2018-2019 Annual Report on North Carolina Supportive Housing Program

Opening the Door to Community: The Transitions to Community Living Initiative

NCGS 122C-20.15

Report to the

Joint Legislative Oversight Committee on

Health and Human Services

North Carolina Department of Health and Human Services

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TCLI Vision Statement: Opening the Door to Community

For people living with serious mental illness or severe and persistent mental illness, permanent housing, combined with supportive services, promotes stability, wellness, recovery, meaningful relationships and the opportunity to become a contributing member of the community. The North Carolina Department of Health and Human Services puts these core concepts into practice in the Transitions to Community Living Initiative (TCLI). For people who are coming out of, or are at risk of entering, institutions, TCLI's Permanent Supportive Housing is integrated into the community and incorporates enhanced, clinically appropriate and innovative services. Its person-centered services and supports and array of individualized, innovative approaches assist people in making the informed choices -- choices that promote health, employment, education and well-being. For each person we serve, TCLI is opening the door to community, a good life and a place to call home.

Lives Transformed: Comments from TCLI Participants

"I never thought I would have my own place. The support helped me push through it... I'm living a normal, successful life..."

"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."

"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... I'm really good now that I'm on my own."

"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 helped me so much; [TCLI] exceeded my expectations."

"My Transition Coordinator...brought me back to life inside and I'm loving it. I now am living in a very nice two-bedroom apartment with two bathrooms."

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

"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. ...I had help, but I did it."

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I. Summary Tables[1]

Transitions to Community Living Initiative (TCLI) opens this year's report with a set of summary tables. While these do not cover all aspects of the program, the information they convey is emblematic of the work the State has done to advance core components of the program. These components are addressed in all monthly reports to the United States Department of Justice (DOJ).

Table 1. LME/MCO Totals for Start of 2018-19

LME/MCO	In-Reach Planning[2]	Transition Planning[3]	Individuals Housed (LOP[4])	Individuals Currently in Housing	RSVP[5] Screenings Processed	ACT[6] Served
Alliance Behavioral Healthcare	1059	60	271	218	246	1127
Cardinal Innovations	1661	54	623	476	498	1363
Eastpointe	659	14	208	140	187	347
Partners Behavioral Health Management	633	27	286	202	259	546
Sandhills Center	577	19	241	170	136	282
Trillium	904	10	273	187	252	316
Vaya Health	731	13	266	187	245	1298
Total	**6224**	**197**	**2168**	**1580**	**1823**	**5279**

Table 2. LME/MCO Supported Employment Totals for Start of 2018-19

LME /MCO	Fidelity Supported Employment Teams[7]	Teams Working Towards Fidelity	Total Served by Fidelity Teams	Total Served by all teams	Total Served by Fidelity Teams for the Priority Population
Alliance Behavioral Healthcare	6	0	798	798	339
Cardinal Innovations	6	0	999	1026	568
Eastpointe	4	0	581	581	84
Partners Behavioral Health Management	2	1	218	314	42
Sandhills Center	3	0	323	331	104
Trillium	7	0	634	634	361
Vaya Health	3	0	827	827	307
Total	**31**	**1**	**4378**	**4509**	**1805**

[1] Under the Department of Justice Settlment Agreement, the State is required to develop and utilize a template for published annual progress reports. The format of this Annual Report follows the basic template that the State has developed and uses each year, with some additions and improvements.
[2] In-Reach is an engagement, education and support effort designed to accurately and fully inform adults who have a serious mental illness (SMI) or a serious and persistent mental illness (SPMI) about community mental health services (including Individual Placement and Supported Employment (IPS-SE)) and Permanent Supportive Housing).
[3] TCLI transition planning assists individuals, identified through the In-Reach or diversion process, who voiced a desire to explore other possible opportunities for living in the community with individualized services and supports.
[4] LOP is Life of Program, the number of individuals placed in housing since the start of TCLI.
[5] As of November 1, 2018, the Referral Screening Verification Process (RSVP) replaced Pre-Admission Screening and Resident Review (PASRR). The RSVP tool screens individuals for TCLI eligibility.
[6] Assertive Community Treatment (ACT) consists of a group of community medical, behavioral health and rehabilitation professionals who use a team approach to meet the needs of an individual with severe and persistent mental illness.
[7] The foundation for this service definition is the Individual Placement and Support (IPS) evidence-based Supported Employment (SE) model and SE Fidelity Scale developed by the Dartmouth Psychiatric Research Center and promoted by the US Substance Abuse and Mental Health Services Administration (SAMHSA).

Table 3. LME/MCO Totals for End of 2018-19

LME/MCO	In-Reach Planning	Transition Planning	Individuals Housed (LOP)	Individuals Currently in Housing	ACT Served	Total receiving In-Reach or Transition Supports
Alliance Behavioral Healthcare	1075	49	408	291	773	65
Cardinal Innovations	1638	103	863	615	1014	416
Eastpointe	575	47	279	174	391	29
Partners Behavioral Health Management	670	17	392	264	602	222
Sandhills Center	516	7	323	233	362	36
Trillium	972	32	415	289	399	44
Vaya Health	699	30	358	248	1285	266
Total	**6145**	**285**	**3038**	**2114**	**4826**	**1078**

Table 4. LME/MCO Supported Employment Totals for 2018-19

LME/MCO	Fidelity Supported Employment Teams	Total Served by Fidelity Teams	Total Served by all Teams	Total Served by Fidelity Teams for the Priority Population
Alliance Behavioral Healthcare	6	932	932	392
Cardinal Innovations	8	1263	1290	680
Eastpointe	5	731	731	107
Partners Behavioral Health Management	2	320	425	93
Sandhills Center	4	545	563	151
Trillium	7	898	899	448
Vaya Health	4	940	944	351
Total	**36**	**5626**	**5781**	**2222**

Table 5. Summary of Transition Expenses

LME/MCO	Rent	TYSR	CLA
Alliance	1,148,163	$227,200	$571,571
Cardinal	3,316,655	$395,363	$450,907
Eastpointe	631,365	$130,722	$351,360
Partners	925,887	$187,706	$409,807
Sandhills	801,574	$156,444	$281,492
Trillium	1,164,231	$157,321	$282,160
Vaya	535,597	$137,416	$169768
Total	**8,523,472**	**$1,392,174**	**$2,517,066**

II. Housing

In FY 2018-19, the strong partnership between the NC Department of Health and Human Services (DHHS) and the Local Management Entity/ Managed Care Organizations (LME/MCO) yielded dividends. The State met the Settlement Agreement's target number for housing for the first time. The DHHS' continued use of Bridge Housing has also helped transitions to be timely and person-centered. Bridge Housing allows the LME/MCOs to stabilize individuals who are in need of immediate housing while they plan for living in the community. Over 85 percent of those individuals who utilized Bridge Housing were able to transition to living in the community. In FY18-19, the LME/MCOs began to administer their own Bridge Housing Programs. This allowed LME/MCOs to be more flexible and responsive to needs in their respective communities. Hotel stays have historically been used to assist in the transition to community-based housing and are part of Bridge Housing. DHHS also supported TCLI's housing efforts by providing additional funding to the LME/MCOs, advancing partnerships with temporary housing providers and expanding and establishing new contracts with community service providers.

Inspections of all potential housing units, employing Housing and Urban Development (HUD) Quality Standards (HQS), ensure safe, sanitary and secure housing for TCLI participants. This task is carried out by the LME/MCOs. Units are re-inspected annually, as well as on an ad hoc basis, if a health and safety issue arose or a tenant or support provider has cause to request a re-inspection. In FY18-19, $218,248 was spent to ensure housing units subsidized for TCLI participants met the HQS upon initial lease execution. Additionally, the Senior Advisor on the Americans with Disabilities Act (ADA) for DHHS visited individuals in the community all across the State and met with each LME/MCO to review processes and TCLI living situations.

The Community Living Integration Verification (CLIVe) system is now fully operational and actively utilized. CLIVe is a payment reimbursement system that supports LME/MCO housing activity by providing a mechanism to input data and receive reimbursement consistent with DHHS' established program policy and procedures. CLIVe also manages and organizes workflow, as well as serving as the system of record for Transition to Community Living Voucher (TCLV)[8] tenancies. Ultimately, CLIVe is the system of record for tenancies for all individuals participating in TCLI. The CLIVe system provides oversight functions that allow for quality review of the TCLV program. These include, but are not limited to, rental costs incurred by each LME/MCO; tracking of late inspections; a record of reasons for "move outs"; and length of stay in housing.

The Targeting Program is a partnership between North Carolina Housing Finance Agency (NCHFA) and DHHS to provide access to affordable housing for low income households in which people with disabilities reside. Properties developed using the federal Low-Income Housing Tax Credit (LIHTC) are required to participate in the Targeting Program. This means that LIHTC properties must set aside at least 10 percent, but no more than 20 percent of their units, and make them available for eligible participants as identified by DHHS. During June 2017, there were 4,866 housing units available upon turnover. In June 2018, there were 5,439

[8] This voucher provides a rental subsidy utilized to access quality affordable housing.

units available upon turnover, an expansion of 573 units. As of June 2019, more than 6,400 apartments in 814 properties across the state were set aside as Targeted units. An additional 1,000 units will be added by the end of 2020.

NCHFA and DHHS have redesigned Targeting Unit Agreements, Property Profiles, and Pre-Leasing Notifications and, additionally, instituted bi-weekly operational and monthly strategic meetings. Revisions to processes have made the Targeted Units more accessible to people in TCLI. To support substantial compliance with the Settlement Agreement, the Targeting Program has implemented a prioritization for TCLI participants. The Vacancy and Referral System creates real-time reports of all vacant units. As a result, DHHS housing coordinators can more efficiently offer TCLI participants units that meet their needs. As of June 2019, there were 606 TCLI households residing in Targeted Units.

Socialserve[9], https://www.socialserve.com, continues to contact landlords for satisfaction surveys. When landlords are dissatisfied, NCHFA follows up with the LME/MCO. LME/MCOs then conduct outreach to the landlord, service provider and/or tenant, resulting in saved tenancies. For purposes of Quality Assurance and Performance Improvement, the data is compiled and analyzed to track and trend the results, allowing DHHS to determine training needs, accessibility issues, areas of concern and successes. Socialserve also continues to provide assistance to LME/MCOs in landlord outreach and engagement.

In FY18-19, DHHS partnered with NCHFA to develop the Integrated Supportive Housing Program (ISHP), a program providing interest-free loans to community developments where up to 20 percent of the units are integrated and set aside for households participating in the TCLI program. These developments are affordable and integrated into the community, with a focus on access to services, grocery stores and other amenities. A total of 11 projects were awarded, bringing 144 additional set-aside units to communities throughout the state. At the end of FY19, DHHS and NCHFA were gearing up to release a Notice of Funds Available for a second round of ISHP funding, with funds committed from both DHHS and NCHFA. This collaborative effort will fund development of additional housing units in all seven LME/MCO catchment areas.

In FY18-19, DHHS worked with the LME/MCOs and Public Housing Agencies (PHA) throughout North Carolina to apply to HUD for funding for the Mainstream Voucher Program. These efforts brought the State approximately 246 additional vouchers, the majority of which resulted from the partnership between the LME/MCOs and PHAs. In late FY18-19, HUD funds again became available for the Mainstream Voucher Program. DHHS began a partnership with the Department of Administration Commission on Indian Affairs' Public Housing Authority and applied for 150 vouchers, with the goal of spreading these throughout counties with high housing need. LME/MCOs also collaborated with PHAs. The result was a significant increase in the number of vouchers requested. Partnerships with the 22 PHAs led to application for over 1200 vouchers. DHHS and the Technical Assistance Collaborative (TAC) provided significant technical assistance--including a webinar, telephonic question and answer sessions--and facilitated coordination between the LME/MCO and the PHAs in the application process. Final applications will be due, and awards announced in FY19-20.

[9] Socialserve is a nonprofit, bilingual call center that connects people to housing and provides supportive, second chance employment.

DHHS, in coordination with the TAC, released the TCLI Housing Pipeline. The Pipeline lays out processes and strategies to increase available housing throughout North Carolina. This tool will assist DHHS, NCHFA and the LME/MCOs in ensuring that the number of units and subsidies are sufficient to reach the Settlement Agreement goal of 3000 by 2021.

In April 2019, DHHS petitioned HUD, requesting a remedial preference for the life of the Settlement Agreement for individuals in TCLI. This remedial preference allows all NC PHAs to amend their administrative plans to ensure that individuals involved in TCLI are provided preference on their respective housing waitlists. The remedial preference was granted and DHHS will be working to implement preferences throughout North Carolina PHAs in FY20.

III. Community Mental Health Services

This year, TCLI has continued to focus on improving the quality of its services and has sought to involve LME/MCOs actively in the process. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) has been providing LME/MCOs with full, fidelity evaluation reports for both Assertive Community Treatment (ACT)[10] and Individual Placement and Support-Supported Employment (IPS-SE).[11] To support fostering growth in these areas of service delivery, DMH/DD/SAS facilitated the first round of LME/MCO ACT and IPS-SE fidelity report reviews. DMH/DD/SAS staff compiled the most recent fidelity evaluations into Excel documents and then used these to begin discussions focused on identifying the strengths and areas of growth for each service. We also reviewed quality areas to distinguish between results of LME/MCO practices and results of network-governed provider practices; tested our assumptions; and processed potential solutions when the performance issue stemmed from an LME/MCO practice. DMH/DD/SAS plans to continue monitoring, at a minimum of every six months. This will ensure that LME/MCOs are actively advancing quality improvement efforts--for themselves, for their provider network and for the services received by state- and Medicaid-funded participants in the TCLI program.

Assertive Community Treatment (ACT)

In FY18-19, LME/MCOs continued to embrace Assertive Community Treatment Teams as a vital service for TCLI participants. In June of 2019 alone, TCLI saw noteworthy increases in the use of the service by recipients: Cardinal increased by 373 recipients; Alliance by 286; Vaya by 62; Eastpointe by 54; Sandhills by 46; Trillium by 40; and Partners by 1.

Twenty-four (24) Assertive Community Treatment (ACT) teams were evaluated for fidelity, using Tools for the Measurement of Assertive Community Treatment[12] (TMACT). One

[10] An Assertive Community Treatment (ACT) team consists of a group of community medical, behavioral health and rehabilitation professionals who use a team approach to meet the needs of an individual with severe and persistent mental illness.
[11] The foundation for this service definition is the Individual Placement and Support (IPS) evidence-based Supported Employment model and Supported Employment Fidelity Scale developed by the Dartmouth Psychiatric Research Center and promoted by the US Substance Abuse and Mental Health Services Administration (SAMHSA).
[12] All ACT teams operate to fidelity using either the Dartmouth Assertive Community Treatment (DACTS) model or the Tool for Measurement of Assertive Community Treatment (TMACT).

evaluation was a second TMACT, following an initial TMACT in 2016, while the remaining 23 TMACTs were third evaluations. The table below shows the shifts in practice between the most recent TMACT evaluation and the evaluation previous to it.

Table 6. TMACT Evaluations

Certification Level	Team Score at Previous Evaluation	Team Score at State Fiscal Year (SFY) 2018-19 Evaluation
Exceptional Practice (4.2-5.0)	0	2
Full Certification (3.7-4.2)	18	14
High Provisional (3.4-3.6)	4	6
Low Provisional (3.0-3.3)	1	1
No Certification[13]	1	1

Overall scores for all ACT teams, statewide, are as follows:

Table 7. Statewide ACT Team Scores

Certification Level	Total number of ACT teams statewide
Exceptional Practice (4.2-5.0)	11
Full (3.7-4.2)	41
High Provisional (3.4-3.6)	19
Low Provisional (3.0-3.3)	2
No Certification	0

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

- Organizational structure to support fidelity
- Medical staff role and team integration
- Co-occurring disorders
- Agency leadership/team leaders
- Person-Centered Planning/Treatment Planning
- Tenancy Supports
- Assertive Engagement

[13] During this period, an agency assumed operation of an ACT team that had previously scored below a 3.0. Under new leadership, the team name changed, and their score improved to a 3.6. During the same period, an agency that previously scored a 3.6 scored a 2.9. The agency contested and but had not scored above the minimum established in contract. As a result, the agency had ACT removed from its contract.

With regard to ACT staff, the University of North Carolina (UNC) Center of Excellence continues to facilitate both trainings on working with people with mental illness and practice circles. Trainings and the practice circles are offered free of charge and assist staff's mastery of skills and competencies.

