2020 - 2021 Annual Report of the North Carolina Transition to Community Living Initiative

NC General Statute 122C-20.15

Report to the Joint Legislative Oversight Committee on Health and Human Services

By

North Carolina Department of Health and Human Services

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CONTENTS

I. OPENING REMARKS

The State of North Carolina entered into a settlement agreement with the United States Department of Justice (DOJ) in 2012. The purpose of this agreement was to make sure that people with mental illness are able to live in communities alongside other North Carolinians. The settlement agreement created Transitions to Community Living (TCL) and gave a group of people with disabilities – those with serious mental illness or severe and persistent mental illness –the opportunity to live and work in the community in places the TCL Settlement Agreement called "the least restrictive settings of their choice." For close to a decade, the NC Department of Health and Human Services has been implementing this landmark systemic change in the delivery of services and supports to people with behavioral health disabilities.[1]

The TCL Settlement Agreement derived from a US Supreme Court Case: *Olmstead v. L.C.*[2] Since the Settlement Agreement, North Carolina has implemented groundbreaking work to support people with disabilities to live in the community and thrive, including TCLI, Money Follows the Person and the Targeting and Key Programs. TCL is the foundation for the State's work to extend the right to "an everyday life" in communities across North Carolina to all people with disabilities served in publicly funded programs. Transitions to Community Living has become more than an initiative. It has become a key, "opening the door to community" to all North Carolinians with disabilities. North Carolina looks forward to continuing this critical work through its Olmstead Plan due to be implemented in 2022.

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[1] Transitions to Community Living | NCDHHS

[2] *Olmstead v. L.C.*, 527 U.S. 581 (1999), is a United States Supreme Court case regarding discrimination against people with mental disabilities. The Supreme Court held that under the Americans with Disabilities Act, individuals with disabilities have the right to live in the community rather than in institutions if, in the words of the opinion of the Court, "the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.

II. ACKNOWLEDGEMENTS

Many thanks to this year's contributors to our annual report and to their efforts all through the year to assist the Department in meeting its obligations to the US Constitution, the Americans with Disabilities Act, and to every citizen in NC who strives to live their best lives in communities across our great State.

- Thea Craft, NC Housing Finance Agency, Manager of Community Living Operations
- Heather Dominique, NC Housing Finance Agency, Community Living Administration Coordinator
- Sherry Lerch, Senior Consultant, Technical Assistance Collaborative
- Kevin Martone, President, Technical Assistance Collaborative
- Lorna Moser, PhD., HSPP, Director, UNC Institute for Best Practices
- Jennifer Olson, NC Housing Finance Agency, Community Living Program Administrator & Strategic Coordinator
- Mark Salzer, Ph.D., Professor of Social and Behavioral Sciences, Director, Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities
- Patricia Rowan, Senior Researcher, Mathematica
- Jessica Ross, Senior Researcher, Mathematica
- LME-MCO Transition to Community Living Staff

III. HOUSING

SUMMARY

Although COVID-19 placed tremendous and often painful burdens on the State and its people, North Carolina continued to make significant strides in Fiscal Year (FY) 2020 - 2021 towards meeting the housing mandates of the US Department of Justice (DOJ) Settlement Agreement, known as Transitions to Community Living (TCL)[3]. The strong partnership among the NC Department of Health and Human Services (DHHS)' Transitions to Community Living (TCL) team, the Local Management Entity/Managed Care Organizations (LME/MCO) and the North Carolina Housing Finance Agency (NCHFA) has helped to rebuild lives, offer hope, and provide real housing solutions. The DHHS further supported TCL's housing efforts by providing additional funding to the LME/MCOs; advancing partnerships with temporary housing providers; and expanding current contracts with community service providers and establishing new ones.

As of the end of FY 20/21, TCL supported 2,957 individuals in the community. Over the life of the program, 4,573 people have lived in permanent supportive housing (PSH). TCL is a stabilizing force in people's lives. In fact, 81% of all participants live in supportive housing for at least a year. With the adoption of the RSVP online referral and diversion system, TCL is effective at diverting people with serious mental illness from entering adult care homes and instead giving people viable options for community living. TCL is opening the door for people to thrive in their community.

BRIDGE HOUSING

DHHS' continued use of Bridge Housing[4] remains a proven and successful tool for getting individuals into permanent supportive housing (PSH).[5] DHHS worked collaboratively with LME-MCOs to continue to grow the use of Bridge Housing, saving taxpayers dollars by reducing hospital days and giving people a safe place to live while looking for a home of their own in the community. Ninety percent (90%) of people who enter bridge housing go on successfully to Permanent Supportive housing. Bridge Housing was expanded during this fiscal year to settings including hotels, leased apartments, and single room occupancy arrangements in socially diverse areas. In addition to its cost savings and other benefits,

[3] Since Transitions to Community Living (TCL) has become part of the way that DHHS does business, we have dropped the reference to "initiative" that formerly was used in the program's name. TCLI is now TCL.
[4] Bridge Housing is an approach that allows the LME/MCOs to stabilize individuals who need immediate housing while they plan for living in the community. The Bridge Housing program is a transitional program for individuals diverted from Adult Care Homes and for individuals transitioning out of State Psychiatric Hospitals. The program offers settings located in areas with ready access to essential resources, such as bus lines, employment opportunities and places to shop for basic needs. Teams for these housing units help people successfully transition to permanent housing in their community of choice. See, e.g., https://pss.unc.edu/pssjobs/peer-support-specialistbridge-housing.

Bridge Housing was vital for many individuals who otherwise would have resided in congregate institutional placements during the peak of the spread of the coronavirus where such settings had higher risks of infection.

TCL June Report: LME/MCO Totals for End of June 2021

LME/ MCO	Completed Targeted Unit Transition Plan (TUTP)	Moved into Supportive Housing During TUTP	Moved into Supportive Housing Post TUTP	Moved into Targeted Unit	Moved into Non-Targeted Unit
Alliance	103	93	4	29	66
Cardinal	76	68	6	13	55
Eastpointe	139	122	3	16	115
Partners	45	42	0	12	30
Sandhills	56	48	0	0	48
Trillium	80	77	0	8	69
Vaya	88	82	5	21	60
Total	**587**	**532**	**18**	**99**	**441**

HOUSING INSPECTIONS

To ensure safe housing, all housing units for TCL participants are required to be inspected using Housing and Urban Development (HUD) Housing Quality Standards (HQS). Due to the ongoing COVID-19 concerns during the year, DHHS continued using a hybrid inspection model to ensure safe, sanitary and secure housing for TCL participants. The LME/MCOs completed either a virtual inspection with the landlord/owner representative using a habitability checklist[6] or a HUD Housing Quality Standards (HQS) inspection for initial move in and annual inspections. Units are re-inspected annually, as well as on an ad hoc basis, if health and safety issues arise or if a tenant or support provider "has cause" to request a re-inspection. In FY 20-21, the State spent $189,400 on HQS inspections to ensure housing units subsidized for TCL participants met the HUD Housing Quality Standards (HQS) upon initial lease execution.

[6] Habitability checklist is a form developed to assist LME-MCO housing staff with assessing the habitability of units receiving Transition to Community Living funding when an in person Housing Quality Standard Inspection cannot be completed due to health and safety reasons related to COVID-19.

DATA SYSTEMS

DHHS and the NCHFA have worked to improve data collection for housing. The Community Living Integration Verification (CLIVe) system is now fully operational and actively utilized as a payment reimbursement system that supports LME/MCO housing activity by providing a mechanism to input data and receive reimbursement, consistent with the DHHS' established program policy and procedures. The CLIVe also manages and organizes workflow, as well as serves as the system of record for Transition to Community Living Voucher (TCLV) tenancies. Ultimately, the CLIVe is the system of record for tenancies for all individuals participating in TCL. The 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 data regarding length of stay in housing.

AFFORDABILITY: RENTAL ASSISTANCE AND VOUCHERS

Transition to Community Living offers several mechanisms to provide access to affordable apartments and rent assistance for to individuals with income as low as Supplemental Security Income (SSI). Transition to Community Living Voucher (TCLV) is the most common mechanism used. The Transitions to Community Living Voucher provides rent assistance to assist people with behavioral health disabilities either be diverted from, or transition out of restrictive settings, so that they can live in the community of their choice. The voucher operates as a partnership between NC DHHS and the state's network of mental health management organizations. TCLV not only provides rent assistance but can also help pay for security deposits and certain costs incurred by property owners. In FY 20/21, 2,183 households utilized TCLV with an average monthly subsidy of $628.

Examples of other programs used to support individuals in Transition to Community Living include but are not limited to the following:

- Key Rental Assistance[7] state funded rental assistance only available in properties participating in the Targeting Program
- Federally funded tenant-based vouchers like Housing Choice Vouchers (Section 8)

[7] Key Rental Assistance is only available in properties participating in the Targeting Program. The Targeting Program is a disability neutral housing program for low-income persons with disabilities who need supportive services to help them live independently in the community. Key rental assistance makes the Targeted apartments affordable to people who have a disability and/or are experiencing homelessness with extremely low incomes and can help pay for security deposits and certain costs incurred by property owners. Community Living Programs | NCHFA

Types of Housing Subsidies Utilized, Currently Housed, June 2021

LME/MCO	Other (Mainstream[8]/Housing Choice Voucher[9]/Shelter Plus Care[10]/Project-Based Rental Assistance[11]/Veterans Affairs Supportive Housing[12])	Targeting/Key	TCLV	Total
Alliance	4	152	281	**437**
Cardinal	19	175	649	**843**
Eastpointe	11	25	227	**263**
Partners	10	60	218	**288**
Sandhills	9	55	275	**339**
Trillium	14	87	302	**403**
Vaya	26	127	231	**384**
Total	**93**	**681**	**2183**	**2957**

[8] Mainstream vouchers assist non-elderly persons with disabilities. Aside from serving a special population, Mainstream vouchers are administered using the same rules as other housing choice vouchers. Mainstream Vouchers | HUD.gov / U.S. Department of Housing and Urban Development (HUD)

[9] The housing choice voucher program is the federal government's major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market. Since housing assistance is provided on behalf of the family or individual, participants are able to find their own housing, including single-family homes, townhouses and apartments. The participant is free to choose any housing that meets the requirements of the program and is not limited to units located in subsidized housing projects. Housing choice vouchers are administered locally by public housing agencies (PHAs). The PHAs receive federal funds from the US Department of Housing and Urban Development (HUD) to administer the voucher program. Housing Choice Voucher Program Section 8 | HUD.gov / U.S. Department of Housing and Urban Development (HUD)

[10] Grants for rental assistance, in combination with supportive services from other sources, to assist hard-to-serve homeless persons with disabilities. Shelter Plus Care (S+C) | HUD.gov / U.S. Department of Housing and Urban Development (HUD)

[11] Project-based rental assistance provides critical affordable housing stock to low-income families across the country. This type of rental assistance allows tenants to live in an affordable unit and pay rent based upon their income. Project-based rental assistance, such as project-based Section 8 rental assistance, can be paired with units in HUD multifamily mortgage programs to provide a deeper level of affordability. With project-based rental assistance, a private for-profit or non-profit owner enters into a contract with HUD to provide affordable units. Project-based assistance is tied to particular units and does not travel with individual tenants. Project-Based Rental Assistance | NHLP

[12] The HUD-Veterans Affairs Supportive Housing (HUD-VASH) program combines HUD's Housing Choice Voucher (HCV) rental assistance for homeless Veterans with case management and clinical services provided by the Department of Veterans Affairs (VA). VA provides these services for participating Veterans at VA medical centers (VAMCs), community-based outreach clinics (CBOCs), through VA contractors, or through other VA designated entities. Veterans Affairs Supportive Housing (VASH) - PIH | HUD.gov / U.S. Department of Housing and Urban Development (HUD)

EXPANDING IMPACT

In 2018, DHHS worked with the Technical Assistance Collaborative (TAC) to assist the State in meeting its TCL Settlement Goals. In its report, TAC recommended that DHHS,

- Identify available vouchers and other funding opportunities to support its population including HUD Mainstream Voucher Program and the HUD 811 Project Rental Assistance funds.
- Through financing strategies, invest in more set-aside units for individuals with disabilities.

DHHS and NCHFA worked to meet both of these recommendations.

- Successfully applying for and receiving HUD 811 Project Rental Assistance in the amount of $7,000,000
- Prioritize TCL participants for other housing voucher programs including HUD Mainstream Vouchers
- Using the Low-Income Housing Tax Credits to expand available Targeting Units (low-income affordable units set aside for individuals with disabilities and/or are experiencing homelessness) to more than 6,317 apartments in 766 properties.[13]
- Investing in Integrated Supportive Housing Programs, as set out in more detail below

The DHHS and the NCHFA collaboration bolstered expansion, across the State, of supportive housing initiatives through the Integrated Supportive Housing Programs (ISHP)[14] and the Targeting Program.[15] Earlier, in FY 18-19, the DHHS partnered with the NCHFA to develop the ISHP, a program providing interest-free loans to community developments where up to 20% of the units are integrated and set aside for households participating in the TCL program. These developments are affordable and part of the community, with a focus on access to community services, such as grocery stores and other amenities. This collaborative effort now funds 16 developments, garnering a total of 243 total permanent supportive housing (PSH) units in six LME/MCO catchment areas. Of those 243 PSH units, construction of 203 units was subsidized with ISHP funds. The utilization rate in the table below is based on the number of ISHP units leased by TCL participants.

