Attachment A: Compliance Chart

Settlement Agreement Reference		Provision	Rating	Comments
III. A.		The State agrees to develop and implement effective measures to prevent inappropriate institutionalization and to provide adequate and appropriate public services and supports in the most integrated setting appropriate to meet the needs of individuals with SMI, who are in or at risk of entry to an adult care home (ACH).		
III. B.		**COMMUNITY-BASED SUPPORTED HOUSING SLOTS**		
III.B.1.		The State will develop and implement measures to provide individuals outlined in Section III (B)(2)(a)-(e).access to community-based Supportive Housing (SH).		
III.B.2		Priority for the receipt of housing slots will be given to the following individuals:		
1.	III.B.2.a.	Individuals with SMI who reside in an ACH determined by the state to be an IMD	NR	There were no reports of newly designated IMDs in FY 2019.
2.	III. B.2.b.	Individuals with SPMI who reside in an ACH licensed for at least 50 beds and in which 25% or more of the residents has a mental illness	C	Individuals in this category are given priority, but the process for access is sometimes a challenge limiting access.
3.	III.B.2.c.	Individuals with SMI who reside in an ACH licensed for between 20 and 49 beds and in which 40% or more of the residents has a mental illness	C	Individuals in this category are given priority, but the process for access is sometimes a challenge limiting access.
4.	III.B.2.d.	Individuals with SMI who reside who are or will be discharged from a state psychiatric hospital (SPH) and who are homeless or have unstable housing	NC	The State has yet to develop effective measures for individuals hospitalized in SPHs to access SH directly upon discharge.
5.	III.B.2.e.	Individuals diverted from entry into ACHs pursuant to the preadmission screening and diversion provisions of Section III (F).	NC	The State has made progress to SH available to individuals at "risk of" inappropriate institutionalization but is still in the process of implementing a new Pre-screening process and access is not timely resulting in some individuals not getting access to SH.
III.B.3.		The State will provide access to 3000 housing slots in accordance with the following schedule:		
The State has not met the housing access requirements; each year a new row will be added to report the State's performance in meeting the Settlement Agreement (SA) Housing slots requirements.				
6.	III.B.3.a.	By July 1, 2019 the State will provide housing slots to at least 2,110 individuals.	C	The State met this requirement in FY 2019 providing housing slots for 2,114 individuals.
7.	III.B.4.	The State shall develop rules to establish processes and procedures for determining eligibility for the Housing Slots consistent with this Agreement.	C	Rules and procedures are in place. It is recommended the State maintain records of time required for determining eligibility its effects on meeting requirement for immediate placement for individuals being diverted from ACHs".
8.	III.B.5.	Over the course of the agreement, 1000 slots will be provided to individuals described in Section III.(B) (2) (a)(b-c) and 2000 slots will be provided to individuals described in Section III. B. 2. (d- e) by July 1, 2021.	NR	The percent of slots provided to individuals in Section III (B) (2)[a-c] increased by a net of 84 individuals in FY 2019. The rate of slots being offered to individuals in III (B)(2)[a-c] is growing but at the current pace will fall short by 700 individuals (in Cat 1-3) living in supported housing on July 1, 2021.

Rating Taxonomy:
C: The State is in full compliance with this requirement
NC: The State is not in compliance with this item either because the steps taken are not effective to meet the requirements, there have be no steps taken or there have not been enough steps taken to rate full Compliance.
D: Deferred, there is not enough information available to rate this item.
NR: Not rated this fiscal year

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9.	III.B.6.	The State may utilize ongoing programs to fulfill its obligations under this Agreement so long as the Housing Slots provided using ongoing programs meets all the criteria.	NR	The State does not utilize ongoing programs. There is not a rating of this provision because there is not a requirement and the term in the agreement is "may use".
	III.B.7.	Housing Slots will be provided for individuals to live in settings that meet the following criteria:		
10.	III.B.7.a	they are for permanent housing with Tenancy Rights;	C	The State has consistently met this requirement.
11.	III.B.7.b.	they include tenancy support services that enable residents to attain and maintain integrated, affordable housing. Tenancy supports offered to people living in supported housing are flexible and are available as needed and desired, but are not mandated as a condition of tenancy;	NC	Results of individual reviews indicate the State is providing tenancy support. However, the service definition is not sufficient to enable individuals to attain and maintain housing at an acceptable level. The State is implementing a more robust service in FY 2020. This may help the State meet this requirement.
12.	III.B.7.c.	they enable individuals with disabilities to interact with individuals without disabilities to the fullest extent possible;	NC	Slots are typically located in multi-family complexes but some complexes are located isolated areas limiting interaction to the fullest extent possible. This is not always possible so arrangements for transportation are necessary.
13.	III.B.7.d.	they do not limit individuals' ability to access community activities at times, frequencies and with persons of their choosing;	NC	Slots are located isolated areas or places where transportation limits individuals' access to community activities at times, frequencies and with persons of their choosing; this is also a "services access" not a housing slot issue.
14.	III.B.7.e. and (i.)	they are scattered site housing, where no more than 20% of the units in any development are occupied by individuals with a disability known to the State (Up to 250 Housing Slots may be in disability-neutral developments, that have up to 16 units, where more than 20%);	C	The State has consistently met this requirement.
15.	III.B.7.f.	they afford individuals choice in their daily life activities, such as eating, bathing, sleeping, visiting and other typical daily activities	NC	Individuals do not always have choice in typical daily activities; this is a services limitation.
16.	III.B.7.g.(i.) and (ii.)	The priority is for single-site housing. *does not include full text*	C	The State has consistently met this requirement.
17.	III.B.8.	Housing Slots made available under this Agreement cannot be used in adult care homes, family care homes, group homes, nursing facilities, boarding homes, assisted living residences, supervised living settings, or any setting required to be licensed	C	The State has consistently met this requirement.
18.	III.B.9.	Individuals will be free to choose other appropriate and available housing options, after being fully informed of all options available.	C	The State has consistently met this requirement.

