Annual Report on North Carolina Supportive Housing Program

NC General Statute 122C-20.15

Report to the

Joint Legislative Oversight Committee on Health and Human Services

By
North Carolina Department of Health and Human Services

October 1, 2017

Vision Statement

North Carolina supports serving individuals with disabilities in the least restrictive and most integrated settings possible, based on what is clinically appropriate as defined by the individual's Person-Centered Planning process. Through the planning process, the N.C. Department of Health and Human Services (DHHS) believes that individuals with disabilities should have the opportunity to live in community settings that reflect community values and standards. These settings will vary depending upon the individual's preferences and supports needed to live in the community.

DHHS continues to build a sustainable system in the implementation of the Transitions to Community Living Initiative (TCLI), and efforts to integrate improvements across systems have been ongoing. Implementation of a comprehensive services system inclusive of the TCLI continues to be the main focus for meeting the requirements of the 2012 settlement between North Carolina and the United States Department of Justice (DOJ), regarding the state's compliance with the Americans with Disabilities and Olmstead Acts. During the last year, DHHS has seen major successes for individuals we serve. Some of these accomplishments include:

- Providing housing and services to 1,470 individuals since the beginning of TCLI. Provided supportive housing to 617 individuals in state fiscal year (SFY)16-17.
- Funding 10 new Individual Placement and Support – Supportive Employment (IPS-SE) teams and expanded eight teams.
- Helping eight new teams of IPS-SE reach fidelity this SFY.
- Having a total of 30 IPS-SE teams meet fidelity.
- Providing quality Supported Employment (SE) services to 3,303 individuals, of which 3,071 individuals were served by teams that met fidelity - specifically providing those services to 1,199 individuals that meet the definition of living in an Adult Care Home (ACH) or at risk of placement into an ACH since the beginning of TCLI. In SFY16-17, 1,214 new individuals were served by IPS-SE teams, 1,316 new individuals were served by teams that met fidelity, and 491 individuals were served that were in or at risk of living in an ACH, or at risk of placement into an ACH.
- Developing and implementing Tenancy Supports service as a state-funded service, and the state has committed to developing a Medicaid service.
- Diverting 139 individuals from entry to an ACH.

Lives Transformed: Comments from some who participated in the Transitions to Community Living Initiative

"I would say that they're very helpful, and that I never thought I would have my own place. The support helped me push through it, and I'm capable of doing different things. I'm living a normal, successful life no matter what the disability terms would be." *Alliance*

"In the past, I used to think I wouldn't be able to work because of my disability, that it would be too hard and everything. When I got linked up with Supported Employment, I see that there is a job out there for everyone. You just have to find the right job for you, and everything is possible." *Alliance*

""I feel like I've been truly blessed to be in this program and I'd just like to thank God for that and the people that have helped me and the whole program – the ACT Team, Cardinal Innovations. I'm really good now that I'm on my own." *Cardinal*

"The most important thing for me is to not go back into the hospital and so far it has been great. I'm just happy. I achieved this. It was me who did it…I had help, but I did it." *Cardinal*

"I have free will to do what I want, eat when I want, take a shower in my own bathroom and have privacy. I have more things to do, shoot pool, walk around and go to restaurants. You all helpmed me so much it exceeded my expeectations." *Smoky*

"My Transition Coordinator is my (Lifesaver) she has brought me back to life inside and I'm loving it. I now am living in a very nice 2 bedroom apartment with 2 bathrooms." *Sandhills*

"I am so happy. This is the first time I have had the opportunity to live on my own." *Partners*

1. **LME/MCO Totals for Start and end of 2016-17**

LME/MCO	In-Reach Planning	Transition Planning	Individuals Housed	PASRR Screenings Processed	ACT Served	Total Population
Alliance Behavioral Healthcare	423	92	77	259	825	**423**
Cardinal Innovations	1014	57	166	383	1185	**1014**
CenterPoint Human Services	324	7	70	92	267	**324**
Eastpointe	540	19	87	237	419	**540**
Partners Behavioral Health Mgmt	381	52	103	223	543	**381**
Sandhills Center	473	17	108	183	259	**473**
Smoky Mountain Center	641	46	100	274	1313	**641**
Trillium	544	28	142	200	407	**544**
Total	**4340**	**318**	**853**	**1851**	**5218**	**4340**

LME/MCO	In-Reach Planning	Transition Planning	Individuals Housed	PASRR Screenings Processed	ACT Served	Total Population
Alliance Behavioral Healthcare	582	73	151	27	862	582
Cardinal Innovations	1231	83	420	41	1406	1231
Eastpointe	965	7	143	15	397	965
Partners Behavioral Health Mgmt	504	30	207	19	558	504
Sandhills Center	495	24	168	11	288	495
Trillium	700	8	202	16	362	700
Vaya Health	617	16	179	20	1184	617
Total	**5094**	**241**	**1470**	**149**	**5057**	**5094**

2. LME/MCO Supported Employment Totals for End of SFY16-17

LME/MCO	Fidelity S.E. Teams[1]	Teams Working Towards Fidelity[2]	Total Served by Fidelity Teams[3]	Total Served by all teams[4]	Total Served by Fidelity Teams that are in the Priority Population[5]
Alliance Behavioral Healthcare	6	0	507	507	**226**
Cardinal Innovations	6	0	620	761	**342**
Eastpointe	5	0	407	407	**59**
Partners Behavioral Health Mgmt	2	1	202	281	**31**
Sandhills Center	3	0	248	260	**34**
Trillium	7	0	448	448	**271**
Vaya Health	2	1	639	639	**236**
Total	**31**	**2**	**3071**	**3303**	**1199**

1. Teams that have scored at least a 74 on the Dartmouth IPS-SE review scale.
2. Teams that have either not yet reached a level of fidelity, or haven't been reviewed. It is presumed that these teams will eventually meet fidelity requirements.
3. All individuals who are or have been served by fidelity level SE teams after the date that the team passed the fidelity marker, all recipients meet the service definition requirements
4. All individuals served by both fidelity SE teams as well as those teams that are presumed to meet fidelity in the future.
5. These individuals are being served by fidelity level teams that have SMI/SPMI, and are either in an ACH or at-risk of entry to an ACH

3. Community Based Mental Health Services

Summary

North Carolina continues to make progress towards fulfilling the promise of TCLI. Our focus continues to be ensuring that our adult mental health service array is person-centered, infused with recovery-oriented practices and has a community focus.

DHHS will continue to broaden our efforts to re-shape the adult mental health service array. Our goal is that all levels of service delivery (from providers, to Local Management Entity/Managed Care Organizations (LME/MCO) staff, to state agencies) provide adults with Serious Mental Illness (SMI) access to evidence based practices and services that support them in living, working, and thriving in the community of their choice. LME/MCOs are quasi-governmental entities that contract with DHHS to provide management and oversight of the public system of mental health, developmental disabilities, and substance use disorder services at the community level.

Assertive Community Treatment (ACT)
ACT is a service-delivery model that provides comprehensive, locally-based treatment to individuals with Severe and Persistent Mental Illnesses (SPMI). The State of North Carolina utilizes the Tool for Measurement of Assertive Community Treatment (TMACT) to measure teams' fidelity adherence to the ACT model. The TMACT evaluates current practices, compares current practices to best practice standards and conducts a needs assessment to guide recommendations, inform broader training needs, and highlight areas of strength.

In SFY16-17, 34 TMACTs were completed. All were second TMACTs completed on teams that scored at least provisional certification. The table below shows the significant shift in practice between first and second TMACT evaluations:

Certification Level	Team Score for SFY14-15	Team Score for SFY15-16	Percent increase/decrease
Full Certification	13	26	+100%
Moderate-High Provisional	18	9	-50%
Low Provisional	10	3	-70%

Many activities facilitated by DHHS staff or through the Institute for Best Practices have led to positive outcomes. TCLI has also initiated the first state-wide focus on quality measurement and improvement for ACT.

DHHS consistently focused efforts and resources on fidelity evaulations, training and technical assistance since SFY14-15, and the outcome is ACT teams are improving fidelity to the ACT Evidence Based Practice model, demonstrated in the table above.

In SFY17-18, DHHS's focus will be providing more team-specific technical assistance, facilitating fidelity evaluations for teams that score in the Low Provisional and Moderate Provisional ranges, and analyzing the data collected during the TMACT process to determine state-wide and LME-MCO specific trends regarding areas of strength and areas of development.

State-level areas of training focus for ACT continue to be:

- Implementation of evidence based practices (which includes: Integrated Dual Disorders Treatment, IPS-SE, Wellness Recovery Action Planning, Psychiatric Rehabilitation, Family Psychoeducational and Wellness Management and Recovery)
- Person-Centered Planning
- Organization and structure (which includes: daily team meeting organization, team scheduling and linking the Person-Centered Plan to scheduling)
- Assertive engagement (which includes rapport building strategies, facilitating meeting basic needs, and motivational interviewing techniques)

- Assessments (which includes: integrating mental health and substance use, being comprehensive and ongoing, and directly influencing the treatment provided)

DHHS sponsored and/or facilitated the following training during 2016-2017 that focused on quality improvement for Adult Mental Health (AMH) services:

- Tenancy Support Training (September 2016, November 2016, April 2017, May 2017)- In both September and November, the Institute for Best Practices provided day-long Tenancy Supports Training covering a range of topics, including areas of functional skill deficits, how motivational interviewing is applied within Tenancy Supports, how to apply Person-Centered Planning when providing tenancy supports, and adult learning theory techniques, and relevant cognitive deficits informing training techniques. A day-long Tenancy Supports Training was provided on April 7, 2017 in Greensboro by Dr. Moser, and again on May 17, 2017 by Dr. Antoine Bailliard, PhD, OT and Dr. Moser. About 175 people attended these training sessions.
- TMACT Evaluator Summit (6/7/17-6/8/17 Winston-Salem) – was facilitated by the Institute for Best Practices, the summit focused on bringing all current lead and second TMACT evaluators together, reviewing data trends, providing technical assistance and training on scoring criteria, planning for third TMACT evaluations, introduction to eTMACT, and obtaining feedback on TMACT implementation across the state. This summit was attended by 26 TMACT evaluators.
- Mental Health and Substance Use 101 Training/Crisis Response Training (8/2/16- Wilmington, 10/18/16- Gastonia, 2/7/17 and 5/31/17- Durham)- was developed and facilitated by the Division of Mental Health, Developmental Disabilities and Substance Use Services (DMH/DD/SAS) AMH staff. This training focused on entry-level mental health professionals to increase understanding of recovery and wellness, Crisis Response training focused on increasing knowledge of screening for crisis/suicidal ideation using current evidence based assessments, identifying crisis responsibilities for different levels of community-based AMH services
- Integrated Dual Disorders Treatment (IDDT)- was facilitated by the Institute for Best Practices (4/25/17 and 5/25/17) in Greensboro. About 115 people attended these training sessions.
- Person-Centered Planning/Medical Necessity Trainings- was facilitated by Dr. Lorna Moser with the Institute for Best Practices (4/26/17 and 5/18/17) in Greensboro. This training was blended with the Tenancy Supports tand IDDT training.