[13] To comply, LIHTC properties must set aside at least 10%, but no more than 20%, of their units and make them available for eligible participants as identified by DHHS.

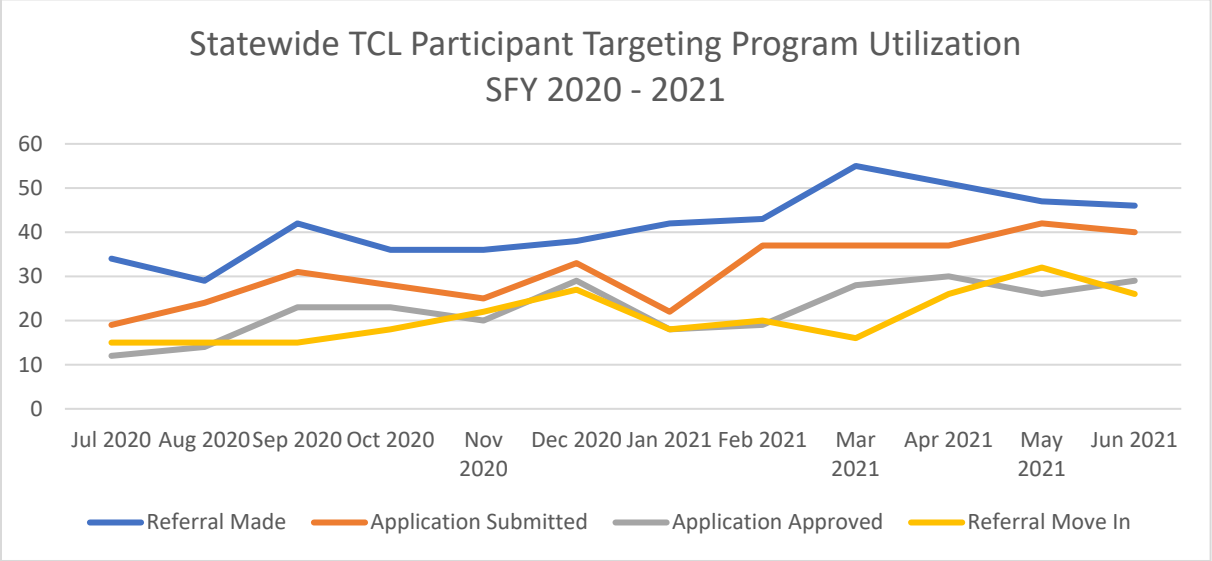
[14] ISHP is a program providing interest-free loans to community developments where up to 20% of the units are integrated and set aside for households participating in the TCL program.

[15] The Targeting Program is a disability neutral housing program for low-income persons with disabilities who need supportive services to help them live independently in the community. Through a partnership between NC Department of Health and Human Services and NC Housing Finance Agency, the program provides access for eligible participants to Low Income Housing Tax Credit properties. The program aims to connect eligible persons to housing that is: affordable, decent, permanent, integrated, accessible, and independent. https://www.ncdhhs.gov/divisions/aging-and-adult-services/permanent-supportive-housing

INTEGRATED SUPPORTIVE HOUSING PROGRAM TABLE

ISHP Property Status	Properties	All PSH Units	ISHP Units	Current TCL Households	Utilization Rate*
Placed in Service	14	226	176	103	58.5%
Under Construction	2	27	27	NA	0%
Total	**16**	**243**	**203**	**103**	**NA**

Status of ISHP Projects	Total ISHP Units per Project	Units filled	Utilization Rate
Placed in Service (Active with referrals)	110	52	47%
To be Placed in Service Next (Active – no referrals yet)	63	0	0%
Pipeline (under construction – not active)	73	0	0%
Total	**246**	**52**	**21%**



TARGETING UNITS

To create more affordable rental units for individuals with disabilities, NCHFA and DHHS invest Low-Income Housing Tax Credits (LIHTC) to create low-income affordable units set aside for individuals with disabilities and/or are experiencing homelessness to more than 6,317 apartments in 766 properties.[16]

DHHS and NCHFA have revised policies, procedures and documentation requirements to make Targeted Units more accessible to individuals with disabilities in TCL.

- Reviewing Property Tenant Selection Policies and Targeting Unit Agreements for LIHTC properties to ensure TCL individuals are not screened out
- Ensuring choice for TCL participants by providing lists of all units in the communities they want to live in.
- Holding weekly Operational Meetings and monthly Strategic Meetings between DHHS and NCHFA to review efficiency and effectiveness of the program.
- Prioritizing TCL participants for available Targeting units using the NCHFA's Vacancy and Referral System.

These strategies have proved successful. As of June 2021, 681 TCL participants resided in Targeting Units.

STRATEGIC HOUSING PLAN

In FY 20-21, the DHHS contracted with the TAC to develop a Strategic Housing Plan in connection with the overarching Olmstead Plan. Over a five-year period, the Strategic Housing Plan will guide DHHS' policy efforts and resource decision making to maximize community-based housing opportunities for people with disabilities who are homeless, living in an institution or at risk of institutionalization. In late spring of FY 20-21, the DHHS and the TAC embarked on a strategic planning process. It included key informant interviews, focus groups and an environmental housing scan, with the purpose of identifying populations most in need of supportive and affordable housing and housing models best suited to meet these needs. Over FY 21-22, the DHHS staff and the TAC will convene the Strategic Housing Plan Leadership Committee and kick-off a series of three planning sessions to develop objectives, as well as the supporting strategies to achieve these.

- Session I: Vision, Mission and Foundational Principles
- Session II: Strategic Objectives
- Session III: Housing and Services Strategies (short- and long-term)

The planning process will culminate with the first iteration of the Strategic Housing Plan which will be presented to the DHHS executive leadership team in July 2022.

[16] To comply, LIHTC properties must set aside at least 10%, but no more than 20%, of their units and make them available for eligible participants as identified by DHHS.

STRATEGICALLY EXPANDING HOUSING THROUGH FEDERAL VOUCHER AWARDS

Much focus has gone into expanding access and utilization of Mainstream Vouchers and the Section 8 Housing Choice Voucher Program[17] set-asides for the TCL population. Through competitive solicitations in FY 2018 and FY 2019, the DHHS and the LME/MCOs worked with 21 local Public Housing Authorities (PHAs) to apply for vouchers through the Mainstream Voucher Program. **These efforts brought the State 556 additional federal vouchers, adding to the dollars available to support housing resources and offset expenses for state-funded rental subsidies.** Each of the PHAs that received the awards got supplemental funds in FY 2020 without having to apply for these.

In April 2019, DHHS petitioned HUD, requesting a remedial preference for the life of the Settlement Agreement for individuals in the TCL. This remedial preference allows all the State's PHAs to amend their administrative plans to ensure that individuals involved in TCL are provided preference on their respective housing waitlists. The remedial preference was granted and DHHS began working to implement these preferences throughout North Carolina's PHAs in FY2020. As of the time of this report, 48 TCL participants have been awarded and/or utilizing a Mainstream Voucher as a source of rental assistance in their housing unit.

In the summer of 2020, the NCHFA was awarded $7,000,000 from HUD under its Section 811 Project Rental Assistance (PRA) program for a five-year project period. The HUD 811 program provides project-based rental assistance funding to eligible state housing finance agencies for extremely low-income persons with disabilities, aged 18 to 61. The final execution of this grant agreement is underway; it provides rental assistance for approximately 188 apartments for extremely low-income people with disabilities who are either transitioning from institutions or at risk of institutionalization.

ATTRACTING MORE TRANSITION TO COMMUNITY LIVING VOUCHER PROPERTY OWNERS

Even with the pandemic crisis, during FY 20-21, the LME/MCOs continued to expand the use of private market units. Using Risk Mitigation Tools and landlord relationship development initiatives, LME/MCOs have encouraged new property owners to participate in the Transition to Community Living Voucher (TCLV) program. With the Risk Mitigation Tool, LME/MCOs may reimburse landlords when expenses exceed the security deposit in the following circumstances:

- Tenant caused unpaid property damage
- Tenant has unpaid rent and late fees
- Tenant abandoned the unit, creating a vacancy
- Landlord/ property owner incurred costs incident to eviction

[17] The Section 8 Housing Choice Voucher Program is the federal government's major program for assisting very low-income families, the elderly, and people with disabilities to afford decent, safe, and sanitary housing. It is for eligible families regardless of race, religion, or political affiliation in the private market. Program funds are awarded to the program by HUD through Annual Contributions Contracts and are used to subsidize the difference between the cost of rent and a maximum of 30% of the household's adjusted gross income.

Combined with an increased investment in property owner outreach and a strong emphasis on customer service, the State's LME/MCOs have expanded the number of participating landlords, broadening the housing choices available to TCL participants. During FY 20-21, 261 new property owners joined the TCLV program. To establish and maintain good working relationships, property owners/landlords were awarded approximately $117,033 in risk mitigation funds.

BEST PRACTICES IN HOUSING

The DHHS, the LME/MCOs and the North Carolina Housing Finance Authority (NCHFA) have continued a variety of best practices to address barriers to accessing housing. These have improved TCL households' experiences during tenancy and decreased separations from housing.

Tenancy Issues Tracking

Social Serve[18] continues to contact landlords for satisfaction surveys. When landlords are dissatisfied, the NCHFA follows up with the LME/MCO. The LME/MCOs then conduct outreach to the landlord, service provider and/ or tenant, resulting in many saved tenancies. For purposes of the TCL Quality Assurance and Performance Improvement, the data is compiled and analyzed, allowing DHHS to determine training needs, accessibility issues, areas of concern and successes. Socialserve also continues to assist the LME/MCOs in landlord outreach and engagement.

Risk Mitigation Tools

The Targeting and Transition to Community Living Voucher (TCLV) programs strive to keep landlords satisfied and engaged, helping to assure housing options for future tenants. As noted above, landlords may receive reimbursement for expenses incurred in excess of the security deposit through a special claims process, after submittal and approval of required documentation.

Housing Policy "Barrier Busters"

The NCHFA requires landlords who participate in agency-administered rental programs to have a written, property-specific Tenant Selection Plan (TSP). The criteria contained in a TSP must not be so restrictive that it creates a disparate impact on groups protected by the federal Fair Housing Act. The criteria must also align with HUD's requirement for housing entities to further fair housing affirmatively and to conform to any applicable HUD guidance.

The NCHFA published the Fair Housing and Tenant Selection Plan policy, initially enforcing it through review and approval of TSPs. Subsequently, it has been enforced based on investigation of complaints, checked for adherence to or violation of the approved TSP language. Provisions

[18] Social Serve is a nonprofit, bilingual call center that connects people to housing and provides supportive, second chance employment. See https://www.socialserve.com

that advance increased access to housing, particularly for individuals with disabilities, include, but are not limited to, the following:

- Prohibition of application fees for those in Targeting units and TCL applicants, in general
- Waiver of credit screening criteria for applicants participating in programs that provide landlords the ability to recover economic losses related to the tenancy
- Model policy on screening applicants with criminal records and factors to consider when individualized assessments are appropriate and necessary19
- Guidance related to reasonable accommodations/ modifications under the Americans with Disabilities Act (ADA), including a provision that companies hold units during the negotiation of reasonable accommodations occurring at the time of application
- Mandatory tax credit lease addendum provision20 related to unit access

Community Service Provider Housing Trainings

The NCHFA, the DHHS, and the NC Justice Center continued to work together in 2020 to offer fair housing trainings across the state.

- Number of Basic Fair Housing Trainings: 28 total (14 for housing providers, 14 for service providers)
- Number of Advanced Fair Housing Trainings: 6 total (for service providers only)
- Basic Fair Housing trainings for providers of housing : 192 attendees
- Basic Fair Housing trainings for service providers: 170 attendees
- Advanced Fair Housing trainings for service providers: 114 attendees

The LME/MCOs themselves have continued to sponsor housing trainings to increase providers' knowledge of housing strategies. For instance, Alliance Health offers Better At Home Trainings and Resources. These have included the following topics:

- Housing Inspections are an Intervention
- What's in Your Lease?
- What Gets in the Way?
- Tenant and Landlord Rights and Responsibilities
- Keeping the Voucher: Understanding Subsidy Administration.

In FY 2021, the DHHS and the NCHFA made several custom e-learning modules available online for "low-to-medium-knowledge" learners. Modules are brief, interactive and scenario-based. Housing skills refresher e-learning topics include:

- Eviction Due to Non-Payment of Rent
- Understanding Reasonable Accommodations and Reasonable Modifications, Part 1 and 2
- Assistance Animals in Housing
- Fair Housing Resources for Service Providers
- Questions to Ask when Calculating Income.