Community Support Team (CST)

TCLI is implementing innovative changes to the service definition for Community Support Team (CST)[14]. The changes to this definition have been made in part to:

- Accommodate the interventions/services that were being provided by Transition Management Services (TMS)[15] teams
- Make CST more clinical so that it can be an appropriate step-down service from ACT
- Clarify the outcomes that are expected from CST
- Improve the recovery orientation of the service and specify the psychiatric rehabilitation services that are to be provided

The purpose of this service is to provide direct treatment, restorative interventions and case management. It is designed to provide:

- Symptom stability
- Restorative interventions
- Psychoeducation
- First Responder intervention (24/7/365)
- Service coordination
- Linkage to community services/resources

The expected outcomes for this service are:

- Increased ability to function across major life domains
- Reduced symptomology
- Decreased frequency/intensity of crisis episodes
- Increased community participation (e.g., working, school, social activities)
- Increased ability to live independently
- Engagement in the recovery process
- Increased ability to self-manage triggers, cues, and symptoms

North Carolina has contracted with the Technical Assistance Collaborative (TAC) to provide intensive training and technical assistance to LME/MCOs, as well as to community service providers, during the rollout of this service. Intensive technical assistance to the LME/MCOs on the new Community Support Team service will ensure that it is implemented within a Permanent

[14] CST services consist of community mental health and substance abuse rehabilitation services and necessary supports provided through a team approach to assist adults in achieving rehabilitative and recovery goals.
[15] Transition Management Services (TMS) is a service provided to individuals participating in the Transition to Community Living Initiative (TCLI). TMS is a rehabilitation service intended to increase and restore an individual's ability to live successfully in the community by maintaining tenancy.

Supportive Housing framework.[16] TCLI's innovative service array and clear focus on implementation will give people the tools to obtain and successfully maintain housing in the community.

Individual Placement and Support - Supported Employment

North Carolina continues to engage in the Individual Placement and Support - Supported Employment (IPS-SE) International Learning Collaborative. This year, DMH/DD/SAS sent three staff to the international conference in Denver, Colorado. At this event, two staff facilitated break out groups on IPS-SE implementation in a managed care environment and implementation of IPS-SE in First Episode Psychosis teams. The State continues to benefit from participation in the Collaborative and it has the added benefit of providing researchers on IPS-SE at Westat direct access to staff.

Currently, 38 teams are providing IPS-SE services across the State. During SFY18-19, one team closed in Trillium and two teams in Sandhills merged under the same agency.

In FY18-19, 23 IPS-SE evaluations were completed. Of these, four were baseline/first reviews. The average baseline score for the year was 92 (Fair Fidelity). Of teams that had had a prior review, 15 of 19 (79%) increased their scores during this fiscal year. The average fidelity score for the 15 teams who improved was 97. Three teams saw scores decrease from their prior fidelity review, and one team's score remained the same. The average score for the four teams who saw their score decrease/remain the same was 88.5. For the year, the overall, average fidelity score for the 23 teams was 94.65.

Table 8. IPS-SE Fidelity Scores

Certification Level	Team Score at Previous Evaluation	Team Score at SFY18-19 Evaluation
Exemplary (115-125)	0	0
Good (100-114)	6	9
High Fair (90-99)	6	5
Low Fair (74-89)	11	4
No Certification	1	0

Overall, we have seen an improvement for the IPS-SE teams we have evaluated, with teams achieving IPS-SE fidelity scores at the following certification levels:

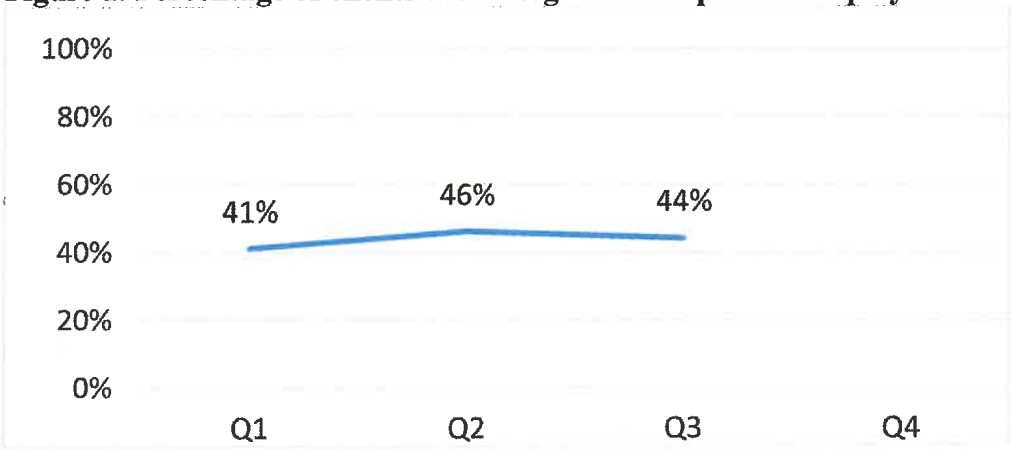
[16] Permanent Supportive Housing combines housing and services for people with low-incomes who have disabilities. This housing model aims to reduce homelessness, promote independence for people with disabilities, improve an individual's health and help individuals retain employment.

Table 9. IPS-SE Certification Levels

Certification Level	Total statewide number of IPS-SE teams[17]
Exemplary (115-125)	1
Good (100-114)	11
High Fair (90-99)	15
Low Fair (74-89)	10
No Certification	0

DMH/DD/SAS began tracking IPS-SE outcomes using the Dartmouth Quarterly Outcomes Report, with some minor modifications. There has been 100% reporting compliance for three quarters, and we can report the following information:

Figure 1. Percentage of clients with integrated competitive employment[18]



[17] The 38th team is new and has completed an initial fidelity evaluation.
[18] The data point in Figure 1 indicates that IPS-SE teams in NC are producing employment-related outcomes in line with national trends reported by Westat.

Table 10. Employment Rate by LME/MCO[19]

Provider Average	Q1	Q2	Q3
Alliance	39%	42%	41%
Cardinal	48%	45%	44%
Eastpointe	53%	41%	43%
Partners	43%	46%	28%
Sandhills	50%	47%	44%
Trillium	39%	43%	43%
Vaya	48%	48%	41%
All Providers	45%	44%	42%

Training for FY19-20 will focus on increasing knowledge and understanding of the IPS-SE model among LME/MCO In-Reach staff. An Adult Mental Health Team staff member from DMH/DD/SAS has been assigned as the lead for improving the connections among In-Reach, Transition and IPS. This position will develop linkages among In-Reach coaches; identify specific barriers encountered by IPS-SE teams; and work with IPS-SE teams, LME/MCOs, and In-Reach and Transition staff to remove barriers.

Another area of focus this year will be the IPS-SE Milestone Payment Pilot (NC CORE), a collaboration among the Division of Vocational Rehabilitation (DVR), DMH/DD/SAS, NC Medicaid, Vaya Health, and the IPS-SE teams in the Vaya network. Vaya's Milestone Payment Pilot will take current, federal and state fee-for-service funding[20] and shift these to an outcome-based reimbursement system. We anticipate this pilot going live on October 1, 2019.

In 2018-2019, trainings for Supported Employment included:

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[19] **Note**: Table 10 data points indicate that, as IPS-SE fidelity scores have increased, the integrated competitive employment rate is above the 35% employment rate for North Carolinians with disabilities.

[20] In DVR's milestone system, organizations are administered funds when an individual receiving services within their program has achieved designated goals or "milestones" on their way toward the goal of integrated competitive employment.

- Foundations of Supported Employment and Recovery
- Strengths-based services
- IPS-SE and DVR integration
- Case consultation
- Career profile development
- Vocational unit meeting
- Documentation and disclosure
- Employment Peer Mentor
- Benefits Counseling for Recovery
- Job Development

Personal Care Services

Personal care services (PCS) provides hands-on assistance for individuals with unmet needs for assistance with Activities of Daily Living (ADL). ADLs are activities such as bathing, dressing, toileting, ambulation, or feeding.[21] Access to PCS is a critical element for participants in the TCLI program to support a successful transition. The ability to perform activities of daily living impacts an individual's ability to function independently.

In 2016, NC Medicaid developed an expedited process for accessing personal care services for TCLI-eligible members. An expedited assessment entitles a person to an immediate review for eligibility for the service, once a request is faxed and the review is completed by phone. The addition of an expedited assessment is critical as people transition from an institution to the community. Many coming out of institutional settings have lost skills; others come with chronic illnesses that making navigating the community more difficult. Timely access to PCS is critical for ensuring success in the community.

If eligible, an individual is immediately, temporarily approved for up to 60 hours of PCS, and is sent to the primary care physician of their choice. If the person needs names of physicians in the area who conduct PCS-related assessments, they will be provided a list of doctors from which to choose. On average, TCLI participants who receive PCS get a total of 46 hours through the mini-assessment and an average of 39 hours during the full face-to-face assessment.

Deaf and Hard of Hearing Participants

TCLI strengthened its work in FY18-19 with the Division of Services for Deaf and Hard of Hearing (DSDHH). Building on its involvement with the NC Institute of Medicine's Task Force on Health Services for Individuals who are Deaf and Hard of Hearing Task Force, TCLI engaged with DSDHH's leadership around transitions to the community for deaf and/or hard of hearing individuals in the State's only psychiatric unit specific to this population, at Broughton Hospital. Working through the Barriers Committee, TCLI is promoting policies and practices designed to promote better communication access for deaf and hard of hearing participants in its program.

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[21] Set-up, supervision, cueing, prompting, and guiding, are included when provided as part of the hands-on assistance with qualifying ADLs. PCS also provides assistance with those home management Instrumentals of Daily Living (IADLs) that are directly related to the beneficiary's qualifying ADLs and essential to the beneficiary's support at home.

This includes consideration of the challenges to recruitment, retention and geographic access of participants to the interpreter workforce. Calling on the consultative skills of interpreters experienced in working in the mental health system, DSDHH, DMH/DD/SAS and TCLI will collaborate to assist LME/MCOs, TCLI coordinators, Broughton Hospital staff and providers to remove the unique service barriers encountered by deaf and hard of hearing TCLI participants.

Community Mental Health Service Patterns

This portion of the report summarizes Calendar Year (CY) 2017 and 2018 services data. This year's DHHS annual report includes CYs 17 and 18 Mental Health service claims data summaries for 1) individuals in supported housing, 2) individuals in in-reach, and 3) individuals within the 90-day window before transition, i.e., the transition planning period.

Analyses are based on NCTracks[22][23] Medicaid and DMH/DD/SAS paid professional (non-institutional) behavioral health service claims. Claims-based data are reported for calendar years rather than state fiscal years to allow sufficient lag time for claims processing after the end of the time period examined.

Claims data were retrieved for the following categories of TCLI participants:

- 1,549 individuals who were in Permanent Supportive Housing for one or more days of Calendar Year 2017 or who previously had been housed and subsequently were re-housed by April 2019.
- 2,046 individuals who were in Permanent Supportive Housing for one or more days of Calendar Year 2018 or who previously had been housed and subsequently were re-housed by April 2019.
- 10,363 individuals who had documented In-Reach during Calendar Years 2017 or 2018, including:
    - 1,437 who subsequently transitioned into Permanent Supportive Housing before April 2019, and
    - 8,926 who had not yet transitioned into Permanent Supportive Housing by April 2019.

[22] NCTracks is the multi-payer Medicaid Management Information System for the NC Department of Health and Human Services.

[23] The 2018 annual report claims summary was based on a combination of DMH/DD/SAS adjudicated claims from NCTracks and LME/MCO paid Medicaid claims that were collected through Community Care of North Carolina (CCNC). Due to known claims processing issues that resulted in incomplete data in the NCTracks system, year-to-year differences should be interpreted with caution. The exact degree of data completeness and the extent to which resulting service use estimates are affected are unknown. Up to 20 percent of Medicaid encounters may not be represented in NCTracks for some months in 2017, for example. This may have a greater impact on estimates of numbers of relatively rare events, such as hospital admissions and emergency department (ED) visits, compared to estimates of numbers of individuals who received ongoing services, for which the opportunity to "detect" a service based on the presence of a claim may be greater due to the larger number of claims. Timely filing limits also may affect the completeness of data currently available, especially for 2018 Medicaid encounters. For reasons such as these, the summaries presented here are most helpful for understanding general service patterns and the array of services provided.

Community Mental Health Service Use Patterns for Housed TCLI Participants

Table 11, below, shows numbers of housed individuals for whom NCTracks queries returned behavioral health claims, by LME/MCO and as percentages of individuals housed one or more days during 2017 or 2018 or later re-housed. By virtue of the method used to retrieve claims, one hundred percent of these individuals received one or more post-transition community mental health service in the calendar years examined.

These individuals first transitioned to Permanent Supportive Housing between 2 days and 5.1 years (2017) or 2 days and 6.1 years (2018) prior to the last day of the calendar year. On the last day of the calendar year, the average time since transition for these individuals was 1.5 years (2017) and 1.8 years (2018), with a median of 1.2 years (2017) and 1.5 years (2018).

Table 11. Housed Participant Populations for Community Mental Health Services Analysis[24]

Current LME/MCO on Record	CY 2017	CY 2018
Alliance Behavioral Health	191	276
Cardinal Innovations Healthcare Solutions	472	631
Eastpointe	123	168
Partners Behavioral Health Management	213	281
Sandhills Center	161	191
Trillium Health Resources	202	264
Vaya Health	187	235
Total	1,549	2,046
Individuals housed one or more days or later re-housed	1,586	2,107
Percent of possible	97.7%	97.1%

Table 12, below, shows numbers and percentages of individuals, counted in Table 12, who had paid claims for core, TCLI community mental health services and other supports. Participants in housing received a variety of other mental health and support services, including, for example, New and Established Outpatient Office Visits (5%, 32%, 2017; 5%, 33%, 2018); b(3)[25] Individual Supports (5%, 3%); Ambulatory, Outpatient, Social Setting, Inpatient Detox services (0.7% combined, both years); and Medication Assisted Treatment (0.7%, 0.6%).

[24]Individual participants and their associated service claims are summarized under the current LME/MCO, which may not be the LME/MCO that housed the individual and/or that managed the reported service. Approximately four percent of TCLI participants have transferred across catchment areas since initially transitioning to Permanent Supportive Housing.

[25] b(3) services are supports for individuals who have Medicaid. They are in addition to the services available to that person under the Medicaid State Plan. These services focus on helping individuals remain in their homes and communities and avoid hospitalization or living in an institution.

Table 12. Calendar Years 2017 and 2018 Community Mental Health Service Rates for Housed TCLI Participants

Calendar Year 2017	Transition Management Services[26] (TMS)		Assertive Community Treatment Team (ACT)		Community Support Team (CST)		Psychosocial Rehabilitation[27] (PSR)		Individual Placement and Support-Supported Employment (IPS-SE)[28]		Peer Support Services	
	N	%	N	%	N	%	N	%	N	%	N	%
Alliance	111	58%	80	42%	27	14%	16	8%	26	14%	11	6%
Cardinal	261	55%	205	43%	43	9%	50	11%	32	7%	93	20%
Eastpointe	76	62%	44	36%	13	11%	12	10%	3	2%	2	2%
Partners	96	45%	111	52%	18	8%	14	7%	11	5%	78	37%
Sandhills	90	56%	77	48%	7	4%	27	17%	11	7%	48	30%
Trillium	141	70%	65	32%	38	19%	21	10%	24	12%	70	35%
Vaya	88	47%	108	58%	31	17%	18	10%	10	5%	17	9%
Total	863	56%	690	45%	177	11%	158	10%	117	8%	319	21%
Calendar Year 2018	TMS		ACT		CST		PSE		IPS-SE		Peer Support Services	
	N	%	N	%	N	%	N	%	N	%	N	%
Alliance	157	57%	128	46%	45	16%	21	8%	35	13%	22	8%
Cardinal	358	57%	257	41%	65	10%	64	10%	41	6%	181	29%
Eastpointe	100	60%	54	32%	14	8%	17	10%	4	2%	17	10%
Partners	135	48%	144	51%	17	6%	23	8%	12	4%	96	34%
Sandhills	101	53%	89	47%	12	6%	24	13%	10	5%	57	30%
Trillium	191	72%	76	29%	36	14%	16	6%	55	21%	87	33%
Vaya	115	49%	125	53%	33	14%	23	10%	11	5%	49	21%
Total	1,157	57%	873	43%	222	11%	188	9%	168	8%	509	25%

[26] Transition Management Services (TMS) is a service provided to individuals participating in the Transition to Community Living Initiative (TCLI). TMS is a rehabilitation service intended to increase and restore an individual's ability to live successfully in the community by maintaining tenancy.
[27] Psychiatric Rehabilitation (Psychosocial Rehabilitation) is a rehabilitative service in a licensed facility designed to assist adults (age 18 and older) with psychiatric disabilities to restore their ability to live successfully in the community.
[28] IPS-SE, provided as a b(3) services under the Innovations waiver, was excluded in error from IPS-SE rates reported in the 2018 DHHS Annual TCLI Report.