DHHS's focus for 2017 will be providing technical assistance to ACT teams based on their most recent TMACT evaluation. Technical assistance will be provided by staff at the Institute for Best Practices and members of the AMH team with DMH/DD/SAS.

ACT teams scoring Provisional Certification will receive scheduling priority, in addition to new teams, which are required to receive a TMACT within six months of start-up per Division of Medical Assistance (DMA) Clinical Coverage Policy 8A-1 and NC DMH/DD/SAS state-funded ACT Service Definition.

DMH/DD/SAS will continue to ensure that ACT teams and LME/MCOs have access to training, technical assistance and learning communities/collaboratives that provide them the resources needed to continue to improve quality and improve their fidelity to the model, focus on tenancy supports and supportive employment quality improvements, support recovery, and facilitate community integration for adults with severe mental illness.

Supported Employment (SE)
North Carolina has five teams that have scored a 100 or higher on their most recent fidelity evaluation. There are now four staff at DMH/DD/SAS that have a significant portion of their time dedicated to IPS-SE training, technical assistance and fidelity. This is in addition to six staff at the Institute for Best Practices that are dedicated to IPS-SE training, technical assistance and fidelity. The institute staff are regionally based, with two staff in the east, two staff in the west, and two staff located in the central part of the state.

At this time, 36 teams are providing IPS-SE services across North Carolina. State-wide access to IPS-SE services continues to be an area of improvement, as well as ensuring individuals seeking mental health services are informed and educated about the IPS-SE model.

In SFY16-17, DMH/DD/SAS worked closely with the Division of Vocational Rehabilitation (DVR) to identify ways to support and improve collaboration between IPS-SE teams and DVR counselors. All funding sources for IPS-SE continue to be underutilized, as IPS-SE teams have had difficulty accessing and maximizing the DVR milestones for the services they provide. Data shows that LME/MCO staff, along with providers, continue to need and benefit from systematic training addressing conversations around employment.

DMH/DD/SAS developed a training (approved for contact hours) to co-facilitate with Institute for Best Practice staff at each LME/MCO that focuses on increasing LME/MCO understanding of IPS-SE. Training started in July, 2017 and will continue through the fall/early winter of 2017. DMH/DD/SAS will also develop training for LME/MCO In-Reach Specialists that focuses on IPS-SE, community inclusion and zero readiness criteria for employment.

The additional IPS-SE staff at the Institute for Best Practices, along with DMH/DD/SAS AMH staff, significantly increased the amount of training and technical assistance provided in SFY16-17. Both teams had a goal of providing at minimum one face-to-face training/consultation with their assigned teams every 60 days. Some staff provided this every 30 days.

DMH/DD/SAS AMH staff and institute staff often paired up to facilitate training, and offered these training sessions to multiple teams to increase collaboration and resource sharing. These training and technical assistance sessions focused on:

- Structuring vocational unit meetings
- Assertive engagement strategies
- Job development
- Career profile development
- Collaborating with local DVR offices
- The role of an IPS-SE steering committee
- Behavioral health integration
- Follow-along supports

Institute for Best Practice staff facilitated 403 individual technical assistance sessions to IPS-SE providers/agency staff. In addition to the team-specific technical assistance, the Institute for Best Practice also facilitated:

- Introduction to Motivational Interviewing (MI) training (6 hours) - facilitated by DMH/DD/SAS with the Institute for Best Practices, two training sessions in February, 2017, and two training sessions in March, 2017, focused on MI and IPS-SE.
- More than 160 individuals completed IPS-SE 101. For this training, a pre and post test was administered to determine the impact the training had on knowledge, understanding and application of IPS-SE. The results were:

Training Date	Pre-Test Average Score	Post Test Average Score
August 2016	67%	80%
October 2016	60%	80%
December 2016	60%	80%
February 2017	43%	67%
June 2017- Jamestown	60%	73%
June 2017- Wilmington	63%	83%

The result of frequent IPS-SE 101 training, as well as the team-specific technical assistance, was seen in the fidelity evaluations completed in SFY16-17. In SFY16-17, 19 IPS-SE teams had a fidelity evaluation completed. Of the 19, 10 were an initial/baseline evaluation.

For the 10 teams having a baseline evaluation, the average score was 84.6, with a range of 74-101. This is compared to SFY14-15 and SFY15-16 (when less training resources were available), when teams that were evaluated had an average score of 79.2, with a range of 63-100.

For the nine teams having subsequent fidelity evaluations, six teams had finalized scores at the time this report was written. Of the six teams:

- Three teams increased their score by five points
- One team increased their score by seven points
- One team increased their score by 10 points
- One team increased their score by 11 points, and moved from Fair Fidelity to Good Fidelity

North Carolina will continue to collaborate with the Rockville Institute (formerly known as Dartmouth). This collaboration has, and will continue to, provide valuable training and technical assistance to staff from DMH/DD/SAS, DVR and Institue for Best Practices.

Critical Time Intervention (CTI)

DMH/DD/SAS and DMA staff received training from the model developers at the Silberman School of Social Work in New York. DMH/DD/SAS staff attended a CTI train the trainer event facilitated by t3 in Boston. They have used these two training sessions, as well as regular collaboration with the Center for Advancement of CTI (CACTI), to develop and facilitate CTI training in-state for providers.

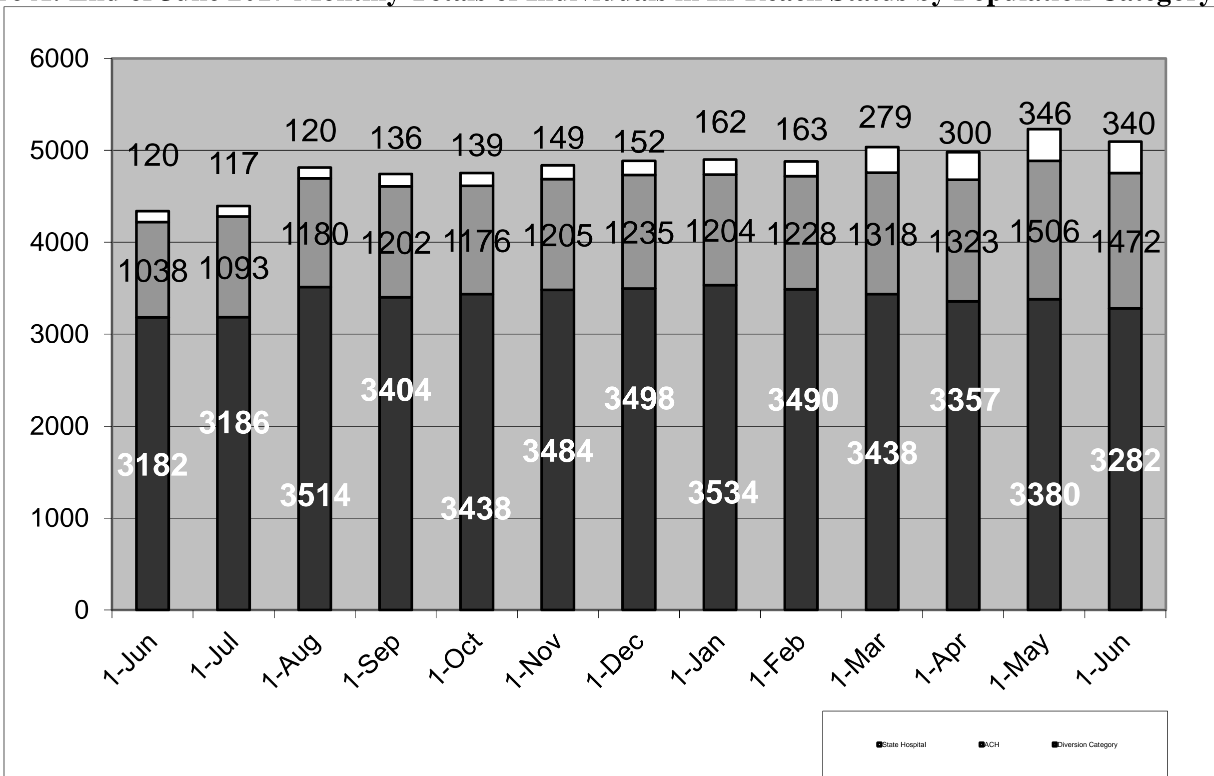
In SFY16-17, DMH/DD/SAS AMH staff developed a CTI fidelity tool based on recommendations from CACTI staff. This tool was presented to the DMH/DD/SAS State Services Committee and approved by DMH/DD/SAS Executive Leadership, with plans to implement in SFY17-18. DMH/DD/SAS staff will also be facilitating site visits for the CTI teams currently in operation at least once every 12 months.

In SFY15-16, funds were allocated via an Invitation to Apply for LME/MCOs to develop CTI teams that focus specifically on individuals that are part of TCLI. Funds were awarded to Easter Seals (Partners LME/MCO), Carolina Outreach (Eastpointe LME/MCO) and Daymark (CenterPoint LME/MCO). The allocation process has made start-up difficult for these teams. DMH/DD/SAS will continue to work with the teams and LME/MCOs to ensure the service is implemented with fidelity to the model, and the teams are serving one of the five priority populations identified in TCLI.

Tenancy Supports
Tenancy Supports has been redesigned as a behavioral health service called Transition Management Services. This redesign has brought coordination of the service to LME/ MCOs and their community service providers. Also this allows each LME/MCO better supervision of the service to assist individuals with their transition back to the community. The LME/MCO has authority to contract with a qualified provider and obtain reports on the effectiveness of the service being provided.

Quality management of the service should be greatly improved by bringing the service to the local system, therefore improving the standard by which the service is provided to the consumer.