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[19] The criteria must be no more restrictive than the Model Policy on Screening Applicants with Criminal Records. https://www.nchfa.com/sites/default/files/page_attachments/TenantSelectionPlanPolicy.pdf

[20] The tax credit lease addendum outlines the provisions of Section 42 of the Internal Revenue Code of 1986, as amended, which are applicable to the lease term. https://www.nchfa.com/sites/default/files/page_attachments/MandatoryTaxCreditReleaseAddendum.pdf

The DHHS and the NCHFA are currently in the process of developing more e-learning modules, including on such topics as informed decision making and how to have effective conversations with TCL participants about engaging in their community.

The DHHS and the TAC implemented a series of Permanent Supportive Housing Trainings (PSH) for providers in FY 20-21. To increase and diversify providers' knowledge, topics included:

- Best Practices for Mainstream Voucher Utilization
- Section 8 Made Simple for Practitioners
- Understanding Your PHA's Housing Choice Voucher Program - Parts 1, 2, 3 and 4
- Shared Housing- Strategies to Open New Opportunities in Your Community's Rental Market
- Effective Landlord Engagement Strategies
- During each module, over 75 participants actively engaged.

Housing Stabilization

Each LME/MCO has implemented at least one housing best practice, and many have chosen to implement several to ameliorate separation from housing. Some of the innovative practices that LME/MCOs implemented this year included the following:

Vaya Health LME/MCO continued hosting landlord mediation for its TCL members to increase empowerment, decrease communication barriers, and streamline the housing process for the LME/MCO and its network providers. As a result, TCL participants were able to address landlord and tenant matters in an efficient and effective manner.

- Sandhills Center LME/MCO continued a resident engagement initiative to link TCL participants with activities in the community of their choice. Those in TCL were more likely to participate in the life of their community, resulting in more successful, long-term housing outcomes.
- Alliance Health LME/MCO, Cardinal Innovations LME/MCO and Vaya Health LME/MCO sustained Assertive Community Treatment Teams (ACTT) and Community Support Team (CST) Learning Collaboratives to address tenancy support issues and to reduce preventable, housing separations. Case studies were used as a springboard for peer-to-peer learning.
- Alliance Health LME/MCO continued their monthly TCL Separations Workgroup in FY 20-21. This workgroup brings together Alliance Health leadership to review housing separations from a systems level, make recommendations and discuss strategies to address issues.
- Eastpointe LME/MCO's use of Alliance of Disability Advocates (ADANC) services, via a pilot program continued this fiscal year and assisted with housing stabilization for many TCL participants. Working with ADANC, individuals are provided with assistance in becoming a part of their new community. These relationships have remedied feelings of boredom and loneliness and have improved housing stability.

- Trillium LME/MCO continued the use of technology to assist people who felt isolated in the community. The LME/MCO acquired small robots. The devices are used to set reminders, explore recipes, tell jokes and check the weather. They are also able to follow participants around in their homes, assisting with various tasks.
- Partners LME/MCO cultivated their Value-Based Contracting method that includes incentives to maintaining TCL participants in housing.
- Each LME/MCO's transition coordination team made concerted efforts to make weekly contact with members during the ongoing COVID-19 crisis to ensure continuity of care and to promote wellness and stability in housing.

- To continue the DHHS' work in improving housing retention for TCL members in FY 2021, DHHS implemented housing stabilization meetings among DHHS regional housing coordinators, DHHS Subject Matter Experts, LME/MCOs and their network providers. The meetings address tenancy issues, historical interventions and suggested new interventions, along with developing and sharing plans with landlords/property managers. The efforts have preserved tenancies in many cases for TCL participants.

IV. COMMUNITY-BASED MENTAL HEALTH SERVICES

SUMMARY

Since the beginning of the Transitions to Community Living program (TCL) in 2013, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and the Division of Health Benefits (DHB) have implemented significant changes to policies, service definitions, contract terms, and quality measures. These systematic changes are designed to have a continuous positive impact, statewide, on the quality of community-based mental health services. Formal monitoring of TCL service gaps and quality also occur through departmental processes, including annual Network Adequacy and Accessibility Analyses (NAAA) and quarterly Intradepartmental Monitoring Team (IMT) reviews.[21] The 2020-2021 Annual Report will build on the progression of community mental health services from 2013 to 2021.

Community-based Mental Health Services implemented a comprehensive plan that focuses on these key goals:

- Implement policies and procedures to ensure that individuals with serious mental illness (SMI) in, or later admitted to, an adult care home (ACH), get access to the array and intensity of services and supports necessary to enable them to successfully transition to and live in community–based settings.
- Ensure that services are evidenced-based, recovery-focused, community-based and individualized to meet the needs of each individual, with all the elements and

[21] NAAA and IMT processes and content are described in detail in the Quality Management section of this Annual Report.

components of a person-centered plan arranged for the individual in a coordinated manner.

- Maintain strong utilization of Peer Support Services and improve access in areas where there is limited or no availability.
- Ensuring individuals have access to high quality Individual Placement and Support-Supported Employment (IPS-SE) services that are sustainable across the state and across diverse funding streams.
- Ensure a statewide crisis system that includes an array of crisis services including Peer-Run Crisis Support, Behavioral Health Urgent Care and Facility-Based Crisis Services.

ASSERTIVE COMMUNITY TREATMENT

Assertive Community Treatment (ACT) has been part of the North Carolina mental health services system since the 1990s. Originally, ACT services were managed at the provider level with minimal oversight by the State. This led to limited access for people who needed the service and it was difficult to measure quality. In recognition of the problem, the State began making concerted efforts to enhance the accessibility and quality of ACT teams, prior to the 2013 implementation of TCL. Soon after implementation of the Settlement Agreement, the Department of Health and Human Services (DHHS) identified the Tool for Measurement of ACT (TMACT) as the fidelity tool to ensure quality statewide. Policy and service definitions were written for both Medicaid and state-funded services to reflect its required use. Language was added into the Local Management Entity/Managed Care Organization (LME/MCO) contract with both NC Medicaid and the DMH/DD/SAS, identifying a minimum score that teams had to achieve to contract as an ACT provider. The DMH/DD/SAS initiated a contract with the Department of Psychiatry, University of North Carolina (UNC) School of Medicine, to develop, as part of the Center for Excellence in Community Mental Health, an ACT Technical Assistance Center, later rebranded as the Institute for Best Practices.

During the first two years of its involvement, the Institute for Best Practices, then the "ACT TA Center," partnered with the DMH/DD/SAS to identify existing ACT providers, gauge practice fidelity, and create and implement a plan for the more comprehensive TMACT evaluations. Providers' participation in TMACT evaluations were a part of policy expectations as of August 2013 (Table 1).

Table 1. NC DHHS ACT Certification

No Certification	Below 3.0
Basic Fidelity (Provisional Certification)	3.0 – 3.6
Moderately High Fidelity (Full Certification)	3.7 – 4.2
High Fidelity (Exceptional Practice)	4.3+

Table 2. TMACT Data Distribution for Certified Teams Across Three Reviews				
		Time 1 (N = 78 teams)	**Time 2** (N=76 teams)	**Time 3**[a] (N = 54 teams)
(N = 76 teams) (N=73 teams)	Mean	3.63	3.80	3.73
	Min	2.49[b]	2.74[b]	2.89[b]
	Max	4.53	4.41	4.38
(N = 59 teams) TMACT Total Rating	Mean	4.08	4.22	4.26
	Min	3.17	3.17	3.50
	Max	4.83	4.83	4.83
Operations & Structure (OS)	Mean	3.86	3.97	3.93
	Min	2.29	2.57	2.29
	Max	4.71	4.86	4.71
Core Team (CT)	Mean	3.45	3.72	3.62
	Min	1.83	1.50	1.67
	Max	4.63	4.75	4.75
Specialist Team (ST)	Mean	3.54	3.65	3.54
	Min	2.63	2.63	2.63
	Max	4.38	4.50	4.25
Core Practices (CP)	Mean	3.18	3.51	3.33
	Min	1.58	2.38	2.25
	Max	4.63	4.63	4.63
Evidence-Based Practices (EP)	Mean	3.24	3.23	3.14
	Min	2.00	3.25	2.25
	Max	4.75	2.25	4.50

A series of daylong trainings on the relevance of fidelity monitoring was offered to the LME/MCOs during the summer of 2013 in preparation for the launch of TMACT reviews. Institute staff contacted each LME/MCO to confirm the list of ACT providers in their network and solicit nominations of prioritized teams.

The TMACT authors led the initial TMACT evaluator training, a series of progressively advanced steps of training. At the time of the pandemic, when the DHHS suspended fidelity reviews, a fifth cohort of provider-evaluators were beginning training. Among the TMACT provider-evaluators were ACT team leaders, program managers and one ACT psychiatrist with affiliations across 14 behavioral health agencies.

Since 2015, 14 new ACT Teams were started; nine of those teams began within the past two years and have not been reviewed because of the pandemic. As depicted in Table 2, which displays descriptive data for a certified team[22] in currently in operation, there has been a steady growth in program fidelity across NC ACT teams. This is a result of ongoing, periodic fidelity assessment,

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quality feedback and guidance, and the DMH/DD/SAS-sponsored training and technical assistance. The DHHS currently funds 9.05 FTE staffing of the Institute, which includes the Director, Dr. Lorna Moser (0.50 FTE), and nine other trainers and consultants with expertise in ACT and/or IPS-SE. Of the ten Institute trainers, eight have direct experience working on ACT.

In Reviews 2 and 3, there was clear improvement in fidelity for most ACT teams, with the percent of "exceptional practice" (4.3% or higher) teams doubling across Reviews 1 and 2, and those in provisional certification status (3.0 – 3.6) decreasing by nearly 50%. The current Review 3 average rating of 3.73 does not account for the 14 teams awaiting a third review, of which the average rating was 4.08 during Review 2. Teams had access to robust fidelity and quality improvement plans through the full fidelity reports. The DMH/DD/SAS invested in the expansion of the Institute for Best Practices in 2016 to offer a fuller menu of technical assistance for providers. Since 2013, the Institute has continued to offer coaching and consultation to all NC ACT teams, facilitated the grassroots NC ACT Coalition, and either facilitated or coordinated the following series of DMH/DD/SAS-sponsored trainings:

Motivational Interviewing Training

Motivational Interviewing (MI) trainings commenced in FY 15 through current contract FY 20 and have included a series of Introductory MI, Advanced MI, MI practice circles, and MI specific to employment services. MI trainings specific to a service area were offered, including employment services, co-occurring disorder services, permanent supportive housing services, and psychiatric providers and nursing staff.

Psychiatric Rehabilitation and Tenancy Supports Training

A series of trainings to orient providers to enhancing the functional and participatory skills of those in community mental health services, particularly in TCL, were offered by the Institute in FY 15 and continue through FY 20. These include a quarterly Tenancy Supports Training; Psychiatric Rehabilitation Workshop; Psychiatric Rehabilitation for Enhanced Social and Community Inclusion; development and training in the use of the Profile of Participation; and monthly, web-based consultations on the topic of Tenancy Supports.

Integrated Treatment for Co-Occurring Disorders (COD)

In 2016, the Institute subcontracted with the Evidence-Based Practice (EBP) Center at Case Western Reserve University to kick-start a program of ongoing trainings in integrated treatment for COD. This series of statewide, two-day trainings aimed for both a broader audience and a smaller group of COD "champions" and continued with yearly offerings through 2018. The Institute again subcontracted with the EBP Center in 2021 to lead a series of virtual trainings, including two Integrated Dual Disorders Treatment Training (IDDT) Cohorts that met weekly: IDDT for family services and IDDT for program leaders.

Person-Centered Planning Workshop

In FY 16, the State undertook challenges in ACT Providers' practice of person-centered planning by bringing in international experts,[23] in partnership with Institute staff. Consultation calls with the

[23]

LME/MCOs focused on the challenges of creating person-centered plans, and targeted both providers and the LME/MCO utilization management staff responsible for authorizing ACT services. Additional consultation addressed the current Person-Centered Planning template.

ACT TEAM SHADOWING

In spring 2016 and spring 2017, Institute staff worked closely with the two UNC ACT teams to host, each year, eight to ten provisionally certified NC ACT Teams. Shadowing was used to teach ACT best practices. Selected teams sent three to four team members and were required to include the ACT team leader and psychiatrist.

TRAINING IN VIOLENCE RISK ASSESSMENT AND RELATED SHORT-TERM SYSTEMATIC, THERAPEUTIC, ASSESSMENT, RESOURCES AND TREATMENT

In the context of person-centered planning and providing personalized supports, this training focused on the use of the START. The FY 17 and FY 18 series included a web-based overview for the LME/MCOs, a broader introductory training, and advanced training workshops. In addition to its use to plan and to assess the need for more assertive engagement interventions, the training also assisted in making a case for the medical necessity for some individuals on ACT.

RECOVERY-ORIENTED COGNITIVE THERAPY (CT-R)

This series of trainings focused on implementing evidence-based psychotherapies for ACT and TCL. It included Community Support Team (CST), ACT, Transition Management Services (TMS), the DMH/DD/SS, and the LME/MCO staff. Institute staff created an application process for clinicians to request to be a part of trainings for CT-R "champions." A dozen CT-R champions, representing agencies across regions and the LME/MCOs, participated in monthly case-based consultations. In subsequent years, Institute staff and a "champion" hosted more local learning circles and additional Introduction to CT-R trainings.

