>- Provide a quarterly status update on project progress and organizational changes that relate to this project.</td>
<td>- Provide technical assistance, including the development of quality improvement project plans and documentation.</td>
</tr>
</tbody>
</table>

### Quality Improvement activities
- Implement an improvement plan and monitor performance.
- Complete required training elements.
- Collaborate with other project participants (e.g., share tools, experiences, barriers, and results).
- Actively participate in local, regional, and national project meetings (webinars, teleconferences, etc.).

### Leadership for LAN Interactions and activities
- Alliant Quality will develop, implement, and facilitate a learning and action network (LAN) comprising community health centers, medical practices, medical associations, and other community stakeholders in collaboration.
  - Host a forum for PQRS and VM learnings.
  - Coordinate LAN meetings: one face-to-face meeting per year and at least two virtual meetings per year.
  - Provide tools and best organization examples.
  - Facilitate networking, learning and sharing among LAN participants.

## Clinical and process measure improvement
- Commit to achieving meaningful improvement.
- Adopt proven quality improvement methodologies and process improvement strategies to improve clinical outcomes.

## Action plan support
- Assist in the development of a provider-specific action plan to achieve quality improvement goals.

## Sustainability of results
- Implement and document processes during the project to support standardization and sustainability.
- Designate a team to oversee standardization and spread.

**Tools and resources**
- Provide access to relevant information, best organization resources, and tools to support improvement.
**Practice List**

**Date:**

**Medical Group Name:**

**Number of Practice Sites:**

Alliant Quality Initiatives Practice is participating in:

Please provide the following information for all practices who intend to participate in Alliant Quality initiatives. Use an additional sheet if necessary.

<table>
<thead>
<tr>
<th>Organization NPI</th>
<th>Practice Name (If practice name is the same yet there are multiple practice sites, add the site name—see example below)</th>
<th>Practice Address, City, Zip</th>
<th>Practice Manager</th>
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<td>901 State Boulevard, Quakertown, PA 18951</td>
<td>Emily Jones</td>
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Family Planning Annual Report (FPAR)

Total Unduplicated Patient Count

2010: 139,982  
2011: 125,230  
2012: 121,010  
2013: 115,446  
2014: 100,523

The total number of unduplicated patients in CY 2014, 100,523, represents a nearly 13% decrease over 2013. The numbers have been declining for the last five years, during which time the decrease has been 28%. The overall trend in teens seeking family planning services at clinics in health departments has been declining since 2001. The percentage of teen females seen has gone from 20.4% in 2010 to 15.1% in 2014. While teen numbers have been declining, the percentage of women over 40 has increased from 6.7% of the 2010 total to 8.3% of 2014's total. The distribution for the other age groups has remained stable, with the majority of patients still in the 20-24 year old age group.

After many years of increases in the percentage of Latino family planning patients, Latinos accounted for only 20% in 2014; that number is down from a high of 29% in 2011.

While the percentage of uninsured patients remained stable between 2010 and 2013 at just over/under 70%, uninsured patients represented 37% of the total in 2014. The number of unknown or unreported number was high in 2014 and many of those patients may also have been uninsured.

Contraceptive choice among female patients has undergone some interesting changes in the last five years. While hormonal injections have remained roughly the same, use of long acting reversible contraceptive methods (LARC)s has increased greatly. We have increased efforts in the last several years to move more women to LARC$s and are pleased with the results. Oral contraceptives and condoms have shown declines in the last year.