Table 12. (cont.). Calendar Years 2017 and 2018 Community Mental Health Service Rates for Housed TCLI Participants

Calendar Year 2017	Psychological Diagnostic, Evaluation, and/or Testing		Psychotherapy (Individual, Group, and/or Family)		Mobile Crisis Management (MCM)		Facility-Based Crisis (FBC)		Substance Abuse Intensive Outpatient Program (SAIOP)		Substance Abuse Comprehensive Outpatient Treatment (SACOT)	
	N	%	N	%	N	%	N	%	N	%	N	%
Alliance	45	24%	48	25%	2	1%	9	5%	1	1%	1	1%
Cardinal	99	21%	78	17%	18	4%	8	2%	4	1%	5	1%
Eastpointe	26	21%	24	20%	3	2%	2	2%	5	4%	6	5%
Partners	37	17%	59	28%	15	7%	4	2%	1	0%	1	0%
Sandhills	58	36%	23	14%	6	4%	1	1%		0%	2	1%
Trillium	57	28%	59	29%	21	10%	4	2%	2	1%		0%
Vaya	38	20%	43	23%	11	6%	2	1%	2	1%		0%
Total	360	23%	334	22%	76	5%	30	2%	15	1%	15	1%
Calendar Year 2018	**Psychological Diagnostic, Evaluation, and/or Testing**		**Psychotherapy (Individual, Group, and/or Family)**		**MCM**		**FBC**		**SAIOP**		**SACOT**	
	N	%	N	%	N	%	N	%	N	%	N	%
Alliance	65	24%	68	25%	5	2%	7	3%	2	1%		0%
Cardinal	127	20%	118	19%	19	3%	6	1%	6	1%	5	1%
Eastpointe	36	21%	35	21%	10	6%	2	1%	6	4%	11	7%
Partners	54	19%	73	26%	14	5%	9	3%	1	0%	1	0%
Sandhills	45	24%	27	14%	3	2%	1	1%	1	1%	5	3%
Trillium	63	24%	71	27%	26	10%	5	2%	4	2%		0%
Vaya	43	18%	57	24%	25	11%	7	3%	5	2%		0%
Total	433	21%	449	22%	102	5%	37	2%	25	1%	22	1%

Community Mental Health Service Use Patterns for TCLI Participants During In-Reach and Transition Planning

Table 13 shows, by LME/MCO, the numbers of individuals who had one or more In-Reach contacts documented in the Transitions to Community Living Database (TCLD)[29] during Calendar Years 2017 and 2018; had not transitioned to Permanent Supportive Housing as of January 1, 2017; and matched to client data in the NCTracks claims data warehouse.[30] Analysis of services provided during In-Reach for these individuals is based on Calendar Years 2017 and 2018 behavioral health service claims, excluding the 90 days prior to transition for those who moved into Permanent Supportive Housing before April 1, 2019.

Calendar Years 2017 and 2018 claims for the subset of 14 percent of individuals who transitioned to Permanent Supportive Housing between January 3, 2017 and March 29, 2019 were retrieved for up to the 90 days prior to each individual's transition date. These claims were examined separately to evaluate services provided during the period that included transition planning. Services provided to the same individuals more than 90 days before their transition dates, are included in the summary of services provided during In-Reach.[31]

Table 13. In-Reach and Transition Planning Populations for Current Service Data Analysis

	Individuals with Calendar Year 2017 or 2018 In-Reach	Subset with Initial Transition to Permanent Supportive Housing before April 2019	
Current LME/MCO on Record		N	%
Alliance Behavioral Health	1,572	227	14%
Cardinal Innovations Healthcare Solutions	2,765	464	17%
Eastpointe	1,222	116	9%
Partners Behavioral Health Management	1,184	187	16%
Sandhills Center	881	122	14%
Trillium Health Resources	1,565	175	11%
Vaya Health	1,174	146	12%
Total	10,363	1,437	14%
Total number with documented In-Reach	10,738	1,437	13.4%
Percent of possible	96.5%	100%	

[29] Transition to Community Living Database (TCLD) is a system developed for the NC Department of Health and Human Services to track and report activity related to the TCLI. Those involved in the initiative use the system to record contact and progress of individuals affected by the initiative.

[30] An additional 273 individuals with initial transition dates of January 1, 2017 and earlier were excluded from this analysis. These individuals were previously housed and received In-Reach during the period examined after leaving housing and/or had post-transition visits documented as In-Reach contacts in error. Another 102 individuals with documented In-Reach contacts did not match to the claims data warehouse, either because they were not Medicaid enrolled with a valid Common Name Data Service (CNDS) Medicaid identification number or because of CNDS error.

[31] The length of the transition planning period may vary across individuals. Including services provided more than 90 days before transition in the In-Reach claims summary may result in slight overestimates of service rates, to the extent that transition planning extended beyond 90 days for some individuals.

Across the service period examined, 65 percent of 10,363 individuals with documented In-Reach received one or more community mental health service. Of the 1,437 individuals who subsequently transitioned to Permanent Supportive Housing before April 2019, 95 percent received one or more community mental health services prior to transitioning.[32]

Table 14 shows overall rates of any paid community mental health service claim for individuals with documented In-Reach, excluding the 90 days before transition, and limited to the period up to 90 days before transition to Permanent Supportive Housing for the subset who transitioned.

Table 14. Calendar Years 2017 and 2018 Community Mental Health Service Rates Among Individuals with In-Reach Contacts During Same Period

	Individuals with In-Reach		Subset with Transition Dates	
Current LME/MCO on Record	Number with Any MH Service	% of Total with In-Reach	Number with Any MH Service in 90 days Prior	% of Total with Transition
Alliance Behavioral Health	980	62%	200	88%
Cardinal Innovations	1,823	66%	441	95%
Eastpointe	561	46%	91	78%
Partners Behavioral Health	845	71%	165	88%
Sandhills Center	456	52%	98	80%
Trillium Health Resources	993	63%	161	92%
Vaya Health	841	72%	132	90%
Total	6,499	63%	1,288	90%

Table 15 shows numbers and percentages of individuals with paid claims for core, TCLI community mental health services and other supports. In addition, rates of new and established Outpatient Office Visits combined were 30 percent for individuals with documented In-Reach and 19 percent during the period up to 90 days before Transition. Smaller percentages of individuals received other services and supports, such as b(3) Individual Supports (1%, 3%); Detox services (1%, 0.3%); and Medication Assisted Treatment (0.3%, 0.6%) during In-Reach or in the 90 days prior to Transition.

As expected, individuals within 90 days of transition were much more likely to receive Transition Management Services. Also consistent with their lower rates of Psychotherapy and of Diagnostic, Evaluation, and Testing services, individuals in the 90-day pre-transition period were twice as likely, or more, as individuals in In-Reach to receive ACT, CST, IPS-SE, and Peer Support services. The mobile Crisis service rate was 75 percent lower for individuals within 90 days of transition and use of Facility Based Crisis beds was 67 percent lower. This is a significant finding that demonstrates the effectiveness of housing and supports overall.

[32] This percentage is based on all CY 2017 and 2018 service dates, including those prior to the 90-day pre-transition period. Percentages with any paid mental health service, including institutional claims, across the two-year claims period examined were 74% among all individuals with documented In-Reach and 99% for the subset who subsequently transitioned.

Table 15. Calendar Years 2017 and 2018 Community Mental Health Service Rates During In-Reach and Transition

In-Reach	Transition Management Services (TMS)		Assertive Community Treatment Team (ACT)		Community Support Team (CST)[33]		Psychosocial Rehabilitation (PSR)		Individual Placement and Support-Supported Employment (IPS-SE)		Peer Support Services	
	N	%	N	%	N	%	N	%	N	%	N	%
Alliance	67	4%	295	19%	172	11%	205	13%	33	2%	129	8%
Cardinal	64	2%	498	18%	151	5%	239	9%	38	1%	263	10%
Eastpointe	6	0.5%	112	9%	46	4%	106	9%	3	0.2%	15	1%
Partners	13	1%	237	20%	54	5%	110	9%	24	2%	139	12%
Sandhills	6	1%	83	9%	21	2%	52	6%	6	1%	27	3%
Trillium	61	4%	128	8%	97	6%	184	12%	51	3%	47	3%
Vaya	19	2%	364	31%	97	8%	122	10%	16	1%	158	13%
Total	236	2%	1717	17%	638	6%	1018	10%	171	2%	778	8%
Up to 90 Days Before Transition	TMS		ACT		CST		PSR		IPS-SE		Peer Support Services	
	N	%	N	%	N	%	N	%	N	%	N	%
Alliance	98	43%	79	35%	38	17%	19	8%	12	5%	11	5%
Cardinal	131	5%	197	7%	68	2%	27	1%	18	1%	109	4%
Eastpointe	11	10%	31	27%	13	11%	11	9%	0	0.0%	3	3%
Partners	33	18%	75	40%	16	9%	18	10%	6	3%	49	26%
Sandhills	23	19%	44	36%	11	9%	13	11%	2	2%	7	6%
Trillium	100	57%	47	27%	25	14%	10	6%	25	14%	30	17%
Vaya	26	18%	68	47%	16	11%	17	12%	4	3%	17	12%
Total	422	29%	541	38%	187	13%	115	8%	67	5%	226	16%

[33] See footnote 27.

Table 15 (continued). Calendar Years 2017 and 2018 Community Mental Health Service Rates During In-Reach and Transition

In-Reach	Psychological Diagnostic, Evaluation, and/or Testing		Psychotherapy (Individual, Group, and/or Family)		Mobile Crisis Management (MCM)		Facility-Based Crisis (FBC)		Substance Abuse Intensive Outpatient Program (SAIOP)		Substance Abuse Comprehensive Outpatient Treatment (SACOT)	
	N	%	N	%	N	%	N	%	N	%	N	%
Alliance	517	33%	308	20%	62	4%	121	8%	35	2%	8	0.5%
Cardinal	986	36%	789	29%	175	6%	53	2%	17	1%	16	1%
Eastpointe	257	21%	166	14%	47	4%	20	2%	28	2%	46	4%
Partners	445	38%	489	41%	158	13%	61	5%	3	0.3%	4	0.3%
Sandhills	247	28%	210	24%	39	4%	1	0.1%	7	1%	16	2%
Trillium	541	35%	450	29%	167	11%	36	2%	30	2%	12	1%
Vaya	409	35%	425	36%	162	14%	39	3%	5	0.4%	3	0.3%
Total	3402	33%	2837	27%	810	8%	331	3%	125	1%	105	1%
Up to 90 Days Before Transition	**Psychological Diagnostic, Evaluation, and/or Testing**		**Psychotherapy (Individual, Group, and/or Family)**		**MCM**		**FBC**		**SAIOP**		**SACOT**	
	N	%	N	%	N	%	N	%	N	%	N	%
Alliance	33	15%	28	12%	1	0.4%	6	3%	5	2%	1	0.4%
Cardinal	50	2%	72	3%	4	0.1%	2	0.1%	3	0.1%	0	0.0%
Eastpointe	22	19%	14	12%	1	1%	0	0.0%	3	3%	6	5%
Partners	20	11%	43	23%	4	2%	3	2%	1	0.5%	2	1%
Sandhills	27	22%	16	13%	4	3%	0	0.0%	1	1%	3	2%
Trillium	27	15%	32	18%	7	4%	1	1%	1	1%	1	1%
Vaya	18	12%	22	15%	4	3%	1	1%	1	1%	1	1%
Total	197	14%	227	16%	25	2%	13	1%	15	1%	14	1%

IV. In-Reach

In November 2017, DHHS approved and released the TCLI In-Reach/Transition manual, abbreviated In-Reach/Transitions to Community Living Tool and newly developed guidance documents for the LME/MCOs. The manual and all supporting documents have been placed on the DHHS website.

In FY18-19, DMH/DD/SAS hired two In-Reach coaches. The first began on October 22, 2018 and covers the following LME/MCOs and hospitals: Cardinal (South); Partners; Sandhills; Vaya; Central Regional Hospital and Broughton Hospital. The second began on November 5, 2018 and is assigned to Alliance; Cardinal (North); Eastpointe; Trillium; Central Regional Hospital and Cherry Hospital. Regional In-Reach coaches support the In-Reach Specialists across the State, working with LME/MCOs and State Psychiatric Hospitals, as well as coordinating statewide training and technical assistance efforts.

Regional In-Reach coaches shadowed In-Reach specialists from January 2, 2019 to June 30, 2019. Over the course of six months, the Regional In-Reach coaches shadowed In-Reach specialists and participated in approximately 80 visits/contacts. During the visits at the Adult Care Homes (ACHs), Regional In-Reach coaches assisted the In-Reach specialists with identifying strengths and barriers regarding their activities and operations. Regional In-Reach coaches provided education and technical assistance to ensure that the specialists have access to supports that enable them to improve practice and quality. The coaches also provided education to ACH staff, In-Reach specialists, transition staff, guardians and other identified stakeholders to assist in continued advocacy and recovery for adults with mental illness.

The following are examples of technical assistance that coaches have provided to In-Reach specialists:

- Educating In-Reach specialists to discuss the different services to which individuals are entitled while in an ACH.
- Clarifying for In-Reach specialists that individuals are not required to remain in the LME/MCO catchment area to receive services and supports.
- Training on how file a complaint with Division of Health Services Regulations (DSHR).
- Reinforcing In-Reach specialists' use of informational materials with TCLI participants.

DMH/DD/SAS In-Reach Lead and Regional In-Reach coaches continue to present Community Integration Planning (CIP) as an ongoing process that leads to the creation of the person-centered plan (PCP) and to provide technical assistance as needed. CIP was, for example, a topic of discussion at the LME/MCO TCLD Refresher training offered at Cardinal Innovations this year.

DMH/DD/SAS In-Reach lead and Regional In-Reach coaches continue to educate the LME/MCOs about the ACH Bill of Rights; how to contact the regional Long-Term Care Ombudsman; how to access the DHSR Complaint Intake Unit when filing a complaint; and how

to use the TCLI In-Reach/Transition Manual's section on *Individual Rights and Reporting Concerns*.

In FY18-19, DHHS changed the referral process utilized by social workers at the three State Psychiatric Hospitals. On November 1, 2018, State Psychiatric Hospital social workers began submitting In-Reach referrals through a new eligibility tool, the Referral Screening and Verification Process (RSVP), to expedite the initiation of In-Reach. Referrals through RSVP require no screening. The LME/MCOs receive real-time notification once each referral is submitted, so they can begin providing In-Reach. The adoption of the new RVSP eligibility process has significantly increased LME/MCO response time for referrals.

LME/MCOs improved their rate of contacts with TCLI participants. In FY18-19, all LME/MCOs ranged between 95% and 100% compliance with the Settlement Agreement requirement of In-Reach visits every 90 days.

An In-Reach Learning Collaborative, coordinated by Alliance Health and Cardinal Innovations Healthcare, began on April 30, 2018. This group met its first milestone by creating a Steering Committee comprised of In-Reach representatives from each LME/MCO. The In-Reach coaches participate in the Collaborative and assisted with planning the first annual conference. The First Annual In-Reach Learning Collaborative Statewide Conference, funded by TCLI, was held on April 11, 2019 in Morrisville, NC, with 75 people in attendance. The group heard from a nationally recognized speaker, Matthew Federici, on the role of peer specialists in systems transformation. Other topics included community inclusion and peer support; the community resiliency model; and an update on the Settlement Agreement. DMH/DD/SAS TCLI Project Manager; DMH/DD/SAS In-Reach Lead; and the regional In-Reach coaches all attended the conference. DHHS will continue to offer technical assistance and support to the Collaborative.

