

**Wake County Health and Human Services Board
Meeting Minutes
May 22nd, 2025**

Board Members Present:

Dr. Ojinga Harrison
Maty Ferrer Hoppmann
Wanda Hunter
Christine Kushner
Trey McBrayer
Terry McTernan
Dr. Jananne O’Connell
Dr. Jim Peterson
Ann Rollins
Dr. Anita Sawhney
Commissioner Cheryl Stallings
Irv Trust
Dr. Kelcy Walker Pope
Birchie Warren

Guests Present:

Deidre McCullers

Staff Members Present:

Debra Baker
Jennifer Brown
Sheila Donaldson
Denise Foreman
Odile Fredericks
Sara Gisler
Ann Godwin
Barbara Gonzalez
Anika Hamilton
Kevin Harrell
Duane Holder
Brittany Hunt
Evan Kane
Rebecca Kaufman
Lee Little
Dr. Joel Lutterman
Jason Mahoney
Ken Murphy
Shanta Nowell
Tina Payton
Toni Pedroza
Melissa Pullen
Jessica Sanders
Yolanda Thacker
Kathryn Thompson
Lechelle Wardell
Rochelle Whitaker
Stantavia Wright

Call to Order

Chair Ann Rollins called the meeting to order at 7:36 a.m.

Next Board Meeting – June 26th, 2025

Approval of Minutes

Chair Ann Rollins asked for a motion to approve the April 24, 2025 Board meeting minutes. There was a motion by Ms. Christine Kushner and Mr. Irv Trust seconded. The minutes were unanimously approved.

Treasurer’s Report

Mr. Terry McTernan, Treasurer, provided the Treasurer’s Report. In March, the fund was reported as \$9,917.95. Since that report, no additions had been made. Therefore, the fund remained unchanged.

Stipends were anticipated to be processed and added during the June 2025 Health and Human Services Board meeting.

Health and Human Services Director's Update

(Presented by Ms. Rebecca Kaufman and Ms. Toni Pedroza)

Ms. Rebecca Kaufman (Health Director) provided the following updates.

- Ms. Sara Gisler was introduced as the Deputy Health Director for Clinical Services. She most recently worked in a children's hospital in Atlanta and had expertise in clinical operations.
- Public Health is hiring both this week and next with the following week scheduled for interviews. The Administrative Director position has its first round of interviews today. Next week will be a second round of interviews for the Deputy Health Director for Community Health. Both positions received great interest and over a hundred applications each. Hiring updates would continue to be provided as Health and Human Services split into Social Services and Public Health as of July 1st, 2025.
- When Ms. Kaufman referenced a potential upcoming septic permit appeal, Mr. Ken Murphy (Senior Deputy County Attorney) clarified that this would likely be continued into the first half of June.
- The 2025 Community Health Needs Assessment (CHNA) was now finished and results would be shared the following month.
- This week, pool technicians have been hired as the pool season is fully underway.

Ms. Toni Pedroza (Senior Deputy Director of Health & Human Services) provided the following updates.

- There are now many bills and proposals at the federal level with the potential to impact Food and Nutrition Services (FNS) and Medicaid.
 1. With FNS, one concern is the proposed increase to the nonfederal share of administrative costs from 25% to 75%. This is a huge shift in administrative cost which equates to staff time. In Wake County alone, this would cost \$9 million.
 2. The Supplemental Nutrition Assistance Program (SNAP) has typically had a timeliness expectation of 95%. One proposal now asks for 100% timeliness. This means that any errors that occur would result in a cost.
 3. Currently there are 220,000 residents in Wake County enrolled in Medicaid. Of those, 48,000 were added through Medicaid Expansion. Some of the proposals in a bill increases the redetermination requirements. Right now, there are reviews once a year for Medicaid. This new proposal increases this to twice a year for those enrolled via Medicaid Expansion. In any given month, the County has around 10,000 reviews due. This would raise this to 13,000 to 15,000 reviews a month for a huge workload differential. This would ultimately require more staff.
 - Another requirement is the cost, share, and benefits paid to persons with Medicaid Expansion. When Medicaid Expansion was passed in North Carolina, there was a statement in the bill stating that if more of the federal share was demanded, Medicaid Expansion could cease. Because of this, this requirement causes great concern.
 - Another proposal has a work requirement for individuals in Medicaid Expansion. These would be able-bodied adults without dependent children (ABAWD), a term already in use in FNS. This poses yet another workload issue. Nationwide 92% of those with Medicaid are already working. Those who are not are working are usually children aged 0 to 18, individuals aged 65 or older, and/or those that are disabled. The proposal, however, does not refer to these groups.