Unduplicated Number of Female Family Planning Users by Primary Method 2010 - 14

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<tr>
<td>Intrauterine device (IUD)</td>
<td>12,750</td>
<td>9%</td>
<td>11,124</td>
<td>9%</td>
<td>11,979</td>
<td>10%</td>
<td>11,661</td>
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<tr>
<td>Hormonal implant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-Month hormonal injection</td>
<td>29,443</td>
<td>22%</td>
<td>27,118</td>
<td>22%</td>
<td>27,561</td>
<td>23%</td>
<td>26,913</td>
<td>24%</td>
<td>23,749</td>
<td>24%</td>
</tr>
<tr>
<td>Oral contraceptive</td>
<td>48,669</td>
<td>36%</td>
<td>44,852</td>
<td>36%</td>
<td>40,145</td>
<td>34%</td>
<td>38,784</td>
<td>34%</td>
<td>27,156</td>
<td>27%</td>
</tr>
<tr>
<td>Male Condom</td>
<td>19,160</td>
<td>14%</td>
<td>21,158</td>
<td>17%</td>
<td>17,730</td>
<td>15%</td>
<td>15,759</td>
<td>14%</td>
<td>9,008</td>
<td>9%</td>
</tr>
<tr>
<td>Total Female Users</td>
<td>136,172</td>
<td>100%</td>
<td>123,888</td>
<td>100%</td>
<td>119,190</td>
<td>100%</td>
<td>113,829</td>
<td>100%</td>
<td>99,016</td>
<td>100%</td>
</tr>
</tbody>
</table>

Total Female Users include all patients who received family planning services and are female.
Care Coordination for Children
Data Dashboard Measure Results

February 2015
Cheryl G. Lowe - CC4C Program Manager
Angel Callicutt – CC4C Project Manager
N.C. Department of Health & Human Services
Division of Public Health
<table>
<thead>
<tr>
<th></th>
<th>CC4C Data Dashboard Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Percent of Medicaid children ages 0-5 years contacted by a CC4C CM.</td>
</tr>
<tr>
<td>2.</td>
<td>Percent of Medicaid children ages 0-5 years engaged in heavy and medium case status.</td>
</tr>
<tr>
<td>3.</td>
<td>Percent of Medicaid children ages 0-5 years deferred due to “unable to contact.”</td>
</tr>
<tr>
<td>4.</td>
<td>Percent of Medicaid children ages 0-5 years due to refused services.</td>
</tr>
</tbody>
</table>
CC4C Data Dashboard Results

Measure 1: % of Medicaid Children Age 0<5 Contacted by CC4C CM Statewide

- Dec 2012: 7.2%
- Jun 2013: 8.1%
- Dec 2013: 7.7%
- Jun 2014: 7.5%
- Sep 2014: 7.8%
CC4C Data Dashboard Results

Measure 2: % of Medicaid Children Age 0<5 in CC4C Hvy/Med Case Status Contacted by CC4C CM Statewide

- Dec 2012: 3.9%
- Jun 2013: 4.6%
- Dec 2013: 4.6%
- Jun 2014: 4.5%
- Sep 2014: 4.7%
Measure 3: % of Medicaid Children Age 0<5
Initially Identified with a Task by CC4C CM
and Deferred for Unable to Contact
Statewide

Dec 2012: 8.1%
Jun 2013: 7.4%
Dec 2013: 5.6%
Jun 2014: 5.7%
Sep 2014: 5.6%
Measure 4: % of Medicaid Children Age 0<5
Initially Identified with a Task by CC4C CM
and Deferred for Refused Services
Statewide

---|---|---|---|---
5.6% | 4.9% | 2.1% | 1.6% | 1.6%
Path to Data Dashboard Measures from IC Home Page:
Home > Local Health Department Standard Reports > *County Name* > CC4C Reports > CC4C Data Dashboard & All LHD CC4C Reports

<table>
<thead>
<tr>
<th>Folder Settings</th>
<th></th>
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<tbody>
<tr>
<td><img src="image" alt="Folder" /></td>
<td>Home &gt; Local Health Department Standard Reports &gt; ALAMANCE</td>
</tr>
<tr>
<td><img src="image" alt="Folder" /></td>
<td>North Carolina Community Care Networks Informatics Center Report Site</td>
</tr>
<tr>
<td><img src="image" alt="Folder" /></td>
<td><strong>CC4C Reports</strong></td>
</tr>
<tr>
<td><img src="image" alt="Folder" /></td>
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</tr>
<tr>
<td><img src="image" alt="Folder" /></td>
<td><img src="image" alt="Folder" /></td>
</tr>
</tbody>
</table>

Screen shot of the CC4C Reports folder found within the NCCN informatics Center
Next Steps

Local staff (CMs, supervisor, local QI staff, etc.) are encouraged to:

