

# NORTH CAROLINA ASSOCIATION OF COUNTY COMMISSIONERS



## PRESIDENT'S MENTAL HEALTH ENGAGEMENT TASK FORCE REPORT AND RECOMMENDATIONS

*Published August 2015*

# TASK FORCE LETTER OF TRANSMITTAL

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Dear President Beale:

On behalf of the NCACC Mental Health Engagement Task Force, I would like to present the NC Association of County Commissioners with our report and recommendations.

The members of this Task Force have taken your charge to heart. We have an unfailing commitment to improving access to services for those in need of behavioral health care treatment and their families. We are equally committed to educating all commissioners about the importance of local involvement in these issues.

At the county level, we govern not through positions of power, but through positions of influence. As commissioners, we can model better communications with the Local Management Entities. We can use every opportunity to learn more about how this massive system works, and we can take an active role in helping those in our counties who need mental health, developmental disabilities and substance abuse services and their families find the help and support they deserve.

It is our hope that every board of commissioners will read, study and act on these recommendations. It has been a privilege to work with such a committed group of county commissioners this year.

Sincerely,

**J. Leon Inman, Stokes County**

Mental Health Engagement Task Force Chairman



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*This report is available online at [www.ncacc.org/mentalhealth](http://www.ncacc.org/mentalhealth).*

# PRESIDENT BEALE'S CHARGE

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## **President Ronnie Beale's Charge to the Mental Health Engagement Task Force**

*Delivered at 2014 NCACC Annual Conference*

"For a good number of years, the State has been restructuring its mental health system. The original goals of Mental Health Reform were to provide a wider base of clients to support a stronger provider network. As the years have unfolded, however, this goal has become enmeshed in many different iterations of organizational approaches which have often left our citizens with no idea where to go or who to call when they have family members in crisis.

With the impending further regionalization of the state's mental health system into even larger management entities, the predominance of time, energy, and human resources available to work on this continued re-design will be necessarily focused on management and organizational issues. All of this means more confusion for the citizens and even less understanding by the county commissioners on how or whether they can help.

As I look at where the leadership power for county commissioners could constructively be focused, it is in this area of understanding and education. For this reason, I am creating a special task force this year to develop an educational program for commissioners on local mental health needs. And I want the NCACC to conduct research to identify service needs based on each disability group by county, so commissioners can understand where the service gaps are. I want to improve commissioners' understanding of their citizen's treatment needs, and the available resources to help meet them.

While the organization of the services management system is important, it is even more vitally important that the clients remain the focus at the county level. Commissioners may be "organized" further and further away from the program management centers, but our citizens who need the services still live in our counties, their family members are still in our counties, and we have a moral obligation to understand how we can help meet their needs."



# TASK FORCE MEMBERS

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Chairman Leon Inman, Stokes County  
Wayne Abele, Burke County  
Susan Allen, Cleveland County  
Bertadean Baker, Warren County  
Jackie Brown, Lenoir County  
Marty Cooke, Brunswick County  
Tony Cozart, Granville County  
Bob Davis, Scotland County  
Beth Dawson, New Hanover County  
Jeff Dixon, Pasquotank County  
Keith Duncan, Rockingham County  
Johnnie Ray Farmer, Hertford County  
Rick French, Alexander County Manager  
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Ed Mims, Granville County  
Michael Page, Durham County  
Renee Price, Orange County  
Mark Richardson, Rockingham County  
Caroline Sullivan, Wake County  
Gloria Whisenhunt, Forsyth County

## **Special Appreciation**

The Mental Health Engagement Task Force wishes to express its sincere appreciation to Mr. Dave Richards, Director of the Division of Medical Assistance, who has provided departmental leadership and guidance throughout our deliberations. Outstanding support and assistance have been provided by Ms. Courtney Cantrell, Director of the Division of Mental Health/Developmental Disabilities/Substance Abuse Services and her staff. Throughout the Task Force's discussions, DMH/DD/SA staff members have been available to give guidance and support; they have attended our meetings, participated in the discussions, and provided practical solutions and ideas to help us formulate recommendations. Their commitment to supporting the NCACC in this effort has been invaluable. In addition to Ms. Cantrell, the committee wishes to personally thank Mr. Dennis Farley, System Performance Team Leader and designated liaison to our Task Force, Ms. Flo Stein, Deputy Director of the Division and LME Team Liaison, and Ms. Mabel McGlothlen, Systems Performance Team Section Chief.