- All of these changes are discouraging to those most in need of the services. And with only a little discouragement, some may choose instead to lose their insurance.
- House Bill (HB) 612 – Foster Care in NC Act – has passed the House. This bill proposed many changes in how Child Welfare would be and how the court system would work as related to Child Welfare. Currently, there are around 8,000 reports a month of child abuse, neglect, and/or dependency. Typically half of these reports are unsubstantiated. This means that they do not meet the definition of abuse, neglect, and/or dependency. The changes in this bill mean that the Director has to call the reporter as well as write a letter to say why the report was not accepted for justification.
 1. Another part of the same bill gives more voice to foster care parents in the court with regards to adoption. However, according to federal law, foster care parents are meant to be more of a tool to work with the biological parents with the primary goal of reuniting the family.
 2. The bill also gives more power to the State to resolve conflicts between counties. These “conflict cases” could arise when one county places a child in foster care only for a report of abuse, neglect, and/or dependency to come in. This would pose a conflict that the county would then ask a neighboring county to take instead. This bill gives the State the authority to step in and make the decision for the county, taking the case and the cost of the case. These are true conflict of interest cases with another example given of a case with a staff member’s child.
 3. Finally, the bill also addresses hospital stays with juveniles. If a juvenile does not need to be hospitalized, the State is allowed to shift the cost to the responsible party. Who this “responsible party” is has always been a question that has shifted answers.
 4. This bill is anticipated to pass the Senate as it has a great deal of support.

Commissioner Cheryl Stallings asked if staff are able to assess and make a determination on the 8,000 reported cases for abuse, neglect, and/or dependency each month. Ms. Pedroza explained that all reports are examined but not all receive assessments as some immediately do not meet the criteria. If a child brings a peanut butter sandwich for lunch for one month, for example, it may not be viewed as the healthiest option, but it, in and of itself, was not a report to be assessed. Ms. Shanta Nowell (Child Welfare Assistant Division Director) added that when the reporter calls, the information that they provide goes into a decision-making tool designed by the State. If the report does not meet the definition of abuse, neglect, and/or dependency according to that structural decision-making tool, then that report is considered a “non-report.” Even when this occurs, an intake worker still notifies the reporter that the report was not accepted and why. Every reporter, even currently, receives a call back. The new bill, however, increases the amount of information that the reporter is given and demands more justification.

Ms. Pedroza noted that if a child received multiple reports that did not meet the definition but presented a clear concern for the child, Prevention was notified. Prevention staff would contact the family to offer voluntary services to address the concerns.

Vice Chair Wanda Hunter quoted Mr. Dennis Gaddy (Founder and Executive Director of Community Success Initiative (CSI)) who stated “When you make it hard for people to do the right thing, you make it easy for them to do the wrong thing.” When pushed into a corner, people would understandably feel frightened and that there was no choice but to fight or to turn to crime. This was exactly what should be discouraged. Ms. Pedroza shared that, historically, when the federal government had come to North Carolina, they came to Wake County because of its closeness. These past evaluations had always included looking for any part of the processes that could be “discouragement” to clients.

Deputy County Manager Duane Holder shared that Board members would begin receiving legislative updates every couple of weeks from Mr. Ben Canada (County Manager Office’s Chief of Staff).

Public Health Fee Schedule and Sliding Scale [Public Health (PH) Accreditation Benchmark #33.5, 33.7., 39.3]

(Presented by Ms. Tisha Adams)

Ms. Tisha Adams (Medical Billing and Coding Manager) reviewed public health fees. There was one suggested change for fiscal year (FY) 2026, outlined below:

“II.

C. Title X Exceptions

4. All Family Planning clients will be asked for income verification at each visit. All approved proofs of income will be accepted including verbal attestations.”

In late 2024, the Title X program income requirements changed requiring income to be verified at every single office visit. This was a current practice for appropriate clinics. However, after a January 2025 audit, North Carolina Department of Health and Human Services (NC DHHS) consultants required that the County added the message to its fee policy.

Vice Chair Wanda Hunter asked if this was required for every visit. Ms. Adams clarified that the question of if the client’s income had changed had to be asked at every visit. Documentation did *not* need to be provided at every visit. A verbal attestation could be accepted, but the client’s response had to be documented in the system. Ms. Rebecca Kaufman (Health Director) added that this was only in Family Planning. The County had already been practicing this – it was only adding it into the fee policy that was a change. The policy change had been submitted to the NC DHHS and was approved.

Next were suggested fee changes. Wake County had a total of 150 medical fees with a change being proposed for the following four.

CPT Code	Code Description	50th Percentile	75th Percentile	Current Fee	Proposed Fee
99211	OFFICE/OUTPATIENT VISIT EST LEVEL 1	42.44	52.21	54.00	52.00
99401	Preventative medicine counseling and/or risk factor reduction intervention provided to an individual up to 15 mins.	65.68	75.78	32.94	65.00
99417	Under Prolonged service on date of in-person visit	110.21*	120.72	31.00	110.00*
S0280	PREGNANCY MEDICAL HOME INITIAL RISK	177.27	177.27	50.00	150.00

* - listed figures were in error. 50th percentile is 100.10. Because of this, the proposed fee was actually \$101.

- 99211 – A nurse visit. Ms. Adams was suggesting a decrease to fall between the 50th and 75th percentile. This fee is only billed to third party payers with an average reimbursement of \$31.86.
- 99401 – This is a preventative counseling code and a rather new one at that. Because there was no suggested rate for the previous year, Ms. Adams had to utilize the Centers for Medicare and Medicaid Services (CMS) reimbursement rate of \$32.94. This is currently reimbursed by most

prepaid health plans (PHPs) at around \$46. The difference with the amounts is occurring due to private payers who are having to pay by the code. Because of this, the 50th percentile was suggested.