Figure A: End of June 2017 Monthly Totals of Individuals in In-Reach Status by Population Category



2016							2017					
Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
4340	4396	4814	4742	4753	4838	4885	4900	4881	5035	4980	5232	5094

The new lead staff person responsible for the in-reach function began in February, 2016. Two primary areas of focus are data integrity and Continuous Quality Improvement (CQI), along with support for the in-reach staff at the LME/MCOs.

Since the inception of the settlement agreement until June 5, 2017, DHHS utilized the TransITions database for TCLI data. Data integrity made it difficult to maintain and assure accuracy of the information entered into the database by LME/MCOs. There were repeated complaints about in-reach visits not showing up in the database after staff entered the data. In addition, the consistency of data was a problem because multiple reports run on different dates for the same time period would reveal conflicting data in regards to overdue in-reach visits.

In SFY 2016-2017, DHHS collaborated with Emphasys, the external vendor for the Transition to Community Living Database (TCLD) project, to replace the TransITions database with a new system. The new system, TCLD, went live June 5, 2017. To date, TCLD has proven to be more user-friendly and has improved overall data quality. In addition, a number of process improvement opportunities were implemented during SFY16-17, such as ongoing technical assistance and face-to-face onsite training for LME/MCO TCLI staff.

An evaluation of the TCLI tool was conducted in conjunction with DMA to support in-reach staff. The evaluation included five of the seven LME/MCOs (one was the pilot group and the other four provided feedback) to determine the effectiveness of the in-reach TCLI tool. The evaluation revealed a requirement to revise the tool to reduce duplication of information and simplify the current in-reach data collection documents. Draft versions of the abbreviated TCLI tool and newly developed guidance documents have been submitted to executive leadership and the DOJ Independent Reviewer.

Guardianship
In an effort to continue improving relationships with state-funded guardians, DMH/DD/SAS partnered with the Division of Aging and Adult Services (DAAS) to provide training to new staff functioning in the role of guardian for mental health consumers.

DAAS contracts with the Department of Social Services (DSS) and private contractors for the guardianship role. Four times a year, in locations across the state, DMH/DD/SAS staff attend new staff training. The focus of the presentation is basic understanding of working with individuals with mental health needs. A heavy focus is placed on the ability of these consumers to recover from the impact of their illnesses and have the possibility of life in the community.

The topic of Supportive Housing is reviewed and it is explained that services are a key piece to assisting individuals who remain in the community. To expand on that topic, DMH/DD/SAS brings representatives from the local LME/MCO to each training session. LME/MCO staff explain how to navigate the service approval process. Opportunity for discussion on difficulties with access and concerns about existing service networks take place. This helps train the new staff and improve relationships between the DSS and LME/MCO systems.

In SFY16-17 the Medicaid county of Origin Specialist conducted intensive research on all individuals who had gone 150+ days without an in-reach visit, and many were found to be no longer eligible for in-reach (deceased, moved out of state, living in the community). Others were located again to allow in-

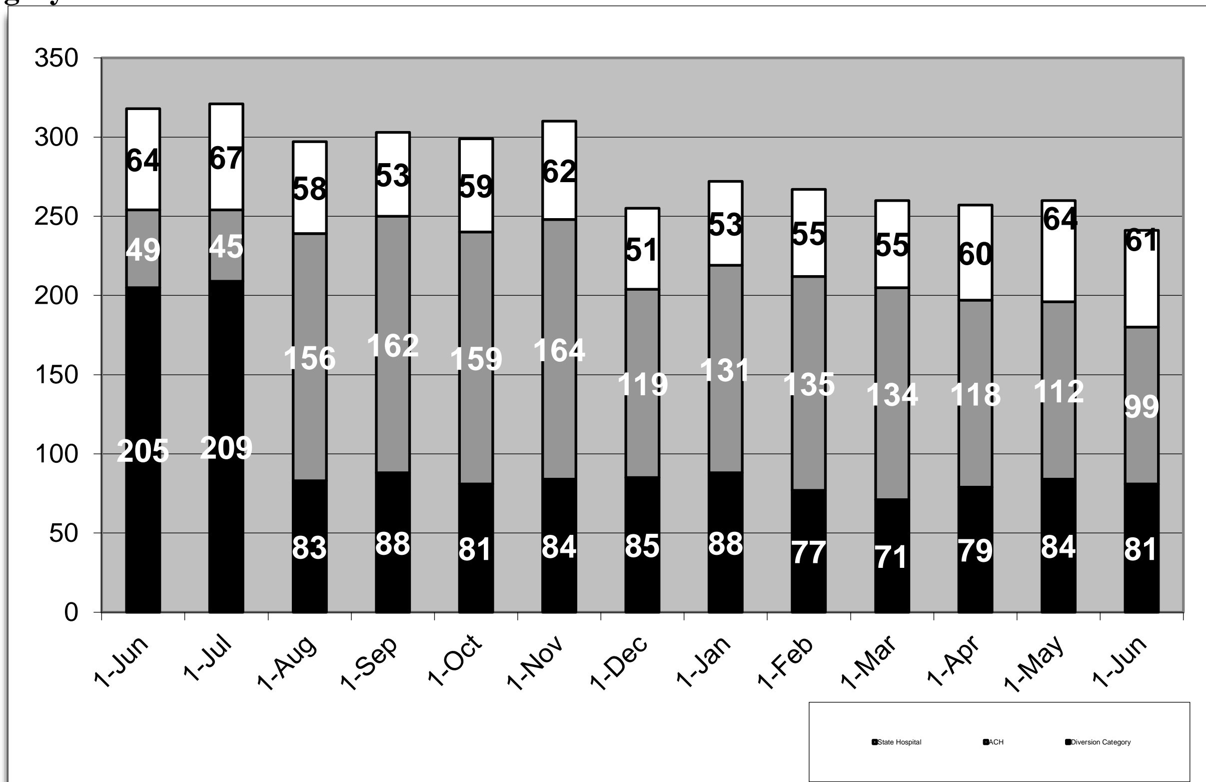
reach to resume. The Medicaid County or Origin specialist also developed partnerships with the State Psychiatric Hospitals to help individuals transition out of them with active Medicaid.

Staffing for LME/MCO in reach and transition coordination staff
Total allocations for in-reach staff as of July, 2016 was 86 statewide and 97 for Transition Coordinators.

In SFY16-17 there were 25,416 in-reach contacts documented for 7,134 individuals. This is about 10,000 more contacts than the previous fiscal year.

There was also a slight increase with in-reach in the state psychiatric hospitals from SFY15-16 (1,031) to SFY16-17 (2,523). To increase the number of individuals receiving in-reach in state psychiatric hospitals during the next year, DHHS has a proposal geared towards initiating in-reach before the individuals are being discharged from the state psychiatric hospitals. The idea is to reach larger groups of individuals sooner than later, while focusing on individuals that are the most interested and represent the greatest opportunity for diversion.

Figure B: End of June 2017 Monthly Totals of Individuals in Transition Status by Population Category



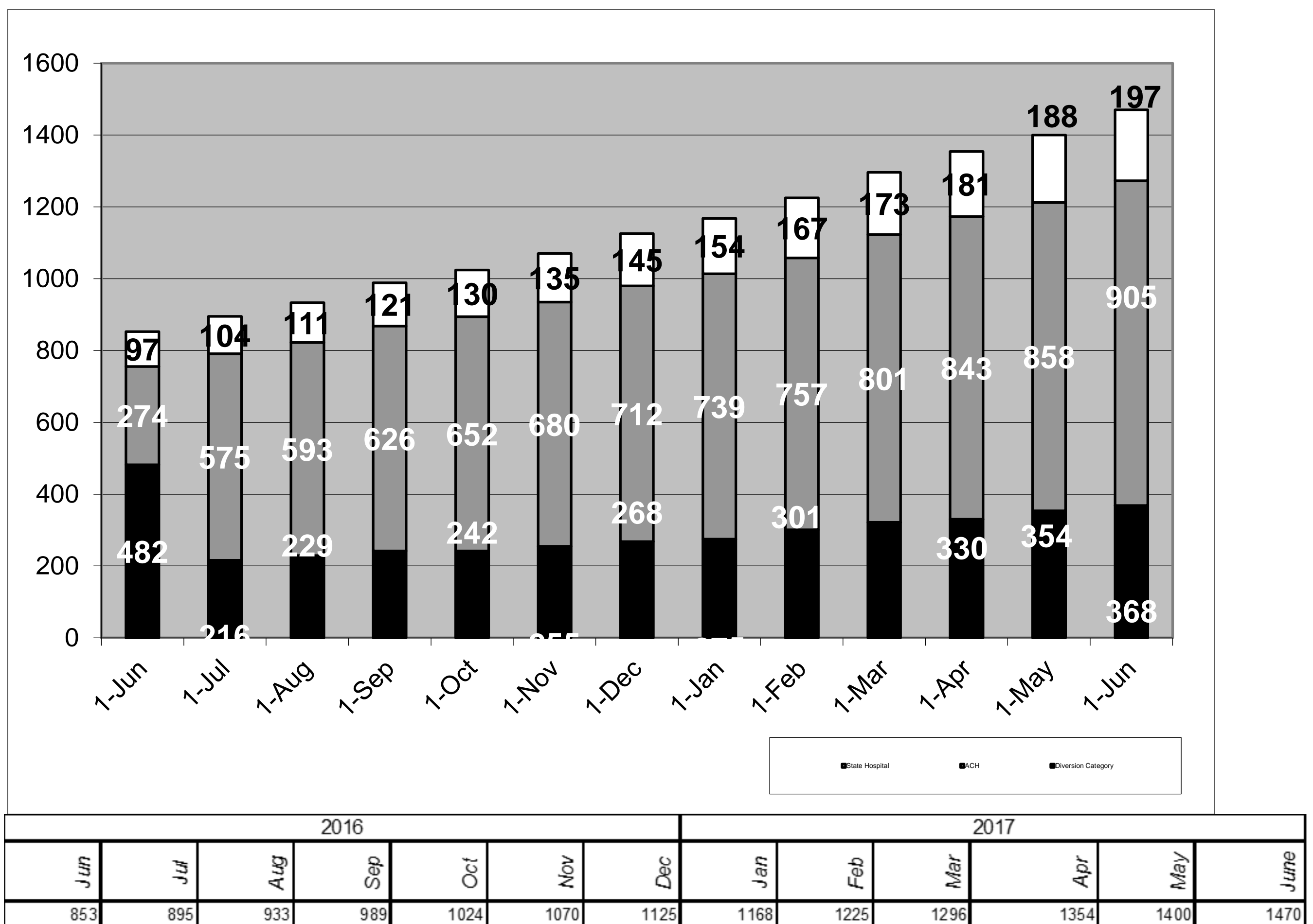
2016							2017					
Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
318	321	297	303	302	310	257	272	268	260	257	260	241

In SFY16-17, the total number of individuals in transition gradually dropped. During this time LME/MCOs were requesting more housing slots than ever, getting more individuals placed than ever, and improving on the percentage of individuals being transitioned within 90 days of the first full transition team meeting.