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III. C.		COMMUNITY BASED MENTAL HEALTH SERVICES		
19.	III. C. 1.	The State shall provide access to the array and intensity of services and supports necessary to enable individuals with SMI in or at risk of entry in adult care homes to successfully transition to and live in community-based settings. The State shall provide each individual receiving a Housing Slot under this Agreement with access to services for which that individual is eligible that are covered under the North Carolina State Plan for Medical Assistance, the Centers for Medicare and Medicaid Services ("CMS") approved Medicaid 1915(b)/(c) waiver, or the State-funded service array.	NC	The State has expanded its array of services but there was not evidence in FY 2019 that individuals had access to the full array. Network management, network sufficiency, eligibility, county of origin problems slow down the process and interfere with timely access. Service providers do not consistently assist individuals to access supported employment and other services in the array.
20.	III. C. 2.	The State shall also provide individuals with SMI in or at risk of entry to adult care homes who do not receive a Housing Slot under this Agreement with access to services for which that individual is eligible that are covered under the North Carolina State Plan for Medical Assistance, the CMS-approved Medicaid 1915(b)/(c) waiver, or the State funded service array. Services provided with State funds to non-Medicaid eligible individuals who do not receive a Housing Slot shall be subject to availability of funds in accordance with State laws and regulations regarding access services.	NC	Same as above
20	III. C.3.a.- d.	The services and supports referenced in Sections III(C)(1) and (2), above, shall: a. be evidence-based, recovery-focused and community-based; b. be flexible and individualized to meet the needs of each individual; c. help individuals to increase their ability to recognize and deal with situations that may otherwise result in crises; and d. increase and strengthen individuals' networks of community and natural supports, as well as their use of these supports for crisis prevention and intervention.	NC	Services are not always recovery oriented. Most services definitions are evidenced based but delivery is not. The ratings on these two items are higher than the remaining three in this requirement. Services and service plans are not always individuals with flexibility to meet individual needs. Services do not always assist individuals to increase their ability to recognize and deal with situations that my otherwise result in crisis nor is there sufficient attention provided to strengthening individual's networks of community and natural supports. The FY 2019 reviews qualitied findings from interviews and chart reviews.

21.	III. C. 4.	The State will rely on the following community mental health services to satisfy the requirements of this Agreement: Assertive Community Treatment ("ACT") teams, Community Support Teams("CST"), case management services, peer support services, psychosocial rehabilitation services, and any other services as set forth in Sections III(C)(1) and (2) of this Agreement.	NC	The State is making ACT and tenancy support available. There is still variability in availability and quality of all services across LME/MCOs. There are deficiencies in the quality, intensity and frequency of services. There are limitations with, network sufficiency, lack of providers in some geographic areas, authorization practices, financing constraints and/or to services, either not offered consistent with recipient need. Providers are not as engaged as TCLI staff on tenancy related tasks and they do focus on recovery and community integration at a level required in the Settlement Agreement. Some services are not as available as needed because of definition restrictions, their availability and/or authorization practices. There are performance requirements for services referenced in the SA.
22.	III. C. 5.	All ACT teams shall operate to fidelity to either, at the State's determination, the Dartmouth Assertive Community Treatment ("DACT") model or the Tool for Measurement of Assertive Community Treatment ("TMACT"). All providers of community mental health services shall adhere to requirements of the applicable service definition.	NC	There is regular TMACT Fidelity monitoring. Results from the 2nd round of Fidelity reviews, indicates a gradual improvement on those scores. Sub-scores varied but overall were lower on rehabilitation and recovery related interventions, frequency and intensity of services. The SA requires all individuals receiving ACT services receive services from employment specialists. This requirement is only reviewed for individuals in the priority populations
23.	III. C. 6.	A person-centered service plan shall be developed for each individual, which will be implemented by a qualified professional who is clinically responsible for ensuring that all elements and components of the plan are arranged for the recipient in a coordinated manner. Individualized service plans will include psychiatric advance directives and/or crisis plans so that such measures can be incorporated into the response to any behavioral health crisis.	NC	PCPs are being completed as required. However plans are not individualized at an acceptable level, there is little evidence of coordination among providers on a single PCP.
24.	III. C. 7.	The State *has implemented* capitated prepaid inpatient health plans ("PIHPs") as defined in 42 C.F.R. Part 438 for Medicaid-reimbursable mental health, developmental disabilities and substance abuse services pursuant to a 1915(b)/(c) waiver under the Social Security Act. The State will monitor services and service gaps and, through contracts with PIHP and/or LMEs, will ensure that the number and quality of community mental health service providers is sufficient to allow for successful transition of individuals with SMI, who are in or at risk of entry to an adult care homes, to supported housing, and for their long-term stability and success as tenants in supported housing. The State will hold the	NC	The PIHP (MCO) and DMH contracts identifying TCLI requirements are in place statewide. The DMH contract improved in FY 2018. There have been improvements in the LME/MCOs network management however there is still a lack of intensity and focus on arranging for services that match the needs individuals have to move to and live successfully in the community. There continue to be significant problems with LME/MCOs maintaining contact and making good connections on behalf of an individual when they move from one catchment area to another. Specific requirements need to be adopted and monitored for this process. THE DMA and DMH contracts do not include requirements that specific required performance.