- 99417 – This code was new and for prolonged services. Last year was the first year that the code had come out. At the time, there were no suggested rates available, so staff set the fee to \$31. The code is now reimbursed at \$80 as Ms. Adams had to utilize the Medicaid allowable.
- S0280 – This is a pregnancy medical home visit. In the past, Medicaid was one of the only payers for this code. Now with PHPs in place, private insurances were also paying and evening out the fee schedule. This code is never billed to self-pay or sliding fee scale – only third party payers.

Chair Ann Rollins, referencing code 99401, noted that the suggested fee (\$65) was less than the 50th percentile (\$65.68). Ms. Adams explained that she generally did whole numbers for the fees as having change in the clinic could be cumbersome. Wanting to stay within the ranges, however, Board members made the following suggestions for the new proposed fees:

- 99211 - \$52
- 99401 - \$66
- 99417 - \$101
- S0280 - \$178

Ms. Adams stated that there were no drug fee code suggestions as these are updated at every single purchase of supply. Staff are required to base these fees off the actual cost of medication. Because of this, Ms. Adams did not evaluate the fees themselves but instead made sure the invoices matched the amount charged.

Chair Rollins asked if there were any other Current Procedural Terminology (CPT) codes outside the 50th percentile that should be considered. Ms. Adams shared that with the new Public Health building coming in FY 2026, the recent restructure of the organization, and the acquisition of labs by LabCorp, staff decided to create a fee committee in Public Health. This committee will work to evaluate current fee structures, ensure equity and sustainability, and make sure accurate updates are provided to all fees and services. Because of this, the Board could anticipate a more in-depth overview of fees in 2026.

Mr. Terry McTernan asked if the fee committee would be temporary or ongoing. Ms. Kaufman stated that it would likely be permanent as more consistency was desired. Ms. Adams was reviewing so many data points from the fee analyzer to 50th percentile to 75th percentile to Medicaid rates. A consistent methodology was needed in order to truly update the fees. There currently was not a lot of consistency with some simply being billed the same for years despite every year bringing slight variations.

Mr. Irv Trust asked about the interface used to find when drugs changed in price. Would drug fees be a part of the consideration for the new fee committee? Ms. Adams noted that Ms. Angela Johnson (Pharmacy Director) would be on the committee. Ms. Johnson was responsible for ordering all medication. It is written in policy how much can be charged versus how much paid. Anytime a drug is ordered, the cost is changing. These drug fees, because of this, have some of the most consistency as they must stay in line per policy rules. When asked if Ms. Johnson monitored modifications to formulas as well, this was confirmed. A future presentation providing an overview of the County's Pharmacy and the Pharmacy Director role in particular could provide was suggested.

Ms. Adams added that there were some programs that offered drugs at a special rate. The clinics have to charge the rate that the drugs were received for most of their clients. Ms. Adams did a monthly to quarterly audit of these invoices to match the price to the invoice.

Chair Rollins voiced concern that the County might lose money if not prescribing fees between the 50th and 75th percentile. Ms. Adams conceded that this was another reason why there were no large changes suggested. Upon review of processes, she realized that there was duplication of work between the County compiling a huge spreadsheet while the State does a cost settlement report giving the exact same information. The State, however, may give the County a cost that is outside of the allowable that still needs to be reviewed. This means that the State is including the amount of resources in the cost list. Ms. Adams reviews the CPT codes and ensures that each is aligned with the cost calculated using the fee analyzer. While this process has worked and is effective, staff want to realign all fees so that no money is being lost without hindering the community at the same time.

Ms. Kaufman shared that around 30% of clients are self-pay. This is another consideration as a balance must be found so that the self-payers are not overly burdened by the costs. Ms. Adams stated that these are among the many considerations of the sliding fee scale. The sliding fee scale considers the income requirements for clients and the percentage that they are responsible to pay. All medical fees are eligible for the sliding scale which is why the question of income at every appointment is so important.

Vice Chair Wanda Hunter asked how much reimbursement was received on CPT code 99211. Ms. Adams stated that this was currently reimbursed around \$31.86, dependent upon the sliding fee. When asked why the fee would not be averaged between the 50th and 75th percentile to avoid a burden on the private payers, Ms. Adams clarified that most of these codes, especially 99211, were charged in Family Planning. The other clinics the code was used at (such as the STD clinics) would not be charging the code. For Family Planning, most clients slide on the fee scale anywhere from 40% to 0%. The 50th and 75th percentiles change annually and staff must also consider what payers will pay. Some will not pay if the coding does not match their preferred coding method.

Next were twenty new medical fees, listed below.