In SFY16-17, DHHS started tracking which individuals should truly count in the diversion category versus coming from an ACH. This effort and change in documentation is reflected in the difference between July and August.

In SFY16-17, 648 housing slots were issued to individuals who chose to move into supportive housing. This is 100 more housing slots than were issued the previous fiscal year.

Figure C: End of June, 2017 Monthly Totals of Individuals in Housing by Population Category



2016							2017					
Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
853	895	933	989	1024	1070	1125	1168	1225	1296	1354	1400	1470

In SFY16-17, 617 individuals were placed in supportive housing. For the life of the program, 1,470 individuals have been placed in supportive housing. For the life of the program, 311 individuals left supportive housing. However, of that number, 174 individuals didn't leave housing for a more restrictive level of care. This represents 55.9 percent of all the individuals who have left housing.

To ensure safe housing, all units are all inspected using HUD Quality Standards (HQS). During SFY16-17, DHHS has turned the responsibility and funding for HQS inspections over to the LME/MCOs. Additionally, in 2017, DHHS staff continued visiting individuals in the community and following-up with LME/MCOs to make sure individuals have well-furnished, safe and decent living arrangements.

In 2017, the North Carolina Housing Finance Agency (NCHFA) included points in their Quality Assurance (QAP) for projects that will be especially helpful to TCLI individuals, and have also attempted to incentivize one bedroom units. The winning applications in 2016 all scored the points that favor TLCI. Additionally, NCHFA now has at least one high value county in all seven LME/MCO catchment areas.

In 2016 The Targeted Unit Transition Program continued to give individuals who need immediate placement a location to stay while all essential services an individual needs to support them living in the community are setup and the housing search takes place. For the life of the Targeted Unit Transition Program, 61 individuals have participated. Of that total, 19 moved into Target/Key units, 34 into other TCLI supportive housing, seven individuals were not able to transition to the community, and one individual entered supportive housing afer leaving the Targeted Unit Transition Program.

In SFY16-17, the maximum subsidy payment was increased across the state to $600, with consideration for higher payment in high cost counties, such as Mecklenburg and Wake.

NCHFA was able to expand the stock of targeted units. During June 2016, there were 3,734 units available upon turnover. In June 2017, there were 4,866 units available upon turnover - an expansion of 1,132 units.

In SFY16-17, DHHS hired a Housing Director to lead a unified housing effort department-wide. This has started to result in a more streamlined process with respect to the various divisions actively working on housing vulnerable individuals.

DHHS continued to contract with NCHFA to implement the Community Living Integration Verification (CLIVe) CLIVe system for Subsidy Administration, which went live in January, 2017. CLIVe is a payment reimbursement system that supports LME/MCO housing activity by providing a mechanism to input data and receive reimbursement based on DHHS established program policy and procedures.

CLIVe also helps manage and organize workflow, as well as serve as the system of record for TCLV tenancies with the goal of being the system of record for tenancies for all individuals participating in TCLI. By the end of the fiscal year, all LME/MCOs were engaging with the new system and collaboratively providing feedback to continually improve and refine the CLIVe system.

Transitions to Community Living Voucher Subsidy Administration duties were transitioned to LME/MCOs, with the termination of the Quadel contract on June 30, 2017. As part of the transition of subsidy administration, LME/MCOs are expected to provide subsidy administration

services based upon the TCLI Housing Policy and Procedure Manual, the three-party Subsidy Administration contract and DMH/DD/SAS contract.

NCHFA is also expected to provide housing administration services to DHHS and LME/MCOs based on the existing DHHS/NCHFA contract, the TCLI Housing Policy and Procedure Manual and the 3 Party Subsidy Administration contract. In support of this, NCHFA, in collaboration with DHHS, has conducted weekly one-on-one calls with LME/MCOs to assist with the transition and work through any issues that arise.

DHHS collaborated with NCHFA to develop a process to access the Community Living Housing Fund, which is composed of unexpended, unencumbered TCLI funds that transfer to NCHFA at the end of each fiscal year. These funds are administered by NCHFA, in consultation with DHHS, and are to be used to provide permanent, community-based housing for individuals with SMI and SPMI. In SFY16-17, the outline of a process was developed that will ensure collaboration with Housing Developers and LME/MCOs. This process will be finalized in early SFY17-18.

In SFY16-17, each LME/MCO developed and submitted a housing plan, not just for TCLI, but for their catchment as a whole.

In SFY16-17, DHHS and NCHFA finalized the Technical Assistance Colloborative (TAC) state housing plan.

Toward the end of SFY16-17, policies around maximum subsidy, fair market rent and rent reasonableness were being researched and evaluated for potential update, based on market demand and housing limitations.

A complement of risk mitigation tools went live on July 1, 2016 to make the TCLI voucher more desireable to landlords. These tools include:

- Increasing the Housing Assistance Payment (HAP) from a maximum of $360 to $600;
- Using program funds (instead of Transition Year Stability Resources (TYSR) funds) to pay security deposits;
- Allowing the use of holding fees to ensure a place is ready when the individual is ready to transition; and
- Providing money to reimburse landlords for costs associated with a failed tenancy, which will reduce the risk to the landlord and ensure the landlord has attempted to remedy the situation.

The intention of these tools is to make it easier to assure landlords that renting to a TCLI individual is a good choice, and to help LME/MCOs to re-house individuals.

To assist individuals TYSR and Community Living Assistance (CLA) is made available for TCLI participants if it is needed. Below is a table that lays out the amount of TYSR spent in SFY 16-17.

LME-MCOs	CLA	TYSR	Rent Payments
Alliance	$174,734.82	$296,319.37	$94,354.00
Cardinal Innovations	$253,705.67	$1,369,604.07	$787,329.00
Eastpointe	$70,664.00	$198,411.32	$162,823.00
Partners BHM	$186,829.19	$604,117.40	$295,060.00
Sandhills	$94,123.04	$88,930.10	$311,651.00
Trillium	$111,434.03	$175,196.65	$362,839.00
Vaya	$111,678.00	$182,289.98	$198,037.00
Total	**$1,003,168.75**	**$2,914,868.89**	**$2,212,093.00**

North Carolina Housing Finance Agency Activities

In 2017, the North Carolina Housing Finance Agency (NCHFA) included points in their QAP for projects that will benefit TCLI program participants, and have also attempted to incentivize one bedroom units. The winnings applications in 2016 all scored the points that favor TLCI. Additionally, NCHFA now has at least one high value county in all seven LME/MCO catchments.

NCHFA was able to expand the stock of targeted units. During June, 2016, there were 3,734 units available upon turnover. By June, 2017, there were 4,866 units available upon turnover - an expansion of 1,132 units.

NCHFA created automated Vacancy and Referral portal software application in collaboration with property management companies and DHHS Regional Housing Coordinators to better track vacancies in the Targeting Program, as well as the referrals provided. The new system went live in April and training was provided to DHHS Regional Housing Coordinators and property management staff. Upon release, NCHFA began developing the analytic tool for program analysis and reporting that is estimated to be completed next fiscal year.

Figure D.

LME/MCO Totals of Individuals in Housing by Population Category, End of June 2016

LME/MCO	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5	Total
Alliance Behavioral Healthcare	3	15	0	24	35	77
Cardinal Innovations	21	48	5	9	153	236
Eastpointe	1	24	3	14	45	87
Partners Behavioral Health Mgmt	16	6	9	18	54	103
Sandhills Center	1	30	10	13	54	108
Trillium	19	8	7	4	62	100
Vaya Health	33	11	4	15	79	142
Total	**94**	**142**	**38**	**97**	**482**	**853**

LME/MCO Totals of Individuals in Housing by Population Category, End of June 2017

LME/MCO	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5	Total
Alliance Behavioral Healthcare	4	55	2	57	33	**151**
Cardinal Innovations	25	209	9	26	151	**420**
Eastpointe	2	75	8	24	34	**143**
Partners Behavioral Health Mgmt	22	95	14	35	41	**207**
Sandhills Center	1	109	11	23	24	**168**
Trillium	38	86	5	23	50	**202**
Vaya Health	22	104	9	9	35	**179**
Total	114	733	58	197	368	**1470**

Note. Population categories are defined as follows:

1- Individuals with SMI who reside in an ACH determined by the State to be an IMD;
2- Individuals with SPMI who are residing in ACHs licensed for at least 50 beds and in which 25 percent or more of the resident population has a mental illness;
3- Individuals with SPMI who are residing in ACHs licensed for between 20 and 49 beds and in which 40 percent or more of the resident population has a mental illness;
4- Individuals with SPMI who are or will be discharged from a State psychiatric hospital and who are homeless or have unstable housing; and
5- Individuals being considered for admission to an ACH and determined through preadmission screening to have SMI.

Figure E.
Diversion Status of Individuals with PASRR Screenings Processed for end of SFY15-16

LME/MCO	Diverted	Not Diverted	In Process*	Total PASRR Screenings Processed
Alliance Behavioral Healthcare	3	16	240	259
Cardinal Innovations	24	128	323	475
Eastpointe	29	156	52	237
Partners Behavioral Health Mgmt	5	38	180	223
Sandhills Center	38	141	4	183
Vaya Health	27	151	96	274
Trillium	13	38	149	200
Total	**139**	**668**	**1044**	**1851**

Diversion Status of Individuals with PASRR Screenings Processed for end of SFY16-17

LME/MCO	Diverted	Not Diverted	In Process*	Total PASRR Screenings Processed
Alliance Behavioral Healthcare	11	57	136	204
Cardinal Innovations	31	53	398	482
Eastpointe	19	144	36	199
Partners Behavioral Health Mgmt	34	135	79	248
Sandhills Center	36	94	13	143
Vaya Health	22	89	111	222
Trillium	26	173	106	305
Total	**179**	**745**	**879**	**1803**

PASRR totals reflect the number of PASRR screenings processed not the number of individuals processed. Total PASRR Screening Processed totals do not include those that were sent to the LME/MCO and in a Diverted Status of In Processt when withdrawn due to a determination made that the individual either moved out of state, deceased, had a primary diagnosis of dementia, IDD, or was not SMI/SPMI, private pay, or not medically or psychiatrically stable. Totals also do not include any PASSR's received by Earthmark that were determined to fall into any of the aforementioned categories and were not sent to the LME/MCO

Figure F.

