Central Region Consumer & Family Advisory Committee

Meeting Minutes

February 2, 2021 - 5:30PM-7:30PM

Via WebEx 1-415-655-0003 | Access Code: 1605386957#

Note: **Due to the COVID-19 pandemic and the Governor's Stay-At-Home Order, this meeting was held by WebEx and conference call.**

Council Members	Voting Member Present = P Absent = A
Allen Dittmer	P
Bob Crayton, Chair	P
Candle Hughes	P
Darlene Cooper	P
Ellen Perry	A
Heather Johnson	P
Janet Sowers – Interim Vice Chair	P
Jeanette Williamson	P
Jeannie Irby	P
Kyle Reece	P
Lea Ottinger - Vice Chair	LOA
Leslie Matthews	P
Marjorie Davis	A
Paula Harrington	P
Stanley Cotton	P
Steve Furman	P
Timothy Jeffers	P
Staff	**Non- Voting**
Stacey Harward, Community Engagement Specialist, DMH/DD/SAS, CE&E Team	A
LaKeisha McCormick, Manager, Member Engagement, Community Ops.	P
King Jones, Director of Member Engagement, Community Ops.	P
Elliot Clark, Director of Regional Affairs – Northern and Central	P
Guests	**Non-Voting**
Jesse Hardin, MA, PCMH-CCE Senior Provider Engagement Coordinator, Carolina Complete Health Network	P
Pamela M. Perry, Vice President, Legislative Affairs and Government Relations, Carolina Complete Health	P
Charles "Ken" Dunham, MD, Medical Director, Carolina Complete Health	P
Faith Samples, Director of Community Partnership & Liaison, Carolina Complete Health	P

1. **Call to Order**
   Meeting called to order at 5:38 p.m. with a quorum present.
   Members and Guests introduced themselves and their county/area of behavioral health.

2. **Approve Minutes and Agenda**
   a. The agenda for February 2, 2021 reviewed and approved.

      Heather Johnson motioned to approve the agenda and Janet Sowers seconded the motion.

   b. The minutes from the January 5, 2021 meeting were reviewed.

      Janet Sowers made a motioned to approve the minutes with corrections. Kyle Reece seconded the motion.

      Roll call taken. All in favor. Motions carried.

3. **Public Comments – Community**
   Bob expressed that this past weekend marked a one-year anniversary of his extended medical leave. He wanted to thank everyone for their support and prayers during that time.

4. **Special Presentation (Dr. Ken Dunham, Faith Samples, Pam Perry, and Jesse Hardin)**
   Jesse Hardin began the presentation with introductions of the Carolina Complete Health team. Carolina Complete Health and Medicaid Transformation presentation consisted of:

   Medicaid Managed Care (Dr. Ken Dunham):
   - Medicaid and NC Health Choice supports the health and well-being of 2.2 million North Carolinians and covers more than 65,000 births
   - Medicaid and NC Health Choice are funded by both the federal government and the state.
   - Federal funds about 2/3 of the Medicaid program.
   - 2020 marked the 50th anniversary of NC Medicaid

   Why Medicaid Transformation?
   - "To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care which addresses both medical and non-medical divers of health"
   - Legislative Mandate: Session Law 2015-245 directed the NC Department of Health and Human Services to transition to managed care to achieve budget neutrality and to achieve better health outcomes and cost savings. This developed into the 1115 waiver and request for proposals.

- Advantages of Medicaid Managed Care
    - Increased the quality of care and services
    - Increases access to care and services
    - Improve the member experience
    - Enhance coordination of care and integration through a focus of holistic health
- Goals for Medicaid Managed Care
    - Measurably improve health of North Carolinians
    - Maximize value to ensure program sustainability
    - Increase access to care
- **Overview of Managed Care – the majority of Medicaid and NC Health Choice beneficiaries will receive Medicaid through Prepaid Health Plans (PHPs)**

  ****Note – certain populations will continue to receive fee-for-service (FFS) coverage on an ongoing basis in Medicaid Direct****

    - NC Medicaid providers will contract with and be reimbursed by the PHPs rather than the State directly
    - Two types of PHPs
        - Commercial plans
        - Provide-led entities
    - Two types of products:
        - Standard Plans for most beneficiaries; scheduled to launch in July 2021
        - Tailored Plans for high-need populations; will launch no sooner than July 2022
    - Continued focus on high-quality, local care management
- **Behavioral Health Integration**
    - Behavioral Health Integration in Standard Plans
        - Standard Plans will offer integrated physical and behavior health services upon managed care launch
        - The majority of Medicaid and NC Health Choice enrollees, including adults and children with lover-intensity behavioral health needs, will receive integrated physical health, behavioral health, and pharmacy services through Standard Plans when Managed Care launches.
        - Standard Plans will offer a robust set of benefits, but certain higher-intensity behavioral health, I/DD and TBI benefits will only be offered under Tailored Plans.