CPT Code	Code Description	50th Percentile	75th Percentile	Current Fee	Proposed Fee
98000	Level 2 (New) Telehealth Audio and Video SF 15	143.80	191.73	47.93	143.80
98001	Level 3 (New) Telehealth Audio and Video LOW 30	210.37	280.5	79.07	210.37
98002	Level 4 (New) Telehealth Audio and Video MOD 45	299.58	399.44	126.18	299.58
98003	Level 5 (New) Telehealth Audio and Video HI 60	372.81	497.08	167.45	372.81
98004	Level 2 (Est) Telehealth Audio and Video SF 10	117.17	156.23	36.98	117.17
98005	Level 3 (Est) Telehealth Audio and Video LOW 20	179.75	239.66	64.82	179.75
98006	Level 4 (Est) Telehealth Audio and Video MOD 30	242.33	323.1	95.45	242.33
98007	Level 5 (Est) Telehealth Audio and Video HI 40	300.91	401.22	126.78	300.91
98008	Level 2 (New) Telehealth Audio Only SF MDM 15 MIN	137.14	182.85	45.55	137.14

CPT Code	Code Description	50th Percentile	75th Percentile	Current Fee	Proposed Fee
98009	Level 3 (New) Telehealth Audio Only LOW MDM 30 MIN	202.38	269.84	75.52	202.38
98010	Level 4 (New) Telehealth Audio Only MOD MDM 45 MIN	283.6	378.14	117.36	283.6
98011	Level 5 (New) Telehealth Audio Only HIGH MDM 60 MIN	347.51	463.35	152.91	347.51
98012	Level 2 (Est) Telehealth Audio Only SF MDM 10 MIN	110.51	147.35	33.87	110.51
98013	Level 3 (Est) Telehealth Audio Only LOW MDM 20 MIN	167.77	223.69	59.28	167.77
98014	Level 4 (Est) Telehealth Audio Only MOD MDM 30 MIN	225.02	300.02	86.44	225.02
98015	Level 5 (Est) Telehealth Audio Only HIGH MDM 40 MIN	299.58	399.44	125.88	299.58
98016	BRIEF COMMUNICATION TECH-BSD SVC EST PT 5-10 MIN	59.92	79.89	15.23	59.92
ADMINF	Administrative Draw Fee	0.00	0.00	20.00	20.00
ADMIN	Administrative Draw Fee	0.00	0.00	20.00	20.00
88720	bilirubin, total, transcutaneous	\$35.14	\$35.21	0.00	35.14

Most of the codes come from new telehealth codes that the American Medical Association (AMA) released on January 1st, 2025. When the COVID-19 pandemic occurred, many medical services were forced to shift to telehealth. This included services that hadn't been provided by telehealth before. Because there were not codes specific to those services, staff had to utilize office visit codes with modifiers. AMA is now trying to match the codes to proper telehealth coding. The current fee represented the Medicare allowable, so the proposed fees looked to the 50th percentile.

ADMINF and ADMIN were both administrative draw fees. These fees are still eligible to slide. A free option must be offered as there are some labs that staff cannot charge for.

Finally, 88720 was a new machine in the Child Health clinic. This non-invasive bilirubin test could identify jaundice and other conditions in infants. This is a brand-new service, so the proposed fee started at the 50th percentile.

Vice Chair Hunter pointed out that the new proposed fees were not in whole dollars. The amended fees, as suggested by the Board, appear below.

- 98000 - \$144
- 98001 - \$211
- 98002 - \$300
- 98003 - \$373
- 98004 - \$118
- 98005 - \$180
- 98006 - \$243
- 98007 - \$301
- 98008 - \$138
- 98009 - \$203
- 98010 - \$284
- 98011 - \$348
- 98012 - \$111
- 98013 - \$168
- 98014 - \$226
- 98015 - \$300
- 98016 - \$60
- ADMINF - \$20
- ADMIN - \$20
- 88720 - \$36

Finally, there were no dental fee changes suggested. This was because there was an extensive reevaluation of dental fees just the year before. The fees had not been increased or updated in years and were now in alignment with the 50th percentile.

Commissioner Cheryl Stallings asked how many individuals were on a sliding fee. Ms. Adams shared that 30% of clients are self-pay which would be eligible for the sliding fee scale if their income met requirements. Ms. Christine Kushner asked if this meant that 70% of clients were funded through Medicaid or Medicare and Ms. Adams confirmed that these would be clients with a third-party payer. For context, Ms. Kaufman stated that Wake Public Health clinics saw 26,796 clients in 2024 for a total of 73,172 visits (as some clients visit more than once a year). So roughly over 8,000 clients would be self-pay and potentially eligible for the sliding fee scale.

Chair Ann Rollins asked for a motion to approve the proposed fee changes. There was a motion to approve the amended fees by Ms. Wanda Hunter. Mr. Irv Trust seconded. The amended fees were then unanimously approved.

Wake County Behavioral Health Strategic Plan

(Presented by Ms. Denise Foreman)

Deputy County Manager Duane Holder explained that organizational changes continued to occur within Wake County government. Years ago, the County had a Mental Health department that was a part of the consolidated agency. With the system reform, the privatization of services, and the regionalization of Local Management Entities and Managed Care Organizations (LME MCOs) by Alliance Health, the County no longer had a Mental Health department. Since then, the County had utilized an Assistant County Manager in the County Manager's Office to be the liaison to Alliance Health. The county funds, with local tax dollars, about \$30 million a year in behavioral health services primarily through Alliance Health (as well as some other contracted organizations).