FAMILY CONNECTIONS

The Institute subcontracted with Bette Stewart, an expert in family psychoeducation and ACT consultant with University of Maryland-Baltimore, in 2021 to host a series of learning collaboratives to teach outreach and engagement skills to ACT and other providers in the context of natural supports.

PEER SUPPORT MATERIALS

The Institute subcontracted with Peer Voice NC in 2021 to develop a behavioral health, human resource toolkit to assist with hiring, training, supervising, and support peer support specialists across service lines, including ACT, IPS-SE, and CST. Peer Voice NC and Institute staff are working in collaboration to create short training videos and facilitator guides to optimize the use of peers across these teams.

Outside of the specific contract with the DMH/DD/SAS, the Institute has offered a range of training and supports for providers, including quarterly, 16-hour ACT 101 workshops; quarterly permanent supportive housing workshops in collaboration with Peer Voice NC; and at least monthly community support team (CST) consultations ("Tea with CST"). The State's LME/MCOs have established

agreements with the Institute to provide more tailored training to their respective networks, with recent offerings of person-centered planning workshops to the Alliance LME/MCO provider network.

Although the first three years of the Institute was focused on fidelity reviews of teams across the state, over time, the Institute for Best Practice refocused its resources on trainings, coaching and consultations and on developing materials to support learning (e.g., website, recorded video skits). This shift was due, in part, to a titrated schedule of fidelity reviews[24] and the continued investment in ACT TA resources, e.g., additional full-time consultants and trainers and part-time media assistance.

In lieu of in-person fidelity reviews during the COVID-19 pandemic, the Institute conducted remote, virtual ACT Evidence-Based Practice Reviews in FY 2020. Institute staff, in coordination with Dr. Maria Monroe-DeVita, developed this alternative process as a reasonable substitute during the pandemic; it was approved by the DMH/DD/SAS. In addition to concerns about staff safety with in-person reviews, ACT practices necessarily had to change during the pandemic and fidelity reviews which may have result in lower ratings. The Institute completed EBP reviews on 18 teams during FY 2021.

As of January 2018, the DMH/DD/SAS shifted its focus from directly completing fidelity evaluations to engaging the LME/MCOs in utilizing fidelity evaluations as a provider network quality management tool. The DMH/DD/SAS facilitates at least annual meetings with LME/MCOs to review their network providers' performances, per most current fidelity findings. To this end, the DMH/DD/SAS staff analyze fidelity evaluation results; review quality improvement plans; discuss steps the LME/MCO is taking to improve ACT teams; and make recommendations for quality improvement actions. The DMH/DD/SAS staff also explore LME/MCO protocols and practices that could be directly or indirectly impacting fidelity. Since January 2021, the Adult Mental Health Team has participated in quarterly monitoring of each LME/MCO for access to employment and community-based mental health services for TCL recipients. The DMH/DD/SAS continues to focus on the provision of high-quality IPS-SE services as part of the ACT team, as well as ensuring that this service is available to individuals that are seeking support in employment or education. Looking to the future, the DMH/DD/SAS will continue to use fidelity information to assess and then address practice issues at a state level.

There is a continued need to provide ongoing, robust support to ACT Teams. Such support can promote on-going improvements in fidelity, as well as identify and address program fidelity drift. Areas of practice for targeted training include working with natural supports; person-centered planning; and revisiting training needs in co-occurring substance use disorders. In addition to ACT providers, directing these trainings to other community mental health providers and managing entities can assist in keeping everyone "on the same page" around practice expectations. Future fidelity reviews will feature the eTMACT, a "software-as-a-service" (SaS) approach designed to reduce the time devoted to reviews, while increasing reliability and accuracy of ratings. Other areas to address include offering providers examples of practice; propelling efforts to develop recorded practice demonstrations and companion guides for use in training; and adapting practices, in response to

[24] For example, full certification teams were reviewed less frequently than provisional certification teams.

COVID-19, from in-person to telehealth. Going forward, the State and its partners will continue to ensure that quality services are offered, even during uniquely challenging times.

Individual Placement and Support – Supported Employment

Individual Placement and Support – Supported Employment (IPS-SE) did not exist in North Carolina prior to 2013. In fact, the Transitions to Community Living (TCL) Settlement Agreement was the driving force behind establishing and expanding this innovative employment service to adults with mental illness. Before 2013, adults with mental illness that wanted support in finding employment would have to access the Division of Vocational Rehabilitation (DVR) independently or seek traditional supported employment services. The TCL elected to advance a more efficient, effective approach to supporting individuals with mental illness in finding and maintaining competitive integrated employment.

In 2013, the State joined the Dartmouth IPS-SE Learning Community (now Westat). The Learning Community not only provided partial funding to support five sites in start-up, but also offered extensive training, technical assistance and support. Four "Dartmouth Sites" were selected in 2013. These were the University of North Carolina (UNC) Center for Excellence in Community Mental Health, Easter Seals - Raleigh, Monarch - Albemarle and Meridian. By March 2014, there were 29 IPS-SE teams across the state. Additionally, the DMH/DD/SAS had 1.5 full-time equivalent (FTE) staff dedicated to training, technical assistance and fidelity support of IPS-SE and a contract with the North Carolina Employment First Technical Assistance Center, adding an additional 2.0 Full time equivalent (FTE) to support IPS-SE implementation. The DVR had 1.0 FTE at the state level dedicated to IPS-SE implementation.

The State subsequently transferred the IPS-SE training and technical assistance work to the UNC Institute for Best Practices and hired a new trainer. The DMH/DD/SAS advocated for increased funding to support additional IPS-SE trainers and proposed they be regionally located and work with no more than five IPS-SE teams, with the goal of improving the quality and fidelity of IPS-SE services. That funding was secured through the TCL budget in 2015, and the Institute added two IPS-SE trainers in the eastern part of the State. Starting in 2014, the Institute, along with staff at the DMH/DD/SAS and the dedicated state-level DVR staff, conducted fidelity evaluations on all IPS-SE teams. All evaluators completed evaluator trainings through Westat. As of June 2021, the state has 33 IPS-SE providers with one pending a baseline fidelity evaluation. A total of 9 teams have discontinued their IPS-SE services, with two such teams doing so during the COVID-19 pandemic. Of the 8 teams that had a Time 3 review, but no Time 4 to date, the average rating was 99. Similar to ACT, it is expected that the eventual review of these 8 teams will result in an average rating higher than 96 for Time 4. As of January 2020, the DMH/DD/SAS staff no longer participate in IPS-SE fidelity evaluations and focus instead on engaging the LME/MCOs in utilizing fidelity evaluations as a provider network quality management tool.

Fidelity Ratings of Currently Operating IPS-SE Teams					
		Time 1 (n=33)	Time 2 (n=30)	Time 3 (n=25)	Time 4 (n=17)
Total IPS-SE Fidelity Score	Mean	85	91	97	96
	Min	63	73	80	81
	Max	115	114	115	118
Staffing (S)	Mean	13	14	14	15
	Min	10	11	11	13
	Max	15	15	15	15
Operations (O)	Mean	24	25	28	28
	Min	15	15	17	20
	Max	34	36	37	37
Services (SV)	Mean	48	52	54	53
	Min	28	43	46	45
	Max	67	67	64	66

When the COVID-19 crisis arrived in March 2020, the Institute and the DHHS worked to create a way to measure practice remotely. A virtual Evidence-Based Practice Quality Assurance process was developed to retain connections with providers, assess practice and provide some targeted feedback on ways to improve practice and avoid significant drift. The process also provided an opportunity for the provider, the Institute, the DHHS staff and the LME/MCO staff to come together to debrief on findings of the report. Since adoption, 17 processes have been conducted by the Institute staff.

In addition to the coaching available to each team, trainings were developed to enhance practice. A two-day IPS-SE 101 training provided background on IPS-SE's role in TCL; recovery; a strengths-based perspective in employment services; an overview of the fidelity components; and an overview of evidence-based practice. Additionally, a series of service-level trainings were developed and provided in-person, on a rotating basis. These included training on how to develop a robust Career Profile; assisting individuals in making informed decisions on their disclosure preferences under the Americans with Disabilities Act; conducting individualized and targeted job development; service documentation; and individualized, follow-along support to sustain employment. Lyn Legere, Senior Training Associate with the Center for Psychiatric Rehabilitation at Boston University and a person in long-term recovery, has provided training for peer support specialists working on IPS-SE teams twice a year. The developers of the IPS-SE model, initially housed at Westat, were brought in to offer training on the Organizational components of the model.

Since its inception in North Carolina, the evolution of collaboration between the DVR and the IPS-SE teams has, as times, been challenging; but, continued work together has yielded substantial improvements. Initial technical assistance included education on the model, shifting culture within the DVR and increasing the understanding of sequential funding. In 2017, a statewide series of trainings were provided to IPS-SE teams and VR counselors to build some basic understanding of

process on each side, encourage conversations about sharing cases, and build rapport on commonality of mission. A targeted, technical assistance webinar series for the DVR staff in 2019, as well as a webinar series for IPS-SE teams on collaboration, proved successful. Technical assistance during 2020 focused on the LME/MCOs leveraging their support for utilization of the DVR milestones, promoting model sustainability.

Beginning in 2021, the DVR's Program Specialist for Behavioral Health participated in monthly meetings with the DVR and IPS-SE teams; joined monthly Team Lead calls led by the IPS-SE trainers at the Institute; and partnered closely with local DVR offices and IPS-SE teams to continue building positive working relationships. Additionally, the DVR's monthly technical assistance calls with DVR IPS-SE liaison counselors, as well as IPS-SE Teams, led to additional refinements to IPS-SE service delivery. The Institute has developed, and provided, a 2-day introductory training to IPS-SE for VR liaison counselors. A tentative plan exists to offer this training three times in 2022, for any counselors working with IPS-SE providers. Additionally, the Institute, the DVR, and the DMH/DD/SAS are discussing additional trainings for VR counselors in the coming years to include, e.g., an advanced, practical training on sharing cases and navigating people in services through both systems and a psychopathology for VR counselors tract on symptomology and its impact on the employment plan. Currently, all IPS-SE teams have contracts with the DVR. The DVR leadership remains committed to increasing collaboration, with high expectations that local DVR offices will work in tandem with the IPS-SE teams. The DVR, moreover, continues to fund the employment components of IPS-SE, increasing funds when evidence suggests high utilization of DVR's milestones.

In 2016-2017, the DMH/DD/SAS leveraged technical assistance through the Office of Disability Employment Policy's (ODEP) Employment First State Leadership Mentoring Program (EFSLMP) to collaborate with the DVR to develop a sequential funding structure for the payment of IPS-SE services. The State funds IPS-SE through either Medicaid (b)(3) funds or State funds combined with DVR funds. Both State and Medicaid funds were, at that time, being paid on a fee-for-service (FFS) basis, while the DVR reimbursed their providers using milestone payments. This was problematic, as providers were unsure which entity to bill for services rendered. As a result, too often providers only billed Medicaid or State funds and underutilized the DVR milestone payments. The Institute, per contract deliverables, attempted to address this challenge through a series of full day VR IPS-SE trainings in 2017 and individual consultation with teams. Recognizing that a broader system change was needed, the DMH/DD/SAS helped develop a new approach to IPS-SE payment: the North Carolina Collaborative for Ongoing Recovery through Employment (NC CORE) initiative.

NC CORE is an innovative payment structure that addresses the discrepancy between FFS and milestone payments by switching both the State and Medicaid FFS payments to milestones. The milestones align with the IPS-SE evidence-based practice and focus providers on the *quality* of service they are delivering versus the *quantity* of service they provide. Most importantly, the approach ensures providers can seamlessly transition from State or Medicaid funds to the DVR funds, maximizing all funding streams.

Vaya Health LME/MCO (Vaya) was involved in the development of NC CORE and volunteered to pilot NC CORE in 2019 across all IPS-SE teams in their network. They facilitated a soft start in November 2019, with the full payment pilot going live on December 1, 2019. The DMH/DD/SAS and the DVR continued to provide technical support and to adapt the model to fit the needs of both Vaya and their network. Vaya has conducted monthly stakeholder meetings throughout the pilot to review progress, While COVID-19 has had an impact on the implementation of NC CORE, the pilot continues to produce positive results. The IPS-SE providers in the Vaya network report a decrease in administrative burden, allowing them to spend more time supporting individuals in employment and educational pursuits. The percent of shared cases is significantly higher in Vaya than in any other LME/MCO receiving IPS-SE and using the DVR milestone payment: Vaya's average percentage was 56% shared, compared to 26% for the combined six other LME/MCOs, from January 2020 – June 2021.[25] All IPS-SE teams in the Vaya network have had their DVR contracts increased to serve more individuals as they approached the maximum of their contracts. Of significance, Vaya saved a considerable amount of state funds in FY 2021. With approval from the DMH/DD/SAS, the LME/MCO utilized some of the savings to fund the start-up of one, additional, IPS-SE team in an underserved area of their catchment region. They also provided stabilization funds to assist existing IPS-SE providers during the pandemic and invested in solutions to remove barriers to service access using, e.g., transportation and communication stipends for IPS-SE recipients and marketing materials to outreach marginalized members.