- Identify undesired trends
- Prioritize the measure that should be addressed first
- Discuss local situations that may have negatively impact results and strategize on how to minimize the impact
- Develop a plan to address the identified measure that:
  - Contains goal(s) written in SMART format
  - Includes a short time frame for assessing impact
  - Uses available data to assess impact
Available Resources

- CC4C Network Lead
- Regional Child Health Nurse Consultant
- CC4C Performance Improvement Strategies Dec 2014
CC4C Performance Improvement Strategies

December 2014

Have healthier outcomes and that measures are met, consider:

- What intervention I'm doing with this client meaningful? Will this work/intervention positively impact this child/family or am I simply "monitoring" to impact another child/family? Am I continuing to work with the client?

Document available in the CC4C Toolkit posted in the CCNC Informatics Center

| Pages 1-5: Menu of strategies to improve Contract Measures |
| Pages 6-8: Menu of strategies to improve Data Dashboard Measures |

CC4C Data Dashboard Results Review
CC4C Data Dashboard

Moving the Data Dashboard measures in the desired direction can assist you in:

- Meeting the Performance Measures in the contract with the local network

  AND

- Improving the health outcomes of children in your county.
REPORT TO ASSOCIATION, N.C. LOCAL HEALTH DIRECTORS

March 19, 2015

By  Barbara Ann Hughes, PhD, RDN, MPH, FAND, President

ANCBH:

Board Conference Call: Thursday morning, April 2, 2015, 8:00  Plan to discuss process of accreditation.

Important pieces of literature are e-mailed to board members on a regular basis. Example: Public Policy Priorities; Talking Points; Local Boards Consolidation (now about 25 counties.)

Vaughn Upshaw Scholarship will be presented to Mara Victoria Howard-Williams, a graduate student in Public Health Leadership Program, April 16, prior to Ford Lecture.

Four $500 scholarships to be awarded for attendance at NALBOH meeting, Louisville, KY, August, 2015

NALBOH:

N C Health Department Dues are being received by Badger Bay. As of yesterday, 25 NC boards of health/human services have paid dues. Benefits of NALBOH membership: Reduced annual conference rate —Louisville, KY; Brown Hotel, August 5 – 7. One free registration for every 10 from a state.

Free webinars—starting February 25 (P.H.Law and PH Law Research Network series);

Quarterly NEWSBRIEF (on line and print) will come out early April; Monthly e-news (schedule established, need NC stories); Interactive Website and member forums.

Join on line: nalboh@badgerbay.co  Have 139 local board members and 9 Associate Members.

Board Meeting today at Noon; Retreat in Omaha, NB, April 12-15. Some support from college of PH

Getting closer to solvency. Debt to Salt Lake Hilton will be paid off by June!