Staff have increasingly recognized the split of tailored plans and standard plans in the behavioral health space. This means that there is not as much coordination by Alliance Health because they are responsible for a smaller number of clients that largely use private health plans (PHPs). In response, the County has decided to form a separate Behavioral Health department. The County's behavioral health work is of the scope and scale that this is a body of work that needs a committed department to manage. Ms. Denise Foreman, former Assistant County Manager and now Director of Behavioral Health, will lead the department.

While the County will *not* provide services directly, it will continue to contract for services while working to facilitate and coordinate between all of the parties within its system. County leadership want to impact change locally with intentionality behind how behavioral health services are managed throughout Wake County.

With this introduction, Ms. Foreman provided an overview of the draft Wake County Behavioral Health Strategic Plan. This was actually the County’s third strategic plan for behavioral health and one that the Wake County Health and Human Services Board helped prompt with its prior Mental Health Temporary Advisory Committee (TAC). Ms. Foreman recalled how she attended a TAC meeting around a year prior to talk about the vision for Wake County and behavioral health for the next decade. From there, staff did focus groups and discussed with people across the Wake County community what the vision of behavioral health should look like. This was a vision that the community could live into in all its roles from the school system to healthcare providers to payer partners. This was true of the intent of the strategic plan as well with a lot of the work to be monitored, coordinated, and collaborated by the Behavioral Health department. With still being at the will of the State, the County was looking to have the best behavioral services despite challenges. In response, the following vision was drafted by community collaboration:

“By 2034, all individuals in Wake County will have the opportunity to thrive. Our community works together to offer a compassionate, accessible, recovery-oriented, and integrated behavioral health system of care.”

Next, key principles that delve more into the key words of the vision statement were shared.

- Accessible to all
- Collaborative integration
- Continuous improvement
- Empowered communities
- Innovation and adaptability
- Lived experience integration
- Person-centered care
- Prevention and early intervention
- Recovery orientation
- Stigma-free environment
- Value-added investment
- Whole health focus
- Youth-centric support

Vice Chair Wanda Hunter asked why there had been a transition away from “mental health” to “behavioral health.” For decades, the community has heard the importance of mental health. Changing the language will leave clients confused as to if mental health is behavioral health without proper outreach. Ms. Foreman explained that behavioral health is meant to encompass both mental health and substance use. In the Behavioral Health department and strategic plan, deliberate work is planned around both as well as how the cooccurring nature of mental health disorders and substance use impacts individuals.

Ms. Foreman also clarified that while it was not uncommon for partners to include intellectual and developmental disabilities with the term “behavioral health,” this was less of a focus for the County’s Behavioral Health department. The work including the intellectually and developmentally disabled would be centered more around any mental health issues.

Commissioner Cheryl Stallings noted the added confusion of the 988 crisis hotline as compared to the typical 911 for emergencies. The goal was to get clients services in a timely manner, streamlining the triage process. However, even Ms. Foreman shared struggles with gaining clarity around when 988 should be used. Many in the county were unaware of 988 as a crisis hotline, much less when it should be utilized.

Continuing with the presentation, the 2025-2027 Wake County Behavioral Health strategic plan was reviewed. As County Manager David Ellis talked with community partners about behavioral health in Wake County, the language and charge that he gave was to craft a plan to help the community develop a “world class behavioral health system.” In response, the plan’s purpose is to articulate the community’s vision, define targeted objectives and strategies, and guide resource allocation and collaboration.

Context for the strategic plan included the following.

- **Rising Behavioral Health Challenges:** Mental health awareness brought both understanding and more demand for services. This created opportunities and challenges on the workforce supporting this work. This includes increasing rates of anxiety, depression, suicide, and substance use disorders, particularly among youth.
- **Medicaid Expansion and Policy Changes:** In Wake County alone, 40,000 lives have been covered by Medicaid Expansion. This includes accessing benefits and programs they need to improve their behavioral health. However, it is unclear if Medicaid Expansion is here to stay, which makes planning difficult. Medicaid Expansion also presented opportunities around policy changes for social drivers of health. Behavioral health does not exist in a silo and though Medicaid Expansion's fate is uncertain, the County holds incorporating supportive services with behavioral health services as a value.
- **State Investments and Funding Uncertainty:** Efforts to strengthen crisis services, justice initiatives, and workforce development persist, but long-term funding sustainability remains uncertain.
- **Growing Service Demand and Workforce Strain:** Rapid population growth is increasing pressure on an already limited behavioral health workforce, especially in crisis and community settings.
- **Unclear Roles and Access Gaps:** Counties support care for uninsured and underinsured individuals, but disparities persist based on race, geography, and income.
- **Need for Coordinated and Sustainable Solutions:** Addressing challenges requires a system focused on equity, prevention, workforce development, and strong community partnerships.