		PIHP and/or LMEs accountable for providing access to community-based mental health services in accordance with 42 C.F.R. Part 438, but the State remains ultimately responsible for fulfilling its obligations under the Agreement.		The GAPS analysis is also not acceptable for identifying gaps for individuals in the TCLI program, especially IPS-SE but other services as well.
25.	III. C. 8.	Each PIHP and/or LME will provide publicity, materials and training about the crisis hotline, services, and the availability of information for individuals with limited English proficiency, to every beneficiary consistent with federal requirements at 42 C.F.R. § 438.10 as well as to all behavioral health providers, including hospitals and community providers, police departments, homeless shelters, and department of corrections facilities. Peer supports, enhanced ACT, including employment support from employment specialists on ACT teams for individuals with SMI, Transition Year Stability Resources, Limited English Proficiency requirements, crisis hotlines and treatment planning will be implemented in coordination with the current PIHP implementation schedule. Finally, each PIHP and/or LME will comply with federal requirements related to accessibility of services provided under the Medicaid State Plan that they are contractually required to provide. *The State will remain accountable for implementing and fulfilling the terms of this Agreement*	NC	The LME/MCOs provide training and information although there was an instance in FY 2019 when there was not an interpreter available for an individual with limited English proficiency and hospitals and providers do not always have information needed to make referrals to the TCLI program.
26.	III. C. 9.	Assertive Community Treatment Team Services: ACT teams will be expanded according to the below timelines, contingent upon timely CMS approval of a State Plan Amendment ("SPA") requiring all ACT teams to comply with a nationally recognized fidelity model (e.g., DACT or TMACT), if one is necessary. By July 1, 2013, all individuals receiving ACT services will receive services from employment specialists on their ACT teams. *The state has selected the TMACT as their fidelity model.*	NC	The State has met its expansion requirements in each year of the Settlement Agreement until FY 2019 when the required number was not met. There was evidence this year that there are individuals receiving ACT, who are in the TCLI program, who are not receiving employment services.
The state met the requirements for the number of persons served by ACT in FY 2013 through FY 2018; each year a new row will be added to report the state's performance in meeting the ACT team requirements.				
27.	III.C.9.c.	By July 1, 2019, the State will increase the # of individuals served by ACT to 50 teams serving 5,000 individuals at any one time, using the TMACT model.	NC	72 teams are operating at fidelity to TMACT but only 4,826 individuals were receiving ACT by July 1, 2019.
28.	III.C.10.a.	Crisis Services: The State shall require that each PIHP and/or LME develop a crisis service system that includes crisis services sufficient to offer timely and accessible services and supports to individuals with	C	Each LME/MCO is developing a crisis system.