Diversion Status of Individuals with Preadmission Screening and Review (PASRR) Process for Adult Care Homes Processed from January 2013 to the end of SFY15-16

LME/MCO	Diverted	Not Diverted	In Process*	Total PASRR Screenings Processed
Alliance Behavioral Healthcare	236	411	449	1096
Cardinal Innovations	319	941	662	1922
Eastpointe	268	616	85	969
Partners Behavioral Health Mgmt	134	461	259	854
Sandhills Center	155	459	10	624
Vaya Health	224	782	146	1152
Trillium	157	527	209	893
Total	**1493**	**4197**	**1820**	**7510**

Diversion Status of Individuals with Preadmission Screening and Review (PASRR) Process for Adult Care Homes Processed from January 2013 to the end of SFY16-17

LME/MCO	Diverted	Not Diverted	In Process*	Total PASRR Screenings Processed
Alliance Behavioral Healthcare	291	529	466	1286
Cardinal Innovations	410	1093	870	2373
Eastpointe	264	750	64	1078
Partners Behavioral Health Mgmt	219	691	171	1081
Sandhills Center	193	557	18	768
Vaya Health	227	772	179	1178
Trillium	276	1019	152	1447
Total	**1880**	**5411**	**1920**	**9211**

*** PASRR totals reflect the number of PASRR screenings processed not the number of individuals processed.**

Total PASRR Screening Processed totals do not include those that were sent to the LME/MCO and in a Diverted Status of In Process when withdrawn due to a determination made that the individual was either moved out of state, deceased, had a primary diagnosis of dementia, IDD, or was not SMI/SPMI, not medically or psychiatrically stable, or private pay (180). Totals also do not include any PASSR's received by Earthmark that were determined to fall into any of the aforementioned categories or were cancelled and were not sent to the LME/MCOs (1288). Total PASRR screenings completed by HP = 8830.

The cumulative total of Preadmission Screening and Review (PASRR) s completed since January, 1, 2013 is 11,275, of which 9,593 were TCLI eligible and sent to the LME/MCO's. The total number of individual PASRRs submitted to the LME/MCO's to process for SFY16-17 slightly decreased from 1,851 to 1,803 from SFY 15-16.

Corrections spreadsheets were sent out to LME/MCO's monthly indicating system issues within each LME/MCO, data entry errors to be corrected and individuals that screenings were completed on that were missing in the database. LME/MCO's worked diligently and assisted in the clean-up of the data. Clean-up efforts have resulted in more accurate and meaningful data to be available for reporting.

On June 5, 2017, all TCLI data was migrated to a new web based database (TCLD). Weekly meetings and initial preparation for the new database began with the inclusion of DMH/DD/SAS Diversion staff in September, 2016. At the end May, 2017, the database was finalized and training webinars were conducted with LME/MCO's along with Emphasys and DHHS staff prior to the June 5, 2017 launch date.

Prior to the final migration of data from the previous TCL database (TransITions) to the new database (TCLD) on June 1, 2017, diversion data clean-up began as early as January 2017. The DMH/DD/SAS TCL Diversion Lead staff worked with each LME/MCO on a monthly basis providing technical assistance as needed and onsite technical assistance when requested. Technical assistance focused on data compliance within the diversion area of the TransITions database as well as providing responses to questions regarding diversion and PASRR.

Continued monitoring is planned to ensure compliance with the diversion process and provide technical assistance to LME/MCOs. For SFY 17-18, efforts will continue to focus on training and data compliance with LME/MCOs regarding systemic issues and the new database. With the development of the TCLD database and continued discussions regarding improving the diversion process, DHHS expects reporting data and compliance to continue to improve.

4. Quality Management

In SFY16-17, North Carolina continued steps to improve Quality Management, both from the work being done by LME/MCOs, as well as DHHS TCLI program administration. To ensure individuals are getting necessary services, DHHS reviewed and insisted on changes to Person-Centered Plans.

As LME/MCOs become more accustomed to Person-Centered Planning, DHHS has allowed subsidy payment to begin prior to approval. Therefore, achieving the 90-day housing requirement has not been impeded. Root Cause Analysis has continued in SFY16-17 and is now being handled at the LME/MCO level. On a monthly basis, DHHS sends a report to the independent reviewer.

Figure G. Incident Reports for TCLI recipients in SFY16-17

Aggregate number of incidents reported in IRIS													
LME/MCO	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Alliance	1	2	1	0	0	1	1	2	0	1	0	6	15
Cardinal Innovations	1	0	1	0	2	0	0	0	1	0	4	0	9
Eastpointe	2	0	0	4	0	0	1	0	0	0	2	1	10
Partners	6	0	0	0	0	0	0	0	0	0	0	0	6
Sandhills Center	0	1	0	0	0	3	1	3	2	3	1	1	15
Trillium	4	2	1	1	2	2	4	2	2	1	4	5	30
Vaya Health	1	0	2	0	0	2	2	0	2	1	2	0	12
Total	**15**	**5**	**5**	**5**	**4**	**8**	**9**	**7**	**7**	**6**	**13**	**13**	**97**

Note. An "incident," as defined in 10A NCAC 27G .0103(b)(32), is "any happening which is not consistent with the routine operation of a facility or service or the routine care of a consumer and that is likely to lead to adverse effects upon a consumer."

- **Level II** includes any incident which involves a consumer death due to natural causes or terminal illness, or results in a threat to a consumer's health or safety or a threat to the health or safety of others due to consumer behavior.
- **Level III** includes any incident that results in (1) a death, sexual assault or permanent physical or psychological impairment to a consumer, (2) a substantial risk of death, or permanent physical or psychological impairment to a consumer, (3) a death, sexual assault or permanent physical or psychological impairment caused by a consumer, (4) a substantial risk of death or permanent physical or psychological impairment caused by a consumer or (5) a threat caused by a consumer to a person's safety.

Incident types:

- Death
- Restrictive Intervention
- Injury
- Medication Error
- Allegation of Abuse, Neglect, or Exploitation
- Consumer Behavior (including suicide attempt, inappropriate sexual, aggressive, destructive, illegal, unplanned absence)
- Suspension, Expulsion from services
- Fire

DHHS tracks the numbers of incidents for TCLI individuals. From July 2016 to June 2017, 97 incidents were documented in the department's Incident Response Improvement System (IRIS), or about eight per month.

In SFY16-17, the monthly dashboard continued to be a strong source of motivation for LME/MCOs to improve aspects of their performance. As LME/MCOs come into compliance with certain dashboard measures, some will be replaced by others in the coming year.

In SFY16-17, DHHS employees utilized the Data Warehouse to send monthly reports of data discrepancies to LME/MCO employees. Most LME/MCOs use these reports to correct errors and identify which individuals served by TCLI need more attention. For example, LME/MCOs are informed who is overdue for an in-reach visit, which allows the LME/MCO to either update the database or to contact the individual.

With the implementation of TCLD at the end of SFY16-17, there is a new reporting system, Tableau. This system allows for some innovative reporting options; for example, mapping where TCLI individuals live across North Carolina.

There was collaboration with Emphasys in SFY16-17 to launch TCLD, as well as multiple training sessions to familiarize LME/MCOs with the system. In SFY 17-18, face-to-face meetings with each LME/MCO will be scheduled to offer further training.

DHHS collects data on where individuals go when they leave supportive housing. By the end of June 2017, 311 individuals had left supportive housing. The below table shows these destinations. In SFY16-17, 108 individuals left housing while 1,159 individuals remained in housing - some for as long as four years.

Figure H. Community Tenure

Based on Fiscal Year

Fiscal Year	Individuals Placed	Still in Housing	Percent Still Housed
12-13	49	29	59.18%
13-14	214	114	53.27%
14-15	218	149	68.35%
15-16	372	286	76.88%
16-17	617	581	94.17%
Total	1470	1159	78.84%

Based on Length of Time in Housing

Threshold	Total Possible	Total that have stayed in housing this long	% to meet this threshold
Not Applicable*	176		
3 Months	1297	1243	95.8%
6 Months	1120	1027	91.6%
1 Year	831	690	83%
1.5 Years	625	467	74.7%
2 Years	494	343	69.4%

Based on Attrition Rate/Year Housed

Year Housed	Attrition Rate	12-13	13-14	14/15	15-16	16-17
12-13		2%	12%	2%	10%	16%
13-14		n/a	9%	20%	9%	8%
14-15		n/a	n/a	7%	16%	9%
15-16		n/a	n/a	n/a	14%	10%
16-17		n/a	n/a	n/a	n/a	6%

For the duration of the program, 78 percent of the individuals placed in supportive housing have maintained their chosen living arrangement. Individuals who left housing were in housing for an average of 395 days. Individuals still in housing have been in housing for an average of 497 days.

In SFY16-17, risk mitigation tools, as well as emergency funding, was used to help individuals maintain housing. DHHS continues to strive towards greater community tenure rates. The average annual attrition rate for TCLI is 10 percent, which is in line with other subsidized housing programs that serve disabled individuals[1,2].

Figure I. Where individuals went to after leaving TCLI housing, end of SFY16-17

Where	Number of People
ACH	79
AFL	8
Family/Friends	40
Independent/Left State	56
Jail/Prison	15
Medical Hospital	5
MHGH	6
S.U. Facility/Oxford House	3
Passed Away	78
SNF	7
State Hospital	7
Unknown	6
Total	311

Figure J. Time from Transition to Entering Supportive Housing

LME/MCO	Average # of days from Housing Slot Issuance to Moving into Housing
Alliance	230
Cardinal	153
Eastpointe	93
Partners	124
Sandhills	161
Trillium	179
Vaya	159

[1] https://www.huduser.gov/publications/pdf/sec8success.pdf

[2] http://nhlp.org/files/01%20NHLP%20Bulletin%20Feb09%20HUD%20guidance%20voucher%20portability.pdf National Housing Law Project Bulletin.