Vice Chair Wanda Hunter asked if there was anything in the strategic plan to support providers. This had been a notable failing of Medicaid Expansion which lacked the amount of providers to truly implement the services needed. Without support for additional applications or assurance of better reimbursements, how could provider participation be encouraged? While there was not a role for Wake County outlined in this strategic plan to recruit more providers to accept Medicaid, Ms. Foreman agreed that it was an ongoing issue. The State was doing more workforce support and had increased Medicaid rates last year. Even so, there was room for improvement as a lot of private insurance companies were not keeping up with Medicaid rates. She added that private payers were a part of a lot of the Behavioral Health workgroups, so they had a voice at the table.

Deputy County Manager Holder added that the strategic plan for Wake County include increasing access to care. It was also one of the highlights that the Board would hear in the 2025 Community Health Needs Assessment (CHNA). The County Manager's Office, with the guidance of Ms. Rebecca Kaufman (Health Director) and Dr. Jose Cabanas (Chief Medical Officer/Deputy County Manager), was looking at provider access countywide. There were currently plans of convening in the fall and winter to see what the landscape for capacity was in order to determine how it could be increased.

Vice Chair Hunter suggested implementing a provider support circle so that those directly impacted and providing the services could voice their challenges, frustrations, and roadblocks. This could allow room for a conversation around compromise as well as collaboration on exactly how many providers were needed to offset the workload demanded. Ms. Christine Kushner added that it was vital to have providers that looked like the community and were culturally competent. Peer supports might be a better fit to serve those with lower-level needs so that skilled providers could focus on the higher levels of crisis. While this would admittedly be a lot to coordinate, it needs to be acknowledged if done in the strategic plan.

Mr. Birchie Warren voiced concern with the delivery model differentiating behavioral health and mental health. When looking at concerns in practices, an integrated healthcare issue is seen where nutrition could be connected to mental health and illness. A holistic approach with proper education about nutrition

and/or pediatrics was needed as it was all connected. Ms. Foreman said that this – the holistic approach – is where she saw Wake County assisting to fill in gaps that traditional payers or practices would not naturally fill. She gave the example of a pilot project included in the upcoming budget. The County will support a program with UNC, Duke Occupational Therapy, UNC Behavioral Outpatient and Primary Care, Duke Occupational Therapy, and Elwyn Adult Behavioral Health. Elwyn, which already has a peer led drop-in center, is creating a center where individuals will have the opportunity to come and enhance their independent living skills. These skills will include things like nutrition classes, money management, technology, and how to pay bills on time. Building such skills can help those with severe mental illness connect with supports they need to live independently, successfully, and have peers working and challenging them on the same things. This includes social events to develop a network of support. This is not a reimbursable or billable service but instead one meant to bolster connection points.

Another example of this was the County’s opportunities with the funding from the national opioid settlement. Over an eighteen-year period, Wake County will receive almost \$70 million to invest in substance use, early identification, treatment, recovery support, and community support. Because of this, there are some deliberate strategies identified throughout the Behavioral Health strategic plan to make sure these opportunities are acknowledged.

Ms. Foreman also assured that, as part of the \$30 million invested into the community, the County had an expectation of Alliance to ensure that individuals that worked as peer supports were paid at a livable level. Historically this has not been the case, but these are individuals who can truly speak to the experience and help others navigate an overwhelming system. It was a deeper level of support the County wished to endorse. Such unique opportunities were ones that the County was in a prime position to and wanting to explore.

Vice Chair Hunter maintained that Mr. Warren’s point of intersectionality was an important one that should not be lost, especially with nutrition. There were opportunities to educate both adults and children on what they ate every single day and how it could impact them.

The three-year Wake County Behavioral Health strategic plan is organized around five focus areas discussed with Wake Directors and represents feedback from a fall 2024 Behavioral Health Summit, stakeholder input, and foundations from prior plans. Its implementation is intended to represent a full community effort, not just Wake County government. It also includes alignment with the Wake County strategic plan.

When it came to focus areas, staff were intentional about the key issues elevated in the plan. Each area has a description of why it matters, objectives, four to five priority strategies, and measures. Ms. Foreman pointed out the draft measures presented a unique challenge as the County is not a service provider and therefore its access to data is very limited and very delayed. Given all this, the five focus areas of the Behavioral Health strategic plan and their priority strategies are as follows:

- Accessibility, Navigation, and Coordination
 1. Train community-based navigators to assist individuals in understanding and accessing available services, ensuring they are equipped to address cultural and linguistic needs.
 2. Support and enhance education, awareness and access to behavioral health services and supportive services in Wake County for all individuals, businesses, partners in Wake County.
 3. Develop and implement a comprehensive navigation system.
 4. Launch Familiar Faces Pilot Project to enhance care coordination and health outcomes for high users of crisis services in Wake County.
 5. Reduce barriers to substance use recovery.