Expanding NC CORE state-wide is a priority for the DMH/DD/SAS. The DMH/DD/SAS facilitates monthly meetings with the DVR and the DHB to this end. In 2020, the Divisions presented an overview of NC CORE to all the LME/MCOs, followed by regular communication to provide technical assistance. In June 2021, the Divisions, with the help of Vaya, collaborated in an overview of the value-based payment model for LME/MCO executive leadership to ensure information was reaching those who would make decisions or influence the future of NC CORE.

Currently, follow-up meetings, providing technical assistance are planned for each LME/MCO that has not yet implemented NC CORE. Partners Health Management LME/MCO (Partners) is in the planning stage, with two IPS-SE providers preparing to transition to NC CORE by the end of the calendar year. Alliance Health LME/MCO (Alliance) plans to implement NC CORE in their network in October 2021, pending review of Alliance's proposals for modifications to NC CORE's payment model.

Individual Placement and Support – Supported Employment will remain a critical component of the adult mental health service array, even after the State successfully exits the TCL Settlement Agreement. It is part of the Tailored Plan service array, and the DMH/DD/SAS continues to explore ways to tie employment-specific outcomes to its contracts. The DVR and the DMH/DD/SAS both continue to advocate for additional LME/MCOs to adopt NC CORE. These developments clearly promote both a valued life outcome for people with mental illness and provider stability.

[25] Data is self-reported by IPS-SE providers and submitted quarterly to DMH/DD/SAS. Average DVR shared cases may not include individuals who were referred but not yet enrolled with DVR and/or may have been closed out by DVR.

COMMUNITY SUPPORT TEAM, TRANSITION MANAGEMENT SERVICES, AND PERMANENT SUPPORTIVE HOUSING

While Community Support Team (CST), Transition Management Services (TMS), and Permanent Supportive Housing (PSH) were not linked at the beginning of the Transitions to Community Living Initiative (TCL), these services are now closely tied together and carefully aligned to promote inclusion into the community.

Prior to the TCL, CST was a Medicaid and state billable service; however, it was not routinely used due to limitations in the policy and in the service definition. Specific issues included:

- Six-month maximum length of treatment, making it difficult to support individuals in achieving their goals.
- Entrance criteria, as written, prevented CST from functioning as a stepwise service. Individuals that had received ACT and needed a lower level of care were often deemed "too stable" to qualify for CST. Individuals who were not meeting their goals at lower levels of care often qualified for CST and ACT and would get referred directly to ACT for the more intensive, wrap around service.
- The training requirements for CST could be costly and difficult to meet. The CST was expected to select one of the interventions listed in the service definition policy and then to ensure that all staff had training on that specific intervention.
- Providers that operated CST found that the model was financially unsustainable due to the training requirements, rate of reimbursement, and prohibitions to working with individuals past six months.
- Psychiatric Rehabilitation and Supportive Housing Interventions were not included as required areas for which team assistance was provided to clients receiving CST.
- Many teams were not fully equipped to treat individuals with primary substance use disorder, as there was no requirement to have a substance abuse professional on staff.
- Transition Management Services (TMS) was not a service before 2013. It was established to address the needs of individuals participating in the TCL who did not clinically qualify for, or did not want to receive, existing services in the Adult Mental Health Service array, but who did need some supports specific to maintaining tenancy. The original service was Tenancy Supports Team (TST), which eventually became Transition Management Services (TMS.) A temporary revision to the TMS service was made on April 17, 2020, due to COVID-19, to include telehealth.[26] Contacts with individuals can now be in-person or through telehealth. In addition, TMS staff training deadlines were extended to 120 days from hire, to allow new staff additional time to receive required trainings.

[26] Telehealth is the use of two-way, real time interactive audio and video to provide care and services when participants are in different physical locations.

In the early years of the TCL, providers had difficulty providing services that aligned with Permanent Supportive Housing (PSH), an evidence-based practice. Initially, the Institute for Best Practices developed a brief tenancy supports training. That training provided a high-level overview of how to support individuals find and maintain housing. The training was four hours long and was required for all TMS staff, as well as at least one staff on each ACT team. Based on housing separation data, emails from landlords, and feedback from the LME/MCOs, the DHHS determined that providers would benefit from a more in-depth training that was centered around the PSH evidence-based practice. The DHHS contracted with the Technical Assistance Collaborative (TAC) to facilitate PSH training across the state and to train a pool of trainers to meet on-going needs. An intensive, 15-hour training was developed as a result: it is an in-depth exploration of the PSH model. It includes lecture, question and answer and role-playing exercises, all designed for staff to better their understanding of the Housing First[27] approach and its goals.

The DHHS requested that each LME/MCO and the Institute for Best Practices identify staff that had the experience and background to serve as PSH trainers. The DHHS additionally reached out through Peer Voice NC to identify individuals with lived experience to become PSH trainers. The call was for peers who had experienced homelessness or had lived in a congregate living setting. The DHHS felt it was critical for these individuals to be selected as PSH trainers, since they were able to dispel any myths or misconceptions, such as "readiness to be housed," and could also speak from firsthand experience about what had supported them in living in the community as well as what had not. In several of the trainings, individuals with lived experience were able to bring attention to the use of non-person-centered language, explaining how that can carry over into the way staff engage with individuals. Those with lived experience underlined how to be person-centered when supporting individuals and shared their successful experiences with a Housing First approach.

Permanent Supportive Housing (PSH) training became a requirement for TMS teams, ACT teams, and CST providers. The DMH/DD/SAS has audited at least one training by each LME/MCO, as well as that of the Institute for Best Practices and a Peer Voice NC partner, to ensure that both the content and practice principles align with the TAC's training. The DMH/DD/SAS intends to continue monitoring PSH trainings and training of new PSH trainers. This will avoid "practice drift," and ensure that providers are receiving information aligned with PSH evidence-based practice.

[27] Housing First is a proven approach in which people experiencing homelessness are offered permanent housing with few to no preconditions or barriers. It is based on significant evidence that with the appropriate levels of services, people experiencing homelessness can achieve stability in permanent housing. Housing First yields higher housing retention rates, reduces the use of crisis services and institutions, and improves people's health and social outcomes. See http://www.tacinc.org/technical-assistance-consultation/knowledge-areas/housing-first/

COMMUNITY SUPPORT TEAM

The State's CST policy and service definition underwent significant revisions, as well as a rate evaluation, to support the CST in better alignment of practice with the PSH approach. The staffing requirements for CSTs were modified to allow for the hiring of a Certified Peer Support Specialist (CPSS). A 30-day pass through was added to permit CSTs to engage with individuals and start providing services on "day one" instead of having to focus on intake and person-centered planning work as a priority. When an individual has been identified as needing support in a housing search, the CST can request additional units for the purpose of providing permanent supportive housing interventions and increased support during the search. The CST caseload size was decreased from one staff working with 15 individuals to one staff working with 12 individuals, with a maximum of 48 individuals served by one CST. Every team is now required to have a substance use professional. Finally, tenancy support interventions were added into the service definition scope of work, as well as requirements to complete a functional assessment, provide psychiatric rehabilitation interventions and actively support individuals with skill acquisition and development.

In April 2020, due to the COVID-19 pandemic, the DMH/DD/SAS and NC Medicaid made temporary modifications to the Clinical Coverage Policy, including the CST service definition. Some of the temporary changes include the following: waivers of training requirements; changes to staffing requirements; paused monitoring of service delivery; and allowance for telehealth services, a real-time, interactive audio and video approach to providing services when people are in different locations. These temporary changes are retroactive to March 10, 2020 and will be in place until the North Carolina state of emergency is lifted or when the Medicaid policy is rescinded.

"TEA WITH CST" CONSULTATIONS

In response to the COVID-19 pandemic, DHHS reached out to the UNC Institute for Best Practices for guidance, support, and technical assistance for CST providers. UNC began facilitating *Tea with CST* in May 2020. The meeting was originally hosted for 45 minutes every other week. The format includes a 15–20-minute educational presentation on various evidence-based practices; a brief question and answer period; and a participant's case example on the presentation topic. The attendance at the meetings was inconsistent, so the meeting was changed to once a month, starting in January 2021. After reaching out to LME/MCOs regarding the benefits of CST providers attending these meetings, DHHS saw a significant increase in attendance.

PEER SUPPORT SERVICES (PSS)

Going into TCL, North Carolina already had a long history of peer supports. There was, for example, an established certification process that established and utilized core standards to certify peer support specialists. The creation of Medicaid "In Lieu Of"[28][1] service definitions and State Alternative

[1] Federal law allows LME/MCOs operating under the 1915(b)(c) waiver to develop services that are cost-effective options to behavioral health services offered by the state. These services are called In Lieu Of or Alternative Services, depending on the funding source. Medicaid-funded services are known as In Lieu Of Services; those supported with state funds are called Alternative Services. Regardless of the funding source, In Lieu Of and Alternative Services are extra supports that may not be covered in the state's approved service array. See https://www.cardinalinnovations.org/Resources/Blog/In-Lieu-Of-and-Alternative-Services#:~:text=Medicaid%2Dfunded%20services%20are%20known,funds%20are%20called%20Alternative%20S

Service definitions also expanded the access to and funding to support PSS. The DMH/DD/SAS collaborated with UNC School of Social Work Springboard program[2] to oversee and manage the certification process, including reviewing and approving--through a CPSS workgroup that included peers--the certification training curricula that are used to certify PSS in NC. The collaboration extended to the management of a statewide database which now has more than 4000 CPSS-registered, certified Peer Support Specialists. In April 2020, the Division issued a call-for-action and the convening of a group of PSSs to develop recommendations for a state CPSS credentialing and accountability board. The response to the call was the establishment of a Peer Support Expert Commission[3] that has developed recommendations for credentialing Peer Support Specialists as service providers. Included are recommendations regarding the powers and duties of a proposed certification oversight board; board membership and selection process; and procedures for responding to complaints, investigations and disciplinary actions. In the summer of 2020, the Commission sought public comment for the recommendations and continued to meet with the DMH/DD/SAS staff to collaborate on implementation of the recommendations. The establishment of an independent oversight/credentialing PSS board is one of the Division's core goals.

While enhancing the certification and oversight process, the DMH/DD/SAS partnered with the DHB to add Peer Support Services (PSS) to the Medicaid State Plan, ensuring that PSS is an entitlement service for Medicaid beneficiaries. The process involved three, stakeholder webinars on the proposed changes, as well as a 45-day public comment period. The PSS Medicaid policy went live December 12, 2019.

The DMH/DD/SAS sought technical assistance from the Georgia Mental Health Consumer Network on engaging individuals with lived experience in program development, service delivery and oversight of CPSS. The DMH/DD/SAS staff subsequently secured funding for a Request for Applications (RFA) for a peer-run organization to establish Peer Operated Respite Services (PORS). These services fill a unique gap in the State's community-based crisis service array. It is a consumer-run, short-term respite program for individuals in the early stage of a behavioral health crisis. Services are voluntary and people seeking support from the respite program are called guests. All staff are CPSSs, and the supports they provide are aligned with Peer Support Services. The program offers no clinical interventions and there is no requirement to meet participation expectations by

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ervices.&text=The%20North%20Carolina%20Division%20of,oversees%20state%2Dfunded%20Alternative%20Services .

[2] University of North Carolina-Chapel Hill (UNC-CH) Behavioral Health Springboard (BHS) at the School of Social work links current research to initiatives in mental health and substance use disorder prevention and treatment. BHS offers curricula development, technical assistance, program consultation, and face-to-face and online educational programs.

[3] The Commission was established with the task to deliver recommendations to the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services on the occupational regulation of peer support practice and related matters. The Commission is composed of a diverse group of experts with representation from various geographical areas, age groups, racial, ethnic, and cross-disability groups, as well as the LGBTQIA community. members have experience working within organizations that provide Medicaid services and state-funded Peer Support Services. Members also are working in peer-run organizations and many are individuals who have lived experience in recovery with mental health and substance use disorders. See https://pss.unc.edu/pss-commission/about

staying at the respite center. Because the service is voluntary, guests can come and go as they need, and can continue to work, go to school, or engage in clinical treatment, as they choose.

In State Fiscal Year (SFY) 2018, Sunrise Community for Recovery and Wellness (Sunrise) received funding to establish the Brian H. Clark Respite Center.[4] The Center began renting a three-bedroom house in Asheville and has done significant outreach to increase awareness of PORS and how to access its supports. Guests are asked, but not required, to leave feedback regarding their stay, and have said the following about the Brian H. Clark Respite Center:

- "I was feeling overwhelmed with my problems and would have ended up hospitalized [if I hadn't stayed at the respite center]."
- "In a hospital, you are expected to get better. In respite, you are provided an atmosphere to get better."
- "I think [respite] is a better alternative for people who are suicidal and experiencing emotional distress."
- "[I experienced] stress from the gauntlet of services that I am theoretically supposed to navigate while depressed and [felt] obliged to camp out way out of town in order to be safe. In many ways, autism is a social disability and forced interactions are ridiculously draining. The respite center became my headquarters and place to retreat while recovering my balance."
- "There is no comparison [between hospital and respite]. You made me feel like I was at home; at the same time, staff were there to help. Respite is heaven… infinitely better than a hospital in all areas."