Figure 2. End of June 2019 Monthly Totals of Individuals in In-Reach Status by Population Category

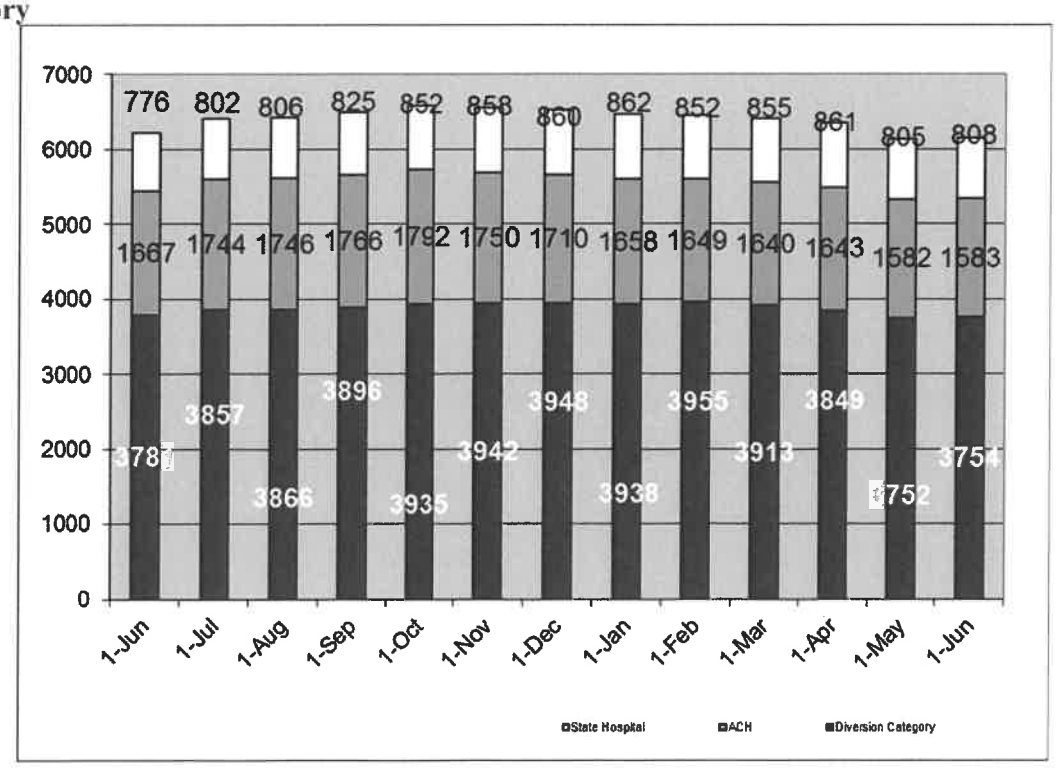


Table 16. In-Reach Type by LME/MCO in FY 2018-19

LME/MCO	In-Person Visits	Phone Call/Letter	Total Visits	Percent Face-to-Face Resulted in a Yes Decision	Percent Phone Call Resulted in a Yes Decision
Alliance Behavioral Healthcare	611	2545	3156	52.7%	8.9%
Cardinal Innovations	1409	3455	4864	45.7%	8.3%
Eastpointe	308	1641	1949	44.5%	3.2%
Partners Behavioral Health Management	1010	1891	2901	7%	1.8%
Sandhills Center	659	1515	2174	15.1%	.5%
Trillium	1022	2025	3047	22.9%	4.7%
Vaya Health	1343	2040	3383	4.9%	2%
Total	6362	15112	21474	24.7%	3.5%

V. Guardianship

Some individuals with SMI/ SPMI need decision-making supports, e.g., limited or full guardianship of the person or the estate, powers of attorney, or supported decision making.[34] To advance innovation in this area, TCLI has continued to partner with the Division of Aging and Adult Services (DAAS), DMH/DD/SAS, Division of Social Services (DSS) and the NC Council on Developmental Disabilities (NCCDD) initiative, Rethinking Guardianship. The workgroup for the Rethinking Guardianship initiative has grown to nearly 140 members over the four years of its funding. Among its members are, in addition to DHHS: clerks and assistant clerks of Superior Court; state legislators; local Department of Social Services directors and social workers; private and public guardians; elder law and disability attorneys; aging and disability advocacy and provider organizations; and families and individuals. The Steering Committee for Rethinking Guardianship, of which TCLI is a member, has met monthly to discuss issues and next steps.

Working together, Rethinking Guardianship has produced these results:

- Shared information on alternatives to guardianship. At the Rethinking Guardianship Summit of on February 25, 2019, a quarter of the clerks of court heard the American Bar Association's Erica Wood discuss less restrictive alternatives to guardianship and received materials on options to full guardianship. Subsequently, on August 27,

[34] Supported decision making (SDM) is an approach that allows people with disabilities to retain their decision-making capacity by choosing supporters to help them make choices. A person using SDM selects trusted advisors, such as friends, family members, or professionals, to serve as supporters. The supporters agree to help the person with a disability understand, consider, and communicate decisions, giving the person with a disability the tools to make her own, informed, decisions. SDM looks different for each person. It means finding tools and supports to help a person with a disability understand, make, and communicate her own choices. Examples of these tools might be: plain language materials or information in visual or audio form; extra time to discuss choices; creating lists of pros and cons; role-playing activities to help the person understand choices; and bringing a supporter into important appointments to take notes and help the person remember and discuss her options.

Rethinking Guardianship hosted "Supported Decision-Making and Less Restrictive Alternatives to Guardianship," with an audience inclusive of clerks of court.

- Collected more than 20 stories from individuals, family members, and professionals who have been impacted by guardianship, and used these to produce a common agenda for problem solving.
- Developed a website, http://rethinkingguardianshipnc.org, with Frequently Asked Questions (FAQs), stories of individuals and families and guardianship, and comprehensive resources on guardianship and its alternatives.
- Produced an educational video, *Understanding Guardianship*, for private guardians and particularly for families.
- Promulgated an informational brochure, *Rethinking Guardianship: An Introduction to Options.*
- Engaged nearly 300 guardianship stakeholders in a summit to learn about guardianship reform efforts in North Carolina and across the country, building awareness and support for legislative, policy and practice changes.
- Initiated a process to develop modifications to NCGS 35A to effect long-term changes in the guardianship system, promote less restrictive alternatives to guardianship, and ensure respect for the rights of individuals under guardianship and those facing guardianship.

The NCCDD will continue to advance alternatives to guardianship, beginning a new initiative in early 2020. TCLI will once again be at the table.

Other work relative to guardianship also continues. DAAS plays a critical role, contracting with private agencies to act as public guardians for individuals. DAAS and DMH/DD/SAS together present training quarterly, in locations across the State, to assist stakeholders who work with people who have mental illness to understand recovery and the importance of informed choice. During these trainings, a topic vital to TCLI, Permanent Supportive Housing, is reviewed along with an array of services and supports used to help TCLI participants and others to lead successful lives. LME/MCO staff are present in the trainings to explain how to navigate the service approval process. In addition, DAAS collaborates with individual county Departments of Social Services (county DSS) in their role as public guardians. DAAS also provides training, in collaboration with the Attorney General's office, for those local DSS staff members who are responsible for the day-to-day work of serving as a guardian.

TCLI has recently begun efforts to address the needs of individuals who express an interest in entering an Adult Care Home (ACH) or remaining in an ACH or State Psychiatric Hospital. TCLI seeks to ensure that each decision is an informed one. TCLI is developing a tool to establish that the information, experience and advice necessary to make a good decision has been made available to the individual.

TCLI continues to support and advance approaches to informed decision making. These are focused on education, improving practice standards and accountability. TCLI's work to support informed decision-making assists individuals to exercise their rights and to make the informed choices that pave the way to community.

VI. Transition

State fiscal year 2018-19 saw the highest number of housing slots issued in any fiscal year since the start of TCLI. There were 971 housing slots issued in 2019, compared to 732 in 2018. The year also saw the highest number of transitions into housing since the program's inception. In FY18-19, 978 individuals transitioned to Permanent Supportive Housing. Alliance and Cardinal were able to transition the most people in 2018-19. Both LME/MCOs share in common some characteristics that help to explain their success. For example, both have a large city in their catchment area and a TCLI program with a close nexus with care coordination. Five of the seven LME/MCOs were able to meet their required number of individuals living in permanent supportive housing.

The average amount of time to transition to the community decreased for every LME/MCO this year. In the previous year, 67% of individuals transitioned did so within 90 days. In FY18-19, 71% of individuals transitioned in a timely manner.

Reliance on Bridge Housing has aided transitions in occurring in a timely, person-centered manner. Bridge Housing allows the LME/MCOs to stabilize individuals who are in need of immediate housing while they plan to live in the community. One of the elements of Bridge Housing is utilization of hotels, which has proven to be an effective and successful tool in transitioning to community based permanent supportive housing. Formerly called the Targeted Unit Transition Program (TUTP), over the life of the program, 129 TCLI individuals have accessed the service, with 112 of those transitioning directly to permanent supportive housing, and another 11 transitioning to permanent supportive housing after leaving a hotel. In addition to using hotels, LME/MCOs have created innovative programs to aid in transitions from state psychiatric hospital and adult care homes. Over 85% percent of those individuals who utilized Bridge Housing ultimately were able to be placed.

In FY 18-19, an additional 978 individuals transitioned to Permanent Supportive Housing. Over the life of the program, 3038 individuals have successfully entered the TCLI Permanent Supportive Housing program and secured qualified housing. At the end of the fiscal year, a total of 2114 individuals transitioned to and were residing in Permanent Supportive Housing, exceeding the Settlement requirement for FY18-19.

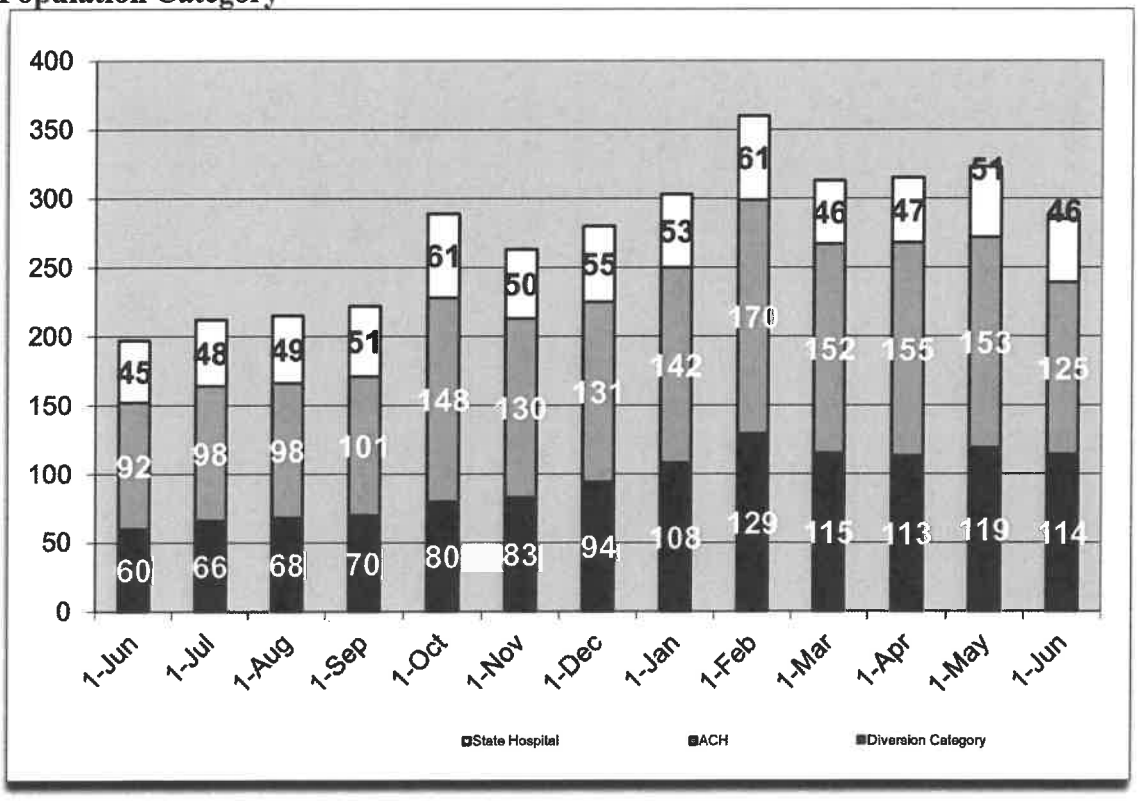
Table 17. LME/MCO Totals of Individuals in Housing by Population Category, Life of Program End of June 2018

LME/MCO	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5	Total
Alliance Behavioral Healthcare	5	117	9	183	94	**408**
Cardinal Innovations	28	444	16	77	298	**863**
Eastpointe	8	144	16	62	49	**279**
Partners Behavioral Health Management	23	203	21	46	99	**392**
Sandhills Center	4	183	15	60	61	**323**
Trillium	40	173	11	52	139	**415**
Vaya Health	23	214	32	16	73	**358**
Total	131	1478	120	496	813	**3038**

Table 18. LME/MCO Totals of Individuals in Housing by Population Category, Currently Housed End of June 2019

LME/MCO	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5	Total
Alliance Behavioral Healthcare	5	75	5	134	72	**291**
Cardinal Innovations	14	304	13	58	226	**615**
Eastpointe	5	77	12	48	32	**174**
Partners Behavioral Health Management	11	134	13	35	71	**264**
Sandhills Center	3	123	13	44	50	**233**
Trillium	19	111	9	36	114	**289**
Vaya Health	8	151	27	11	51	**248**
Total	65	975	92	366	616	**2114**

Figure 3. End of June 2019 Monthly Totals of Individuals in Transition Status by Population Category



VII. Diversion

In 2018-19, DHHS developed, trained, and implemented the Referral Screening Verification Process (RSVP). This process has replaced ACH PASRR, allowing LME/MCOs to expedite identification of people being considered for admission to an ACH, and opportunity to divert them. The RSVP differs significantly from its predecessor, PASRR, placing more responsibility on LME/MCOs to screen people for TCLI.

Initially, LME/MCOs saw numerous, inappropriate referrals come through RSVP, largely as a result of referral sources misunderstanding regarding the use of the new tool. Following LME/MCO training on the tool and in-person and phone consults along public access webinars for referral sources, these problems have substantially decreased. With more appropriate referrals now taking place, LME/MCOs are better able to manage the volume of referrals.

Table 19. Diversion Status[35] of Individuals with PASRR/ RSVP Screenings Processed for End of Fiscal Year 2018-19[36]

LME/MCO	Diverted (with and without slots)	Not Diverted	In Process	Withdrawn/ Removed	Total Diversion Attempts[37]
Alliance Behavioral Healthcare	36	50	256	53	395
Cardinal Innovations	27	198	339	55	619
Eastpointe	44	75	23	7	149
Partners Behavioral Health Management	17	155	57	8	237
Sandhills Center	58	57	40	2	157
Trillium	88	118	116	15	337
Vaya Health	84	199	221	43	547
Total	**354**	**852**	**1052**	**166**	**2441**

[35] Tableau is the datasource for obtaining Diversion data from TCLD.
[36] Due to State Psychiatric Hospital (SPH) not requiring a pre-admission screening, as of the 11/1/18 implementation of RSVP, SPH screening are no longer included in the Diversion Results
[37] Total Diversion attempts are the screenings that resulted in a determination of TCLI Eligible. Withdrawn/Removed includes deaths, moved out of state, does not meet criteria (dementia/Alzheimer's/TBI/IDD primary diagnosis).

Table 20. Cumulative Diversion Results from January 2013 through the end of June 2019[38]

LME/MCO	Diverted (with and without slots)	Not Diverted	In Process	Withdrawn/ Removed	Total Diversion Attempts[39]
Alliance Behavioral Healthcare	508	1013	263	165	1949
Cardinal Innovations	706	2036	465	347	3554
Eastpointe	326	900	23	46	1295
Partners Behavioral Health Management	305	1249	101	66	1721
Sandhills Center	262	723	43	24	1052
Trillium	411	1234	129	87	1861
Vaya Health	408	1396	226	115	2145
Total	**2926**	**8551**	**1250**	**850**	**13577**

VIII. Olmstead

To comply with the Americans with Disabilities Act's (ADA) integration mandate, a public entity must "reasonably modify" policies, procedures, or practices when necessary to avoid discrimination against people with disabilities. In a key case, stemming from Title II of the ADA, *Olmstead v. L.C.*[40], the US Supreme Court held that unjustified institutionalization of individuals with disabilities constitutes illegal discrimination on the basis of disability. It also held, however, that the right to receive services in the least restrictive environment is not unqualified. Specifically, the Court held that the failure of a state agency to place an individual with disabilities in a community-based setting, when it is medically appropriate and the individual so desires, is a violation of Title II of the ADA unless the state can prove that providing a community-based setting for the individual would be a fundamental alteration. The Supreme Court's *Olmstead v. L.C.* ruling suggested that a state would not be in violation of the ADA if it "were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable modifications standard would be met." As part of the reinvigoration of its Olmstead Plan, DHHS has placed staff on the TCLI team to assist in expanding TCLI's work

[38] See Note 34

[39] 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, was deceased, had a primary diagnosis of dementia, IDD, or was not SMI/SPMI, not medically or psychiatrically stable, or private pay (538). Totals also do not include any PASSR/RSVPs 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 (2066).

[40] 527 U.S. 581 (1999).

to other disability groups within the Department. In fall of 2019, TCLI released a Request for Proposals for technical support to assist in addressing the charge and will begin engaging stakeholders in Olmstead Plan development in early 2020.

IX. Quality Management

The State has designed its Quality Assurance System to ensure that community placements and services provided through TCLI are developed and delivered in accordance with the Settlement Agreement, and that individuals who receive services or housing slots, pursuant to the Agreement, are provided with the services and supports they need for their health, safety, and welfare. Development of a comprehensive Quality Assurance/ Performance Improvement (QA/PI) Plan was a key focus of State team efforts this year. The Plan is designed to ensure that all of the State's mental health and other services/supports are of good quality and are sufficient to help individuals achieve increased independence and greater community integration; obtain and maintain stable housing; avoid harm; and reduce the incidence of hospital contacts and institutionalization.