6. Expand capacity and service array for behavioral health and supportive services.
- Community Support Services
 1. Increase access to stable housing for vulnerable populations.
 2. Support collaboration of community providers addressing social determinants of health needs for individuals with behavioral health needs.
 3. Enhance workforce development initiatives aimed at individuals recovering from mental health and substance use disorders (could include vocational training, job placement services, and ongoing support to help them secure stable income).
 4. Support access to harm reduction strategies for individuals managing substance use challenges.
 - Crisis Services
 1. Through community partnerships, improve access to crisis services, and address gaps in the crisis continuum.
 2. Establish community-wide values around standards of care, engagement strategies, and trauma competence.
 3. Improved coordination between community crisis providers to ensure successful transitions between levels of care and re-integration back to the community.
 4. Establish effective, efficient, and dignified pipeline to transition people in crisis to essential social/housing services.
 5. Address the cycle of crisis for individuals by enhancing programs that build resilience.
 - Justice Services
 1. Expand safe and supportive housing options for individuals with behavioral health needs exiting incarceration.
 2. Convene and facilitate community partners that intersect with behavioral health and justice services to improve access to diversion, treatment, support, and re-entry services.
 3. Expand non-law enforcement response options for emergency calls related to behavioral health crisis.
 4. Support access to substance use treatment and supportive services for individuals engaged in the criminal justice system.
 - Youth and Families
 1. Develop a comprehensive County-wide plan for behavioral health needs of youth and families.
 2. Enhance collaboration between mental health services, schools, juvenile justice, and child welfare to create a seamless network of support.
 3. Integrate mental health, substance use, and primary care services in single locations to make it easier for young people and their families to access comprehensive care.
 4. Conduct public awareness campaigns to reduce stigma, improve awareness of needs, share resource availability, and invite collaborative care.
 5. Increase the number of resources focused on supporting young people and their families in Wake County.

Ms. Foreman spoke to a few of these focus areas beginning with the distrust of law enforcement by some of the community. The hope is to expand response options so that escalation can be avoided in a behavioral health crisis. With the justice system, staff are aware there is an overrepresentation of individuals with mental health and substance use needs. Many should be in treatment and care instead of incarceration. There were many efforts in the area of diversion – diverting before law enforcement interaction, diverting before incarceration, and diverting before recidivism. The State had been providing

financial support in this area in recent years, but that funding was not guaranteed. The Wake County Sheriff's Office had representation in the pilot program in North Carolina intended to help individuals proceed faster in cases where they were incarcerated for too long.

The "Youth and Families" focus area was new for a Behavioral Health strategic plan, though there had always been strategies surrounding youth in the prior editions. However, hearing the community meant understanding the suffering and the need for support for families. Staff hope to conduct a comprehensive evaluation of programs and services available in the community, identify gaps and needs, then make recommendations and implement key strategies for improvement.

Next steps for the Behavioral Health strategic plan included refinement before being presented to the Wake County Board of Commissioners (BOC). This is tentatively anticipated to occur in August of 2025. Once approved, staff would proceed with implementation, refine performance measures, and establish a public dashboard. Some of the initiatives outlined have already begun or were in the current budget. Other initiatives were underway through partners and the State is continuing its investment. Some initiatives, however, would be prioritized in the next year's budget.

When asked if the intent was for the County to partner with community organizations already providing services, Ms. Foreman confirmed that this was the vision for the Behavioral Health strategic plan.

Vice Chair Hunter asked if the Wake County Public School System (WCPSS) would be a part of the collaboration. The school system was the largest in the county and with resources needed at younger ages, they could be a strong partner. Vice Chair Hunter recalled her work on the Wake County Youth Health Council hearing from high school aged youth voicing concerns around mental health, substance abuse, and coping skills – a clear want for resources. Ms. Foreman explained that there were a number of Behavioral Health teams convening and WCPSS staff were active in several of them. One such team that leads this work is the Wake Directors, which includes Commissioner Cheryl Stallings, the District Attorney, and several department heads including the Health Director and Social Services Director. In June, the focus of Wake Directors will be to discuss youth and families. During this meeting, WCPSS staff are scheduled to present about their work and challenges. In addition, the National Alliance on Mental Illness (NAMI) is working with WCPSS on early identification and intervention efforts.

Wake County's work with Alliance Health also helps WCPSS. The County funds a school-based mental health team at Alliance Health that are integrated into the school system. This team works directly with the schools for early identification. While they do not provide services, they do act as 'navigators' for families to connect them with existing services in the community.

Ms. Christine Kushner stated that with over 160,000 children attending school in the WCPSS, it is important for the school system to have community support. The County seemed like a natural partner in this endeavor with school nurses already established. Ms. Kushner pointed out the value to the community of justice services being one of the focus areas as the interactions with law enforcement can very well exacerbate someone already in crisis.

Ms. Maty Ferrer Hoppmann recalled the earlier suggestion for peer supports – notably Community Health Workers (CHWs) – to assist with individuals with lower-level needs. The University of North Carolina – Greensboro (UNCG) had its "Strong Minds, Strong Communities" initiative through its Center for Youth, Family, and Community Partnerships (<https://cyfcp.uncg.edu/strong-minds-strong-communities/>). Ms. Hoppmann offered to connect Ms. Foreman with staff at UNCG to discuss further.