Figure K: Percentage of Individuals Transitioned within 90 days by Fiscal year

LME/MCO	12/13	13/14	14/15	15/16	16/17
Alliance	100%	66%	27%	28%	24%
Cardinal	100%	70%	35%	30%	45%
Eastpointe	100%	93%	81%	56%	76%
Partners	100%	75%	73%	43%	57%
Sandhills	100%	69%	39%	46%	57%
Trillium	100%	71%	54%	28%	61%
Vaya	100%	57%	28%	20%	44%

Figure L. Community Engagement (Life of Settlement)

	Hours Reported
Activities/Hobbies	16,544
Volunteering	222
School	398

Figure M. Employment (Life of Settlement)

	10-15 Hours Weekly	15-25 Hours Weekly	25+ Hours
Number of Individuals	12	9	1

Figure N. Hospitalization, Crisis Beds, and ER Visits (Life of Settlement)

Community Hospital (Days)	2865
Crisis Bed (Days)	730
Emergency Room (Visits)	606

Figure O. Admissions to State Hospitals, ACHs or Inpatient MH Facility SFY16-17

LME/MCO	State Hospitals	ACHs	Inpatient Facility	All individuals left housing in 16-17 (including independent, deceased, family, etc.)
Alliance	0	1	1	9
Cardinal	0	11	1	38
Eastpointe	1	2	2	14
Partners	3	10	8	26
Sandhills	2	5	1	14
Trillium	2	6	1	24
Vaya	2	1	4	11
Total	10	36	18	136

5. State Hospital Information

Figure P. Hospital Census for fiscal year 16-17 (Either from Cindy or monthly reports)

SFY16-17	Admits	Discharges	Average Daily Census
Broughton	**346**	**341**	**256**
Adult Admissions	300	254	112
Adult Long Term	3	31	86
Geriatric	9	14	35
Medical Unit	23	28	11
Deaf Unit	11	14	9
Cherry	**652**	**605**	**171**
Adult Admissions	623	487	63
Adult Long Term	2	83	77
Geriatric	20	18	22
Medical Unit	7	17	7
CRH	**965**	**957**	**338**
Adult Admissions	748	728	209
Adult Long Term	0	13	9
Geriatric	81	83	37
Medical Unit	46	43	3.9
Forensic Unit	90	90	77
Grand Total	**1963**	**1903**	**77**

Adult Admissions Units are acute care units with typical length of stays around 30 -60 days. Length of stay on the adult admissions units may be less than 1 month. Adult admissions units admit people 24/7/365, taking many individuals waiting in community emergency departments for psychiatric hospitalization.

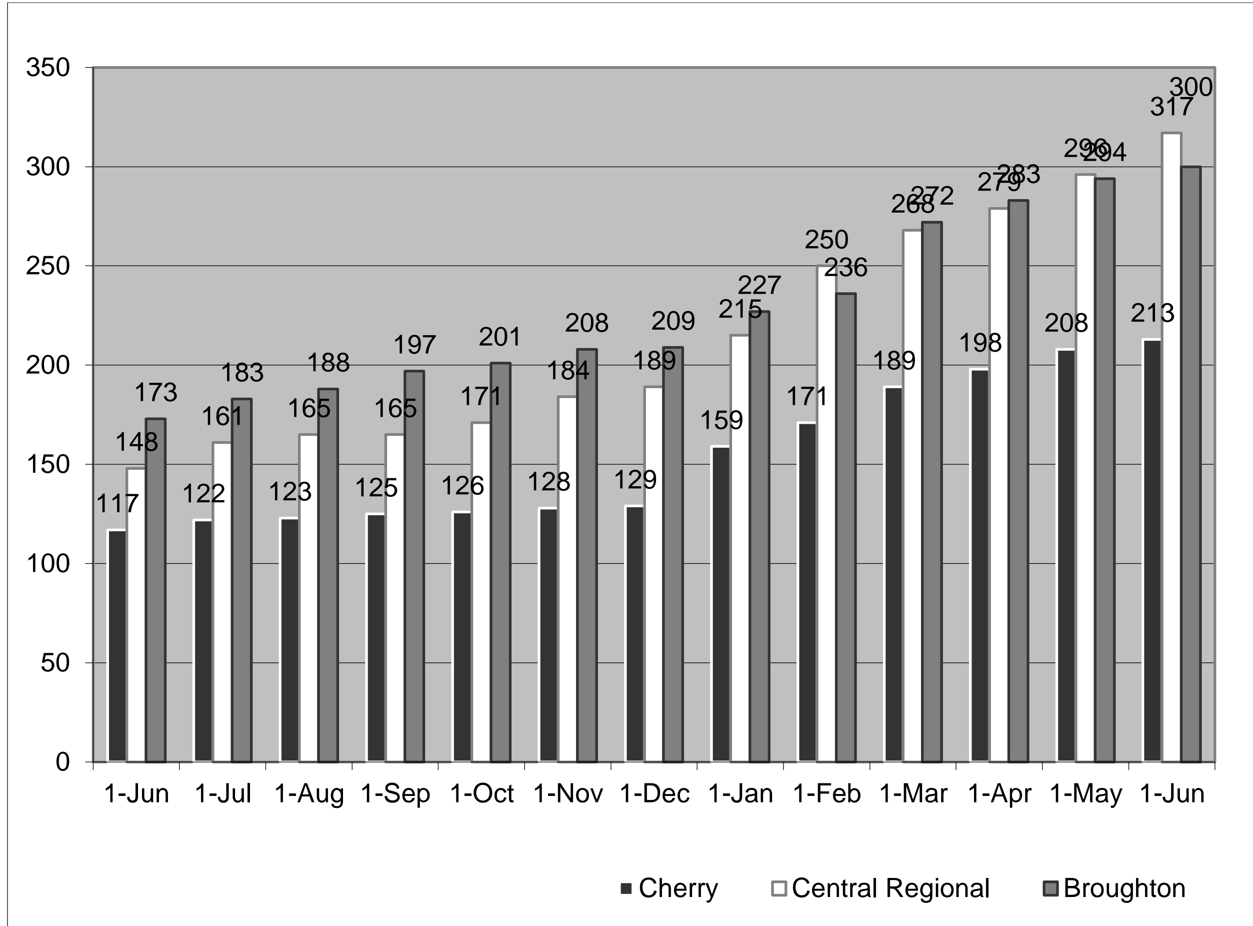
- Adult Long Term units are for individuals who need longer term care at the hospital level. Often individuals on long term units have serious mental illness complicated by legal problems, poor response to treatment, co-occurring intellectual/developmental disabilities, chronic illness and cognitive deficits.
- Geriatric units typically serve people 64 and older but may include people in younger age ranges who have needs similar to the older individuals.
- Individuals in need of care for a medical condition that can be treated at the State hospital are admitted to the medical units.
- All of these units may have individuals who qualify for TCLI therefore individuals on all units are referred to the MCO for In Reach.
- Discharge numbers are higher in the data compared to the following discharge destination table because transfers out for medical care cannot be removed from this data.

Figure Q. Hospital Discharge Data for SFY16-17

SFY16-17 Discharge Destination	Broughton	Cherry	CRH	Grand Total
Private Residence	125	340	404	**869**
Correctional Facility	49	71	96	**216**
5600 Group Home	18	36	105	**159**
Adult Care Home	52	61	43	**156**
Homeless Shelter	6	18	62	**86**
Hotel	7	13	15	**35**
Psychiatric Community Hospital	10	5	20	**35**
Alcohol and Drug Abuse Treatment Center	6	6	13	**25**
TCLI Housing	6	7	11	**24**
Halfway House	2	9	13	**24**
Boarding House	1	6	15	**22**
Skilled Nursing Facility	6	4	9	**19**
Neuro Medical Center	2	2	11	**15**
Alternative Family Living	0	1	10	**11**
Innovations Waiver Group Home	2	1	6	**9**
Deceased	0	1	6	**7**
Developmental Disability Center	2	4	0	**6**
I/DD Group Home	1	3	1	**5**
Intermediate Care Facility/MR Group Home	2	1	1	**4**
Therapeutic Community	1	2	1	**4**
Veteran Administration Hospital	0	0	3	**3**
Psychiatric Residential Treatment Facility	0	0	3	**3**
Therapeutic Home	1	1	1	**3**
Community Respite	1	0	1	**2**
Supported Living	0	0	2	**2**
Oxford House	0	0	2	**2**
Alcohol and Drug Treatment Center	0	0	2	**2**
Community Hospital	1	0	1	**2**
Community Detox Center	0	0	1	**1**
Neuromedical Treatment Center	0	0	1	**1**
Whitaker	0	0	1	**1**
Grand Total	**301**	**592**	**860**	**1753**

Please note that this table provides information about where individuals were discharged directly to from State psychiatric hospitals. This data does not capture people the hospitals referred and the MCOs started to work with who discharged to an available location prior to transitioning to TCLI housing.

Figures R and S: Individuals who started In Reach in a State Hospitals[3]



In SFY16-17, 50 percent of the 1,753 individuals discharged from state hospitals were discharged to a private residence, currently defined as any private home in the community. ACHs accounted for eight percent of the discharge locations in SFY 2017. Both of these figures are slight improvements over SFY15-16.

The total number of individuals who started in-reach services while in a state psychiatric hospital increased from 245 (reported last year) to 364 during SFY 17. Starting in-reach is defined by contact from the LME/MCO to the person and/or guardian to talk about TCLI while the person is still in the state psychiatric hospital.

State psychiatric hospitals and LME/MCOs continue quarterly meetings to collaborate on increasing the number of people in state hospitals entering the TCLI programs. LME/MCOs continue to receive referrals by utilizing an urgent referral form. These referral lists are updated monthly and provide details about the individuals referred, including discharge and guardian contact information to assist LME/MCOs in follow-up.

[3] **Please note:** A review of the State hospital TCLI referral database, where these numbers are tracked, found duplicates reported in the data August, September and October of 2015. Differences in the numbers from previous reports are due to corrections made to remove duplicates. In May 2016 Trillium lost one due to a correction by the State hospital.

DHHS will continue working with LME/MCOs to refer individuals who qualify for the settlement and increase the number of people in state psychiatric hospitals who start in-reach and/or transition, including direct discharges to TCLI housing. This includes taking action to ensure in-reach begins in the state hospitals for more eligible individuals.