  Rationale for Integration – Currently, NC Medicaid beneficiaries have their behavioral health benefit administered separately from their physical health benefit through LME-MCSs. Integrating behavioral and physical health benefits will better enable care managers and providers to deliver coordinated, whole person care.

- **Health Plans Providing Managed Care**
    - On February 4, 2019, NC DHHS announced the selection of Prepaid Health Plans (PHPs) that will participate in Medicaid managed care when the program launches on July 1, 2021.
    - NC DHHS will delegate the direct administration and management of certain health services to PHPs. PHPs will be required to contract with "any willing qualified provider."
    - Four Statewide PHP Contracts:
        - AmeriHealth Caritas of North Carolina, Inc.
        - Blue Cross and Blue Shield of North Carolina
        - UnitedHealthcare of North Carolina, Inc.
        - WellCare of North Carolina, Inc.
    - One Regional Provider-Led Entity
        - Carolina Complete Health, Inc., (Regions, 3, 4, & 5)
- Medicaid Transformation Timeline
    - 3/15/21 – begin open enrollment
    - 5/14/21 – conclude statewide open enrollment
    - 5/15/21 – auto enrollment
    - 7/1/21 – tribal option & managed care launch
    - 9/29/21 – end of choice period
    - Local DSS will continue to determine Medicaid Eligibility and direct beneficiaries to the proper support system
    - Enrollment Broker will provide beneficiary support through choice counseling
    - Health plan will provide beneficiary support through website content and member services
- **Mission – to transform the health of our community, one person at a time.**
- **North Carolina's Only Physician-Led Medicaid Plan**
    - A joint venture between Centene Corporation, the North Carolina Medical Society (NCMS), the North Carolina Community Health Center Association (NCCHCA) and the individual practitioner shareholders in the CCH Network to collaborate on a patient-focused, provider-led approach to Medicaid Transformation
        - A first of its kind partnership – Carolina Complete Health is the result of a collaboration between the NC Medical Society, the NC Community Health Center Association, and Centene Corporation.
        - Provider-led – We give doctors and FQHCs (Federally Qualified Health Centers) a voice in key policymaking. We believe providers are essential to Medicaid Transformation and are committed to helping providers remain strong and viable, especially important during the pandemic.
        - Patient-centered – Carolina Complete Health helps patients get the care they need, when they need it, through local, regional, and community-based resources.

- **Carolina Complete Health Partners**
    - North Carolina Medical Society
    - North Carolina Community Health Center Association
    - Centene Corporation – moving headquarters to Charlotte, North Carolina
- **Carolina Complete Health will provide a totally integrated solution**
    - Physical health
    - Behavioral Health
    - Pharmacy Services
    - Ancillary Services
    - Healthy Opportunities
- **Carolina Complete Health Value Added Services – (Faith Samples)**
    - Wellness
    - Youth
    - Education
    - Asthma Support services
    - Pregnancy services
    - Phone program services
    - SafeLink wireless services
    - Behavioral health services
    - Alternative healing
    - Transportation services
    - Patient, peer, and online support
    - Chiropractic care services
    - Home-delivered meals
    - Pain management services
    - Vision services
    - Other care grant – a yearly amount for supports, resources, and supplies for members who qualify
- **Member Ombudsman (Pam Perry)**
    - DHHS has selected Legal Aid of NC (Legal Aid) to provide Medicaid Managed Care Ombudsman services for the state's Medicaid beneficiaries
    - Legal Aid will partner with the Charlotte Center for Legal Advocacy and Pisgah Legal Services to educate and inform beneficiaries about the state's transition to Medicaid managed care through outreach events, a public website, and a toll-free number
    - The Ombudsman will also help beneficiaries resolve issues within the Medicaid managed care delivery system. The member Ombudsman services will begin in spring 2021

- Provider Ombudsman inquiries, concerns or complaints can be directed to the Medicaid.ProviderOmbudsman@dhhs.nc.gov email distribution address, or providers may utilize the Medicaid Managed Care Provider Ombudsman line at 919-527-6666.