		SMI experiencing a behavioral health crisis. The services will include mobile crisis teams, walk-in crisis clinics, community hospital beds, and 24-hour-per-day/7-days per week.		
29.	III. C. 10.b.	The State will monitor crisis services and identify service gaps. The State will develop and implement effective measures to address any gaps or weaknesses identified.	NC	The State monitors gaps but not all the LME/MCOs identify how they will address gaps and weaknesses in crisis services.
30.	III.C.10.c.	Crisis services shall be provided in the least restrictive setting (including at the individual's residence whenever practicable), consistent with an already developed individual community-based crisis plan or in a manner that develops such a plan as a result of a crisis situation, and in a manner that prevents unnecessary hospitalization, incarceration or institutionalization.	NC	TSM staff who sees individuals most often in their home are not permitted to intervene or have been trained in crisis intervention. There is not a consistent use of crisis plan to prevent crisis or intervening in crisis.
	III. D.	**SUPPORTED EMPLOYMENT**		
31.	III.D.1.	The State will develop and implement measures to provide Supported Employment Services to individuals with SMI, who are in or at risk of entry to an adult care home, that meet their individualized needs. Supported Employment Services will assist individuals in preparing for, identifying, and maintaining integrated, paid, competitive employment. Services offered may include job coaching, transportation, assistive technology assistance, specialized job training, and individually- tailored supervision.	NC	The State and LME/MCOs have continued to develop and implement measures to provide IPS-SE. The State and LME/MCOs have not taken sufficient measures to make this service available to individuals interested in going to work who are in Adult Care Homes and moving to the community or who are "at risk of" or diverted from ACHs. The State is falling short of taking effective steps to plan for the services, build adequate capacity, establish an incentivize performance to achieve better outcomes, fill the pipeline, and establish a business model for providers to improve performance, delivery, and sustainability of services for the target population.
32.	III.D.2.	The State shall provide Supported Employment Services with fidelity to an evidence- based supported employment model for supporting people in their pursuit and maintenance of integrated, paid, competitive work opportunities. The State shall use an established fidelity scale is used to assess supported Employment Services such as the scale included in the Substance Abuse and Mental Health Services Administration supported employment toolkit.	C	The State has employed a strong IPS-SE fidelity review system and has built capacity to provide training and complete these reviews on a timely basis.
33.	III.D.3.	By July 1, 2019, the State will provide Supported Employment Services to a total of 1885 individuals with SMI who are in or at risk of entry into ACHs that meet their individual needs;	C	The State exceeded this requirement with 2,222 individuals in the "in or at risk" population receiving services, an increase of 19% in FY 2019.

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III. E.		**DISCHARGE AND TRANSITION PROCESS**		
34.	III.E.1	The State will implement procedures for ensuring that individuals with SMI in, or later admitted to, an adult care home or State psychiatric hospital will be accurately and fully informed about all community-based options. This includes the option of transitioning to supported housing, its benefits, the array of services and supports available to those in supported housing, and the rental subsidy and other assistance they will receive while in supported housing.	NC	The procedures for ensuring individuals will be accurately and fully informed of community options in accordance with this requirement, are in place. There are still delays and there are still some individuals not informed of community-based options before moving to an ACH following pre-screening and individuals not given this option prior to SPH discharge.
35.	III.E.2.	In-Reach: The State will provide or arrange for frequent education efforts targeted to individuals in adult care homes and State psychiatric hospitals. The State will initially target in-reach to adult care homes that are determined to be IMDs. The State may temporarily suspend in-reach efforts during any time period when the interest list for Housing Slots exceeds twice the number of Housing Slots required to be filled in the current and subsequent fiscal year. The in-reach will include providing information about the benefits of supported housing; facilitating visits in such settings; and offering opportunities to meet with other individuals with disabilities who are living, working and receiving services in integrated settings, with their families, and with community providers. In-reach is provided by individuals who are knowledgeable about community services and supports, including supported housing, In-reach will not be provided by operators of adult care homes. The State will provide in-reach to adult care home residents on a regular basis, but not less than quarterly.	NC	Staff are still not always knowledgeable about community supports generally as a result of information not being made available to them. There is not sufficient evidence that In-reach staff facilitates visits or offer opportunities for individuals to meet with other individuals with disabilities who are living, working and receiving services in integrated settings, with their families, and with community providers.
36.	III.E.3.	The State will provide each individual with SMI in, or later admitted to, an adult care home, or State psychiatric hospital operated by the Department of Health and Human Services, with effective discharge planning and a written discharge plan. The goal of discharge planning is to assist the individual in developing a plan to achieve outcomes that promote the individual's growth, well-being and independence, based on the individual's strengths, needs, goals and preferences, in the most integrated setting appropriate in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare and relationships).	NC	The SPH discharge planning process was written into the LME/MCO-SPH contracts in FY 2019 but there has not been sufficient progress on implementation of those requirements for the State to meet this requirement. .