In addition, the DMH/DD/SAS invested in funding a service provider network—United Partners of Health—to increase CPSS in areas that have high rates of COVID-19 with a particular focus on Highly Marginalized Populations (HMPs). This contractor is hiring and training CPSS to partner with community health workers as liaisons among BH/IDD consumers, Public Health, and DSS agencies in rural NC communities with high numbers of COVID-19 cases and/or limited access to testing and access to services. Peers will assist individuals experiencing mental health crisis, or at risk of emergency department utilization, in navigating healthcare systems and service delivery modalities, including: telehealth; testing and contact tracing; services to address social determinants of health; and support for adherence to treatment plans. Peers will also assist in the development of positive relationships, to reduce stigma as a barrier to whole-person care, and in building inclusive communities.

In SFY 2021, another competitive RFA was released to support the standing up of two Peer Run Wellness Centers with a business incubator to help with stand up. Promise Resource Network was awarded the contract for the incubator with Green Tree Peer Support Program in Forsyth County and Green Tree in Macon County. Promise Resource Network will develop a plan for the centers to become Peer Run Wellness Centers, with the opportunity to grow into a Peer Operated Respite over the next two to three years.

[4] See http://www.bhcrc.sunriseinasheville.org/

CRISIS SERVICES:

Crisis services are the most basic element of mental health care because the service immediately and unconditionally accepts everyone seeking help. These services align with the needs of the person when the person needs it most. The DMH/DD/SAS has worked collaboratively with the DHB to ensure that, as Medicaid Transformation progresses, Standard Plans and Tailored Plans contract with all crisis services.

Following are highlights of the crisis services accomplishment for this annual report:

- Federal legislation mandating the rollout of the 9-8-8 implementation[29] has enabled the development of a full comprehensive crisis system, including enhancement of the NC Lifeline, increased mobile crisis teams, and increased follow-up for those in crisis.
- The DMH/DD/SAS was awarded the planning grant for crisis services planning. This grant provides technical assistance from Vibrant Emotional Health to fulfill eight Core Criteria for 9-8-8 planning and implementation in partnership with North Carolina's current National Suicide Prevention Lifeline (NSPL) –REAL Crisis Intervention, Inc.
- As part of the comprehensive crisis system, planning is in progress to implement the Crisis Referral System Tracker. This is a state-of-the-art crisis, inpatient and residential bed tracking and crisis referral system that monitors real time tracking of bed availability, demand, trends and use of residential and crisis beds for children and adults. It also shares outcomes across systems and develops dashboards to track youth and adults in residential care, emergency departments and out-of-state placements.
- New Behavioral Health Urgent Care (BHUC) and Facility-Based Crisis (FBC):
    - Daymark Recovery Services opened a BHUC and Adult FBC program in Randolph County adding 16 beds in the Sandhills area. They also opened a child BHUC with anticipating a child FBC in Richmond County.
    - Recovery Innovations re-opened the adult FBC and opened an BHUC in Cumberland County.
    - Guilford County opened a BHUC and an adult FBC
    - Guilford County's child FBC is under construction, with an anticipated opening in December of 2021.

PERSON-CENTERED PLANNING:

During this period, the DMH/DD/SAS worked on new guidelines for its Person-Centered Planning process. The new guidance focuses on self-advocacy and places an enhanced emphasis on self-determination and choice for individuals. This guidance is rooted in the belief that all people have the right to live, love, work, learn, play, and pursue their dreams in their community. The framework of this belief consists of the following values and principles:

- Person-centered planning builds on the individual's/family's strengths, gifts, skills, and contributions.
- Person-centered planning supports consumer empowerment and provides meaningful options for individuals/families to express preferences and make informed choices to identify and achieve their hopes, goals, and aspirations.

[29] The National Suicide Hotline Designation Act, federal legislation designating 988 as the three-digit dialing code for the Lifeline, was signed into law in October 2020. This was the outcome of many years of activism by the mental health community for the creation of an easy-to-remember telephone number that would increase accessibility of the Lifeline. The Federal Communications Commission has required telephone providers to make calling to the Lifeline via 988 accessible by July 16, 2022.

- Person-centered planning is a framework for providing services, treatment and supports that meet the individual's needs, and that honors goals and aspirations for a lifestyle that promotes dignity, respect, interdependence, mastery and competence.
- Person-centered planning supports a fair and equitable distribution of system resources.
- Person-centered planning creates community connections. It encourages the use of natural and community supports to assist in ending isolation, disconnection and disenfranchisement by engaging the individual/family in the community.
- Person-centered planning sees individuals in the context of their culture, ethnicity, religion, sexual orientation and gender identity. All the elements that compose a person's individuality are acknowledged and valued in the planning process.
- Person-centered planning supports mutually respectful and partnering relationships between individuals/families and providers/professionals, acknowledging the legitimate contributions of all parties.

This guidance enables the development of each Person-Centered Plan and covers various life domains. It defines a person-centered action plan, as well as a comprehensive crisis plan. Additionally, the DMH/DD/SAS is developing state-approved training, as well as the monitoring indicators for providers and LME/MCOs.

COMMUNITY INCLUSION:

At the inception of the Transitions to Community Living Initiative (TCL), there was no direct focus on community inclusion. There was indirect work occurring, e.g., technical assistance on psychiatric rehabilitation to Assertive Community Treatment (ACT) teams and increased access to employment in the community through Individualized Placement and Support–Supported Employment (IPS-SE). Still, nothing in the early years of TCL focused on actively supporting people to become a part of the community; nor was there any overt consideration of the impact that being included can have on individuals remaining in community housing.

In 2017, this changed. Key staff from the DMH/DD/SAS, along with the Executive Director of the Alliance of Disability Advocates of North Carolina (ADANC), attended the Temple University Summer Institute on Community Inclusion. The conference highlighted existing and emerging research basis for community inclusion; illustrated how community inclusion can be woven into and directly impact specific domains of everyday community life; and reviewed the work of targeted community inclusion programs. This led to the TCL staff embracing community inclusion as in and of itself essential and central, as opposed to an "add-on" to another service definition.

The TCL then made, a significant change to enhance its focus on community inclusion. It developed a contract with the Alliance of the Disability Advocates of North Carolina (ADANC)[30] to provide community inclusion supports to individuals participating in TCL, initially in the Eastpointe Local Management Entity-Managed Care Organization (LME/MCO) catchment area. The DMH/DD/SAS provided funding to support the ADANC and Eastpointe staff to access training and technical

[30] The ADANC is a federally recognized Center for Independent Living that uses Title VII funding to provide services to the citizens of Raleigh, Durham, and the surrounding area. Although ADANC's services focus on Raleigh-Durham surrounding areas. By design, CILs are consumer-controlled, community-based, cross-disability, non-residential, private non-profit agencies that serve their surrounding communities. See https://adanc.org/about-us/history/

assistance provided by Temple University. This included how to use Temple's engagement and assessment tools, as well as, more broadly, how to support individuals to engage in their communities. All staff working with the ADANC on this pilot have a disability; both staff and TCL participants indicate that peer-to-peer engagement has enhanced the service.

Incident to the pilot, the Eastpointe LME/MCO has seen an improvement in its TCL housing retention numbers. The US Department of Justice (DOJ) has called the partnership between a Center for Independent Living (ADANC) and an LME/MCO an "innovative approach to addressing the TCL Settlement Agreement." The Independent Reviewer for the Settlement Agreement has noted the positive impact the focus on community inclusion has had on housing retention.

The TCL program has advanced a second significant change by dedicating funds to support the National Alliance on Mental Illness North Carolina (NAMI NC) affiliates in community inclusion work. In 2019-2020, NAMI NC provided funding to five of its affiliates to develop and implement community inclusion pilots, using Temple's online community inclusion tools. That same year, NAMI NC held four Community Inclusion (CI) Trainings across the state for two members of each NAMI affiliate. NAMI NC developed a process, in partnership with the DMH/DD/SAS, to help affiliates implement events in their local communities. Five affiliates applied for and received grants for seven CI projects.

In 2020, CI projects and events carried on, despite COVID-19. These projects included initiatives such as pet adoption classes, library "read and share" programs and a mental health symposium. In 2020-2021, NAMI NC continued its efforts, providing additional trainings for affiliates across the state and encouraging affiliates to apply for mini grants to implement CI events/ projects of their own. In the last quarter of this fiscal year, NAMI approved two more affiliates (Durham and South Mountains) for CI grants for a total of eight approved projects. The DMH/ DD/ SAS added community inclusion as a deliverable in the new contract with NAMI NC. They are projected to implement six to nine community inclusion events, through affiliates across the state, during this contract year.

NAMI NC affiliates across the state have all been trained in Temple University's Community Inclusion Model and have embraced the opportunity to implement CI projects in their communities. With expansion Mental Health Block Grant money, they are working to increase access to support groups for Spanish-speaking persons with mental illness.

The ADANC has supported 138 people with 3.75 staff in the Eastpointe LME/MCO catchment area. The pilot received Freedom Funds which helped people purchase, e.g., gym memberships, scooters, and bicycles to support better access to the community.

The ADANC and Alliance LME/MCO community inclusion pilot is approaching its first year in operation. Currently, ADANC is serving 58 people with 1.5 staff. Referrals have been steady, and the collaborative monthly meetings continue.

A third ADANC community inclusion pilot is in the works in the Sandhills LME/MCO catchment area. Sandhills has approved the proposal and the implementation plan is being finalized.

Mark Salzer, Ph.D., along with Bryan McCormick, Ph.D, at Temple University Collaborative on Community Inclusion reached--through webinars, conference presentation, training, and technical assistance--the following audiences across the state: In-Reach professionals, Centers for Independent Living staff, TCL providers, and LME/MCO staff.

They reached over 320 people involved in TCL on topics which included the following:

- Basics of Community Inclusion
- Approaches for promoting community inclusion and participation
- Strategies for LME/MCOs to promote community inclusion
- Introduction to Community Inclusion and fundamentals

Dr. Salzer and his team at Temple University will continue providing the State with community inclusion training and technical assistance. The scope of work for this year will include further collaboration with DMH/DD/SAS, specifically with its Housing and Transitions team.

DHHS closes this section with a quote from an individual in the NAMI NC community:

″Community Inclusion is near and dear to NAMI North Carolina because it's so central to our mission. We're grateful that our local affiliates have had the opportunity to create and expand local spaces that celebrate difference and welcome individuals with serious mental illness and their families.″

TCL AND OTHER COMMUNITY INCLUSION ACTIVITIES IN NORTH CAROLINA IN FY 20-21

Mark Salzer, Ph.D, Temple University Collaborative on Community Inclusion, offers this contribution to the TCL Annual Report, in sections U-W:

ADANC/Eastpointe Initiative (Dr. Salzer)

During FY 20-21, we continued to support the Alliance of Disability Advocates of North Carolina (ADANC)/Eastpointe TCL initiative, including the review of data to inform future decision-making regarding the program. In this section I review the main observations and mention future directions.

Participation Data

More than 100 TCL consumers were referred to ADANC for services as of 12/9/20. Approximately 75% of these individuals engaged to some degree with ADANC supports. Many individuals were referred in early 2020 as the pandemic was emerging, which complicated data collection activities involving the use of the Temple University Community Participation measure (TUCP) with these individuals. TUCP data from 47 individuals, as they began their engagement with ADANC, were available and analyzed. The results suggest the following:

- TCL participants have many interests that are important to them upon entry into the program: Participants had an overall mean of 17.70 out of 24 areas that were important to them. This is similar to the number of important areas we see in the general population, and the individual areas that TCL participants indicate as important to them (e.g., work for pay; spending time with friends) are comparable to the general population.

- TCL participants are doing "enough" in very few areas that interest them upon entry into the program: Participants indicated that they did "enough" in an average of only 2.13 areas that are important to them (out of 24 possible areas). Sufficiency of participation was 14%, which is possibly the lowest level of sufficiency I have seen with any population of individuals with serious mental illnesses (SMI) using the TUCP. Approximately half of the individuals are not doing enough in any of the areas that are important to them when they enter the ADANC TCL program. These results support the need for the ADANC TCL initiative.
- We have baseline and follow-up data from a very small sample of ADANC/TCL program participants. While some caution should be taken with small sample sizes, our results indicate that these participants experienced a very large increase in areas that are important to them and where they indicate doing enough in (an average of 5.5 more areas) and experienced a 30% increase in sufficiency (number of areas that are important where they report doing enough divided by the total number of important areas), which is substantial.