Quality Assurance System Structure

The State's Senior Advisor on the American Disabilities Act oversees the development and implementation of the QA/PI Plan. Quality assurance and performance improvement activities are planned, carried out, and evaluated by committees and agencies of DHHS, the North Carolina Housing Finance Agency, LME/MCOs and the External Quality Review Organization (EQRO)[41]. Primary Quality Assurance areas relate to substantive provisions of the TCLI Settlement Agreement, including Pre-Admission Screening and Diversion, Discharge and Transition, Permanent Supportive Housing, and community mental health services. Annual progress in these areas is described in other sections of this Annual Report. The fifth area, Participant Outcomes, is addressed later in this report section.

TCLI Oversight Committee

The DHHS established the TCLI Transition Oversight Committee (TOC) this year under the leadership of the Deputy Secretary for Behavioral Health and Intellectual and Developmental Disabilities, its chairperson. Through TOC, the DHHS' executive leadership provides guidance and monitors monthly progress in implementation of the Settlement Agreement. Each of the following entities report to the TOC on progress being made to achieve TCLI goals: Division of Health Benefits (NC Medicaid); Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS); Division of State Operated Healthcare Facilities (DSOHF); State Hospital Team Lead and CEOs; Money Follows the Person (MFP) Program; and LME/MCOs. The NC Housing and Finance Agency (NCHFA) and DHHS Divisions of

[41] An External Quality Review (EQR) is the analysis and evaluation by an external quality review organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that an MCO or PIHP, or their contractors, furnish to Medicaid recipients. An EQRO must meet the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review, other EQR-related activities as set forth in 42 CFR 438.358, or both.

Aging and Adult Services (DAAS), Vocational Rehabilitation (DVR) and Health Service Regulation (DHSR) report to TOC as needed.

DHHS Transition Team and Barriers Subcommittee

The state-level Transition Team was also formally established this year. This team offers state-level guidance and addresses barriers to transitioning to the community. The team oversees local transition teams to ensure that State Psychiatric Hospital facilities and their leadership and LME/MCO Transition Coordinators are adequately trained and that individuals are effectively informed of community opportunities. When individuals decide to remain in an Adult Care Home or State Psychiatric Hospital, this team monitors to ensure that individuals are informed about options; barriers to transition to a more integrated setting are identified; local teams attempt to address the barriers; and local team members continue to engage and educate the individual about community living options.

The Transition Team includes DHHS agency representatives who have expertise in the resolution of problems that arise during discharge planning and in the implementation of discharge plans. The team meets bi-monthly and includes staff from DMH/DD/SAS, NC Medicaid, DSOHF, DAAS, DHSR, DVR, Office of Rural Health, Division of Services for the Deaf and Hard of Hearing, and LME/MCOs. Other agencies are invited on an ad hoc basis.

The Barriers Subcommittee receives information related to In-Reach and person-centered discharge and community placement efforts, including successful and unsuccessful placements and problems transitioning individuals to, or maintaining individuals in, the most integrated setting. The Subcommittee reviews this information on a semi-annual basis; develops and implements measures to overcome barriers; and assists local transition teams to identify, address, and overcome identified barriers.[42]

TCLI Quality Assurance Committee

TCLI also established he Quality Assurance Committee this year. Chaired by the State's Senior Advisor on American Disabilities Act, the Quality Assurance Committee works with policy and program subject matter experts across DHHS to evaluate program data and assess the sufficiency of TCLI processes to meet substantive provisions of the Settlement Agreement. The committee provides input into TCLI requirements; content for LME/MCO annual Network Adequacy and Accessibility analyses, External Quality Reviews, and quarterly Intradepartmental Monitoring Team reviews; evaluates LME/MCO submissions and responses; and provides feedback and follow-up with LME/MCOs as needed. Committee members also aggregate, review, and analyze data to meet monitoring and reporting requirements and to ensure program quality. The Quality Assurance Committee includes representatives from the DHHS Secretary's Office, DMH/DD/SAS, NC Medicaid and NCHFA.

[42] The requirement for a semi-annual measure review stems from the Settlement Agreement and applies to in-reach, discharge, and community placement efforts i.e., to information on successful and unsuccessful placements; barriers to transition; and efforts to keep individuals in most integrated setting. Barriers data and separation review data are both reviewed semi-annually.

Local Management Entities/ Managed Care Organizations

The Department's contracted regional Lead Management Entities/ Managed Care Organizations (LME/MCOs) are responsible for managing service capacity and quality of publicly funded mental health, developmental disabilities, and substance abuse services and for oversight of network providers. Standard performance contract scopes of work include governance and capacity; business management and accounting; information management and data analysis; service claims processing and reimbursement; provider network management and monitoring; benefit plan management; consumer access and referrals; care coordination; community collaboration; customer service; and quality management.

Additional LME/MCO contract responsibilities are specific to TCLI. These include, but are not limited to, meeting annual TCLI housing goals; performing transition planning functions, including Diversion and In-Reach; providing and ensuring care coordination, person-centered service planning, and access and referrals to community mental health services; and monitoring services for the TCLI population.

DHHS monitors LME/MCO functions, services and identified gaps, as well as the implementation and success of LME/MCO strategies to address service gaps, using multiple methods and processes, including but not limited to: contract performance measures and reporting; consumer adverse incident reporting; LME/MCO management reports; annual LME/MCO Network Adequacy and Accessibility Analysis; Local Business Plans; Network Development Plans; LME/MCO quality management and performance improvement projects and consumer surveys; quarterly Intra-Departmental Monitoring Team reviews; and annual External Quality Reviews. LME/MCO TCLI gaps analyses are addressed in Section XI and Appendix B to this Annual Report.

Intra-Departmental Monitoring Team

The DHHS Intra-Departmental Monitoring Team (IMT) provides routine monitoring and oversight of LME/MCO contract functions. NC Medicaid leads the IMT, which includes DMH/DD/SAS and the LME/MCOs. The IMT also participates in External Quality Reviews and ensures the effective operation of LME/MCOs and compliance with state and federal requirements.

The IMT uses a Continuous Quality Improvement (CQI) approach to review LME/MCO performance. It routinely interprets performance indicators, reports and data, and timeliness of submission of reports. Monitoring objectives include identification of problems, deficiencies, and barriers to desired performance of contracted functions; development of improvement strategies; determination of need for Corrective Action Plans (CAPs); and monitoring of CAP implementation.

IMT Quarterly Monitoring reviews include TCLI-specific agenda items pertaining to service gaps and the initiatives to address them, as well as LME/MCO activities, barriers, and achievements relevant to key Settlement Agreement provisions.

External Quality Review Organization

The State's EQRO conducts annual reviews of mental health service system policies and processes. The EQR includes extensive review of LME/MCO documentation; staff and stakeholder interviews; and data validation, with focus on service monitoring, grievances and appeals, medical chart review, and individual provider follow-up. EQR provides the State with monitoring information related to LME/MCO marketing; program integrity; information made available to beneficiaries; grievances; timely access to services; Primary Care Provider /specialist capacity; coordination/ continuity of care; coverage/ authorization; provider selection; and quality of care. The EQR also includes TCLI-specific content. EQR findings are presented in Section X of this Annual Report.

Quality Assurance System Activities

The State's Quality Assurance System is designed to be comprehensive and ongoing. When fully implemented, it will cover all aspects of TCLI, inclusive of all substantive provisions of the Settlement Agreement. The system incorporates data from multiple sources for monitoring and evaluation of progress toward TCLI goals; program quality and effectiveness; and impacts of performance improvement activities. Ongoing QA/PI Plan activities correspond to four interrelated processes:

- **Data collection for ongoing monitoring** includes developing and implementing databases such as TCLD and RSVP, as well as tools and protocols for ongoing monitoring and evaluation, such as dashboard and contract performance measures.

- **Data aggregation, analysis, and evaluation** entails the use of data to evaluate the quality of services and supports and progress toward intended outcomes of increased integration, stable integrated housing, and decreased hospitalization and institutionalization. These processes are largely carried out by Quality Assurance system committees.

- **Quality assurance and performance improvement activities** involve the use of data to determine when action is needed to meet program goals, and the evaluation of performance improvement activities and outcomes. These activities may range from data cleaning and validation to revising service definitions.

- **Progress and performance reporting** consist of developing and publishing monitoring and progress reports, including internal reports, as well as monthly progress reports and this Annual Report.

Personal Outcomes

The State's approach to the measurement of personal outcomes flows from a best practice, articulated in the Settlement Agreement. Specifically, services are to "be flexible and individualized to meet the needs of each individual." This requires that measurement focus not on a standard of sufficiency of services based, for example, on the quantity, intensity, billing

units or the frequency of delivery of a service. Instead, TCLI's measures are centered on outcomes, designed to assess the quality of life of its participants. Key activities of the State's Quality Assurance System include collecting, monitoring, evaluating, and reporting data related to personal outcomes for participants. These outcomes generally relate to the State's use of institutional settings and its work to support quality of life and community integration for TCLI participants. In short, success may mean something different for each TCLI participant. Personal outcomes are, then, reflective of the program's capacity to tailor an array of services and supports to meet each participant's unique needs and, in doing so, to facilitate the successful transition of a particular person to a full life in his or her community. Collectively, these outcomes measure the success of TCLI as a whole.

Use of Institutional Settings

Institutional census tracking and length of stay are monitored through the State Psychiatric Hospital Healthcare Enterprise Accounts Receivable Tracking System (HEARTS)[43] and through the NCTracks claims data warehouse. State Psychiatric Hospital census, admissions, and discharge data are reported in Section IX of this report.

Analyses reported here with regard to State Psychiatric and Inpatient Psychiatric admissions/ re-admissions and Emergency Department visits/ repeat visits are based on Calendar Year (CY) 2017 and Calendar Year 2018 NCTracks paid Medicaid institutional claims and State Psychiatric Hospital and Alcohol and Drug Abuse Treatment Center (ADATC) admissions data from HEARTS. Institutional claims and encounters and State Psychiatric and ADATC admissions records were retrieved for all TCLI participants in Permanent Supportive Housing for one or more days of Calendar Years 2017 or 2018 and for TCLI participants who had previously been housed and were re-housed as of the end of April 2019.

State Psychiatric Hospital Admissions and Re-Admissions

Table 21 shows numbers admitted to a State Psychiatric Hospital in 2017 and the percentage that were re-admitted that year or the following year. Approximately 27 percent of admitted individuals in 2017 and 12 percent in 2018 were readmitted within the same calendar year. Forty-six percent of individuals with one or more 2017 admission were readmitted in 2018.[44,45]

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[43] HEARTS is the basis of reporting on State Psychiatric Hospital census, admission and discharge data.

[44] Updated 2017 HEARTS admission data and 2018 data were matched by CNDS number to TCLI participants in housing or who subsequently were re-housed. Admissions were included in the analysis if they occurred after individuals' initial transitions to Permanent Supportive Housing. Administrative re-admissions following direct discharges or transfers to and from medical visits or other facilities were excluded.

[45] Current year analyses incorporate a revised methodology and population definition that retains individuals who were not in Permanent Supportive Housing for the calendar years examined but who subsequently were re-housed. This revision may account for the larger number of 2017 admissions (2.6% of TCLI population) retrieved and reported in the current summary compared to the 2018 DHHS Annual Report (1.4% of TCLI population).

Table 21. Calendar Year 2017 and 2018 State Psychiatric Hospital Admissions and Re-Admissions

	Individuals with 2017 SPH Admissions	Percent of Housed	Subset with 2017 Re-Admissions	Individuals with 2018 SPH Admissions	Percent of Housed	Subset with 2018 Re-Admissions	Subset with 2017 to 2018 Re-Admissions
Alliance	11	5.8%	2	20	7.2%	2	6
Cardinal	6	1.3%	0	9	1.4%	0	1
Eastpointe	8	6.5%	3	18	10.7%	3	4
Partners	4	1.9%	0	7	2.5%	2	1
Sandhills	5	3.1%	3	4	2.1%	0	3
Trillium	5	2.5%	3	6	2.3%	1	3
Vaya	2	1.1%	0	3	1.3%	0	1
Total	41	2.6%	11	67	3.3%	8	19

Inpatient Psychiatric Admissions and Re-Admissions

Table 22 shows numbers of individuals with inpatient admissions and re-admissions within each calendar year, and numbers with 2018 re-admissions after one or more 2017 admission. Among individuals with 2017 and 2018 admissions, 33 and 36 percent were readmitted within the same calendar year. Thirty-seven percent of individuals with 2017 admissions had one or more 2018 admission.[46] Figures 4 and 5 show estimated numbers of participants with between one and seven or more admissions.

Table 22. Calendar Year 2017 and 2018 Psychiatric Inpatient: Community Hospital and Psychiatric Facility

	Individuals with 2017 Admissions	Percent of Housed	Subset with 2017 Re-Admissions	Individuals with 2018 Admissions	Percent of Housed	Subset with 2018 Re-Admissions	Subset with 2017 to 2018 Re-Admissions
Alliance	26	13.6%	6	39	14.1%	13	9
Cardinal	40	8.5%	13	78	12.4%	30	18
Eastpointe	19	15.4%	6	24	14.3%	8	7
Partners	36	16.9%	16	37	13.2%	14	15
Sandhills	24	14.9%	5	18	9.4%	5	5
Trillium	27	13.4%	12	49	18.6%	20	11
Vaya	24	12.8%	7	28	11.9%	9	7
Total	196	12.7%	65	273	13.3%	99	72

[46] Community Hospital and Psychiatric Facility claims were analyzed for participant admissions and re-admissions that occurred after individuals' transitions to housing. Series of claims for the same individual with consecutive service dates are counted as single events. Each new series of claims with consecutive dates is counted as a re-admission if the date of service is more than three days after the previous date of service. This method may result in overestimates of admissions due to claims lag and missing data and/or in underestimates in cases of true re-admissions within three days. Inpatient admission estimates also may be affected by missing data in NCTracks, especially for 2017 Medicaid encounters, and by timely filing limits, especially for 2018 Medicaid encounter claims.

Figure 4. Calendar Year 2017 Estimated Inpatient Psychiatric Admissions and Re-Admissions

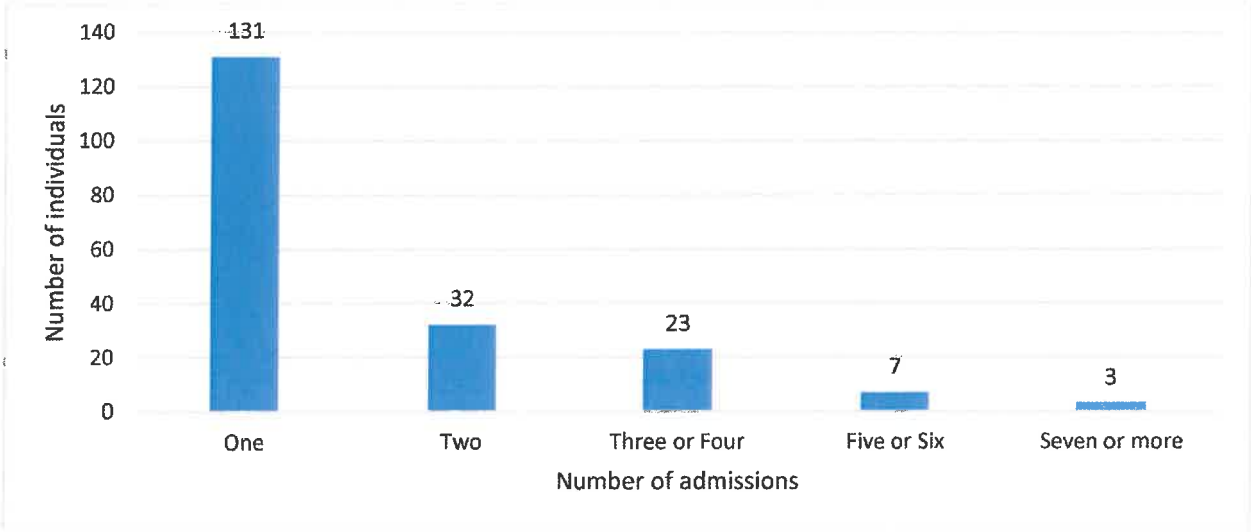
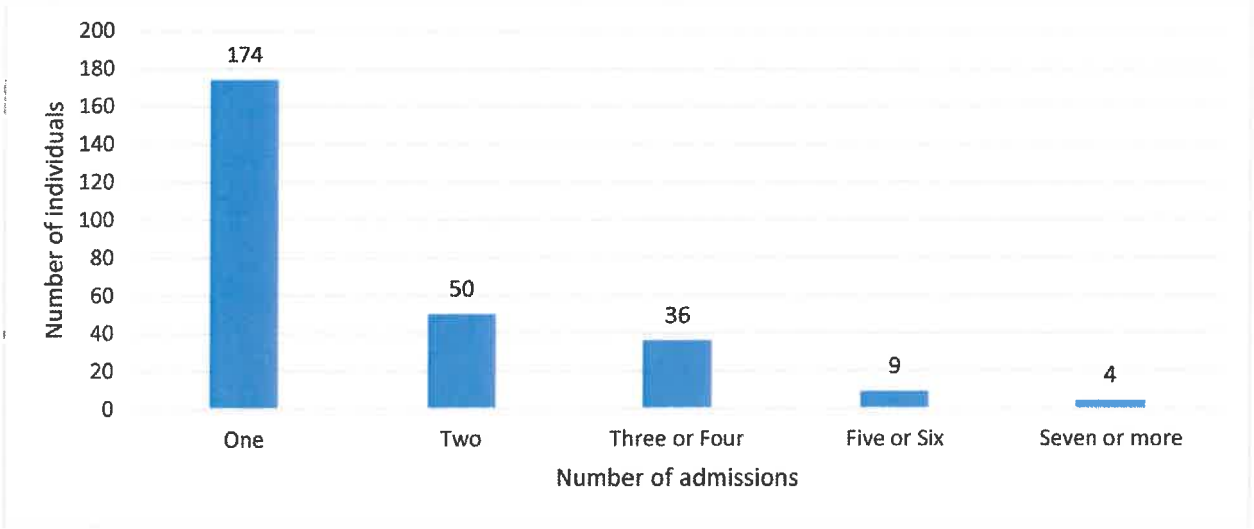