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III.E.4		Discharge planning will be conducted by transition teams that include:		
37.	III.E.4.a.	persons knowledgeable about resources, supports, services and opportunities available in the community, including community mental health service providers;	NC	The SPH and LME/MCOs do not operated with one transition team. Individual reviews revealed that SPH staff do not have sufficient knowledge of community supports, services and resources.
38.	III.E.4.b.	professionals with subject matter expertise about accessing needed community mental health care, and for those with complex health care needs, accessing additional needed community health care, therapeutic services and other necessary services and supports to ensure a safe and successful transition to community living;	NC	Same as above
39.	III. E.4.c.	persons who have the linguistic and cultural competence to serve the individual;	C	There was no evidence of deficiencies with linguistic and cultural competence.
40.	III. E. 4. d.	Peer specialists when available	NC	Since discharge planning is conducted in silos between the hospital staff and LME/MCOs, Peer specialists who are available are not always included in discharge planning.
41.	III.E.5	For individuals in State psychiatric facilities, the LME/MCO transition coordinator will work in concert with the facility team. The LME/MCO transition coordinator will serve as the lead contact with the individual transitioning from an adult care home or State psychiatric hospital, including during the transition team meetings and while managing the required transition process.	NC	There is not a defined role for an LME/MCO transition coordinator. Most LMEs have a "liaison" with SPH. The "liaison" does not lead a transition team meeting nor do they lead transition planning in SPHs. Only 5% of individuals discharged from a SPH moved directly to Supported Housing. This in part is related to there not being a process for this to increase.
42.	III.E.6	Individuals shall be given the opportunity to participate as fully as possible in his or her treatment and discharge planning.	C	There continues to be evidence individuals are participating as fully as possible in treatment and discharge planning.
III. E.7		Discharge planning:		
43.	III.E.7.a.	begins at admission	NC	SPH discharge planning does not always begin at admission and does not always begin at admission for individuals admitted to ACHs. It was difficult for LMEs to begin this process of individuals admitted to ACHs because the LME/MCOs were not always aware of admissions.
44.	III.E.7.b.	is based on the principle that with sufficient services and supports, people with SMI or SPMI can live in an integrated community setting;	NC	Not all staff, particularly SPH staff and Guardians ascribe to this principle so in theory this is State position, in practice it is still not reality.
45.	III.E.7.c.	assists the individual in developing an effective written plan to enable the individual to live independently in an integrated community setting;	NC	Plans are not effective as written for individuals to live independently in an integrated setting with the necessary, services, supports, resources and supported housing. .
46.	III.E.7.d.	is developed and implemented through an effective written plan to enable the individual has a primary role and is based on the principle of self-determination.	NC	This is the State's policy but not always practiced.
47.	III.E.8	The discharge planning process will result in a written discharge plan that:	NC	See E.7.c. comments above.
48.	III.E.8.a.	identifies the individual's strengths, preferences, needs, and desired outcomes;	NC	See E.7.c. comments above.

49.	III.E.8.b.	identifies the specific supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes, regardless of whether those services and supports are currently available;	NC	See E.7.c. comments above.
50.	III.E.8.c.	includes a list of specific providers that can provide the identified supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes;	NC	Specific lists are still quite limited because of lack of choice of available providers and inadequacy of provider networks.
51.	III.E.8.d.	documents any barriers preventing the individual from transitioning to a more integrated setting and sets forth a plan for addressing those barriers;	NC	Barriers are often documented but plans are sometimes limited; there are many exceptions where staff have worked with individuals to eliminate barriers and develop very creative plans.
52.	III.E.8.d.(i)	Such barriers shall not include the individual's disability or the severity of the disability.	NC	Barriers related to an individual's physical and mental disabilities persist with insufficient attention to developing resources and plans that can overcome these barriers.
53.	III.E.8.d.(ii.)	For individuals with a history of re-admission or crises, the factors that led to re-admission or crises shall be identified and addressed	NC	Staff were able to articulate triggers although not always successfully addressed
54.	III.E.8.e.	sets forth the date that transition can occur, as well as the timeframes for completion of all needed steps to effect the transition; and	NC	Many performance issues and obstacles still exist creating delays in transition and discharge planning; The State is not meeting the SA requirement for timeliness of transitions. In part this is attributable to lack of timely actions
55.	III.E.8.f.	prompts the development and implementation of needed actions to occur before, during, and after transition.	NC	Same issue as III.E.(8){f}, transitions are still slowed by actions not being taken in a timely or satisfactory manner.
56.	III.E.9	The North Carolina Department of Health and Human Services ("DHHS") will create a transition team at the State level to assist local transition teams in addressing and overcoming identified barriers preventing individuals from transitioning to an integrated setting. The members of the DHHS transition team will include individuals with experience and expertise in how to successfully resolve problems that arise during discharge planning and implementation of discharge plans.	NC	The TCLI Senior Advisor convened a state-level Barriers Committee in late FY 2018. The Team has been very effective in addressing barriers identified by a wide range of State and local staff. Once there are organized local transition teams submitting barriers to the State team, this requirement will be met.
57.	III.E.10.	The DHHS transition team will ensure that transition teams (both State hospital facility staff and leadership and PIHP and/or LME Transition Coordinators) are adequately trained. It will oversee the transition teams to ensure that they effectively inform individuals of community opportunities. The training will include training on person-centered planning. The DHHS transition team will assist local transition teams in addressing identified barriers to discharge for individuals whose teams recommend	NC	See reference to transition teams above (III. E.5)