- **Questions/Answers:**
    - Stanley – Will your organization have services that will allow for members to be involved in groups or committees?
        - Faith – We will incorporate our members into our ~~community~~ Member Advisory Committees.
    - Jesse Hardin will send a .pdf copy of the presentation. Below, she also supplied the group with resources that can be reviewed online:
        - https://ncmedicaidplans.gov
        - https://medicaid.ncdhhs.gov
        - www.carolinacompletehealth.com
        - Fact sheet – introduction to Medicaid transformation part 1 – overview
        - Fact sheet – introduction to Medicaid transformation part 2 – enrollment and timelines
        - NC Medicaid Transformation to Managed Care Webinar for Community Partners: Jan. 27, 2021

5. Cardinal Innovations Reports/Community Operations Updates (King Jones, LaKeisha McCormick, Elliot Clark)

a. County Action Plan January Progress Report (Elliot Clark)

- Access to Care:
    1. We committed to processing 50% all treatment authorization requests within 72 hours, by December 31st and we have exceeded this goal by 9% for all authorizations, and by 48% for children in foster care.
    2. As of January 1, we have reached out goal of creating a new service program for members. This includes welcome calls, where we connect new members with needed support. In the first ten days, we made 39 referrals, including appointments for healthcare, linkage to care coordination and/or member engagement and connection to needed social services, like food and transportation.
    3. New member orientations are scheduled through May and our full training and events calendar by county can be accessed online.
- Emergency Department Utilization
    1. We are continuing work to reduce admissions by identifying members who frequently visit the Emergency Department and connecting them to appropriate services through both our hospital partners and direct member outreach. Kimberly Webb is the new Cardinal employee tasked with helping with the ED utilization process.

2. We added a full-time staff member to Novant Rowan Regional Hospital to support Emergency Department and Inpatient staff with diversion and transition planning (in addition to staff recently placed at BH Atrium).

- Network Capacity – Availability of services and providers
  1. We added five new Therapeutic Foster Care Agreements, exceeding our goal of four.
     a. Alexander Youth Network, Inc.
     b. Pinnacle Family Services of North Carolina, LLC
     c. Thompson Child and Family Focus
     d. Alamance Academy
     e. The fifth addition was a second agreement with Thompson Child & Family Focus
     f. Through this effort, we have more than tripled our capacity to serve children, and have already placed 14 members from three counties into new services
     g. We have a new Network Vice President that is currently onboard to help with this process.
- Carding for children and families
  1. Cardinal Innovations expanding our initial goal of aligning licensed, clinical staff with county DSS offices staff and has assigned staff to remaining counties. Formal programs are now being finalized for Cabarrus, Davidson, Orange, Rockingham, Rowan, and Stanly County.
  2. Cardinal Innovations is improving our focus on prevention by targeting outreach to pre-custody and early-risk identification programs such as Child Protective Services and In-Home teams.
  3. We joined the Child Maltreatment Consortium in Mecklenburg County, and are actively identifying other local and regional collaboratives to address child welfare and at-risk youth.
  4. Elliot will provide additional feedback when it becomes available.

b. Community Crisis Services Plans – Central Region (King Jones)

- King will send the Community Crisis Services Plans to the group immediately after this meeting.

c. Bonnie Schell Scholarship fund update (King Jones)

- We have had several candidates apply within the past few weeks. We have approximately around $3,000 remaining in the scholarship fund. King explained to the group that money would be equally distributed between all of the regions until April 1st.

King encouraged the group to continue to remind other members that these scholarship dollars area available. CFAC members are reminded to use CFAC training dollars for trainings, seminars, etc., before applying for the Bonnie Schell Scholarship.

d. Central Region CFAC Budget Update – King will send budget information to the group.

6. DHHS Report/CE&ET Updates – Stacey Harward – no report

7. New Business & Action Steps

CFAC Recommendations for 122C – (CFAC Members)

a. Bob informed the group that CFACs are running out of time to give input on changes concerning the 122C. Bob thanked Sarah Potter for sharing her report summary concerning the 122C recommendations. Bob reminded the group that we have known that 122C was going to be updated for about 2 years now. DHHS liaisons visited all the Local CFACs to discuss the details, and a survey was sent out November 2019. Attendees to the Statewide CFAC meeting hosted by Sandhills in Greensboro were divided into groups to discuss areas of change. Suzanne located the notes and resent them to the LCFACs Friday, January 29th. Bob stressed that we are currently in crunch time, and if we want to have our voices represented, we need act fast. It was recommended that a single proposal would be better, including recommendations agreed to by LCFACs, SCFAC, and BIANC for 122C-171. BIANC submitted a proposal last year, and Jean Andersen added that those recommendations probably wouldn't need to be changed. For changes to 122C, we could include input from all groups: NAMI, MH Collaborative, MH Coalition, The ARC, SU Coalition, SU Federation, but we are on a tight schedule. DHHS also submits recommendations, especially regarding the appointing authorities for SCFAC members. Suzanne offered to help put everything together for us, but they can't actually send it in. Our recommendations should be in a proposal submitted by SCFAC. This is the timeline which occurs before our next Regional CFAC meetings:

- Tuesday 2/2 - Central CFAC
- Monday 2/8 - Triad CFAC
- Tuesday 2/9 - Northern CFAC
- Wednesday 2/10 -next SCFAC meeting
- Tuesday 2/16 - Southern CFAC
- Tuesday 2/16 - final document to Denise Baker/DHHS to prepare for submission

Suzanne was very helpful in suggesting what we should look at, emphasizing the importance of the RFP for the Tailored Plans and recommending we read it. We need to figure out where and what we want to advise on. Things to be considered:

- the interaction of CFACs with the PHPs and Standard Plans,
- financial and clinical benchmarks the PHPs need to meet (GA needs to hold them accountable),
- budgets,
- quality improvement,
- clients' rights,
- clinical deliverables, monitoring,
- input into contracts.

Bob asked for suggestions to be shared and agreed upon via email to meet the February 16th deadline. It is presumed that the final document will be shared with the LCFACs before being submitted. Bob apologized if he or Sarah may have left out some important details regarding the process. Please let Bob or Janet know how you would like for the Central CFAC to proceed. Please give them any suggestions as to how the information should be compiled.

Please see the CFAC Recommendations for 122C:

Vaya CFAC

- Members that have co-occurring physical disabilities should be included
- Co-morbidity may need to be added to the 122C – 170
- Individuals or their family members need to receive services from the Tailored Plan to be on CFAC
- No requirement to live in the catchment area to be on CFAC
- Interaction collaboration with Standard Plan Advisory Committees should occur via quarterly meetings
- Consider having CFAC members on Standard Plan Advisory Committees and vice versa
- CFAC responsibilities should remain the same
- More education on the Tailored plans so that they will be able to advise the board on areas as they begin to change
- CFACs interact with the Tailored Plans should remain the same
- Opportunities may exist for consumers and families in Tailored and Standard Plans In the form of education for members and community, Town Hall meetings, listening sessions, and focus groups
- The implementing of changes to CFAC/advisory opportunities should occur within 0-90 days after implementation

Eastpointe

October

- No requirement to live in the Tailored Plan catchment area to be on CFAC
- The two plans should have the same structure requirements and expectations.
- CFAC responsibilities remain the same
- CFAC should continue to have individual committee bylaws that reflect the differences in geography and culture across the state

September & November

- Include members with co-occurring physical disabilities.
- No co-occurring physical illness should be required.
- People who move between the two plans should be able to serve on both plans advisory committees
- No requirement to live in the Tailored Plan catchment area to be on CFAC
- The two committees need to act as a collaborative team
- PHP member advisory committees should be organized and run like CFACs
- CFAC should remain self-governing and self-directed
- Consumers and family members should be able to serve on internal committees of both plans
- CFACs should be given at least six months after any changes to the statute in order to implement those changes

Sandhills Center

November

- Include members with co-occurring physical disabilities
- People need to be receiving services from the Tailored Plans to serve on a CFAC
- The requirement of living in the catchment areas needs to be determined by the bylaws
- The two groups should review each other's meeting minutes
- Statute should dictate that Standard Plan Member Advisory Committees should have CFAC representatives on them
- PHP Member Advisory Committees should have representation on the SCFAC
- When the Tailored Plans begins, CFAC responsibilities should be at least as much as there is now plus the addition of members with the physical health comorbidity
- No changes in CFACs interaction with the Tailored Plan's

- Statute should state that CFACs will continue to exist
- CFACs should continue to be self-governing
- Need at least six months to a year will be needed to implement changes to CFACs.