Housing Tenure

We examined housing data for the 75 individuals in Eastpointe's TCL program who were referred to ADANC prior to March 16, 2020 (start of the pandemic). We excluded 11 of these individuals from the analyses because they were never housed, leaving us with a sample of 64. Fourteen of these 64 (18.67%) individuals never had a contact with ADANC. Thirty-eight out of 50 (76%) who had at least one contact with ADANC remained housed during the evaluation period through July 2020. We have been informed that the statewide TCL continuous housing rate since 2013 is 66%. The results from our evaluation are promising, but we must also keep in mind that it is currently unknown whether ADANC TCL participants differ in some way, either positively or negatively, compared to those who did not choose to participate.

Service Utilization

ADANC supports are consumer-driven and emphasize problem-solving around meeting consumer identified needs and desires. Increased engagement in certain mental health services that are preventative, and decreased crisis and hospital services, were hypothesized as possible outcomes of the supports offered by ADANC. De-identified service utilization data were obtained from Eastpointe to address these hypotheses.

We have now analyzed changes over time in service utilization for the 50 individuals who were housed, referred to ADANC by 3/16/20, and who had at least one contact with ADANC staff. Here are our findings:

1) There was an <u>increase</u> in service use from the pre-ADANC time period to post-ADANC time period (after their first contact through July 2020).
    - ACTT units went from an average of 0.9 units of service per month to 1.8 units of service per month.
    - CST units went from an average of 3 units of service per month to 6.6 units of service per month.
2) There was no change in emergency department visits or psychiatric hospital days.

The increase in ACTT and CST units indicates that these TCL participants had service needs and that working with ADANC may have facilitated their engagement with ACTT and CST service providers. This is a positive outcome and suggests that ADANC may be helping to further activate self-determination and self-care among TCL participants with whom they work. The lack of identified pre-post changes in emergency department visits and hospital days is likely because these are relatively infrequent events, and it is generally hard to detect changes over time in these areas.

Reflections and Next Steps with ADANC TCL Initiatives

1) I would encourage ADANC, Eastpointe, and the other LME/MCOs that have become engaged in similar partnerships with ADANC (e.g., Alliance) to remain motivated to gather and review these types of data as they continue with this initiative. This includes consistently gathering TUCP data, reviewing information about program participation, and examining housing tenure and service utilization patterns.
2) One caution is that the continuing influences associated with the pandemic will likely impact our ability to identify substantial impacts on participation using the TUCP. I am involved in other efforts with adults with serious mental illness (SMI) and autism, which clearly demonstrate that the pandemic is impacting their lives as well as everyone else's. Nonetheless, gathering data using the TUCP will continue to be useful to ADANC staff as they provide supports.
3) I would also encourage ADANC to document the anecdotal experiences they are having with consumers, which I believe are very impressive and complement the types of other information we have about the impact of the program.
4) In May 2021, ADANC and Eastpointe enthusiastically pursued the use of "Freedom Funds" that were made available by the State to support the self-directed community inclusion goals of TCL consumers. I was impressed with the efforts of ADANC to quickly work with consumers to identify their needs and to rapidly purchase goods and services that were consistent with their community inclusion goals. I was also impressed with Eastpointe's efforts to support these purchases while providing appropriate administrative oversight. I look forward to working with ADANC to document the impact of these purchases on the lives of TCL consumers. I would also encourage the State to continue to consider expanding the availability of "Freedom Funds" and provide as much lead time as possible for their use.

NAMI COMMUNITY INCLUSION CONVERSATIONS AND PILOT PROJECTS (DR. SALZER)

It has been a pleasure to continue to work with NAMI NC leadership; they clearly understand and support community inclusion as essential for the lives of individuals with SMI. During this past fiscal year, I was engaged in monthly conversations with their local affiliates to discuss various things they might consider doing to promote community inclusion in domains such as work, education, faith, leisure and recreation, volunteering, and other areas. Next steps include supporting NAMI NC and their affiliates in developing and implementing community inclusion pilot projects that further an authentic, sustainable community inclusion agenda within their communities. Consumer- and family member-led efforts to promote community inclusion are essential for making it a reality.

STATEWIDE TRAINING ON COMMUNITY INCLUSION (DR. SALZER)

Over the past fiscal year, we have delivered 17 separate trainings to TCL program staff across the state, LME/MCO staff, NAMI affiliates, and others. A conversation also occurred with the statewide Olmstead Plan Stakeholder Advisory (OPSA) Committee on Quality Assurance and Quality of Life. There was clear interest in community participation as a possible quality of life indicator. The continuing pursuit of community participation as an Olmstead Plan indicator would provide a huge boost to incentivize providers to further attend to it as a critical indicator of community inclusion not only in TCL programs, but across all programs.

Final Thoughts

The pandemic has made everyone aware of the importance of social interactions in our lives. Dramatic changes in how we spend our days, especially limitations on our participation, have increased social isolation and loneliness, which are identified as social determinants of health. These experiences should heighten our awareness of the importance of these issues for people with serious mental illnesses who experienced high rates of social isolation and loneliness prior to the pandemic, and even more during the pandemic.

Next steps should include a continued focus on the promotion of community participation that facilitates social interactions and "mattering," where people with SMI feel wanted by others and their communities. Attention also needs to be paid to those who were engaged in activities prior to the pandemic but may need assistance in "re-starting" their participation. Finally, the continuing ambiguity about the pandemic and restrictions on participation suggest a need to support participation, as much as possible, virtually and in other ways that maintain health and safety.

V. TCL COMMUNITY-BASED MENTAL HEALTH SERVICE PATTERNS

Tables in this section summarize numbers of participants who received core TCL services as required in III.G.8.a. of the Settlement Agreement: "The State will publish, on the DHHS website, an annual report identifying the number of people served in each type of setting and service described in this Agreement." Service summaries are based on NCTracks Medicaid and the DMH/DD/SAS adjudicated behavioral health service claims for the TCL participant populations described in Table 1 and for Calendar Year (CY) 2020 service dates.[31,32,33]

Table 1: CY 2020 Service Claims Query Participant Populations

Participant Status	Description	Unduplicated Count
TCL Housing	Individuals in TCL housing for one or more days of CY 2020 or who were previously housed and subsequently rehoused by April 30, 2021; at end of CY20, these individuals had been in housing for an average of 2.4 years, ranging from 1 day to 8 years; they were in TCL housing an average of 302 days in CY20, ranging from 1 to 366 days; the service period for under 1% of these individuals was less than 7 days	3,163
Transition Planning	Individuals initially housed by March 30, 2021 and for whom one more pre-transition days after the earlier of housing slot approval or the 91st day preceding transition occurred in CY 2020; the average length of the CY20 service period examined for these individuals was 96 days; the service period for 3% of these individuals was less than 7 days	923
In-Progress (In-Reach and Diversion)[c]	Individuals with a seven-day or longer Transitions to Community Living Database (TCLD) status of "In-Progress" in CY 2020 and who matched to clients in NCTracks; the average length of the CY20 service period examined for these individuals was 276 days	7,979
Housed in the Community without a TCL Housing Slot[d]	Individuals with a seven-day or longer period of CY 2020 TCLD status of housed in the community without a TCL slot and who matched to clients in NCTracks; the average length of the CY20 service period examined for these individuals was 305 days	3,322
Total		**13,043**

[31] NCTracks is the multi-payer Medicaid Management Information System for the NC Department of Health and Human Services.
[32] Analysis is based on claims for CY 2020 dates of service that were adjudicated through July 27, 2021. Timely filing limits may affect data completeness, especially for services provided late in CY 2020.
[33] Service summaries and other service-based outcome measures in this Annual Report are based on a Calendar Year (CY) rather than State Fiscal Year (SFY) due to lag time been service delivery and the availability of service claims information in the NCTracks data warehouse.

a- A subset of 567 (61.4%) of individuals in the Transition Planning group have Diversion activity documented in the DHHS Referral Screening Verification Process (RSVP) during CY20.
b- The In-Progress category primarily includes individuals who received In-Reach services during CY20. A subset of 1,406 (17.6%) also have Diversion activity documented in RSVP during CY20.
c- A subset of 193 (5.8%) individuals housed in the community without a TCL housing slot also have Diversion activity documented in the RSVP during CY20.

The total unduplicated count of 13,043 individuals in the initial claims query included 10 (0.08%) participants who had all four statuses at different points during the year, 449 (3.4%) duplicated across three status categories, and 1,414 (10.8%) with two statuses. The large majority, 11,170 (85.6%), had one status during the year.

Professional (non-institutional) fee-for-service and Medicaid encounter behavioral health service claims for the full calendar year were initially queried for all 13,043 individuals. Claims for services provided within date ranges that participants had one of the active program status categories in Table 1 were retained for further analysis; all other claims were excluded from further analysis.

Individuals are included in the service claims analysis for each status they had during the year, with dates of service of claims examined for each individual limited to the date range the individual had the corresponding status. For individuals who transitioned to supportive housing, status periods of In-Progress or Housed-in-Community were end-dated on the earlier of the housing slot approval date or the 91st day before the transition to housing. Services for those dates through the day before transition are included under the Transition Planning status.

Table 2 shows numbers of individuals for whom the NCTracks query returned claims for mental health (MH), substance use (SU), and/or intellectual/ developmental disabilities (I/DD) services within each individual's CY20 "from" and "to" date range for each status. The totals reported in Table 2 are used as denominators in calculations of percentages of individuals served in the tables that follow.

Table 2: Participant Population Sizes for Community Mental Health Services Analysis

LME/MCO [a]	TCL Housing	Transition Planning	In Progress	Housed in Community
Alliance	431	133	995	193
Cardinal	855	217	1489	373
Eastpointe	252	72	351	255
Partners	361	74	525	177
Sandhills	317	72	285	138
Trillium	471	143	680	305
Vaya	392	133	902	382
Statewide Total	3,078	843	5,222	1,823
Total Queried	*3,163*	*963*	*7,979*	*3,322*
Percent with CY 2020 MH, SUD, or I/DD Service Claims	*97.3%*	*87.5%*	*65.4%*	*54.9/*

d- Reported percentages of individuals served are based on housed individuals' LME/MCO at the time of the claims query or the LME/MCO on record in TCLD for the period of the corresponding status category. Approximately 5% of TCL participants have transferred across catchment areas since initially transitioning to community-based supportive housing, and some services reported under the LME/MCO on record may have been managed by a different LME/MCO. Small numbers of individuals also are duplicated across status/LME/MCO combinations.

Data tables that follow show statewide and LME/MCO numbers and percentages of individuals within each TCL status category who had adjudicated claims for services within each category shown in Table 3 within the date range of the status period.

Table 3: Core TCL and Support Service Categories

Service Category	Services Included
ACT	Assertive Community Treatment Team
CST	Community Support Team
Crisis Services	Behavioral Health Urgent Care (BHUC) Mobile Crisis Management (MCM) Facility-Based Crisis (FBC)
Evaluation & Management Office and Outpatient Visits	New and Established Patient Office/Outpatient Visits Office Consultations Behavioral Health Counseling Outpatient Psychiatric Services Mental Health Partial Hospitalization
IPS-SE	Individual Placement and Support - Supported Employment (IPS-SE) (b)(3) IPS-SE
Peer Support Services	Self-Help/Peer Support
Psychological Diagnostic, Evaluation, and Testing	Neuropsychological Testing and Evaluation Psychological Testing and Evaluation Psychiatric Diagnostic Evaluation
PSR	Psychosocial Rehabilitation Services
Psychotherapy	Individual Psychotherapy Group Psychotherapy Family Psychotherapy Outpatient Dialectical Behavior Therapy (Group and Individual) Psychosocial Rehabilitation Services
Substance Use Services and Treatment	Alcohol/Drug Group Counseling, Halfway House, and Residential Ambulatory, Inpatient, and Social Setting Detox Counseling for smoking and tobacco use Medication Assisted Treatment (MAT) Substance Abuse Comprehensive Outpatient Treatment (SACOT) Substance Abuse Intensive Outpatient Treatment (SAIOP)
Transition Management and Tenancy Support Services	Tenancy Support Team (TST) Critical Time Intervention (CTI) (b)(3) Individual Supports

As in previous years, observed service rates demonstrate that the State is meeting the requirement to provider tenancy support services to members with housing slots, through TMS, CST, or ACT services. Crisis service use remains low and is highest for individuals living in the community without TCL housing slots. Significant percentages of individuals in all pre-transition statuses, as well as after transitioning to TCL supportive housing, received core services and other supports. Service rates for comprehensives services, such as ACT, tend to be higher for TCL Housing and Transition Planning categories, while rates for services such as Psychotherapy are higher for individuals in pre-transition planning statuses. A substantial increase in percentages of individuals who received CST and corresponding decreases in percentages receiving other services that include a tenancy support service component was also observed; this change was expected due to CST program changes described in the Services section of this Annual Report

Table 4: Individuals Who Received Core TCL Services and Supports While in TCL Supportive Housing, Calendar Year 2020