		that an individual remain in a State hospital or adult care home, or recommend discharge to a less integrated setting (e.g., congregate care setting, family care home, group home, or nursing facility). The DHHS transition team will also assist local transition teams in addressing identified barriers to discharge for individuals whose teams cannot agree on a plan, are having difficulty implementing a plan, or need assistance in developing a plan to meet an individual's needs.		
58.	III.E.11	If the individual chooses to remain in an adult care home or SPH, the transition team shall identify barriers to placement in a more integrated setting, describe steps to address the barriers and attempt to address the barriers (including housing). The State shall document the steps taken to ensure that the decision is an informed one and will regularly educate the individual about the various community options open to the individual, utilizing methods and timetables described in Section III(E)(2).	NC	LME/MCO In-reach and Transition Coordinators do this for individuals remaining in ACHs but not remaining in SPHs. Steps being taken to address barriers at both the State and local level to eliminate barriers.
59.	III.E.12	The State will re-assess individuals with SPMI who remain in adult care homes or State psychiatric hospitals for discharge to an integrated community setting on a quarterly basis, or more frequently upon request; the State will update the written discharge plans as needed based on new information and/or developments	NC	Individuals are re-assessed but there still needs to be a mechanism for more frequent assessments and engagement that is facilitated by the SPHs and LME/MCOs need to follow through with any requests in a timely manner.
III.E.13		Implementation of the In-Reach, Discharge and Transition Process		
60.	III. E. 13.a.	Within 90 days of signing this Agreement, the State will work with PIHP and/or LMEs to develop requirements and materials for in-reach and transition coordinators and teams.	C	This requirement was met.
61.	III.E.13.b.	Within 180 days after the Agreement is signed, PIHP and/or LMEs will begin to conduct ongoing in-reach to residents in adult care homes and State psychiatric hospitals, and residents will be assigned to a transition team, consistent with Section III(E)(2).	C	See above
62.	III.E.13.c.	Transition and discharge planning for an individual will be completed within 90 days of assignment to a transition team. Discharge of assignment to a transition team provided that a Housing Slot, as described in Sections II(A) and III(B), is then available. If a Housing Slot is not available within 90 days of assignment to the transition team, the transition team will maintain contact and work with the individual on an ongoing basis until the	NC	Transition planning is not always completed within 90 days. The lowest percentage for any LME/MCO was 71% and the highest was 100%. Some LME/MCOs improved their percentage. Hurricane response interfered with this process for several month for two of the LME/MCOs. There was some improvement In-reach contacts are made every 90 days 95% of the time. There are multiple reasons for this requirement not being met including but limited to housing access and lack of available housing, County of Origin

		individual transitions to community-based housing as described in Section III(B)(7).		issues and other eligibility delays, It is not clear that the 90 day transition to housing slot provision is being interpreted the same across the state.
III.E.13.d.		The State will undertake the following procedures with respect to individuals with SMI in an adult care home that has received a notice that it is at risk of a determination that it is an IMD, in addition to any other applicable requirements under this Agreement:		
63.	III.E.3.d. (i.)	Within one business day after any adult care home is notified by the State that it is at risk of being determined to be an IMD, the State will also notify the Independent Reviewer, DRNC, and the applicable LME or PIHP and county Departments of Social Services of the at-risk determination.	NR	There were no homes identified in FY 2019.
64.	III.E.3.d .(ii.)	The LME and/or PIHP will connect individuals with SMI who wish to transition from the at-risk adult care home to another appropriate living situation. The LME and/or PIHP will also link individuals with SMI to appropriate mental health services. For individuals with SMI who are enrolled in a PIHP, the PIHP will implement care coordination activities to address the needs of individuals who wish to transition from the at-risk adult care home to another appropriate living situation.	NR	See above.
65.	III.E.13.d. (iii.)	The State will use best efforts to track the location of individuals who move out of an adult care home on or after the date of the at- risk notice. If the adult care home initiates a discharge and the destination is unknown or inappropriate as set forth in N.C. Session Law 2011-272, a discharge team will be convened.	NR	See above
66.	III.E.13.d.(iv.)	Upon implementation of this Agreement, any individual identified by the efforts described in Section III(E)(13)(d)(iii) who has moved from an adult care home determined to be at risk of an IMD determination shall be offered in-reach, person-centered planning, discharge and transition planning, community-based services, and housing in accordance with this Agreement. Such individuals shall be considered part of the priority group established by Section III(B)(2)(a).	NR	See above
67.	III.E.14.	The State and/or the LME and/or the PIHP shall monitor adult care homes for compliance with the Adult Care Home Residents' Bill of Rights requirements contained in Chapter 131D of the North Carolina General Statutes and 42 C.F.R. § 438.100, including the right to be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy; to associate and	NC	There were reports that the State is not always responsive to LME/MCO complaints. This discourages reporters and can impede their work. The remedy for this problem is for the State to implement a timely feedback loop to LME/MCOs on complaints.