Will receive draft of proposed new bylaws and Emeritus committee resolutions

Will add a new board member to replace a board member moving into the pres.-elect position
<table>
<thead>
<tr>
<th>County</th>
<th>Name</th>
<th>County</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alamance</td>
<td>Stacie Turpin Saunders</td>
<td>Jackson</td>
<td>Paula Carden</td>
</tr>
<tr>
<td>Albermarle District</td>
<td>Jerry Parks</td>
<td>Johnston</td>
<td>Marilyn Pearson</td>
</tr>
<tr>
<td>Alexander</td>
<td>Leeanne Whisnant</td>
<td>Jones</td>
<td>Wesley Smith</td>
</tr>
<tr>
<td>Anson</td>
<td>Fred Thompson</td>
<td>Tee</td>
<td>Terrell Jones</td>
</tr>
<tr>
<td>Appalachian District</td>
<td>Beth Lovette</td>
<td>Lenoir</td>
<td>Joey Huff</td>
</tr>
<tr>
<td>Beaufort</td>
<td>James Madison</td>
<td>Lincoln</td>
<td>Maggie Dollar</td>
</tr>
<tr>
<td>Bladen</td>
<td>Cris Harrelson</td>
<td>Macon</td>
<td>Jim Bruckner</td>
</tr>
<tr>
<td>Brunswick</td>
<td>David Stanley</td>
<td>Madison</td>
<td>John Graeter, Int.</td>
</tr>
<tr>
<td>Buncombe</td>
<td>Jan Shepard</td>
<td>MTW District</td>
<td>Terrell Davis</td>
</tr>
<tr>
<td>Burke</td>
<td>Rebecca McLeod</td>
<td>Mecklenburg</td>
<td>Marcus Plescia</td>
</tr>
<tr>
<td>Cabarrus Health Alliance</td>
<td>William Pilkington</td>
<td>Montgomery</td>
<td>Mary Perez</td>
</tr>
<tr>
<td>Caldwell</td>
<td>Denise Michaud</td>
<td>Moore</td>
<td>Robert Wittmann</td>
</tr>
<tr>
<td>Carteret</td>
<td>David Jenkins</td>
<td>Nash</td>
<td>William Hill, Jr.</td>
</tr>
<tr>
<td>Caswell</td>
<td>Fred Moore</td>
<td>New Hanover</td>
<td>David Rice</td>
</tr>
<tr>
<td>Catawba</td>
<td>Doug Ureland</td>
<td>Northampton</td>
<td>John White, Int.</td>
</tr>
<tr>
<td>Chatham</td>
<td>Layton Long</td>
<td>Onslow</td>
<td>Angela Lee</td>
</tr>
<tr>
<td>Cherokee</td>
<td>Towanna Roberts</td>
<td>Orange</td>
<td>Colleen Bridger</td>
</tr>
<tr>
<td>Clay</td>
<td>Janice Patterson</td>
<td>Pamlico</td>
<td>Dennis Harrington</td>
</tr>
<tr>
<td>Cleveland</td>
<td>Dorothea Wyant</td>
<td>Pender</td>
<td>Carolyn Moser</td>
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<tr>
<td>Columbus</td>
<td>Kim Smith</td>
<td>Person</td>
<td>Janet Clayton</td>
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<td>Craven</td>
<td>Scott Harrelson</td>
<td>Pitt</td>
<td>John Morrow</td>
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<tr>
<td>Cumberland</td>
<td>Buck Harrelson</td>
<td>Randolph</td>
<td>Mimi Cooper</td>
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<tr>
<td>Dare</td>
<td>Sheila Davies</td>
<td>Richmond</td>
<td>Tommy Jarrell</td>
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<td>Davidson</td>
<td>Moneta Thomas</td>
<td>Robeson</td>
<td>William Smith</td>
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<td>Davie</td>
<td>Suzanne Wright</td>
<td>Rockingham</td>
<td>Glenn Martin</td>
</tr>
<tr>
<td>Duplin</td>
<td>Ila Davis</td>
<td>Rowan</td>
<td>Nina Oliver</td>
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<tr>
<td>Durham</td>
<td>Gayle B. Harris</td>
<td>LARC District</td>
<td>James Hines, Jr.</td>
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<tr>
<td>Edgecombe</td>
<td>Karen Lachapelle</td>
<td>Sampson</td>
<td>Wanda Robinson</td>
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<tr>
<td>Forsyth</td>
<td>Marlon Hunter</td>
<td>Scotland</td>
<td>Wayne Raynor, Int.</td>
</tr>
<tr>
<td>Franklin</td>
<td>Chris M. Szwagiel</td>
<td>Stanly</td>
<td>Dennis Joyner</td>
</tr>
<tr>
<td>Gaston</td>
<td>Chris Dobbins</td>
<td>Stokes</td>
<td>Scott Lenhart</td>
</tr>
<tr>
<td>Graham</td>
<td>Allicia Parnam</td>
<td>Surry</td>
<td>Samantha Ange</td>
</tr>
<tr>
<td>Granville-Vance District</td>
<td>Lisa Macon-Harrison</td>
<td>Swain</td>
<td>Alison Cochran</td>
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<tr>
<td>Greene</td>
<td>Michael Rhodes</td>
<td>Toe River District</td>
<td>Lynda Kinnane</td>
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<tr>
<td>Guilford</td>
<td>Merle Green</td>
<td>Transylvania</td>
<td>Elaine Russell</td>
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<td>Halifax</td>
<td>Cardra Burns</td>
<td>Union</td>
<td>Phillip Tarte</td>
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<tr>
<td>Harnett</td>
<td>John Rouse</td>
<td>Wake</td>
<td>Sue Lynn Ledford</td>
</tr>
<tr>
<td>Haywood</td>
<td>Carmine Rocco</td>
<td>Warren</td>
<td>Andy Smith</td>
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<tr>
<td>Henderson</td>
<td>Steve Smith</td>
<td>Wayne</td>
<td>Davin Madden</td>
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<tr>
<td>Hertford</td>
<td>Ramona Bowser, Int.</td>
<td>Wilkes</td>
<td>Ann Absher</td>
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<tr>
<td>Hoke</td>
<td>Helene Edwards</td>
<td>Wilson</td>
<td>Teresa Ellen</td>
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<tr>
<td>Hyde</td>
<td>David Howard</td>
<td>Yadkin</td>
<td>Kimberly Harrell</td>
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<tr>
<td>Iredell</td>
<td>Jane Murray</td>
<td></td>
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</table>
March 19, 2015
NCALHD Attendance Roster - Health Director Initial by County
(Bold Indicates NCALHD Dues paid)