# EXECUTIVE SUMMARY

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## Findings

1. One strength of our mental health system is that it is local; the service providers are embedded in our communities and agencies, and there is potential for flexible funds to meet particular needs as the system evolves.
2. A weakness of our mental health system is that there is no local door, no central local presence; people in need do not know where to go, community leaders such as commissioners, law enforcement officers, businesses and schools, do not know who to call for help.
3. The NCACC Mental Health Engagement Task Force and the entire body of county commissioners can exercise leadership at the county level to influence changes that will improve behavioral health services to our citizens.

## Recommendations

1. Strengthen the Relationship between the LME/MCOs and each member of the Board of Commissioners.
  - Actively engage the LMEs in discussions about your individual county's service needs;
  - Be thoughtful in making appointments to the LME boards and any advisory committees;
  - Designate a county staff liaison to the LME organization and have regular contact with the LME.
2. Focus on access to services at the county level.
  - There should be no wrong door for entry into behavioral health care; all county agencies should post information on their websites about where people can get care, and municipalities and schools should also be included. The NCACC will help execute this recommendation with templates and other materials.
  - System of Care, a successful collaborative model for providing services to children, should be implemented in all counties; it incorporates a team approach that involves families, schools, and other public agencies in supporting and treating children with behavioral health needs.
  - Enroll your local public health department in providing access to behavioral health services. Our public health departments are visible and well-known in our counties; they have a network of community agencies and outreach clinics, and there is no stigma attached to going there. The Community Health Assessment process provides a valuable opportunity for commissioners to enlist their support and engagement. Integrating physical and behavioral health at the local level is a holistic model of treatment.
  - Make sure all of your law enforcement officers are trained in Crisis Intervention.
3. Focus on prevention at the county level.
  - Youth Mental Health First Aid is a program available through the Area Health Education Centers and LME/MCOs that teaches people who work with kids how to recognize early warning signs of mental illness. There are trainers available in every county. County governments can be instrumental in spreading the word about availability of this program, especially with the school systems and including the community colleges. Commissioners should use their positions of influence in the counties to talk about this program and the importance of prevention.
4. Continue to study and educate commissioners about behavioral health needs and services.
  - The NCACC should create a tool kit of materials to help every board of commissioners implement these recommendations.
  - County commissioners have positions of influence, which can be a positive force for change with local service providers, school systems, law enforcement officials and municipal governments. The NCACC should continue to educate commissioners about the MH/DD/SA system, the services that are provided and the avenues for access that citizens need.
  - Additional study should be given to the following areas: the potential for use of a 311 call system for non-emergency behavioral health services, involuntary commitment of children and the wrap-around services provided to their families, and the service needs of the elderly, especially those in group home environments.

# INTRODUCTION

The Mental Health Engagement Task Force held its organizational meeting in December 2014, and met four additional times in the ensuing months. To develop its work plan, a facilitator was engaged to help the Task Force focus its energy and interests by leading the members in a discussion of the strengths and weakness of the current system from the counties' perspective, and to identify actions the Task Force could recommend to commissioners statewide to build on the strengths and address the weaknesses. The Task Force found:

## Strengths of System

- It is LOCAL; service delivery is local – it is embedded in community agencies; there is a local presence;
- There are flexible funds available to meet locally-identified priorities (B3);
- Crisis Intervention Teams work well and minimize pressure on law enforcement agencies; DHHS has also developed a new Veterans module and there are State funds available for the training;
- Tele-psychiatry works in the rural areas.

## Weaknesses of System

- There are not enough services available for the elderly, schools and colleges (teen suicides), veterans, and homeless;
- There is no local identity; providers are scattered and there is no visible “door.” People, businesses, organizations, and commissioners do not know where to go or who to call for help;
- There is no local accountability for outcomes; the role of local elected officials is weak.
- Regions are too large and change is constant; the LME/MCO organizations are not seen as stable.