		communicate privately and without restriction with people and groups of his or her own choice; to be encouraged to exercise his or her rights as a resident and a citizen; to be permitted to make complaints and suggestions without fear of coercion or retaliation; to maximum flexibility to exercise choices; to receive information on available treatment options and alternatives; and to participate in decisions regarding his or her health care. In accordance with 42 C.F.R. § 438.100, the State will ensure that each individual is free to exercise his or her rights, and that the exercise of rights does not adversely affect the way the PIHP, LME, providers, or State agencies treat the enrollee.		
III. F.		**PRE-ADMISSION SCREENING AND DIVERSION**		
68.	III.F.1	Beginning January 1, 2013, the State will refine and implement tools and training to ensure that when any individual is being considered for admission to an adult care home, the State shall arrange for a determination, by an independent screener, of whether the individual has SMI. The State shall connect any individual with SMI to the appropriate PIHP and/or LME for a prompt determination of eligibility for mental health services.	NC	The State made Pre-screening and Diversion changes on November 1, 2018 as proposed in FY 2017. The State gave the responsibility for these tasks to the LME.MCOS. The State did not have time prior to making these changes to test run the changes in the computerized system and to test the decision process and the flow of the process. Their previous vendor did not agree to extend their contract so this could occur. The State adjusted the process throughout FY 2019. Based on changes made in May and June 2019, there will be a full review of Pre-screening and Diversion in FY 2020.
69.	III.F.2	Once an individual is determined to be eligible for mental health services, the State and/or the PIHP and/or LME will work with the individual to develop and implement a community integration plan. The individual shall be given the opportunity to participate as fully as possible in this process. The development and implementation of the community integration plan shall be consistent with the discharge planning provisions in Section III(E) of this Agreement.	NC	As referenced above, the State made changes to these processes in FY 2019. One key challenge is the ability of the LME/MCO to develop and implement a community integration plan. The State released a Community Integration Guide in May 2019 and a Joint Communication Bulletin in June 2019. The LME/MCOs will need to assist an individual to develop and implement this plan in a timely and effective manner for the State to meet this requirement.
70.	III.F.3	If the individual, after being fully informed of the available alternatives to entry into an adult care home, chooses to transition into an adult care home, the State will document the steps taken to show that the decision is an informed one. The State will set forth and implement individualized strategies to address concerns to objections to placement in integrated settings and shall offer in-reach, person centered planning, and other services in accordance with this agreement.	NR	Based on this process just getting started in FY 2019, Section III. (F)(1) and (2) could be reviewed but not Section III. (F)(3). There has not be sufficient time to conduct a full review of this requirement across all of the LME/MCOs. .

Attachment A: Compliance Chart

III. G.		QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT		
71.	III.G.1.	The State will develop and implement a quality assurance and performance improvement monitoring system to ensure that community-based placements and services are developed in accordance with this Agreement, and that the individuals who receive services or Housing Slots pursuant to this Agreement are provided with the services and supports they need for their health, safety, and welfare. The goal of the State's system will be that all mental health and other services and supports funded by the State are of good quality and are sufficient to help individuals achieve increased independence, gain greater integration into the community, obtain and maintain stable housing, avoid harm, and decrease the incidence of hospital contacts and institutionalization.	NC	The State has not developed a Quality Assurance and Performance Improvement Plan to ensure that the Settlement Agreement is monitoring in accordance with this requirement. The State has taken a number of action steps to implement this system. These have to be pulled together under one Plan sufficient for decision makers and staff to monitor and make changes the entire set of requirements in this Agreement. The Special Advisor and key staff have identified "big rocks" which is a helpful process for monitoring key decisions. The system does not yet include measures of effectiveness at a level required in the SA.
72.	III.G.2.	A Transition Oversight Committee will be created at DHHS to monitor monthly progress of implementation of this Agreement, and will be chaired by the DHHS Designee The DMA, DMHDDSA, DSOHCF, State Hospital Team Lead, State Hospital CEOs, Money Follows the Person Program, and PIHPs and/or LMEs will be responsible for reporting on the progress being made. PIHPs and/or LMEs will be responsible for reporting on discharge-related measures, including, but not limited to: housing vacancies; discharge planning and transition process; referral process and subsequent admissions; time between application for services to discharge destination; and actual admission date to community-based settings.	NC	The State is very close to meeting this requirement. In FY 2020, there will be a review of the Committee's review and actions regarding all the measures listed in the Settlement Agreement.
III.G.3.		DHHS agrees to take the following steps related to Quality Assurance and Performance Improvement:		
73.	III.G.3.a.	Develop and phase in protocols, data collection instruments and database enhancements for on-going monitoring and evaluation;	NC	The State is taking steps to develop and phase in protocols, instruments and enhancements for ongoing monitoring and evaluation. Additional steps are necessary for monitoring to be consistently effective. Monthly reports generate 60% of required information. Per the narrative reference regarding this requirement, recommend the State identify items to report on monthly, quarterly and annually.
74.	III.G.3.b.	Develop and implement uniform application for institutional census tracking;	C	The ACH tracking system is in place with. Individual's names entered into the TCLD database at admission. The DHSOF tracks SPH census. There is a need to improve this system to use it to enhance performance.
75.	III.G.3.c.	Develop and implement standard report to monitor institutional patients length of stay, readmissions and community tenure;	NC	The State contracts include requirements are reporting hospitalization per 1000 Medicaid members or Uninsured Persons, 30-day