Figure 5. Calendar Year 2018 Estimated Inpatient Psychiatric Admissions and Re-Admissions



Emergency Department Visits and Repeat Visits

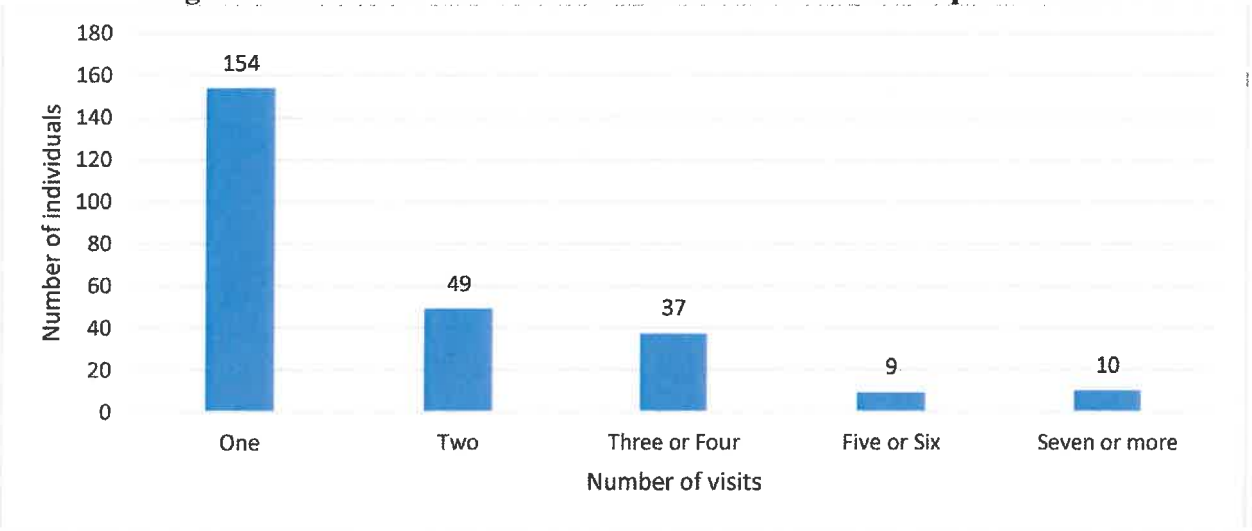
Table 23 shows numbers of individuals with paid claims for Emergency Department (ED) visits and repeat visits within each calendar year, and numbers with 2018 ED visits after one or more in 2017. Approximately 41 and 43 percent of individuals with 2017 and 2018 ED visits, respectively, had repeat visits within the same calendar year. Forty-three percent of individuals

with 2017 ED visits also had one or more 2018 visit.[47,48] Figures 6 and 7 show estimated numbers of individuals with between one and seven or more ED visits

Table 23. Calendar Year 2017 and 2018 Emergency Department Visits and Repeat Visits

	Individuals with 2017 ED Visits	Percent of Housed	Subset with 2017 Repeat Visits	Individuals with 2018 ED Visits	Percent of Housed	Subset with 2018 Repeat Visits	Subset with 2017 to 2018 Repeat Visits
Alliance	27	14.1%	13	58	21.0%	23	14
Cardinal	77	16.3%	29	118	18.7%	50	35
Eastpointe	21	17.1%	12	34	20.2%	18	13
Partners	36	16.9%	12	44	15.7%	19	8
Sandhills	30	18.6%	12	35	18.3%	10	13
Trillium	40	19.8%	17	47	17.8%	23	13
Vaya	28	15.0%	10	35	14.9%	15	15
Total	259	16.7%	105	371	18.1%	158	111

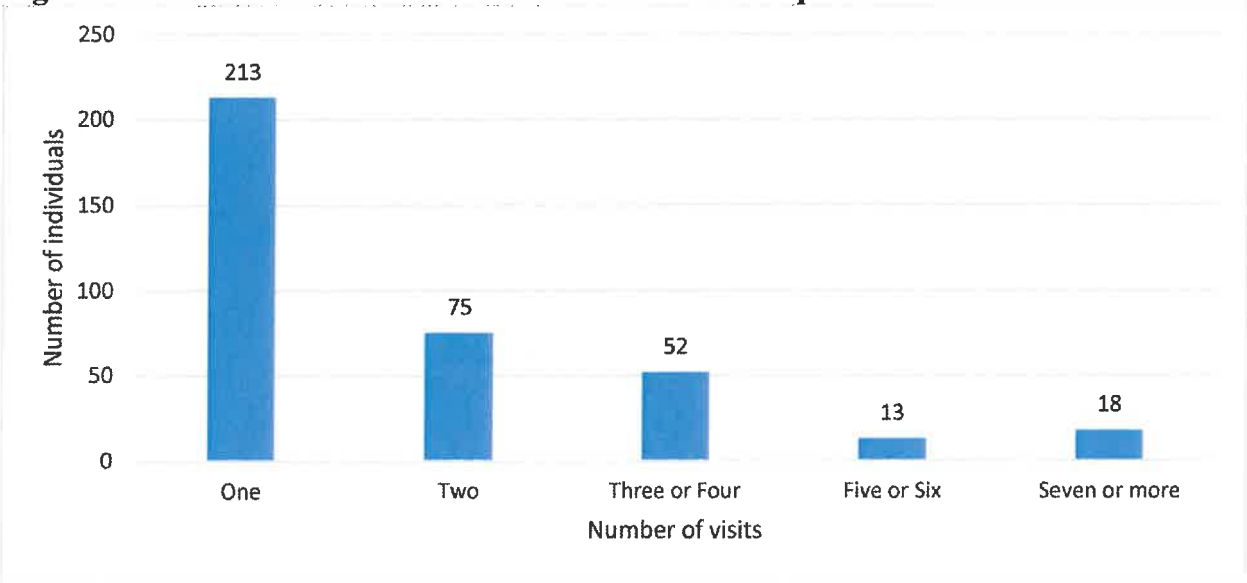
Figure 6. Calendar Year 2017 Estimated ED Visits and Repeat Visits



[47] Emergency Department claims were analyzed for participant visits and repeat visits that occurred after individuals' transition dates. Claims for the same individual with consecutive service dates are counted as single events. Each new series of claims with consecutive dates is counted as a repeat visit if the date of service is more than three days after the previous date of service. This method may result in overestimates due to claims lag and missing data and/or in underestimates in cases of true repeat visits within three days. ED visit estimates also may be affected by missing data in NCTracks, especially for 2017 Medicaid encounters, and by timely filing limits, especially for 2018 Medicaid encounter claims.

[48] This analysis is limited to standalone behavioral health-related ED visits that do not overlap or immediately precede (result in) psychiatric inpatient admissions reported in the previous section.

Figure 7. Calendar Year 2018 Estimated ED Visits and Repeat Visits



Other Crisis Bed Use

As reported in the Section III of this Annual Report, NCTracks service claims analysis indicated that two percent of housed individuals in both CY 2017 and CY 2018 used Facility Based Crisis beds. Table 24 shows ADATC admissions for 0.6 percent of the population in both years, and few re-admissions within or across calendar years.

Table 24. Calendar Year 2017 and 2018 Alcohol and Drug Abuse Treatment Center Admissions and Re-Admissions

	Individuals with 2017 ADATC Admissions	Percent of Housed	Subset with 2017 Re-Admissions	Individuals with 2018 ADATC Admissions	Percent of Housed	Subset with 2018 Re-Admissions	Subset with 2017 to 2018 Re-Admissions
Alliance		0.0%		1	0.4%		
Cardinal	3	0.6%	1	2	0.3%		
Eastpointe	2	1.6%		1	0.6%		
Partners		0.0%		2	0.7%		
Sandhills		0.0%		1	0.5%		
Trillium		0.0%		2	0.8%		
Vaya	4	2.1%		3	1.3%	1	1
Total	9	0.6%		12	0.6%		

Community Integration and Quality of Life

TCLI participant quality of life is assessed through standardized surveys administered to individuals during the transition planning period and again at 11 and 24 months after transition.

An updated summary of results for surveys administered through SFY 2019 is presented in Appendix A to this Annual Report.

In all LME/MCOs, individuals who transitioned to Permanent Supportive Housing reported more positive perceptions and experiences than individuals surveyed prior to transition. Analysis of the same individuals' responses across the three survey points (pre-transition and at 11 and 24 months, post-transition) confirms improvements in reported quality of life and satisfaction after transitioning to Permanent Supportive Housing, and of maintenance of those gains through the second year in housing.

Survey results from the most recent year again indicate positive perceptions and experiences among most individuals in Permanent Supportive Housing. This relates to areas such as services and staff support; housing; and choice and control in daily activities. While greater percentages of housed individuals reported positive experiences in virtually every domain queried, substantial numbers also reported obstacles to health and wellness, meaningful day, community integration, and natural supports.

Community Integration and Engagement in Community Life

This year's annual report includes Quality of Life survey data on community integration and engagement in community life, inclusive of information on daily activities, employment, school attendance, and natural supports networks.

Results of analysis of Quality of Life Survey items most related to community integration is also reported in Appendix A. On average, 19 percent more individuals in housing compared to those surveyed pre-transition reported satisfaction with daily activities, having enough to do, and going out into the community to do things when they want or choose.

Pre-transition and housed individuals did not differ, on average, in the number of daily activities they reported as typical; however, they did differ in the rates at which they selected specific activities. More individuals in housing selected cooking/cleaning, and fewer selected physical activity, work, volunteering, and socializing, although the rate of socializing at 24 months was higher than at 11 months. Percentages who said they go into town/community did not differ by transition status.[49] Significantly lower percentages of individuals in housing said that doing nothing/sitting around/resting/sleeping were typical daily activities.

People Employed or Attending School[50]

Reports of work and school as typical daily activities in Quality of Life survey responses were lower among individuals in housing compared to those surveyed before transition. Five percent

[49] However, as reported immediately above, significantly larger percentages of individuals in supportive housing did report going out into the community to do things *when they want or choose*.

[50] Effective October 2019, NC-TOPPS assessments will be required for TMS as well as for ACT and other enhanced services, with the effect that more outcomes data will be available on a more frequent basis for virtually all TCLI participants in supportive housing. NC-TOPPS assessments are administered by provider agency staff and include outcomes related to work, educational program enrollment, and other social determinants and outcomes. When available, data from these assessments will be used to enhance monitoring of these and other personal outcomes, potentially to include problems interfering with daily functioning, participation in positive community activities, thoughts of self-harm and suicide, criminal justice system involvement, readiness to address recovery, mental health symptoms, and functioning in other major life domains.

of 11-month survey respondents and six percent of 24-month respondents reported work as a typical daily activity, compared to 15 percent of pre-transition respondents. Six and four percent of individuals at 11 and 24 months reported performing odd jobs, compared to 13 percent pre-transition. Three and four percent of 11-month and 24-month respondents reported school, compared to six percent prior to transition, although this was not a significant difference.

Natural Supports Networks

Analysis of Quality of Life survey items related to the strength of individuals' community and natural supports networks indicates that an average of 10 percent more survey respondents in housing reported positive experiences and perceptions. Larger percentages of housed individuals reported visiting or talking in the past 30 days with family or friends who support their recovery; having someone to talk to when sad, angry, upset or lonely; and that family or friends help them become the person they want to be. Individuals in Permanent Supportive Housing were approximately one-third less likely to report feeling lonely in the past week.

Time Spent in Congregate Day Programming

Calendar Years 2017 and 2018 rates of Psychosocial Rehabilitation service use for individuals in housing are reported in Section III of this report. Results of additional analysis of paid NCTracks claims for PSR are shown in Table 25.

Table 25. Calendar Year 2017 and 2018 Time in Congregate Day: Psychosocial Rehabilitation[51]

	N (2017)	Average Duration (Weeks)	Average Total Hours	Average Hours/ Week	N (2018)	Average Duration (weeks)	Average Total Hours	Average Hours/ Week
Alliance	16	16.1	277.2	19.5	21	18.1	262.7	15.3
Cardinal	50	26.9	280.5	12.5	64	30.0	338.9	13.2
Eastpointe	12	21.9	523.9	24.4	17	28.3	564.9	20.6
Partners	14	21.5	267.6	11.9	23	26.9	379.3	14.0
Sandhills	27	23.3	464.0	19.8	24	31.0	588.8	18.4
Trillium	21	21.6	258.7	13.2	16	26.8	364.8	12.9
Vaya	18	18.1	256.9	17.9	23	28.5	267.2	11.4
Total	158	22.6	323.3	16.0	188	27.8	381.1	14.6

[51] Time spent in congregate day programming is expressed both in terms of duration, the length of the interval between the earliest and latest PSR service claim dates of service within the calendar year, and as average hours spent in PSR per week for the duration of the service. Each reimbursed 15-minute service unit is converted into hours and aggregated to derive each individual's total hours of PSR in the calendar year. Time spent in PSR is expressed as the average number of PSR hours per week. Average hours of PSR per week was previously calculated for the 2018 DHHS Annual Report based on the number of calendar year days each individual was in housing rather than on the length of the service interval.

Community Tenure and Separation

For the life of the program, 69.5 percent of individuals transitioned to Permanent Supportive Housing were in that housing at the end of SFY 2019, with an average of 657 days (1.8 years) from their initial transition dates. For those no longer in housing, the average length of time from the initial transition was 476 days.

The State also tracks where people go after they leave housing or leave the TCLI program. Over the life of the program, 924 individuals left supportive housing. Of that number, 223 returned to an ACH. In-Reach services were provided to those individuals who moved or returned to ACHs, and a substantial proportion were subsequently re-housed.

In fiscal year 18-19, TCLI staff began conducting clinical reviews of the files of individuals who had recently left housing. TCLI's efforts will identify reasons that people separate from housing and assist in generating systemic improvements. The first round of these reviews and a statewide summary will be completed in early fiscal year 19-20. These reviews focus on the intensity, duration, and access to services by TCLI recipients, helping to ensure that appropriate services and plans are in place when individuals transition to the community.

Table 26 shows numbers and percentages of individuals in housing three months to two years after the initial transition date. Table 27 shows attrition rates by year. Table 28 shows the total number of individuals who have left housing over the life of the program, including numbers and percentages deceased or who returned to Adult Care Homes or other facilities.

Table 26. Life of Program Maintenance of Housing[52]

Threshold	Total Possible	Total that have stayed in housing this long	Percent to meet this threshold
Not Applicable[53]	278		
3 Months	2755	2619	95%
6 Months	2473	2210	89.3%
1 Year	2059	1630	79.2%
1.5 Years	1676	1209	72.1%
2 Years	1337	883	66%

[52] The State has defined "maintenance of chosen community arrangement," a requirement in the Settlement Agreement, as tenure in supported housing.

[53] Not Applicable refers to those individuals who were placed less than three months ago and thus aren't applicable for this table.