## What the Task Force Can Do

- Be active: educate commissioners, share ideas about model practices and successful programs;
- Identify the services available in the counties and how citizens can access them;
- Consider a web-site template counties can use to help connect citizens to services;
- Improve commissioners' understanding of the LME/MCO business model;
- Study the following issues, particularly:
  - Crisis Intervention Training for law enforcement
  - Services to veterans, homeless, and elderly
  - Connections to Schools
  - B3 funds (how to access these flexible funds)
  - How to communicate mental health needs to citizens



## What Commissioners Can Do

- Hold LMEs Accountable - Demand a welcoming, friendly environment, a friendly front door, and easy access;
- Get involved with your LME; ask the LME to meet with the Board of Commissioners;
- Create networks between the LMEs, churches, and schools; get the Local Public Health agency and Board involved.
- Help commissioners understand the financial impact of mental illness on county law enforcement agencies.

NCACC staff was asked to create a web-based resource page to share all the information the Task Force gathers. Meeting summaries and presentations are posted to this on-line resource center, along with reference readings on successful program models, multi-media presentations on topics of interest, links to important contacts in the LME/MCOs, and relevant statutory references. This resource page will continue to have information added as new or improved practice models and sources of assistance are found. You can access it at [www.ncacc.org/mentalhealth](http://www.ncacc.org/mentalhealth).

# RECOMMENDATIONS

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The Mental Health Engagement Task Force developed four key recommendations to address the most pressing mental health issues as described previously:

## **Recommendation #1: Strengthen the relationship between the LME/MCOs and the Boards of County Commissioners.**

Every board of commissioners should be actively engaged with their local management entities (LMEs) and managed care organizations (LME/MCOs). Specific recommended strategies include:

1. Ask for presentations to your board that give a face to the behavioral health needs of your citizens;
  - Numbers and graphs present data, but can also dehumanize the information;
  - Presentations should be interactive and encourage a dialogue about the service needs; conduct a serious conversation with the LME/MCO leadership team about your specific county service needs and how to address them.
2. If your county has an appointment to the LME Board, make sure it is filled with a commissioner who is active and engaged, who cares about behavioral health issues and who will ask questions. Set the expectation that these appointees will keep the boards of commissioners well informed, through regular and timely reports of LME board discussions and actions.
3. Designate a liaison from the county to serve as a contact person to the LME staff; this person should have regular contact with the county's LME team leader, and stay informed about issues of mutual interest and concern.

## **Recommendation #2: Focus on access to services at the county level.**

Create a community-wide environment where there is “No Wrong Door” to treatment, so that a person who has a behavioral health need will find the right path to treatment in your county, regardless of where they present.

For children's services, the System of Care model of service coordination is a known evidence-based practice. Under this model, collaboration between the child, family, schools, and other agencies involved in the family's life takes place. Agencies may include the department of social services child and family services sections, child support enforcement, child care, public health, public schools, and any service providers. Children and their families are provided coordinated treatment and support services.

Forsyth County is operating this team approach to care under the leadership of Director of Social Services Debra Donahue, and the NC Division of Mental Health/Developmental Disabilities/Substance Abuse Services has System of Care Coordinators in every LME. The Substance Abuse and Mental Health Services Administration (SAMSA) of the US Department of Health and Human Services is a valuable resource for learning more about this model of practice. For a copy of the 2009 SAMSA report to Congress on the effectiveness of this model, refer to: <http://store.samhsa.gov/shin/content/PEP12-CMHI2009/PEP12-CMHI2009.pdf>. Also helpful is the technical toolkit available here: [www.tapartnership.org/systemsOfCare.php](http://www.tapartnership.org/systemsOfCare.php) Specific strategies to improve children's access to mental health services in your counties are:

1. Ask your county social services director to meet with the System of Care coordinator on your LME staff to explore implementation of this coordinated team approach to services for children.
2. Commissioners should ask their staff to identify and address any barriers to implementation of the System of Care model of service coordination for children.