Alliance Feedback

November Johnston

- No co-occurring physical illness should be required.
- TBI should be represented on the CFAC
- Receiving services should not be a requirement for membership

November Cumberland

- No co-occurring physical illness should be required.
- TBI can be represented on the CFAC in some fashion
- Receiving services should not be a requirement for membership
- Live in the Tailored Plan catchment area to be on CFAC

December Durham

- Does not want any changes made

December Steering Committee

- Does not want any changes made

Partners CFAC

- Local CFAC shall be a self – governing and a Self- directed organization
- Each of the disability groups shall be equally represented on the CFAC and the CFAC shall reflect as closely as possible the racial and ethnic composition of the catchment area
- Include TBI change SAS to SUD
- Need to include individuals with co-occurring physical disabilities
- Individuals or their family members need to receive services from the Tailored Plan to be on CFAC
- Open communication and should be conducted on a regular basis
- Allow a CFAC member on their committee- or at least quarterly meetings

- Responsibilities should be as they are now but with the understanding that their scope may change and will need to have additional training so that they can learn what the MCO scope is and be able to advise the board on the new areas
- CFACs should interact with the Tailored Plans

Cardinal

- CFACs should remain self – governing and a self – directed
- Disability groups should be equally represented on the CFAC. CFACs should reflect the racial and ethnic composition of the catchment area
- The terms of members shall be three years and no member may serve more than three consecutive terms
- Inclusion of members that have co-occurring physical disabilities
- No requirement to receive services from the Tailored plan to be on CFAC
- Person should be required to live in the catchment area
- Quarterly meetings
- More training on Standard Plan Member Advisory Committee
- CFAC responsibilities should remain the same when Tailored Plans begin

Trillium CFAC

November

- No co-occurring physical illness should be required.
- Individuals or their families should not be required to be receiving services to be included
- No requirement to live in the catchment area to be on CFAC
- CFAC responsibilities should be the same as they are now
- CFACs should be self-directed and self-governing
- CFAC interaction with the Tailored Plans should remain unchanged
- The statute should continue to grant self-direction and self-governance to CFACs, and their bylaws should reflect individual communities needs
- Advisory opportunities exist in the form of Town Hall meetings for CFAC members and other community members who are not on the CFAC. Public Forums, surveys about their experiences
- The time frame for implementing changes should be 90 days after the statute has been changed
- Include members with co-occurring physical disabilities
- No co-occurring physical illness should be required.

- No requirement to live in the catchment area to be on CFAC
- Interaction and collaboration should happen with Standard Plan Member Advisory Committees with participation from families and individuals
- Families/individuals on boards/committees should be included in all aspects of policy making.
- Audits should be conducted to See what degree families/individuals really are included
- The time frame for implementing changes to advisory committees should be as soon as possible.

November

- People with co-occurring disabilities should be included on the CFAC
- Person should be required to live in the catchment area
- Responsibilities should continue as now
- Nothing should change until the statute changes and stated that until the RFP goes out for the Standard Plans
- CFACs need to remain self – governing and have their ability to create by-laws
- Implementation timeframe should be one year from when the Standard Plans go into effect

November

- No co-occurring physical illness should be required.
- Individuals or their families should not be required to be receiving services to be included
- No requirement to live in the catchment area to be on CFAC
- CFAC responsibilities should be the same as they are now
- CFACs should be self-directed and self-governing
- CFAC interaction with the Tailored Plans should remain unchanged
- The statute should continue to grant self-direction and self-governance to CFACs, and the bylaws should reflect individual communities needs
- Advisory opportunities exist in the form of Town Hall meetings for CFAC members and other community members who are not on the CFAC. Public Forums, surveys about their experiences
- The time frame for implementing changes should be 90 days after the statute has been changed
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- Audits should be conducted to See what degree families/individuals really are included
- The time frame for implementing changes to advisory committees should be as soon as possible.

8. Central RHC Updates – (Bob Crayton)

Regional Health Improvement Plans

Listed below are the priorities based on the individual county health assessments. We will work to complete the main goals and work on formulate strategies with the group later. This outline will be sent to the group with behavioral health information included for additional concerns and/or comments.

Access to Care

- Transportation
    - Increase the availability of public transportation options and improve internet access for telehealth, especially in rural areas.
- Lack of providers
    - Increase the availability of co-located services for behavioral health and physical health, leveraging technology to provide services wherever possible.
- Lack of insurance/coverage
    - Continue to advocate on the State and Federal level for Medicaid expansion and other programming funding.

Social Determinants of Health (SDoH)

- Affordable Housing
    - Increase availability of affordable housing and education about housing opportunities and supports.
- Poverty/Income
    - Identify and increase awareness of job training opportunities.
- Race
    - Gather data to make strategic initiatives towards racial inequities.