Table 27. Based on Attrition Rate/Year Housed

Year Housed	Number housed in relevant year	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
2012-13	46	2%	15%	11%	11%	8%	9%	11%
2013-14	201	n/a	10%	21%	11%	9%	9%	4%
2014-15	210	n/a	n/a	7%	16%	11%	14%	10%
2015-16	331	n/a	n/a	n/a	10%	16%	14%	11%
2016-17	600	n/a	n/a	n/a	n/a	10%	21%	14%
2017-18	692	n/a	n/a	n/a	n/a	n/a	9%	21%
2018-19	971	n/a	n/a	n/a	n/a	n/a	n/a	8%

Table 28. Life of Program Housing Separation Outcomes and Destinations, End of 2018-19

Outcome or Destination	N	Percent
Adult Care Home	233	25.2%
Alternative Family Living (Unlicensed)	7	0.8%
Adult Living Facility	17	1.8%
Deceased[54]	202	21.9%
Family/Friends	116	12.6%
Hospice	2	0.2%
Independent	182	19.7%
Jail/Prison	49	5.3%
Medical Hospital	27	2.9%
Mental Health Group Home	27	2.9%
Skilled Nursing Facility	18	1.9%
State Psychiatric Hospital	26	2.8%
Substance Use Facility	14	1.5%
Unknown	11	1.2%
Total	924	

Incidents of Harm

The State's Incident Response and Improvement System (IRIS) is a web-based, incident reporting system for reporting and documenting responses to adverse incidents involving individuals receiving mental health, developmental disabilities and/or substance use disorder services. Incidents are defined as "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."

[54] Average age of death was 57 years.

Level I incidents are events that, in isolated numbers, do not significantly threaten the health or safety of an individual but could indicate systematic problems if they were to occur frequently. Level I incidents are not submitted to the IRIS.[55]

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.

Incidents types include 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; and Fire.

Incidents involving TCLI participants are retrieved, reviewed, and reported in aggregate on a monthly basis. Table 29 summarizes by LME/MCO the number of incidents returned each month.

Table 29. Aggregate Number of Level II and III Incidents Reported in IRIS, SFY18-19

LME/MCO	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Alliance Behavioral Health			2	1	2	2	5		2	1	2	0	17
Cardinal Innovations	2	0	4	0	1	2	3	4	4	1	6	1	28
Eastpointe	2	2	1	0	1	0	0	0	0	0	0	0	6
Partners Behavioral Health	2	0	0	0	0	0	1	0	0	0	0	0	3
Sandhills Center	0	0	4	2	6	2	1	1	3	2	3	5	29
Trillium	3	1	0	1	2	0	2	0	1	1	0	1	12
Vaya Health	4	0	2	5	1	0	1	1	2	2	1	2	21
Total	**14**	**3**	**13**	**9**	**13**	**6**	**12**	**6**	**13**	**7**	**12**	**9**	**116**

[55] Level I incidents are documented on the provider agency's internal forms. For more information on incident response, see the DMH/DD/SAS' Incident Response and Report Manual at https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/incidentmanual2-25-11.pdf.

Table 30. Costs to Transition Individuals

LME/MCO	Rent	TYSR	CLA
Alliance	$1,148,163	$227,200	$571,571
Cardinal	$3,316,655	$395,363	$450,907
Eastpointe	$631,365	$130,722	$351,360
Partners	$925,887	$187,706	$409,807
Sandhills	$801,574	$156,444	$281,492
Trillium	$1,164,231	$157,321	$282,160
Vaya	$535,597	$137,416	$169768
Total	**$8,523,472**	**$1,392,174**	**$2,517,066**

Sixty six percent (66%) of participants' monthly rental payments are funded through the TCLI program. The other 33% of participants have rental vouchers funded through other programs. Transition Year Stability Resources (TYSR) is used to purchase items necessary to set up individual apartments upon moving to community living. Community Living Assistance (CLA) is a need-based cash assistance program provided to individuals on a short-term basis to provide living expenses. Table 30, above, shows the amount of money spent on these in FY 2018-2019.

X. State Psychiatric Hospitals

Table 31. Hospital Census for Fiscal Year 2018-19[56]

Fiscal Year 2018-19	Admits	Discharges	Average Daily Census
Broughton	**281**	**290**	**256**
Adult Admissions	226	204	111
Adult Long Term	6	35	87
Geriatric	7	18	37
Medical Unit	21	12	9
Deaf Unit	21	21	11
Cherry	**679**	**660**	**205**
Adult Admissions	639	508	71
Adult Long Term	4	114	98
Geriatric	22	20	21
Medical Unit	14	18	13
CRH	**762**	**768**	**340**
Adult Admissions	590	533	145
Adult Long Term	0	59	74
Geriatric	53	54	37
Medical Unit	47	47	4
Forensic Unit	72	75	76
Total	**1722**	**1718**	**800**

[56] 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 Psychiatric 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 LME/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.
-Adult Long-Term Units typically do not take direct admissions. Instead, they take transfers from the admissions units. These are approximately equal to the discharges from the long-term unit.

Table 32. Hospital Discharge Data for Fiscal Year 2018-19[57]

Discharge Destination	Broughton	Cherry	CRH	Grand Total
TCLI Housing	9	4	20	33
TCLI Bridge Housing			2	2
Private Residence	96	364	305	765
Adult Care Home	43	65	45	153
Correctional Facility	56	67	99	222
5600 Group Home	13	36	92	141
Homeless Shelter	6	29	26	61
Hotel	3	11	20	34
Alcohol and Drug Abuse Treatment Center	3	13	4	20
Psychiatric Community Hospital	1	1	10	12
Developmental Disability Center	1	1	3	5
Therapeutic Home			1	1
Skilled Nursing Facility	5	4	3	12
Therapeutic Community		2		2
Neuro Medical Center			6	6
IDD Group Home	3	12	3	18
Halfway House	1	14	10	25
Boarding House	1	13	14	28
Community Hospital		1		1
Hospice	1			1
Alternative Family Living	5	4	2	11
Deceased	1	2	5	8
Community Detox Center	1			1
Oxford House	1		3	4
Veteran Administration Hospital			2	2
Community PRTF			1	1
Veteran Administration Skilled Nursing Facility	1			1
Cross Area Service Provider			1	1
Supported Living			1	1
Total	**251**	**643**	**678**	**1572**

[57] This table provides information about the setting to which individuals were discharged directly from State Psychiatric Hospitals. The data does not capture people that the hospitals referred to the LME/MCOs, whom the LME/MCOs subsequently discharged to an available location prior to transitioning to TCLI Permanent Supportive Housing.

Figure 8. Individuals who Started In-Reach in a State Psychiatric Hospitals for Fiscal Year 2018-2019

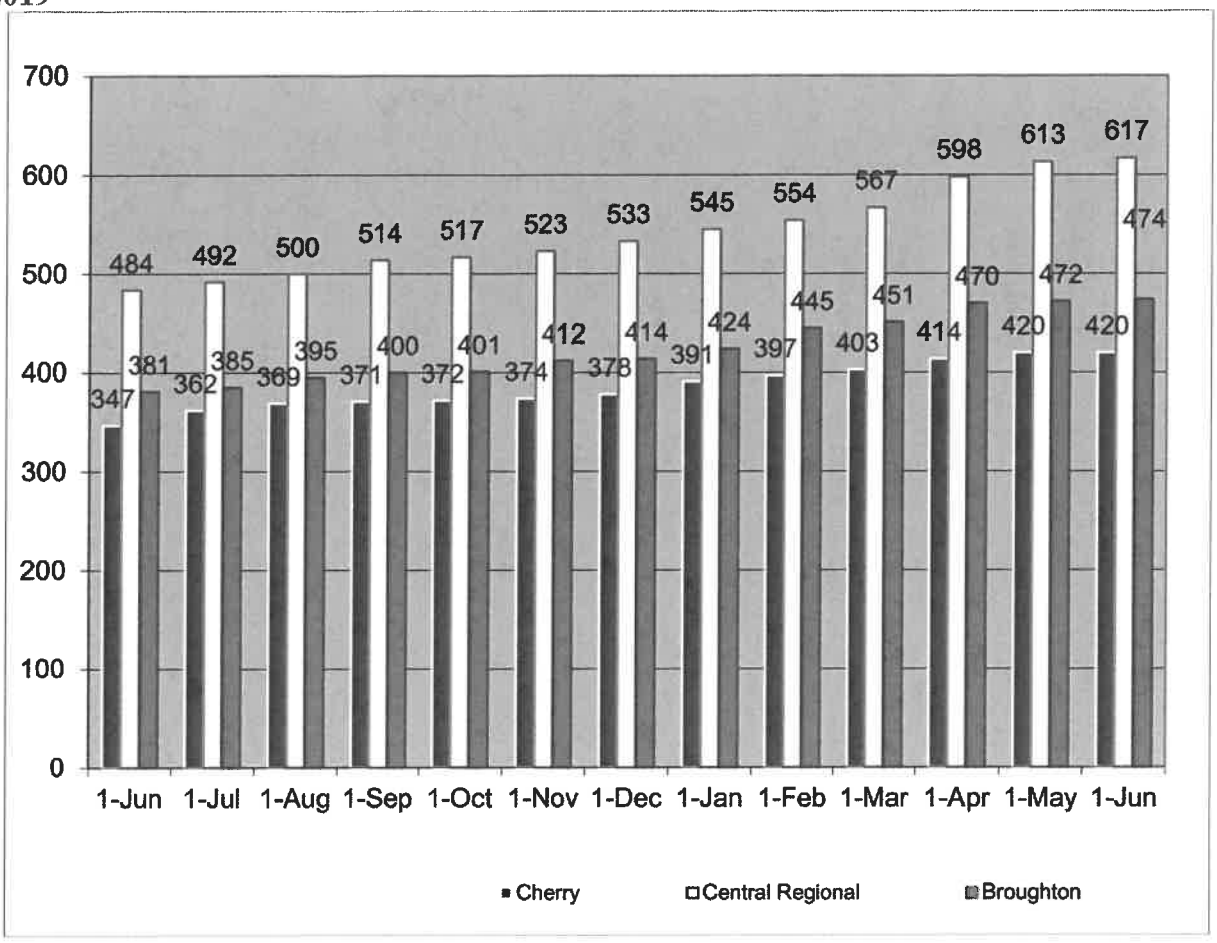


Table 33. Number of Individuals that have started In-Reach while in a State Psychiatric Hospital, by LME/MCO[58]

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Alliance	286	293	301	309	313	320	326	336	345	353	360	365	367
Cardinal	297	302	309	317	317	322	327	337	354	357	371	379	381
Eastpointe	120	127	128	128	128	129	129	134	136	138	142	146	146
PBHM	78	79	81	81	81	83	85	86	89	94	108	108	108
Sandhills	107	107	108	109	109	109	111	112	113	115	125	130	131
Trillium	168	173	176	179	179	179	180	182	184	189	197	198	198
Vaya	156	158	161	162	163	167	167	173	175	175	179	179	180
Total	1212	1239	1264	1285	1290	1309	1325	1360	1396	1421	1482	1505	1511

[58] Note: Totals are cumulative.

XI. External Quality Review Findings

The annual External Quality Review (EQR) for the LME/MCOs considers various aspects of the TCLI program. The 2018 EQR included a review of the following TCLI standards:

1. TCL functions are performed by appropriately licensed, or certified, and trained staff.
2. The LME/MCO has policies and procedures that address the TCLI activities and includes all required elements, including:

    a. Care Coordination activities occur as required;
    b. Person-Centered Plans are developed as required;
    c. Assertive Community Treatment, Peer Support Services, and Supported Employment services are included in the individual's transition, if applicable;
    d. A mechanism is in place to provide one-time transitional supports, if applicable;
    e. *Quality of Life (QOL) Surveys* are administered timely.

3. A diversion process is in place for individuals considering admission into an Adult Care Home (ACH).
4. Clinical reporting requirements are met and the LME/MCO submits the required data elements and analysis to NC Medicaid within the timeframes determined by NC Medicaid.
5. The LME/MCOs has a TCLI communication plan for external and internal stakeholders, providing information on the TCL initiative, resources, and system navigation tools, etc. This plan should include materials and training about the LME/MCO's crisis hotline and services for members with limited English proficiency.
6. A review of files demonstrates the LME/MCO is following appropriate TCLI policies, procedures and processes, as required by NC Medicaid, and developed by the LME/MCO.

The EQR showed that TCLI functions are performed by appropriately licensed, or certified, and trained staff. The certification requirements for Peer Support Specialists were present in all LME/MCO policies and procedures, except for Trillium.

LME/MCO policies and procedures included details addressing TCLI activities and generally included all the required elements. There was improvement in the documentation and monitoring of "One-time Transitional Funds" this year. Details regarding these funds and the process for accessing and monitoring them were within all of the LME/MCOs' policies and procedures. Additional detail was needed in some instances, resulting in best practice recommendations from the External Quality Review Organization (EQRO).

The completion of *Quality of Life (QOL) Surveys* continued to improve for all LME/MCOs in the past year. Sandhills did not monitor the completion of the 11 and 24-month QOL surveys and, as a result, several of the files reviewed were lacking these surveys. Nonetheless, the State

has fully complied with the QoL survey requirement for at least both of the last two SFYs.[59] Over the life of the program, TCLI has received 84% of surveys for individuals who transitioned and/or reached 11 and/or 24 months in housing. That reflects 77% of expected surveys in SFY15, 75% in SFY16, 76% in SFY17, 89% in SFY18, and 86% in SFY19.[60] These figures are stronger indicia of compliance than previous dashboard measures, e.g., "timely" survey administration and submission.

The LME/MCOs demonstrated that they have a diversion process in place for individuals considering admission into an ACH. Each of the LME/MCO clinical reporting requirements were met. Performance measures and performance improvement projects were validated by the EQRO and show high confidence.

The LME/MCOs had materials available used to educate internal and external stakeholders about TCLI. The EQRO made some recommendations to improve the availability of these materials. Trillium was asked to add information about TCLI in their *Provider Manual* and Sandhills was asked to include information about TCLI in their *Member Handbook.* Alliance and Sandhills did not have materials designed for individuals with limited English proficiency. Partners needed to add additional information regarding the availability of the TCLI program to the *Member Handbook* reflecting the availability of materials about the crisis hotline and the availability of information for members with limited English proficiency. Notably, Eastpointe had a *TCLI Communication Plan* that outlined different tiers of education provided to internal staff across the organization and training provided to providers at stakeholder meetings.

The EQRO completed file reviews for a select number of TCLI members. Eastpointe's progress notes did not mention Peer Support or Supported Employment, even in instances where the notes reflect that the member wants to obtain employment. Vaya's progress notes did not mention the use of One-Time Transitional Funds. Alliance did not target the member's individual goals, such as employment, in Person-Centered Plans. The EQRO recommended that Alliance enhance the monitoring process of Person-Centered Plans to ensure TCLI members are receiving the support and quality of services to address their identified needs. Cardinal files showed that members are regularly linked to Assertive Community Treatment (ACT) services, but rarely linked with Supported Employment services, even when members identified seeking employment as a goal. The LME/MCOs made necessary corrective actions during the last phase of the EQR process. The implementation of best practice recommendations will be monitored during the quarterly Intra-Departmental Monitoring Team process.

[59] From inception, TCLI expanded the Settlement Agreement's survey requirement (those transitioning out of facilities) to include individuals *diverted* from ACH admission.
[60] Survey participation is voluntary, so we do not expect 100% completion.

XII. Monitoring of Service Gaps

LME/MCOs are required on an annual basis to analyze and report on service gaps in accordance with their DHHS Performance Contracts. These analyses are part of a continuous assessment and action process that drives development of LME/MCO local business plans and network development plans, and implementation of strategic plans through quality improvement actions. The DHHS distributed process and report guidelines in January 2019 for SFY 2019 LME/MCO Network Adequacy and Accessibility Analysis (previously called the Gaps and Needs Analysis), with a July 1, 2019 report submission deadline.

LME/MCOs report on network availability and accessibility for Medicaid and non-Medicaid Outpatient, Location-Based, Community/Mobile, Crisis, Inpatient, Specialized and Waiver services; use geo-mapping to report provider locations; address obstacles and barriers to service-specific geographic, cultural or special populations; and report on direct input from consumers and other stakeholders regarding service gaps.

Analysis requirements also include evaluating and describing LME/MCO gaps, needs, obstacles, barriers, and initiatives around Permanent Supportive Housing, community mental health services and supports, and Crisis Service for the TCLI population (See Table 34).

Table 34. 2019 LME/MCO Network Adequacy and Accessibility Analysis Requirements, Transitions to Community Living Initiative

A. Permanent Supportive Housing Slots
   1. Describe service gaps and needs, obstacles and barriers, and recent activities and projects in the LME/MCO to:
      a. Identify and engage eligible individuals in the TCLI priority population;
      b. Provide access and transition individuals to community Permanent Supportive Housing;
      c. Transition individuals within 90 days of assignment to a transition team; and
      d. Support individuals' housing tenure and ability to maintain Permanent Supportive Housing.