For adult services, the local public health system can be invaluable in providing access to care. As a model of practice, integration of physical health and behavioral health is one way to remove the “stigma” that attaches to mental health, and the NC Division of Public Health is supportive of this kind of collaboration. Additionally, most citizens in a



county are familiar and comfortable with the local public health department. Even in multi-county health areas, the local public health clinic is an accessible door. Identifying and treating all of a person's health care needs is the role of the local health department, and clinical health assessments can often uncover behavioral health issues, such as depression, alcoholism, and substance abuse, before a crisis occurs.

In Johnston County, Behavioral Health Services is co-located and collaboratively managed with the Johnston County Public Health Department. Beginning in 2012, the Mental Health Director, Dr. Janis Nutt, and the Public Health Director, Dr. Margaret Pearson, developed cooperative agreements between their respective agencies and the hospital. Since 2013, safety net services have been available in the local public health department; services available include psychiatric evaluations, medication management, medication administration, "specialty" psychotherapy, prescription assistance, and walk-in crisis assessment. The county government webpage has links to both agencies, and the health department website has a link for behavioral health services that describes the services available and the phone numbers to call for assistance.

Strategies for improving local access to adult and youth services are:

1. Explore opportunities for providing behavioral health information, access, and triage through the local public health departments and their community networks.
2. As a board of commissioners, be actively engaged in the local public health department's Community Health Assessment process.
  - Invite your Local Public Health Board to meet with the Board of Commissioners to identify and discuss common issues and concerns about the behavioral health needs in your county.
  - Ask them to review the most recent county community health assessment with the board of commissioners; learn whether behavioral health issues are included as priority concerns. Your LME staff can help coordinate and facilitate this meeting.
  - If behavioral health issues are included in your county's community health assessment, learn what steps are being taken to address the needs and provide support to those efforts; if not, talk with the Public Health Board about how to incorporate behavioral health needs such as underage drinking, substance abuse, and teen suicide, into the next community health assessment process.
  - Your county's cycle of Community Health Assessment can be found here: <http://publichealth.nc.gov/lhd/cha/cycle.htm>.

For those who are incarcerated, the National Association of Counties (NACo) has undertaken a special initiative this year through a partnership with the Council of State Governments (CSG) Justice Center, and the American Psychiatric Foundation (APF), to provide technical support and model programs to help counties reduce the incidence of incarceration of those with mental illnesses. The initiative is called, "Stepping Up," and more information can be found at [www.naco.org](http://www.naco.org). Also, enhanced law enforcement training known as Crisis Intervention Training (CIT) provides a special 40-hour curriculum that teaches law enforcement officers how to recognize behaviors indicating a mental health crisis, to defuse a crisis situation, and to get these individuals to appropriate treatment rather than treating them as criminals. The LME/MCOs can help make this training available in your county. To reduce the incarceration of the mentally ill, the following strategies are recommended:

1. Convene a discussion group of local officials (judges, Sheriff, District Attorney, a magistrate, mayors and town managers from municipalities within your county, the school superintendent, housing authority, and county staff leaders) to meet with your LME/MCO directors to discuss a collaborative approach to reducing the incarceration of the mentally ill in your jail;
2. Encourage your county to participate in the National Association of Counties' Stepping Up Initiative;
3. Assure that your county law enforcement officers participate in Crisis Intervention Training.

For individuals in crisis, knowing where to go for help is often difficult. People frequently show up in hospital emergency rooms or jails because they do not know where else to go.

NC DHHS has a Crisis Solutions Section that is focused on expanding crisis intervention training for law enforcement officers, developing more walk-in crisis centers, and providing technical support for local initiatives that improve crisis access. In addition to Crisis Intervention Training, some successful models being implemented and studied include facility-based crisis units and behavioral health urgent care centers, training paramedics in crisis intervention, and collaborating with hospital emergency rooms to have on-site mental health triage available.