Figure S: Number of Individuals that have started In-Reach while in a State Hospital, by LME/MCO

LME/MCO	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Alliance	80	88	93	91	92	102	107	118	137	151	155	170	170
Cardinal	88	95	95	100	101	102	102	91	137	165	177	180	180
Eastpointe	48	49	50	50	51	52	53	54	58	67	74	78	78
Partners	38	42	45	46	48	51	52	53	54	60	62	65	65
Sandhills	34	36	36	36	40	41	41	49	60	62	64	67	67
Trillium	56	58	58	60	60	62	62	91	95	99	101	105	105
Vaya	94	98	99	104	106	110	110	112	116	123	127	133	133

Note. Totals are cumulative.

6. External Quality Review

The Balanced Budget Act of 1997 (BBA) requires that a state which contracts with a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) conduct an External Quality Review (EQR) of each entity and prepare an annual technical report that describes the manner in which data for activities conducted in accordance with 42 Code of Federal Regulations (CFR) 438.358 were aggregated and analyzed. This provision is applicable to the LME/MCOs. To comply with these regulations, DHHS and DMA contracted with the Carolinas Center for Medical Excellence (CCME), an External Quality Review Organization, to aggregate and analyze the data, and prepare an annual technical report. The contract between CCME and DMA stipulates that a compliance review be conducted for the PIHPs every year.

The process used for each of the review activities was based on the protocols for external quality review of Medicaid Managed Care Organizations and PIHPs developed by the Centers for Medicare & Medicaid Services (CMS). This included a desk review of documents submitted by the health plan, a two-day onsite visit for the compliance review, a teleconference to discuss the validation findings and a review of any corrective action plans submitted.

All seven Managed Care Organizations have been reviewed by CCME for compliance with the required TCLI areas:

- Marketing
- Information to beneficiaries
- Grievances
- Timely access to services
- Primary Care Provider/Specialist Capacity
- Coordination/Continuum of Care

- Coverage/Authorization
- Provider Selection
- Quality of Care

Findings

To determine the state's PIHP's compliance with state and federal requirements, CCME developed and DMA approved a set of standards which address access, quality and the timeliness of the care and services received by enrollees for LME/MCO. Areas of review were identified as meeting a standard (Met), acceptable but needing improvement (Partially Met), failing a standard (Not Met), Not Evaluated, or Not Applicable. For results that were out of compliance, each LME/MCO developed a plan of correction to resolve the noted issues. The findings for each MCO, as will be outlined in the compliance findings, are:

Alliance	• TCLI activities are not addressed in their entirety in Alliance's policies and procedures. See the DMA Contract, Section 15, for TCLI requirements. Onsite discussion revealed that some activities are addressed in desk procedures.
Cardinal	• There are no policies and procedures for TCLI. For example, update the In-Reach Function Document to reflect the DMA Contract Amendment effective July 1, 2016. • At the time of the record review, documentation was limited or not present in the clinical record of members in TCLI. • At the time of review, there was no specific policy and or procedure on the use of one-time transitional supports per NC DMA Contract Section 15. • At the time of review, there was no evidence that the Quality of Life (QOL) surveys were completed. In addition, no specific policy and/or procedure on administration of the QOL surveys were found. See NC DMA Contract Section 15. • At the time of review, elements for TCLI, per NC DMA Contract Section 15, were not evidenced in the record reviews.
Eastpointe	None

Partners	• Policy 9.08, MHSA Care Coordination TCLI DOJ/Transition to Community Living Initiative, provides a general overview of the initiative. NC DMA Contract Standard, Section 15 denotes activities not included in the current PIHP policy. For example, PIHP should provide policies and procedures for completing the QOL surveys (pre-transition, 11 month and 24 month survey), diversion activities, and one-time transitional costs. • At the time of review, there were no distinct policies and procedures for this required activity per NC DMA Contract Standard, Section 15, (9). • Policies and procedures regarding this activity were not included in Policy 9.08, MHSA Care Coordination TCLI DOJ Initiative, as addressed in the DOJ Settlement Agreement and NC DMA Contract Standard, Section 15, Amend 2, (4). • Policies and procedures regarding the diversion process for individuals considering admission into an ACH were not included in Policy 9.08, MHSA Care Coordination TCLI DOJ Initiative, as addressed in the DOJ Settlement Agreement and NC DMA Contract Standard, Section 15, Amendment 2, (10).
Sandhills	None
Trillium	• Transition Planning Tools were not submitted for three files; however, transition planning was documented in the notes. Documentation indicated staff members adhered to appropriate intervals for follow-up after transition.
Smoky/Vaya	• DMA Contract, Section 15.2 states the population identified in the DOJ Settlement Agreement is a required "Special Healthcare Population". Page 31 of the Member and Family Handbook lists the diagnosis and conditions of ID/DD and MH/SU members that would meet the definition of Special Needs Population. The TCLI population is not included in this list. • TCLI staff qualifications are not addressed in TCLI Policy 2404, in-reach to eligible individuals for TCLI, and Policy 2405, Transition Coordination of Participants in the Transition to Community Living Initiative. CCME's onsite discussion confirmed that TCLI staff meets the contractual requirements for licensure and training. • Policy 2405, Transition Coordination of Participants in the Transition to Community Living Initiative, states the QOL Survey is administered just prior to the enrollee moving in to their housing option and at around 11 months after transitioning. The policy does not address the requirement for completion of the 24-month QOL Survey.

7. Monitoring of Service Gaps

LME/MCOs are required to annually conduct and submit Provider Capacity, Community Needs Assessment and Gaps Analyses ("Gaps Analyses") in accordance with their DHHS Performance Contracts. The Gaps Analyses are part of a continuous assessment and action process that drives development of and updates to LME/MCO local business plans and network development plans, and implementation of strategic plans through quality improvement projects and actions.

The DHHS distributed Gaps Analyses process and report guidelines in October, 2015 for LME/MCO SFY15 reports to be submitted in April, 2016. LME/MCOs were required to address the following in their gaps analyses:

- Progress and achievements in addressing gaps identified in the previous year's gaps analysis report;
- Analysis by service type of access and choice standards, service needs and gaps;
- Goals, strategies and timelines for reducing and eliminating identified service gaps; and
- Strategies and timelines to address goals and service gaps related to specific departmental initiatives, including Recovery-Oriented Systems of Care, Crisis Solutions, employment and housing.

LME/MCO reports were reviewed by three-person DHHS teams. Teams identified areas of concern and strength in each LME/MCO's gaps analyses and developed recommendations regarding requests for additional information, areas for consideration in the implementation of strategies to address identified gaps and needs, and approval of the reports. Results of the final review and recommendations for future needs and gaps analyses were sent to LME/MCOs to inform ongoing activities and future needs and gaps analyses.

All LME/MCOs were required to evaluate the full service array in their assessments and gaps analyses. In doing so, they also identified and described service gaps, priorities and initiatives, including many of special relevance to TCLI. LME/MCO priorities, strategies and initiatives described in the April 2016 Gaps Analyses reports include, and are not limited to:

<u>Crisis Solutions</u>

- Expand capacity for crisis, hospital diversion and respite services
- Assure the availability of high-quality, accessible and effective mobile crisis services in all counties and increase capacity
- Expand access to and capacity of walk-in crisis centers, including evening hours
- Provide education to urgent care and primary care practices about crisis response resources and how to access them
- Implement Critical Time Intervention in additional counties
- Increase availability of facility-based crisis (FBC) beds and services
- Develop 24-hour Behavioral Health Urgent Care center
- Expand FBC to addition regions
- Coordinate linkage between Emergency Medical Services (EMS) and local providers to promote development of Emergency Department (ED) alternative sites for crisis response
- Build FBC centers

- Increase crisis services, develop behavioral health urgent care centers, provide continuing education on crisis services
- Increase number of FBC service providers
- Provide assertive outreach to Medicaid members discharging from hospitals
- Increase availability and quality of crisis prevention, intervention, response and stabilization services
- Decrease length of stay in EDs
- Increase number of ED and jail diversions for individuals whose needs can more appropriately be met in other settings
- Reduce inappropriate inpatient psychiatric admissions
- Reduce readmissions of individuals to EDs and inpatient psychiatric treatment
- Evaluate regional crisis response system to determine which services are vital to create effective, sustainable system
- Train additional staff to ensure 100 percent of crisis calls are answered by call center
- Promote Access Point Kiosks

Housing

- Complete residential continuum study and develop Housing Plan and new Director of Housing position to address housing gaps
- Increase breadth, access and quality of housing options
- Identify additional housing resources with proximity to medical/behavioral and community resources
- Contract for technical assistance to perform housing needs assessment
- Define alternative housing solutions, renovate public housing complexes, provide landlord education and locate low-income housing tax credit properties
- Expand affordable housing options
- Reassign Transition Coordinator positions as Community Integration Coordinators to focus on integration as TCLI individuals move into their new communities
- Increase TCLI Housing Staff to outreach, qualify and assist members who can benefit from transitioning to community settings
- Employ Peer Support Specialists to support TCLI members during and after transition

Employment

- Increase availability of resources for employment
- Increase utilization of SE services
- Increase SE enrollments and in particular the at risk population
- Offer SE to all TCLI members in in-reach
- Increase collaboration with external programs that assist individuals with competitive employment opportunities
- Hire Employment Specialist and develop employment plan focused on consumer driven needs
- Increase opportunities for SE Expand capacity for SE services
- Add IPS-SE specialist to work with providers to promote Employment First
- Expand SE opportunities through projects including Supported Employment Enterprise Development Initiative (SEED)

- Add IPS-SE providers and teams
- Increase training opportunities for IPS-SE providers
- Develop stronger and targeted contract requirements for IPS-SE providers
- Evaluate provider network to determine which providers determine Mental Health/Substance Use Disorder SE with fidelity
- Expand IPS-SE services to eliminate service gaps and ensure all TCLI settlement priority population have access to an IPS-SE provider
- Increase IPS-SE participation of TCLI settlement population

<u>Other Services and Supports</u>

- Increase availability of resources for transportation
- Provide training and consultation for providers to promote improved quality and implementation of evidence based practices
- Develop service definition to fill service gap between Assertive Community Treatment (ACT) and Community Support Team
- Contract with Psychosocial Rehabilitationprovider in additional county
- Improve quality of community-based intensive treatment services, e.g., Community Support Team (CST), ACT
- Develop transformation plan to ship paradigm towards recovery oriented system of care
- Implement peer recovery based program in crisis facility
- Offer provider training focused on improving quality of person-centered plans
- Implement ACTT Step Down service
- Promote Peer Support services
- Establish Wellness Centers in rural counties
- Increase provider training in recovery-oriented systems of care, and link people to services and supports that help sustain long-term recovery
- Visit local recovery communities and identify opportunities to partner in peer-related projects, transportation and other collaborative ventures
- Educate staff in Recovery-Oriented Systems of Care model
- Increase awareness of availability of Medicaid transportation
- Expand capacity for peer support
- Increase ACT provider capacity
- Have adequate medication management throughout network
- Evaluate feasibility of adding new or increasing capacity of ACTT teams

The state continues to monitor Crisis Services and Community-Based Mental Health services that are required to enable the successful transition to supportive housing. Services and identified gaps, as well as the implementation and success of LME/MCO strategies to address service gaps, are monitored by DHHS through multiple activities, including:

- the annual Gaps Analysis review process
- review and monitoring of LME Local Business Plans
- review of LME/MCO Network Development Plans and Quality and Performance Improvement Plans and Projects

- Intradepartmental Monitoring Team (IMT) review of LME/MCO performance relative to contract requirements and performance standards.