Attachment A: Compliance Chart

				Readmission Rate, ALOS, but not TCLI specific data in these categories. SH tenure reported but not community tenure.
76.	III.G.3.d.	Develop and implement dashboard for daily decision support;	C	The State has generated a new dashboard, reporting on LME/MCO performance in housing (4 items), supported employment (2 items), in-reach (2 items), transition (4 items), quality of life (1 item). The dashboard indicators track reasonably well with SA requirements but there are changes needed to capture information driving compliance.
77.	III.G.3.e.	Develop and implement centralized housing data system to inform discharge planning;	NC	A housing data system has improved but does not have functionality to inform discharge planning.
78.	III.G.3.f.	Develop and utilize template for published, annual progress reports.	NC	The State has not presented a template for a comprehensive annual progress report.
79.	III.G.3.g	Develop and utilize monitoring and evaluation protocols and data collection regarding personal outcomes measures, which include the following:	NC	There are improvements in expanding data monitoring in some but not all categories. Where there have not been reported outcomes, the item is marked as not yet in compliance.
80.	III.G.3.g. (i.)	number of incidents of harm	C	There are reports made on Incidents of harm but these are not always forwarding in a timely manner to the reviewer.
81.	III.G.3.g. (ii.)	number of repeat admissions to State hospitals, adult care homes, or inpatient psychiatric facility	NC	There are no reports on repeat admissions to ACHs. There are reports of individual who separate from housing and return to ACHs.
82.	III.G.3.g. (iii.)	use of crisis beds and community hospital admissions	C	Data on of use on crisis beds and community hospital days are reported including patterns of use and re-admissions are now reported.
83.	III.G.3.g. (iv.)	repeat emergency room visits	NC	This reported for individuals living in supported housing only.
84.	III.G.3.g. (v.)	time spent in congregate day programming	NC	The State reports only reports on the number of individuals living in SH getting at least one unit of PSR annually not individuals in the TCLI program living in other settings.
85.	III.G.3.g. (vi.)	number of people employed, attending school, or engaged in community life; and	NC	The state does not track and report on individuals “engaged in community life”
86.	III. G.3.g .(vii.)	maintenance of a chosen living arrangement.	NC	The State reports tenure in housing slots but not maintenance of other living arrangements

87.	III.G.4.	Quality Assurance System: The State will regularly collect, aggregate and analyze in-reach and person-centered discharge and community placement data, including information related to both successful and unsuccessful placements, as well as the problems or barriers to placing and/or keeping individuals in the most integrated setting. The State will review this information on a semi-annual basis and develop and implement measures to overcome the problems and barriers identified.	NC	The State has not taken all the necessary steps to implement a comprehensive system. There is still not a Quality Assurance and Performance Improvement Plan to guide the implementation of a QA system. The monthly dashboard has increased awareness and interest in collecting and responding to reporting requirements. The State has been tracking information on an ad hoc basis. The newly initiated Barriers Committee is demonstrating success on identified barriers and the Transition Oversight Committee is tracking "big rocks". The next step will be identifying barriers through the new QA Plan and tracking barriers identified through data.
88.	III.G.5.	Quality of Life Surveys: The State will implement three quality of life surveys to be completed by individuals with SMI who are transitioning out of an adult care home or State psychiatric hospital. The surveys will be implemented (1) prior to transitioning out of the facility; (2) eleven months after transitioning out of the facility; and (3) twenty-four months after transitioning out of the facility. Participation in the survey is completely voluntary and does not impact the participant's ability to transition.	C	The reviews are completed and submitted in a timely fashion. The State meets these requirements. As referenced in the Reviewer's Annual Report, there are more useful and practical methods for assisting individuals to report on their quality of life and to improve services and supports and assist individuals in their recovery the State may consider so that QOL can be an integral part of the QA/PI system.
89.	III.G.6.(a.-j.)	External Quality Review ("EQR") Program: As part of the quality assurance system, the State shall complete an annual PIHP and/or LME EQR process by which an EQR Organization, through a specific agreement with the State, will review PIHP and/or LME policies and processes for the State's mental health service system. EQR will include extensive review of PIHP and/or LME documentation and interviews with PIHP and/or LME staff. Interviews with stakeholders and confirmation of data will also be initiated. The reviews will focus on monitoring services, reviewing grievances and appeals received, reviewing medical charts as needed, and any individual provider follow up. EQR will provide monitoring information related to: marketing, program integrity, information to beneficiaries, grievance, timely access to services, primary care providers/specialist capacity. Coordination/continuity of care, coverage/authorization, provider selection and quality of care.	C	These EQR process is timely and informative. There is adequate attention given TCLI requirements in these reviews.

90.	III.G.7.	Use of Data: Each year the State will aggregate and analyze the data collected by the State, PIHPs and/or LMEs, and the EQR Organization on the outcomes of this Agreement. If data collected shows that the Agreement's intended outcomes of increased integration, stable integrated housing, and decreased hospitalization and institutionalization are not occurring, the State will evaluate why the goals are not being met and assess whether action is needed to better meet these goals.	NC	The State has not provided information on why goals are not being met and their assessment of whether or not action is needed to better meet these goals.
91.	III.G.8.	The State will publish, on the DHHS website, an annual report identifying the number of people served in each type of setting and service described in this Agreement.	NR	The State does not publish its Annual Report from the previous year until after this Annual Report is completed and released. In prior years, there was a review but always a year late. This year rather than provide a review of the FY 2017 report, there will be a separate review and report.
92.	III. G. 9.	In the annual report, the State will detail the quality of services and supports provided by the State and its community providers using data collected through the quality assurance and performance improvement system, the contracting process, the EQRs, and the outcome data described above..	NR	See above