The Crisis Solutions Section has an extremely helpful website (<http://crisissolutionsnc.org/>) with a drop-down menu for county-by-county provider names and phone numbers and clear instructions that help a person in need or a family member know what to do to access care. The Task Force recommends the NCACC undertake the following strategies to enable counties to help citizens in crisis:

1. NCACC should collaborate with the DHHS Crisis Solutions Section to develop a county web template that mirrors the information available on the agency's website.
  - This template with county-specific information should be posted on every county website.
  - The information should include the name and address of the LME/MCO, the 1-800 phone numbers for 24 hour crisis care, the number and address of walk-in clinics in the area, and phone numbers and instructions to access mobile crisis units.
2. NCACC should create a brochure template with this same crisis access information for distribution to every county.
  - The template should be in a format that allows the county to adapt it for printing and distribution within the county.
  - Commissioners and other county officials should take every opportunity to distribute these brochures widely through the schools, civic groups, libraries, faith community, United Way, and any other relevant community networks.

### **Recommendation #3: Focus on prevention at the county level.**

Waiting to address a behavioral health need when a person is in crisis is costly in many ways. Learning to recognize warning signs is a way to prevent such crises arising. Young people may act out in ways that are disruptive or show anger without knowing what is wrong. Even adults often do not realize they are experiencing a mental illness: they may self-medicate to make the pain go away or engage in criminal behavior to support addictions. There is a cost to their dysfunction – it may be in loss of family relationships, loss of productivity at work, or deterioration of school grades. Prevention services are available and county commissioners can be instrumental in spreading the word.

The Area Health Education Centers (map located here: <https://www.med.unc.edu/ahec/>) offer a curriculum called Youth Mental Health First Aid which is taught frequently throughout the state. The target audience for this program is caring adults who work with young people; participants are taught to recognize risk factors and warning signs of mental illness. Mental Health First Aid is a laymen's program, rather than for those in the behavioral health professions. The program is evidence-based and trainers have to be certified by the National Council for Behavioral Health. Reaching young people before they experience a crisis is an excellent way to prevent a downward spiral. The class helps teachers, counselors, youth group coordinators, and others who work with young people recognize indicators of potential mental illnesses. In addition to learning warning signs, participants also learn how to help parents and other caring adults get children and young people connected to treatment.

There are also Mental Health First Aid curricula for Adults, and for the higher education environment. The LME/MCOs are involved in training individuals to teach these one-day classes, and some are dually trained to teach the youth and adult classes. There are people in each county who have this training, and others can be trained to teach it. County commissioners can be instrumental in helping spread the word about the availability of these classes.

Prevention strategies recommended include:

1. The NCACC should create public service announcements about the Youth Mental Health First Aid Program and provide these to all the public access channels;

2. Create a network of communication with the local faith community, including churches and partner organizations such as United Way, to fully inform them about how citizens can access behavioral health services locally. Let them know that the commissioners are interested in making sure citizens know where to go and how to get services.
3. Invite your AHEC to use county agencies, including the boards of commissioners, as information distribution points for the Youth Mental Health First Aid seminars:
  - Provide the AHEC with contact information for county public information officers so that dates and locations of training can be publicized on county websites and in agencies that serve families and children, including Cooperative Extension Services, and Boys/Girls Clubs.
  - Ask the county public access channels and civic groups to promote and advertise the Youth First Aid programs in your area.

**Recommendation #4: Continue to study and educate county commissioners through the NCACC about the behavioral health needs of their citizens.**

Understanding the behavioral health needs in a county takes a special effort, so the NCACC should create a toolkit of materials to help commissioners implement the recommendations embodied in this report.

The Association should continue this effort to enhance commissioners' knowledge and understanding of the behavioral health care system. The following topics for future study were noted:

1. Explore potential for use of a 311 hotline call system for citizens to call to access non-emergency behavioral health service.
2. Study the involuntary commitment of children and the wrap-around services available to their family members to see if there are opportunities for counties to improve family outcomes.
3. Learn how the mental health needs of the elderly are being addressed in North Carolina, especially for those in group home environments, and identify appropriate avenues for supporting those efforts.



Ruby Brown-Herring, Associate Director, Mental Health & Public Health, Wake AHEC, speaking about Youth Mental Health First Aid.