<table>
<thead>
<tr>
<th>DPH Liaisons</th>
<th>Robin Cummings</th>
<th>NCALHD Exec Dir</th>
<th>Lynette Tolson</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️ Phyllis Rocco</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✔️ Larry Michael</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Guests Liaisons from other Organizations

<table>
<thead>
<tr>
<th>Steve East</th>
<th>Frances DHHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jill Mann</td>
<td>HCC SBC</td>
</tr>
<tr>
<td>Anna Scherer</td>
<td>UNC NCAPHA</td>
</tr>
<tr>
<td>Jan Gilstrap</td>
<td>Cartersville</td>
</tr>
<tr>
<td>Julie Murrey</td>
<td>TECB, CDI Sect. DHEC</td>
</tr>
<tr>
<td>Kristine C. Bowman</td>
<td>NCAPHA</td>
</tr>
<tr>
<td>Karen Davis</td>
<td>NCALHD</td>
</tr>
<tr>
<td>Barbara Ann Hughes</td>
<td>ANC &amp; BH</td>
</tr>
</tbody>
</table>

JFG  DORE DHHS
North Carolina Association of Local Health Directors, Inc.

Balance Sheet

<table>
<thead>
<tr>
<th>ASSETS</th>
<th>Mar 31, 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Assets</td>
<td></td>
</tr>
<tr>
<td>Checking/Savings</td>
<td></td>
</tr>
<tr>
<td>CD-SECU *4185</td>
<td>40,000.00</td>
</tr>
<tr>
<td>Checking-SECU *6586</td>
<td>16,929.12</td>
</tr>
<tr>
<td>Money Market-SECU *0321</td>
<td>358,487.56</td>
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<tr>
<td>Savings-SECU *1387</td>
<td>42.17</td>
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<td>Total Checking/Savings</td>
<td>415,458.85</td>
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<tr>
<td>Accounts Receivable</td>
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<td>Accounts Receivable</td>
<td>33,629.68</td>
</tr>
<tr>
<td>Total Accounts Receivable</td>
<td>33,629.68</td>
</tr>
<tr>
<td>Total Current Assets</td>
<td>449,088.53</td>
</tr>
<tr>
<td>TOTAL ASSETS</td>
<td>449,088.53</td>
</tr>
</tbody>
</table>

| LIABILITIES & EQUITY                        |           |
| Liabilities                                 |           |
| Current Liabilities                         |           |
| Accounts Payable                            |           |
| Accounts Payable                            | 17,485.35 |
| Total Accounts Payable                      | 17,485.35 |
| Total Current Liabilities                   | 17,485.35 |
| Total Liabilities                           | 17,485.35 |
| Equity                                      |           |
| Opening Bal Equity                          | 50,793.88 |
| Temporarily Restricted Funds                 |           |
| Legal Fund                                  | 34,388.00 |
| Total Temporarily Restricted Funds           | 34,388.00 |
| Unrestricted Net Assets                      | 285,340.50|
| Net Income                                  | 61,080.80 |
| Total Equity                                | 431,603.18|
| TOTAL LIABILITIES & EQUITY                  | 449,088.53|
North Carolina Association of Local Health Directors, Inc.
Income & Expense Budget vs. Actual