Mr. Irv Trust asked if Wake County was "on an island" to itself or if it interfaced with the other ninety-nine counties in the State. With so many people and so many transitioning in and out of the county, how

could success really be gained if clients received a level of care dependent on living and receiving services in Wake County? Ms. Foreman said that while the County was not on an island, there was not a system to interface with the other counties in the State. Every county addressed behavioral health a bit differently as the only State expectation was to invest in behavioral health, not *how* to invest. This means even with similar challenges, the counties and the LME MCOs all managed services differently. This was one of the reasons Medicaid Expansion was so celebrated – it brought some consistency across the state. One effort also being explored was an informatic system tracking how people are crossing counties in North Carolina. The first several years would be tailored to individuals who are high utilizers before developing capacity for low utilizers. Such a statewide informatic would help to understand exactly why people are moving and, in turn, how they could best be supported.

Environmental Health and Safety – Proposal to Amend Local Pool Regulations

(Presented by Ms. Jennifer Brown)

Ms. Jennifer Brown (Environmental Health and Safety Director) provided a brief preview of a project the division wants to move forward. The County has local pool regulations that are managed by Environmental Health and Safety (EHS) and led by Ms. Jessica Sanders (Environmental Health Program Manager – Plan Review). These regulations were first adopted in 1991 and last revised in 2020. In response to department changes (i.e., EHS transitioning from Environmental Services to Public Health), these regulations will need to be revised again. In addition, staff are surveying the landscape. There are some industry design trends and advancement in technology that make now an opportune time for opening the rules and doing a comprehensive assessment.

Due to this, a workgroup will convene in the next month to review the rules, follow the process for stakeholder engagement, and finally bring the proposed changes before the Public Health Committee and Health and Human Services Board. These recommendations are anticipated in late fall 2025. The goal is to have the revised rules reviewed and approved well in advance of the next pool season (which starts April 1st). This would give time to train staff as well as any industry members or operators on the changes.

Current local pool regulations can be found online at www.wake.gov/pools. This landing page includes ways to stay engaged. Ms. Brown welcomed questions as staff move forward with gathering feedback around potential and proposed changes.

Committee Chairs Update

(Presented by Chair Ann Rollins, Dr. Anita Sawhney and Vice Chair Wanda Hunter)

Chair Ann Rollins noted that the Regional Networks Committee report was included in the Board's agenda packet for review.

Dr. Anita Sawhney (Chair of the Public Health Committee) provided an overview of the last Public Health Committee meeting on May 16th. Ms. Rebecca Kaufman (Health Director) notified the Committee of the upcoming split to Health and Human Services into Social Services and Public Health. This restructuring will formally take place on July 1st, 2025. Public Health is staying busy with an accreditation site visit in September and the new Public Health building opening later in the year.

Mr. Marcellos Allison (Live Well Wake (LWW) Program Manager) updated the Committee on the Community Health Needs Assessment (CHNA). He highlighted the top three priorities – access to healthcare, mental health, and affordable housing. The final CHNA report was anticipated to be presented to the Wake County Board of Commissioners (BOC) in July. Additionally, Dr. Sawhney reminded Board

members that the LWW Wellness Hub was now accepting wellness events or trainings to promote.

There was also an annual Chronic Disease Public Health Report from Ms. Morgan Poole (Epidemiology Program Manager) and Ms. Sarah Plentl (Health Promotion and Disease Prevention Section Manager). Seven of the top ten causes of death in Wake County are chronic diseases with significant disparities with race and ethnicity. Finally, Mr. Justin Milstein (Environmental Health Program Manager – On-Site Wastewater) provided an overview of wastewater, septic systems, soil evaluation, and inspections.

Vice Chair Wanda Hunter (Co-Chair of the Social Services Committee) shared that the Social Services Committee last met on May 2nd. There was a summer Low Income Energy Assistance Program (LIEAP) scam in circulation that staff warned the Committee about to inform the community. If a client asks specifically for “summer” LIEAP, it is not an actual program and instead something to steer away from.

Cool for Wake started on May 1st. Fans can be picked up at any local Regional Center. While some air conditioners are available, they require a letter of medical necessity. A donation link was available on the Cool for Wake landing page (<https://www.wake.gov/departments-government/health-human-services/programs-assistance/utility-bill-assistance-help-heating-cooling-and-water/cool-wake>).

Finally, May was Foster Care Awareness Month. The team at Child Welfare released an Instagram reel titled “Where the FAMS at?” (<https://www.instagram.com/reel/DJH1egnvY5y/>). Dancing, complete with fans, the Child Welfare staff challenged the community and families to get involved to help with respite care and other needs related to foster care awareness. If someone has the capacity to help, put the call out. Even if it’s respite care for one weekend, that still ensures the child(ren) receive the best care as well.

Public Comments

- Ms. Deidre McCullers stated that the Behavioral Health strategic plan failed to acknowledge or have any action plan surrounding the racism and corruption at the foundation of the country. She spoke to the suffering all the way from countrywide to the neighborhood level caused by racism. Presentations and plans omitting this – the corrupt system – would leave children and youth in the same condition as before. She maintained that the system had to be dismantled and started anew before real change could occur.
- Ms. McCullers also pointed out that the crack epidemic had not been addressed despite the \$70 million being allotted to the opioid epidemic.

Adjournment

The meeting was adjourned at 9:22 a.m.

Board Chair’s Signature: 

Date: 06/26/2025

Respectfully submitted by Brittany Hunt