Integrated Health

- Improve health outcomes to prevent and reduce chronic health problems such as diabetes, heart disease, chronic stress, etc. through programs that address:
    - Physical Activity
        - Improve overall health through promotion and availability of physical activity programs, including training on special populations to instructors/providers.
    - Overweight and Obesity
- COVID-19
    - Promote and increase social connectedness while remaining physically distant

9. NC DSP Workforce Update (Bob Crayton & Heather Johnson)

The Arc of North Carolina is making an advocacy push in light of a letter from Deputy Secretary Dave Richard and NCDHHS to John Nash and The Arc declining to prioritize adults with IDD for COVID vaccination prioritization.

People with IDD are three times more likely to die of COVID-19 than patients without those disabilities, according to an analysis by FAIR Health, a nonprofit that operates a database of American private insurance claims.

That analysis of data in the U.S. is furthered by Public Health England, which has found that people with learning disabilities [the correlate in the U.K. to IDD] were three to six times more likely to die from COVID-19 than the general population during the pandemic's first wave. Age-specific COVID-19 death rates per 100,000 population were higher for people with learning disabilities in all adult age groups, and by an even greater margin in younger age groups: those aged between 18 and 34 had 30 times the death rate of the general population.

Ray Hemachandra keeps wanting to highlight the disparity with Tennessee:

North Carolina's immediate neighbor, Tennessee, has a COVID-19 vaccination plan that places adults with intellectual and developmental disabilities in Phase 1a1—its highest prioritized phase. Thousands of adults with IDD have already received their first dose.

Brad Turner, the Commissioner of the Tennessee Department of Intellectual and Developmental Disabilities, explains why Tennessee includes adults with IDD in Phase 1a1. "The last thing we want to do is look ourselves in the mirror and say we didn't do enough," Turner says. "The death rate is 3 times as high in comparison to a traditional community. That really shows us the urgency around what our strategy needs to look like to make sure that we continue to fight for (people) with disabilities. Every life is precious."

10. Community Involvement Updates – Trainings/Conference/Events – CFAC Members

January 30, 2021 - 43rd Legislative Virtual Breakfast on MH

Legislative Breakfast shined a light on Mental Health: The 43rd Legislative Breakfast on Mental Health was held on January 30th. Much of the discussion was centered on the “uptick” of mental health needs because of the pandemic and the critical need to address the gap in health insurance coverage. In addition, there were several deeper conversations related to addressing the mental health needs of children. Deputy Secretary Kody Kinsley pointed out that North Carolina was 42nd in youth access to behavioral health services prior to the pandemic. He noted that children with behavioral health needs move through at least three systems very quickly in their lives. They begin with much of their interaction being with health care providers and then, as they are in school, educators become the professionals who work most closely with these children and later, as their needs become clearer, they interact most closely with the behavioral health system. Kinsley stated, “This doesn’t feel like a recipe for success.” Legislators followed up on this point by giving some legislative action that could strengthen the children’s behavioral health system. Those points include: increasing the workforce trained to serve children, focus on early childhood services and supports, focus on early intervention and prevention, addressing the insurance coverage gap and increasing parity between coverage for health care and behavioral health care coverage. Secretary Cohen emphasized the importance of moving forward on a whole person care approach to health and human services. “COVID has shown that we need to keep focusing on whole person well-being,” Cohen stated. She acknowledged that the mental system was challenged prior to the pandemic and noted that we now need to focus on the core structure of the system.

February 26, 2021 – NC MedAssist Chatham Co. OTC Drive-thru
May 6, 2021 – Faith Connections on MI Virtual Conferences
June 9 – 11, 2021 – NC “One Community in Recovery” Conference

11. Comments/Next Agenda Items

- **a.** Heather brought some concerns regarding Cardinals’ Facebook page to the CFAC committee. Her concerns were around some of the comments within the postings, she feels that Cardinal is missing an opportunity to help consumers within the central region. Cardinal employees will escalate this information to our communications department for follow-up.

- **b.** Jeannette shared with the group that she has been working within the community to give her time as well as monetary gifts to those in need. For the month of January, Jeannette purchased gift bags for 6 residents and distributed them to an organization called Helping Hands 12. She stressed that she would continue these efforts for the remainder of 2021 and encouraged others to inform her of any needs that they may see within the community.

c. Next Central CFAC meeting Tuesday, March 2, 2021 at 5:30 pm until 7:30 pm via WebEx technology.

12. Adjournment

Kyle Reece motioned to adjourn the meeting. Leslie Matthews seconded the motion. All in favor. Motion carried. Meeting was adjourned at 7:35 pm

Submitted By: Darlene Russell, Cardinal Innovations Operations Business Administrator.