<table>
<thead>
<tr>
<th>Ordinary Income/Expense</th>
<th>Jan - Mar 15</th>
<th>Budget</th>
<th>$ Over Budget</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest/Dividend Income</td>
<td>746.47</td>
<td>2,280.00</td>
<td>(1,533.53)</td>
<td>32.74%</td>
</tr>
<tr>
<td>Meeting/Conference Income</td>
<td>10,200.00</td>
<td>900.00</td>
<td>9,300.00</td>
<td>1,133.33%</td>
</tr>
<tr>
<td>Membership Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NACCHO Rebate</td>
<td>0.00</td>
<td>2,500.00</td>
<td>(2,500.00)</td>
<td>0.0%</td>
</tr>
<tr>
<td>NCALHD Dues</td>
<td>49,056.68</td>
<td>60,000.00</td>
<td>(10,944.32)</td>
<td>81.76%</td>
</tr>
<tr>
<td>Total Membership Income</td>
<td>49,056.68</td>
<td>62,500.00</td>
<td>(13,444.32)</td>
<td>78.49%</td>
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<tr>
<td>Total Income</td>
<td>60,002.15</td>
<td>65,680.00</td>
<td>(5,677.85)</td>
<td>91.36%</td>
</tr>
<tr>
<td>Expense</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative Services</td>
<td>12,900.00</td>
<td>51,600.00</td>
<td>(38,700.00)</td>
<td>25.0%</td>
</tr>
<tr>
<td>Awards</td>
<td>598.37</td>
<td>1,000.00</td>
<td>(401.63)</td>
<td>59.84%</td>
</tr>
<tr>
<td>Bank Charges</td>
<td>1.00</td>
<td>12.00</td>
<td>(11.00)</td>
<td>8.33%</td>
</tr>
<tr>
<td>Gifts</td>
<td>0.00</td>
<td>150.00</td>
<td>(150.00)</td>
<td>0.0%</td>
</tr>
<tr>
<td>Licenses and Permits</td>
<td>504.00</td>
<td>504.00</td>
<td>0.00</td>
<td>100.0%</td>
</tr>
<tr>
<td>Meeting/Travel Expense</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meetings/Conferences</td>
<td>686.81</td>
<td>3,500.00</td>
<td>(2,813.19)</td>
<td>19.62%</td>
</tr>
<tr>
<td>Travel</td>
<td>583.29</td>
<td>1,000.00</td>
<td>(416.71)</td>
<td>58.33%</td>
</tr>
<tr>
<td>Total Meeting/Travel Expense</td>
<td>1,270.10</td>
<td>4,500.00</td>
<td>(3,229.90)</td>
<td>28.22%</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>10.00</td>
<td>100.00</td>
<td>(90.00)</td>
<td>10.0%</td>
</tr>
<tr>
<td>Professional Services</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounting Fees</td>
<td>0.00</td>
<td>2,000.00</td>
<td>(2,000.00)</td>
<td>0.0%</td>
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<tr>
<td>Consulting</td>
<td>3,333.32</td>
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<tr>
<td>Technology</td>
<td>3,650.00</td>
<td>3,500.00</td>
<td>150.00</td>
<td>104.29%</td>
</tr>
<tr>
<td>Total Professional Services</td>
<td>6,983.32</td>
<td>5,500.00</td>
<td>1,483.32</td>
<td>126.97%</td>
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<tr>
<td>Sponsorships</td>
<td>100.00</td>
<td>1,800.00</td>
<td>(1,700.00)</td>
<td>5.56%</td>
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<td>Website</td>
<td>10.00</td>
<td>300.00</td>
<td>(290.00)</td>
<td>3.33%</td>
</tr>
<tr>
<td>Total Expense</td>
<td>22,376.79</td>
<td>65,466.00</td>
<td>(43,089.21)</td>
<td>34.18%</td>
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<tr>
<td>Net Ordinary Income</td>
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<td>214.00</td>
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