# NC Balance of State Continuum of Care

Regional Committee Structure Workgroup
May 5, 2015
1:00-2:00 PM

## Thanks for making time to serve on this workgroup

- Conference call logistics
  - *6 to mute/unmute line
  - Please do not put us on hold
    - Hold music is disruptive

## Agenda

- Introductions
- Sample structures
- Assignments & next steps

## Tell us a little more about yourself and your Regional Committee

- Name
- Agency
- Regional Committee
  - Something about your Regional Committee that is working well and do not want to lose
  - Something about your Regional Committee that could be improved

## There are currently 27 Regional Committees either Active or Pending


## Four basic requirements

1. Regular, public meetings
2. Posting meeting minutes
3. Regularly attending Steering Committee
   - Regional Lead & alternate count for voting
   - Any Regional Committee member counts for attendance
   - Affects CoC project application scoring
4. Underway with coordinated assessment planning or implementation

## The current structure is bottom-up and let's communities tell us what works locally

- What's working
  - Organic and fluid
  - No change needed to keep current system
  - Local relationships important to meet need, coordinated assessment
  - Each Regional Committee meeting has individual flavor, format

## The Current Structure has high administrative burden and allows Regional Committees of vastly different sizes to be considered equal

- Potential improvements
  - All Regional Committees given same weight
    - Caswell and Piedmont each 1 vote
      - Vastly different need/resources/geographic area
  - 2014: 30 Regional Committees means required admin functions duplicated many times over
    - Minutes, ESG funding process, coordinated assessment
    - CoC oversight function also expanded x 30

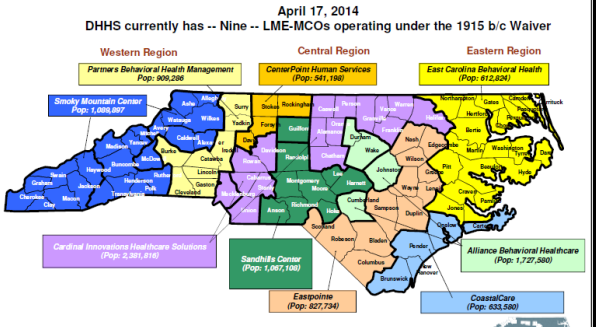
## Feedback from Regional Leads and alternates from in-person meeting on March 30 was varied

- Current structure works very well
- Protect existing relationships/trust/group dynamics
- Intimidating to have to educate or re-educate neighboring counties about BoS, homelessness, housing
- Some small Regional Committees would like to join with another/larger Regional Committee
  - Share the overhead/admin responsibilities
  - Have more people at the table for discussion
- Intrigued by new opportunities to increase leadership

## Using LME-MCO boundaries would result in fewer Regional Committees and could efficiently leverage existing relationships

- What could work well
  - Many are already PSH CoC grantees
  - Fewer Regional Committees would employ economy of scale
  - MCOs intimately involved in coordinated assessment, would align mission
  - Prevent RCs from crossing MCO lines

## LME-MCO Boundaries




## Using LME-MCO boundaries would result in fewer Regional Committees and could efficiently leverage existing relationships

- What could work well
  - Many MCOs cover large areas
    - Smaller committees or other local structure needed
      - 3 structures
        - CoC – MCO – subcommittee
      - Piedmont model
        - Local meetings monthly
        - Quarterly meetings of entire Regional Committee – rotating location
    - Subdivide some MCOs
      - EX. ECBH North, ECBH Central, ECBH South

## LME-MCO boundaries remain in flux

- Potential challenges
  - Prioritization of housing varies greatly between MCOs
  - MCO mergers/structure in flux
    - Using LME/MCOs as the basis is treacherous because of possible future changes to mental health system in NC
    - BUT – writing on the wall seems relatively clear…?
      - Trend – larger MCOs not smaller
  - Large change to current structure

We could restructure Regional Committees based on a set of criteria like coverage area or number of beds

- What could work well
  - Would create "apples"
    - Regional Committees similarly sized / resourced
    - Voting more equitable
      - Representing the same number of counties/beds/etc

What criteria to use and how to determine among the potential challenges of this approach

- Potential challenges
  - Potentially vastly different geographic areas
    - Beds centralized around suburban areas
    - Many counties with few beds
  - Could not take advantage of natural alliances
    - Dividing counties that naturally work together
      - LME-MCO areas
      - Other regional alliances
      - Historical partnerships

## Feedback from Regional Lead in-person meeting on March 30th was varied

- Run a pilot project on proposed structure changes
- Conduct a survey to take the temperature about structure change
- Identify lower capacity Regional Committees to merge/change
  - Coordinated Assessment Regional Committee tiering
- Based on natural population sharing
- Need to keep in mind what do the people we serve want

## Questions from Regional Lead in-person meeting on March 30th

- How would changing Regional Committee structure impact grantee performance and match requirements
- How would affect coordinated assessment?
- How would affect funding streams (ESG, etc)
- Would this help to expand BoS coverage to counties without active Regional Committees?
- What are the goals of the Regional Committee? Can we define so we can develop a plan to meet them?

## Other structures to consider and how to consider them

- CCNC groups
- Others?

- What information about each structure do you need to evaluate?
  - What it is
  - What could work/potential challenges
  - Other?

## Assignments & Next Steps

- Goal: Decide Regional Committee structure in 2015
  - Change or no change
  - If change, to what?
- Divide structures, research and report back at next meeting?
- Continue with monthly phone meetings?

## Wrap Up

- Keep in touch
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