8. Quality of Life Survey

The TCLI Quality of Life Surveys assess participant perceptions and satisfaction related to housing, daily living, and personal control; community integration, supports, and services; and individual well-being and recovery support. The Initial (Pre-Transition) survey is administered during the individual's transition planning period. Follow-up surveys are administered 11 and 24 months after the individual transitioned to the community.

As of March 31, 2016, initial surveys of 1,183 TCL participants had been administered and submitted by LME/MCOs. Nearly all individuals reported positive perceptions about the transition planning process (96 percent).

Responses to 11-month follow-up surveys of 435 individuals and 24-month surveys of 202 individuals continue to show improvements related to individual well-being, community integration and personal control. More individuals also report satisfaction with their services, daily activities, and varied aspects of their housing and communities after transitioning.

Survey results, including areas of need and lower reported satisfaction and descriptive follow-up survey response summaries by LME/MCO, are presented in the attached Appendix, TCLI Quality of Life Survey Summary Results (July 2017).

9. Crisis Services Initiative Update

During the past fiscal year, DHHS continued to focus on its established priorities for improvement in crisis services. The work began on those priorities in 2014 after the establishment of The Crisis Solutions Initiative (CSI) in November, 2013. This initiative focuses on identifying and implementing the best-known strategies for crisis care throughout the continuum of prevention, intervention, response and stabilization. Initiative projects are intended to support the development of appropriate levels of intervention for individuals in behavioral health crises, and to reduce avoidable visits to EDs and involvement with the criminal justice system. The initiative is built upon two key strategies:

- Work in partnership with all the stakeholders in the crisis system; and
- Discover effective crisis intervention strategies in locations across the state and nation. Evaluate the potential for replication. Find ways to replicate and sustain successful models by eliminating barriers, and establishing policy and funding to support those models.

Crisis Solutions Coalition

- The Crisis Solutions Coalition meeting is held semi-annually with representatives from LME/MCOs, providers, law enforcement, EMS, hospitals, advocates, DHHS staff, and others who meet to learn about innovative crisis intervention strategies, network and learn from each other, and to guide the department's work on the priority areas previously established. The most recent Crisis Solutions Coalition was held on September 22, 2017 and focused on the local community partnerships network developed in Asheville, NC with panel staff present from RHA,

Vaya Health, and Mission Hospital, the Cures Grant and Opioid Treatment Programs, Innovations Waiver Crisis Services, and the upcoming Behavioral Health Crisis Referral System (BH-CRSys) scheduled for implementation early January 2018.

Noted below are areas of priority the Coalition identified for 2017:

- Need for additional inpatient beds
- Improved coordination of care
- Alternative community-based settings (FBC centers, Behavioral Health Urgent Care Center (BHUCs), etc)
- Increased services for individuals with intellectual and developmental disabilities
- Additional mobile crisis teams
- More transitional housing
- Increased transportation options
- More education and training

The Crisis Solutions Coalition will meet again in the Spring 2018 to further the discussion about priorities noted as well as areas across the state containing programs, collaborative efforts made, networks and partnerships developed in order to best address those in need within our MH/SA crisis system.

Behavioral Health Urgent Care and Facility-Based Crisis Program Updates

The NC General Assembly appropriated funds to build crisis response services that will effectively divert individuals in behavioral health crisis from the unnecessary use of emergency departments into settings staffed with behavioral health specialists more connected to other community-based services. (Behaviorial Health Urgent Care (BHUC) centers - an alternative to a hospital ED for individuals in behavioral health crisis for:

- Specialized assessment
- 23-hour observation
- Barrier free gateway to FBC
- A partner in the jail diversion partnership with Crisis Intervention Team (CIT) programs

FBC - An alternative to inpatient psychiatric hospitalization for individuals

- Typically, 3 –7 day stays in units of 16 or fewer beds
- May be designated to accept individuals on involuntary committment
- Usually have “closer to home” advantages

Noted below is latest information for BHUCs and FBCs in North Carolina:

- Child FBCs are currently being developed by Alliance Behavioral Healthcare and Vaya Health
- Cardinal Innovations’ child FBC site is currently under construction with the anticipated opening in November 2017.
- Vaya Health’s 24/7 C3356 Comprehensive Care Center opened July 2016, and receives an average of 272 walk-ins per month with 2,994 episodes of crisis care stabilization occurring
- Eastpointe recently held a grand re-opening ceremony of their 24/7 BHUC and co-located 16 bed FBC in Lumberton, in August 2017.

- Cardinal Innovations and its provider agency Daymark are opening a 24/7 BHUC in Winston-Salem which will be co-located with outpatient services and a medical clinic by October 2017. and is opened an FBC in Davidson County in Spring of 2017
- There are six Tier IV Behavioral Health Urgent Cares (24 hour)
- There are 19 Tier III Behavioral Health Urgent Cares (23 hour)
- 7,676 – visits to BHUC's of patients either emergent or urgent in Quarter 1 of SFY17
- The six sites that operate 24/7 offer a combined 38 observation chairs
- 22 Adult FBC's across the state provide 294 beds that serve as an alternative to an ED

Community Paramedicine Behavioral Health Crisis Response Pilot Program
The DHHS Office of Emergency Medical Services (OEMS) and LME/MCOs have partnered on ways to fund, replicate and sustain a model of crisis intervention and diversion from unnecessary visits to the hospital EDs for individuals in behavioral health and substance use crisis.

This pilot program has 13 EMS sites participating and uses specially trained EMS staff to intervene with people experiencing behavioral health crisis. Incentives are also provided for the EMS participating to either treat on-scene or successfully divert those individuals not needing medical treatment to lower cost alternatives, such as BHUCs, instead of to hospital EDs.

EMS agencies have also maintained partnerships with their LME/MCOs and community-based behavioral health crisis providers. Mutually agreed-upon protocols are contributing factors that make the diversion from local hospital EDs for individuals in behavioral health or substance use crisis, successful.

Successful ED diversion offers an advantage to the individual who is directed to an alternative location for a specialty behavioral health or substance use crisis intervention. It also offers an advantage to EDs that are increasingly overwhelmed with individuals in behavioral health or substance use crises, by having local alternative community-based settings as another option for receiving treatment.

For SFY 2015-2016, $225, 000 in state funding was provided to 12 participating EMS agencies. Carry-forward funding supplemented by the Mental Health Block Grant (MHBG) enabled this project to continue through SFY 2016-2017. The state budget for SFY 2017 – 2019 allots $60,000 per year for each of the next two years to be appropriated for the continuation of this project's implementation. Additional funds are being sought through the SABG to cover the amount needed to reimburse for these services provided.

Mental Health First Aid
Mental Health First Aid is an evidence-based, eight-hour curriculum that helps the public identify, understand and respond to signs of mental illnesses and substance use disorders. People trained in Mental Health First Aid have greater confidence in providing help to others and are more likely to advise them to seek professional help. As of July, 2017, there are more than 40,000 individuals trained in Mental Health First Aid in the state of North Carolina with more than 500 trained instructors.

Psychiatric Advance Directives
DMH/DD/SAS has contracted with NAMI-NC for several projects aimed at expanding the range and efficacy of crisis intervention services, and of decreasing overuse of hospital EDs and inpatient

psychiatric hospitalizations. One of these strategies is to expand the use of Psychiatric Advance Directives (PADs) as a recovery tool to address crises earlier and attempt to prevent the need for ED or inpatient treatment.

PADs allow competent individuals, through advance instructions and/or appointment of a surrogate decision maker, to state their preferences from future mental health treatment in the event of an incapacitating psychiatric crisis. Updates for this project include:

- Alliance Behavioral Healthcare sponsored and hosted a training for a six-hour curriculum, led by Dr. Marvin Swartz, which was completed in September, 2016.
- Another PAD training took place at the Fall NAMI conference in October, 2016.
- The Duke Endowment recently funded a proposal which grants Southern Regional AHEC as the recipient of the three-year funding project. The goal is to translate PAD Facilitation to Community-Based Mental Health settings Mecklenburg, Durham, Wake and Cumberland counties.
- Training curriculum is being developed for individuals who are health care agents (HCAs) regarding responsibilities of HCAs, what legal powers they have. This includes learning how to advocate on behalf of the individual with crisis providers and others.
- NAMI-NC sponsored a PADs workshop at the CIT conference in Raleigh in February, 2017.
- Dr. Swartz and Dr. Slubicki presented a workshop at Central Regional Hospital entitled "Psychiatric Advance Directives: A Compelling Idea in Search of Implementation." in April, 2017. which was attended by a cross section of psychiatrists and residents, social workers, hospital administration and clinical directors, nurses and other staff.
- Launched the first part of a two-part training Psychiatric Advance Directives: How to Facilitate, on June 19, 2017 (online course)and the second part on July 12, 2017.
- Providing ongoing coaching and support to facilitators and will be building a learning community in near future.
- A PADs workshop is being offered at the NAMI Conference scheduled for Friday, October 13th at the Durham Convention center.

Closing Statement

DHHS continues to be strongly committed to meeting requirements of the DOJ settlement agreement while building a system that assures the vision of a community-based system is in place for people with Disabilities.

We are working closely with all of our partners and stakeholders, and are adjusting our strategies as we identify opportunities to improve. We are confident that this approach will result in a substantial compliance with the settlement.

Social determinants of health are an important factor in building a sustainable system of supports, and DHHS is committed to working with partners across divisions and departments to develop a system that is more cohesive and provides the most integrated care to assist individuals to live in their communities as independently as possible.