# GLOSSARY OF TERMS

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## **AHEC: Area Health Education Center**

The North Carolina AHEC Program evolved from national and state concerns with the supply, distribution, retention and quality of health professionals. In 1970, a report from the Carnegie Commission recommended the development of a nationwide system of area health education centers. There are nine Area Health Education Centers located throughout North Carolina, and associated with the medical schools and teaching institutions. A map showing the NC AHEC system is found here: [www.ncahec.net/centers](http://www.ncahec.net/centers). AHECs provide educational programs and services for health care workers who are required to have on-going training and certifications. Their programs and activities are focused in four key areas: improving the distribution and retention of health care providers, with a special emphasis on primary care and prevention; increasing the representation of minorities and disadvantaged populations in all health professions; enhancing the quality of care and improving health care outcomes; addressing the health care needs in underserved communities and populations.

## **B3 Funding: Section 1915(b)(3) of Title XIX of the US Social Security Act (Medicaid)**

This section of the federal law allows the Medicaid oversight agency (CMS) to waive certain requirements of the Medicaid Act for the states. NC's waiver program is authorized under section 1915(b); section (b)(3) allows the State to share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver.

## **Crisis Intervention Training (CIT)**

Crisis Intervention Training for law enforcement officers helps them recognize the signs and symptoms of mental illnesses and the medications used to treat them. The goal of the program is to help persons with mental disorders access medical treatment rather than place them in the criminal justice system due to illness-related behaviors. Crisis Intervention Training in North Carolina is available through the Local Management Entities. Officers receive 40 hours of training on a variety of topics, including an Overview of Mental Health, Geriatrics, Substance Abuse/Co-Occurring Disorders, Special Concerns with Adolescents, Mental Health Commitment Process, Personality Disorders, Developmental Disabilities, Autism, Suicide, Trauma and its aftermath, Homelessness, Crisis Intervention and De-escalation.

**DHHS:** NC Department of Health and Human Services

**MH/DD/SA:** Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

## **LME: Local Management Entity**

Local Management Entities (LMEs) are responsible for managing, coordinating, facilitating and monitoring the provision of mental health, developmental disabilities, and substance abuse services in the area that they serve. There are currently eight Local Management Entities in NC. Contact information can be found here: [www.nc-council.org/find-your-local-lmemco](http://www.nc-council.org/find-your-local-lmemco).

## **MCO: Managed Care Organization**

Under NC's waiver program, the Local Management Entities (LMEs) are now Managed Care Organizations for purposes of managing and overseeing services to Medicaid eligible clients within a capitated rate system.



## **Mental Health First Aid**

Much like CPR, but for mental rather than physical health, this program is designed for those with no clinical training. It helps families, colleagues, teachers and others assist someone experiencing a mental health related crisis. The program is designed and disseminated by the National Council for Behavioral Health, and teaches participants how to recognize risk factors and warning signs for mental health and addiction concerns, strategies for how to help someone in both crisis and non-crisis situations, and where to turn for help. There are separate programs for adults, adolescents, veterans, and higher education environments. Youth Mental Health First Aid is an 8-hour course designed to teach parents, teachers, and other citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. In NC, this program is taught through the AHECs and the LMEs.

## **System of Care**

The System of Care approach to children's services takes a holistic approach to mental health services for children. Working across county agencies and the school system, this model of care coordination is a team approach. It incorporates services from public health, social services, mental health and the public schools, and Guardian Ad Litem. Child and family teams are created based on the individual child's needs. Much more successful outcomes are realized for children using this model of care coordination. A toolkit for building and sustaining System of Care collaboratives at the local level exists at: [www.ncdhhs.gov/mhddsas/services/serviceschildfamily/Toolbox/collaboratives/collaboratives](http://www.ncdhhs.gov/mhddsas/services/serviceschildfamily/Toolbox/collaboratives/collaboratives).

## **Tele-psychiatry**

Tele-psychiatry is the use of interactive audio and video connections to provide psychiatric assessments to determine an appropriate course of action for individuals experiencing a mental health crisis. It is especially effective in rural areas where access to care may be limited.



# NOTES

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# NOTES

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