B. IPS-Supported Employment
   1. Describe the network adequacy of IPS-Supported Employment services including:
      a. number of fidelity teams;
      b. location of fidelity teams;
      c. capacity of fidelity teams;
      d. the LME/MCO's total service capacity requirements (including but not limited to the TCLI population); and
      e. service gaps and needs.
   2. Describe obstacles and barriers, as well as recent activities and projects, to engage and refer individuals in the TCLI priority population, including individuals with SMI living in Permanent Supportive Housing and individuals living in or at risk of entry to Adult Care Homes.

C. Community Mental Health Services
   1. Describe the array and intensity of community mental health services provided to individuals living in Permanent Supportive Housing, as well as their sufficiency.
   2. Describe personal outcomes indicative of greater integration in the community. Personal outcomes addressed in response should include the following:
      a. Permanent Supportive Housing tenure and maintenance of chosen living arrangement;
      b. hospital, Adult Care Home, or inpatient psychiatric facility admissions;
      c. use of crisis beds and community hospital admissions;
      d. emergency room visits;
      e. incidents of harm;
      f. time spent in congregate day programming;
      g. employment;
      h. school attendance/enrollment; and
      i. engagement in community life.
   3. Describe gaps and needs in the community mental health services provided to individuals in TCLI Permanent Supportive Housing.[61]
   4. Describe obstacles and barriers as well as recent activities and projects to address gaps in the array, intensity, and sufficiency of community mental health services provided to individuals in Permanent Supportive Housing.

D. Crisis Services
   1. Describe the network adequacy of the LME/MCO crisis service system including:
      a. the geographic availability of services,
      b. the crisis service array and intensity of services,
      c. the sufficiency to offer timely and accessible services and supports to individuals experiencing a behavioral health crisis, and
      d. service gaps and needs.[62]
   2. Describe the extent to which crisis services are provided in the least restrictive setting and consistent with an already developed individual community crisis plan or in a manner that develops such a plan as a result of the crisis situation, and in a manner that prevents unnecessary hospitalization, incarceration or institutionalization.
   3. Describe obstacles and barriers as well as recent activities and projects to address gaps related to crisis service availability, delivery, sufficiency, and outcomes.

[61] This item refers to gaps and needs related to the provision and outcomes of services for the TCLI population, and not solely to the access and choice standards.
[62] This item refers to gaps and needs related to the provision and outcomes of services for the TCLI population, and not solely to the access and choice standards addressed in Section One.

LME/MCO excerpted responses to the 2019 Analysis TCLI requirements are presented in Appendix B of this Annual Report. Summaries of service gaps/obstacles and initiatives identified by the LME/MCOs are presented in Tables 35 through 38, below

Table 35. Summary of Identified Service Gaps, Obstacles, and Initiatives in Permanent Supportive Housing

	Gap, Needs, Obstacles, and Barriers	Activities and Initiatives
Alliance	Limited housing in Wake/Durham. Limited housing that meets individual requirements. High volume of Diversion screening referrals. In-Reach and Transition Coordinator caseloads at capacity Dual responsibilities of Transition Coordinators Backlog in Transition planning status 90+days. Increase in housing separations. Limited capacity to monitor tenancy supports providers.	FY18 Landlord Incentive program. Landlord risk-mitigation resources to assist with landlord recruitment.
Cardinal	Lack of transportation. Ongoing tenancy support. Member and group home provider education about transportation. Ability to complete Comprehensive Clinical Assessments (CCA) for ACH residents. Separations due to evictions and abandonment.	Asking group homes to improve transportation capabilities. Education about Medicaid transportation. Online tool for searching local social services resources. Provider learning collaborative to improve tenancy support. Post-transition population health management. Increased nursing support. Monitoring number of ACT Team visits. Bridge Housing pilot.
Eastpointe	Lack of understanding of eligibility. Environmental obstacles, aftermath of natural disasters and impact on housing. Delays related to provider assessments and referral documentation. Provider RSVP learning curve. Housing/member preference matching. Family involvement in housing decision. Member stability in housing, including related to Substance Use Disorder. Fragmented data sources.	Quality Improvement project to educate members and providers about TCLI eligibility and benefits. Provider forums. Housing presentations and housing collaborative meetings for ACHs. Staff follow-up with members beyond 90 days post-transition. Community inclusion pilot. Close monitoring of individuals with hospital admissions, ACH return, inpatient admissions. Collaborative work with State Psychiatric Hospitals around admission notifications. Bridge Hotel pilot program.
Partners	Member criminal history. Member financial and medical problems. Lack of housing options in preferred location. Lack of accessible units. Contractual issues involving care coordination.	Housing fund grant applications. Landlord education and training. Hired additional Housing Coordinator. Pursuing Master Leasing option. Exploring alternative for diversion in Burke Co. Increasing housing units via building proposals. Weekly calls with Transition Management Services (TMS).
Sandhills	Natural supports may discourage members from independent living. Member concerns about losing benefits. Isolation among those who transition into the community. Criminal and credit background barriers to transition. Limited affordable housing in preferred areas. Limited availability of targeted key units.	Weekly workgroup to discuss barriers. Monthly member-focused meetings with TMS providers. Monthly follow-up with members in In-Reach. Hired staff to perform community integration activities with eligible individuals, including viewing units, touring Psychosocial Rehabilitation (PSR) programs, meeting with others who have transitioned. Expanding role of housing specialists to develop landlord relationships. Annual breakfast meeting to recruit landlords. Retroactive and current reviews of how to meet member needs in the community. Clinical team meetings for members who are struggling.
Trillium	Transportation, especially in rural counties. Available affordable housing. Member criminal and credit backgrounds Accessible housing. Limited access to PCS and difficulty. establishing PCS in timely manner. Damaged housing due to hurricane.	Continuous provider education. Implementation of revised contracts. Establishing bridge housing. Re-housed members displaced by hurricane. TCLI and Housing staff work with private property owners around new housing opportunities. Monthly post-transition follow-up. Added nursing staff to TCLI program.
Vaya		TCLI Community Liaison educates around TCLI and RSVP. TCs request monthly updates from Tenancy Support providers. Worked with TMS to build addition team for new members. Monthly meeting with TMS to forecast potential gaps and barriers. ACT Team Learning Collaborative that addresses tenancy support and separation rates.

Table 36. Summary of Identified Service Gaps, Obstacles, and Initiatives in IPS-Supported Employment

	Gap, Needs, Obstacles, and Barriers	Activities and Initiatives
Alliance	One out of seven teams have a waitlist. Insufficient rates for licensed clinicians to attend meetings. Availability/funding of benefits counselors. Outreach to ACHs is not billable. High turnover rate on teams. Provider uncertainty related to pending CST policy changes.	Limited new authorization of services to in/at risk population. Converted non-UCR allocations to fund service. Requested additional fund conversion. Prioritizing TCLI referrals Focus on increasing TCLI eligible in all phases (In-Reach, Transition, Housed) Monthly IPS-Supported Employment (IPS-SE) Collaborative. Use of a TCLI referral form. IPS-SE training for In-Reach staff. IPS-SE teams expanding to accommodate increasing number of referrals.
Cardinal	Staff turnover. Coordination of Primary Care Providers (PCP) across providers. Lack of viable employment options. Lack of staff training in Benefits Counseling. Inadequate state funding to continue provider milestone payments. Provision of service to TCLI population.	DVR training for providers about milestone payments. Added second team in Mecklenburg Co.
Eastpointe	Lack of understanding of service definition and eligibility requirements. Member concerns about losing benefits. Effectiveness of benefits counseling. Lack of employer awareness of time and salary constraints and job constraints. Limited jobs in the community. Number of vocational and job training support programs. Member concerns about stigma in educational and employment settings.	Participation in provider steering committee an IPS-SE Coalition training.
Partners	Service capacity requirements in catchment area exceed provider capacity. Rate structure. How fidelity scoring is implemented.	Employment option training. Benefits counseling. Additional fidelity provider anticipated in 2019. Providers hiring staff and increasing capacity. RCA to explore recruiting difficulties. Ongoing TA from Supported Employment/Enhanced Services Learning Collaborative. QIP around marketing IPS-SE to all individuals. Developing strategic IPS-SE communication and marketing plan. Provider contract incentives for serving in/at risk population.
Sandhills	One provider recently unable to accept new clients; some rural counties without coverage. Member concerns about losing benefits. Natural supports may discourage members from returning to work. Members may not believe they are able to work. Burden of providing increasing amount of documentation to demonstrate in/at-risk.	Request for Proposals (RFP) for additional providers and identification of provider to cover some of the rural counties without coverage. Added Community Integrated Work Program (CWIPs) and Community Work Incentive Coordinators (CWICs) to service definition allowing for higher rate. Use of Supported Employment fact sheet to assist in engaging members.
Trillium	Nash and Columbus not covered. Provider education needed to increase referrals. Low incentive to hire more staff due to low referrals. Displaced staff due to hurricane; staff team numbers have decreased. Displaced members due to hurricane; members discharged due to moving out of area to find affordable housing. Low employer participation; many teams in rural areas with few employers; employer numbers have decreased due to hurricane. Access to transportation to make employment sustainable. Member concerns about loss of benefits.	Completed RFP and new team serving Nash and Columbus effective 2019; non-UCR funds awarded for this purpose. IPS Workgroup to work with IPS-SE teams and providers. Dedicated Contract Mangers to work with IPS-SE teams. Regional IPS-SE Coalition. Provider allocations of non-UCR funds for benefits counseling.
Vaya	One team is at capacity. Private and paid guardian understanding of TCLI and member capabilities for independent living. Limited housing stock. Lack of natural supports.	TCLI participants are prioritized in the case of a waitlist.

Table 37. Summary of Identified Service Gaps, Obstacles, and Initiatives in Community Mental Health Services

	Gap, Needs, Obstacles, and Barriers	Activities and Initiatives
Alliance	Need for increased focus on tenancy and employment supports. Service capacity for non-Medicaid is reduced Peer Support underutilized. Various obstacles related to tracking personal and service outcomes. Unclear how RSVP will impact network capacity.	ACT and TMS provider training on Community Inclusion. Value-based payment Community Inclusion Initiative for providers. Develop strategies for performance-based payment. Increase provider accountability. Education for TMS and Peer Support to increase utilization of Peer Support. Monthly ACT Collaborative. Work with ACT providers on outcomes monitoring and reporting. Data analysis to evaluate trends, payment methods, impact of ongoing initiatives.
Cardinal	Choice of fidelity ACT Team providers. Effective service delivery. Coordination of care. Social isolation.	Bi-monthly ACT Team Learning Collaborative. Person-Centered Planning training.
Eastpointe		(See additional initiatives listed under housing.)
Partners	Members previously reported difficulty reaching providers. Member-provider conflict. Geographic limits on certain service availability, e.g., Surry, Yadkin, Iredell counties. Member medication adherence. Limited funding for b(3) peer services.	Peer training in support for daily living skills, adherence to leases, and financial guidance. Implemented formal process for providers to notify if fired by member. Focus on solving transportation issues. Education around medications.
Sandhills	Four counties with limited CST coverage: Anson, Montgomery, Richmond, Moore. Providers have differing views about individuals with SMI living in the community; some opt to assist members to return to congregate living. Member isolation and loneliness.	Anticipate expanding CST with revised service definition. Coordinated with UNC Center for Excellence in Community Mental Health on ACT Team provider training, with TMS and CST providers also invited. Member education on Medicaid transportation, and peer provision of transportation.
Trillium	No data included.	No data included.
Vaya	Service gaps in the most rural counties limit choice. Lack of transportation. Lack of dentistry accepting Medicaid. Tenancy support provider education.	Increased TMS provider capacity.

Table 38. Summary of Identified Service Gaps, Obstacles, and Initiatives in Crisis Services

	Gap, Needs, Obstacles, and Barriers	Activities and Initiatives
Alliance	Maintaining sufficient services to meet needs. Lack of inpatient psychiatric beds. Uneven county availability of all levels of crisis continuum. High volume at local crisis facilities. Lack of funding to expand walk-in services. High utilizers, use of Emergency Department for primary behavioral health care.	Ongoing resource investment to expand service continuum. County-level Crisis Collaboratives. Provider contracting process detailed expectations. Expanded Behavioral Health Urgent Care to Wake. Wake EMS Enhanced Mobile Crisis Pilot. Selected new provider for Cumberland Co. Crisis.
Cardinal		Provider Crisis Plan development training. ACT Team provider involvement with members using Emergency Department (ED) or inpatient.
Eastpointe	ED recidivism. Lack of community engagement and integration to prevent and mitigate crisis events. Lack of substance use services. Lack of resources for mobile crisis teams.	Emphasis on identifying facility admissions, care coordination, and early discharge planning. Increased referrals for Peer Support. Added RN to staff. Increasing services delivered in the community. Community inclusion/crisis planning. Use of mystery shoppers to evaluate provider responsiveness. Crisis collaboratives and provider meetings. MH First Aid training with first responders. Evaluating START Program for potential implementation. Non-hospital detox program involvement in post-overdose rapid response team. Quality Improvement Plan to reduce ED utilization. Technical assistance for Mobile Crisis Management (MCM) providers Pilot program for transportation after crisis episode
Partners	TMS providers do not have training to conduct assessments in a crisis.	Provided training for TMS to assist with crisis referral process.
Sandhills		New contract for adult Facility-Based Crisis (FBC)/ Comprehensive Care Center (CCC) in Randolph Co. Constructing a child FBC/CCC in Richmond Co. to open 2020.
Trillium		Collaboration with Wellness Cities. Root Cause Analyses conducted in the event of three crisis episodes. Expanded MCM into Columbus Co. Offered contracts to all Eastpointe MCM providers who had served Columbus Co. members in past year.
Vaya	Member use of ED when lower level of care appropriate.	Education around FBC and Behavioral Health Urgent Care. Working to ensure these facilities become designated Involuntary Commitment (IVC) drop offs. Comprehensive Case Management pilot for adults with MH and SUD treatment needs.

XIII. Budget

For SFY 18-19, we were able to make changes to our budgeting processes to improve oversight and collaboration with the LME/MCOs for increased optimization and management of the TCLI funds.

As a result of our changes, we implemented the following:

- Monthly budget reporting for leadership staff and LME/MCOs
- Additional budget reviews with LME/MCOs to ensure alignment.
- Quarterly reviews for reallocation of funds in a timely manner.

With the updated processes, ongoing oversight and monthly reporting, appropriate allocations and utilization improved which decreased the amount of reverted funds to $750,000 (a vast decrease from the $7.2 million reversion the previous year). The SFY 18-19 budget also included a move of $3.5 million towards housing development plans.

For SFY19-20, ongoing planning exercises occurred from February to June of 2019 to review spending, determine proposed allocations and make timely budget decisions for the SFY19-20 budget. As a result, we were able to issue allocation letters to all LME/MCOs the first week of July 2019.

Our priority areas for SFY 19-20 funding are: Housing, Bridge Housing, IPS-Supported Employment, and Diversion. Investments have been made in priority areas to allow for effective planning and implementation.

Other important areas may have received less funding this year. However, we will closely monitor spending throughout the year. When necessary, we will redistribute funding to line items that are critical to achieving compliance with the Settlement Agreement.

XIV. Closing Statement

In SFY 2018-2019, the Transitions to Community Living Initiative (TCLI) renewed and strengthened its commitment to meeting the requirements of the Settlement Agreement with the United States Department of Justice. This commitment was evident in the area of supportive housing, one of the pillars of the Agreement. An exceptional partnership among the State, Local Management Entities/ Managed Care Organizations and NC Housing Finance Agency produced significant, statewide expansion in voucher subsidized housing units. In another achievement at the heart of the Agreement, TCLI developed the Referral/ Screening Verification Portal (RSVP) tool, demonstrably increasing diversion from Adult Care Home entry.

Collection, monitoring and analysis of data to evaluate progress and outcomes continue to be a hallmark of TCLI's work. The commitment to data-driven quality outcomes saw TCLI bring to

the table stakeholder expertise in a newly formed Barriers Committee. Professionals removed challenges to living in the community in "real time." The Barriers Committee members escalated complex, systemic issues to the Department's top leadership in another, new element of policy infrastructure: The Transition Oversight Committee.

In all facets of its work, TCLI continued to innovate. This was particularly apparent in the rollout of a re-envisioned Community Support Team service definition. Ascertaining that its partners in policy and practice--the LME/ MCOs and their provider networks--were fully engaged in TCLI's system change work was crucial to this year's success. Extensive stakeholder training opportunities and the provision of top-flight technical assistance helped to ensure that TCLI's gains would be sustainable.

As TCLI moves into State Fiscal Year 2019-2020, we are reaching out to the broader community of people with disabilities contemplated by the US Supreme Court's decision in *Olmstead v. L.C.* We anticipate that the State's investments in this exceptional undertaking will open the door to community for North Carolinians for years to come.

In closing, the NC Department of Health and Human Services thanks the NC General Assembly in advance for its consideration of the *2018 - 2019 Annual Report, Opening the Door to Community: The Transitions to Community Living Initiative.*