	All Services		Assertive Community Treatment Team (ACT)		Community Support Team (CST)		Crisis Services		Evaluation & Management Office/ Outpatient Visits		Individual Placement and Support-Supported Employment (IPS-SE)	
	Denominator		N	%	N	%	N	%	N	%	N	%
Alliance	431		202	47%	180	42%	12	3%	133	31%	53	12%
Cardinal	855		278	33%	201	24%	32	4%	243	28%	28	3%
Eastpointe	252		97	38%	41	16%	10	4%	83	33%	8	3%
Partners	361		170	47%	86	24%	24	7%	103	29%	25	7%
Sandhills	317		161	51%	68	21%	4	1%	73	23%	21	7%
Trillium	471		148	31%	105	22%	35	7%	170	36%	36	8%
Vaya	392		204	52%	154	39%	12	3%	88	22%	20	5%
Statewide	3,078		1,259	41%	835	27%	129	4%	893	29%	191	6%
	Peer Support Services		**Psychological Diagnostic, Evaluation, and Testing**		**Psychosocial Rehabilitation (PSR)**		**Psychotherapy (Individual, Group, and/or Family)**		**Substance Use Services and Treatment**		**Transition Management and Tenancy Support Services**	
	N	%	N	%	N	%	N	%	N	%	N	%
Alliance	29	7%	107	25%	20	5%	66	15%	14	3%	95	22%
Cardinal	236	28%	170	20%	51	6%	171	20%	26	3%	451	53%
Eastpointe	54	21%	59	23%	11	4%	46	18%	20	8%	104	41%
Partners	87	24%	77	21%	28	8%	92	25%	10	3%	155	43%
Sandhills	36	11%	65	21%	30	9%	42	13%	12	4%	98	31%
Trillium	107	23%	120	25%	15	3%	101	21%	12	3%	284	60%
Vaya	57	15%	57	15%	18	5%	69	18%	12	3%	95	24%
Statewide	606	20%	655	21%	173	6%	587	19%	106	3%	1,282	42%

Table 5: Individuals Who Received Core TCL Services and Supports While in the Pre-Transition Period, Calendar Year 2020

	All Services		Assertive Community Treatment Team (ACT)		Community Support Team (CST)		Crisis Services		Evaluation & Management Office/ Outpatient Visits		Individual Placement and Support-Supported Employment (IPS-SE)	
	Denominator		N	%	N	%	N	%	N	%	N	%
Alliance	133		49	37%	56	42%	1	1%	43	32%	12	9%
Cardinal	217		61	28%	53	24%	2	1%	34	16%	6	3%
Eastpointe	72		27	38%	28	39%	0	0%	18	25%	3	4%
Partners	74		30	41%	15	20%	1	1%	9	12%	4	5%
Sandhills	72		29	40%	23	32%	1	1%	16	22%	4	6%
Trillium	143		47	33%	56	39%	6	4%	43	30%	7	5%
Vaya	133		71	53%	56	42%	2	2%	28	21%	4	3%
Statewide	843		313	37%	287	34%	13	2%	191	23%	40	5%
	Peer Support Services		**Psychological Diagnostic, Evaluation, and Testing**		**Psychosocial Rehabilitation (PSR)**		**Psychotherapy (Individual, Group, and/or Family)**		**Substance Use Services and Treatment**		**Transition Management and Tenancy Support Services**	
	N	%	N	%	N	%	N	%	N	%	N	%
Alliance	14	11%	32	24%	7	5%	19	14%	3	2%	17	13%
Cardinal	92	42%	29	13%	14	6%	37	17%	3	1%	47	22%
Eastpointe	4	6%	16	22%	1	1%	17	24%	6	8%	3	4%
Partners	14	19%	11	15%	3	4%	18	24%	1	1%	8	11%
Sandhills	1	1%	15	21%	5	7%	10	14%	1	1%	1	1%
Trillium	9	6%	23	16%	8	6%	23	16%	0	0%	41	29%
Vaya	12	9%	17	13%	2	2%	13	10%	4	3%	5	4%
Statewide	146	17%	143	17%	40	5%	137	16%	18	2%	122	14%

Table 6: Individuals Who Received Core TCL Services and Supports During In-Reach, Calendar Year 2020

	All Services		Assertive Community Treatment Team (ACT)		Community Support Team (CST)		Crisis Services		Evaluation & Management Office/ Outpatient Visits		Individual Placement and Support-Supported Employment (IPS-SE)	
	Denominator		N	%	N	%	N	%	N	%	N	%
Alliance	995		270	27%	177	18%	40	4%	349	35%	33	3%
Cardinal	1489		281	19%	131	9%	65	4%	413	28%	25	2%
Eastpointe	351		59	17%	33	9%	10	3%	125	36%	6	2%
Partners	525		137	26%	22	4%	36	7%	111	21%	5	1%
Sandhills	285		58	20%	20	7%	10	4%	81	28%	4	1%
Trillium	680		99	15%	73	11%	38	6%	296	44%	8	1%
Vaya	902		385	43%	132	15%	52	6%	217	24%	14	2%
Statewide	5,222		1,289	25%	587	11%	251	5%	1,592	30%	95	2%
	Peer Support Services		**Psychological Diagnostic, Evaluation, and Testing**		**Psychosocial Rehabilitation (PSR)**		**Psychotherapy (Individual, Group, and/or Family)**		**Substance Use Services and Treatment**		**Transition Management and Tenancy Support Services**	
	N	%	N	%	N	%	N	%	N	%	N	%
Alliance	78	8%	277	28%	148	15%	179	18%	28	3%	24	2%
Cardinal	214	14%	413	28%	180	12%	444	30%	30	2%	53	4%
Eastpointe	22	6%	90	26%	48	14%	61	17%	7	2%	7	2%
Partners	48	9%	143	27%	49	9%	208	40%	10	2%	16	3%
Sandhills	9	3%	80	28%	40	14%	77	27%	4	1%	2	1%
Trillium	31	5%	198	29%	93	14%	167	25%	20	3%	49	7%
Vaya	129	14%	237	26%	72	8%	219	24%	29	3%	29	3%
Statewide	531	10%	1,438	28%	630	12%	1,354	26%	128	2%	180	3%

Table 7: Individuals Living in the Community Without a TCL Slot Who Received Core Services and Supports, Calendar Year 2020

	All Services	Assertive Community Treatment Team (ACT)		Community Support Team (CST)		Crisis Services		Evaluation & Management Office/ Outpatient Visits		Individual Placement and Support-Supported Employment (IPS-SE)	
	Denominator	N	%	N	%	N	%	N	%	N	%
Alliance	193	49	25%	25	13%	12	6%	96	50%	4	2%
Cardinal	373	94	25%	48	13%	18	5%	160	43%	6	2%
Eastpointe	255	62	24%	27	11%	17	7%	114	45%	1	0%
Partners	177	50	28%	9	5%	13	7%	62	35%	2	1%
Sandhills	138	41	30%	10	7%	5	4%	67	49%	1	1%
Trillium	305	59	19%	24	8%	28	9%	166	54%	6	2%
Vaya	382	134	35%	52	14%	38	10%	134	35%	3	1%
Statewide	1,823	489	27%	195	11%	131	7%	799	44%	23	1%

	Peer Support Services		Psychological Diagnostic, Evaluation, and Testing		Psychosocial Rehabilitation (PSR)		Psychotherapy (Individual, Group, and/or Family)		Substance Use Services and Treatment		Transition Management and Tenancy Support Services	
	N	%	N	%	N	%	N	%	N	%	N	%
Alliance	17	9%	59	31%	37	19%	44	23%	7	4%	4	2%
Cardinal	44	12%	96	26%	34	9%	86	23%	13	3%	16	4%
Eastpointe	23	9%	69	27%	32	13%	52	20%	22	9%	9	4%
Partners	18	10%	50	28%	12	7%	53	30%	2	1%	9	5%
Sandhills	5	4%	28	20%	20	14%	22	16%	4	3%	2	1%
Trillium	24	8%	92	30%	44	14%	80	26%	10	3%	37	12%
Vaya	64	17%	102	27%	19	5%	125	33%	16	4%	17	4%
Statewide	195	11%	496	27%	198	11%	462	25%	74	4%	94	5%

VI. IN-REACH, INFORMED DECISION MAKING AND ADULT CARE HOMES

SUMMARY

In Fiscal Year (FY) 20-21, the Department of Health and Human Services (DHHS) continued to work with the Local Management Entities/Managed Care Organizations (LME/MCOs) to oversee the provision of In-Reach and frequent education of individuals and/or guardians about the opportunities to transition to community-based services and supports. In-Reach and educational efforts are critical to transition planning, supporting individuals to acquire supportive housing and to exit Adult Care Homes (ACHs) and State Psychiatric Hospitals (SPHs). With a strategic focus on areas in which the State has not yet met the Transitions of Community Living (TCL) Settlement Agreement standard of substantial compliance, the DHHS shifted its efforts in 2021 to address continuous quality improvement; targeted monitoring and guidance; staff education and training; and additional education on the guiding principle of informed consent.

SETTLEMENT AGREEMENT REQUIREMENTS

With regard to In-Reach, active monitoring has occurred for individuals currently residing in Adult Care Homes (ACHs) and State Psychiatric Hospitals (SPHs). Monitoring ensures contacts are as frequent as requested, but not less than quarterly. The reassignment of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services' (DMH/DD/SAS) Community Transitions and Integration (CTI) Team to the Office of the Secretary TCL Team, in the summer of 2020, increased staffing resources for TCL. In addition, the reassignment resulted in the initiation of two major projects. The first project, the Transitions to Community Living Database (TCLD) Clean-Up Project, began on January 4, 2021 and ended June 30, 2021. Its purpose was to obtain an accurate account of all the individuals, residing in ACHs and SPHs, that receive In-Reach services. At the conclusion of the project, approximately 900+ individuals were removed from active In-Reach status as a result of being deceased; change of permanent residence to a state other than NC; and after verification of a serious mental illness/severe and persistent mental illness (SMI/SMPI) diagnosis did not meet TCL criteria.

The second project, the ACH Transitions Project, began on January 4, 2021 and will continue until the state reaches substantial compliance with the Settlement Agreement requirement that 2,000 individuals residing in ACHs transition into the community by July 1, 2023.. The result of the first six months of the project was targeted monitoring and identification of those individuals residing in ACHs that have already said "yes" to transitioning into the community. In addition, the project identified individuals still residing in ACHs who had previously started the transition planning phase, but later decided not to move into the community. The LME/MCOs were notified to re-engage with these individuals and to complete the Informed Decision Making (IDM) tool to identify barriers to community transition and individualized strategies for removing these. The State provided the LME/MCOs with guidance and the clear expectation that individuals with SMI/SPMI that choose to reside in an ACH must receive In-Reach upon admission and regularly offered the opportunity to participate in the IDM process when they choose not to transition into the community. Since January 2021, the CTI Team Lead has been sending a bi-monthly report to the court-appointed TCL Independent Reviewer. The report includes the following: breakdown of LME/MCO activity

including In Reach and transition timelines; identification of ACHs where there is a COVID-19 surge; IDM tool completions; and the number of IDM tools reviewed by DHHS for continuous quality improvement.

For most of FY 20-21, In-Reach Specialists conducted the majority of monitoring for ACHs virtually. In May and June 2021, the In-Reach Coaches returned to in-person evaluations. These in-person evaluations allowed In-Reach coaches to provide one-on-one guidance to the In-Reach Specialists about strengthening assertive engagement strategies when encountering individuals and/ or guardians who are reluctant to consider the option of supportive housing. It was occasional observations and shadowing of TCL staff (In-Reach Specialists and Transition staff), conducted in-person, by phone or virtually, that allowed for updates to the In-Reach Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis. Strengths, areas for improvement, and training needs were identified. Trainings conducted during FY20-21 included: TCL Informed Decision-Making (IDM) tool; Exploring Engagement; and Resident Rights and Resource Guide, presented at the Spring 2021 In-Reach Collaborative Conference.

In-Reach Coaches also collaborated with Division of Aging and Adult Services (DAAS) and Division of Health Service Regulation (DHSR) to present information at the In-Reach Conference about guardianship; filing a complaint related to Resident Rights in ACHs; and the Ombudsman program. While past, annual In-Reach Collaborative Conferences were held in person, this year's conference was a four-day, virtual event, provided across the state to all LME/MCO In-Reach Specialists.

Residents Rights and Resource Guide

In-Reach Coaches created a quick reference, resource guide that includes information regarding North Carolina's Adult Care Home Bill of Rights, DHSR and Division of Aging and Adult Services (DAAS) Ombudsman contact information, as well as various division website links. From this resource guide, a TCL developed a training to present at the 2021 In-Reach Collaborative Conference in collaboration with DHSR and DAAS. The training provided an explanation of resident rights, as well as the roles of DHSR and the Ombudsman, in the complaint process for individuals residing in ACHs.

TCL Informed Decision-Making Tool

This training defined individual decision making (IDM); participant engagement in the context of IDM; the use of IDM within TCL, specifically during the In-Reach process; and offered a time for questions and answers. Staff trained all seven LME/MCOs' In-Reach Specialists and Managers in August 2020, in preparation for implementation of the IDM Tool on September 1, 2020. Feedback from surveys indicated that increased knowledge of talking points helped to ensure that participants exercise choice and are as informed as possible. Specifically, the feedback noted that the IDM Tool provides a streamlined format for the user; promotes an intentional approach to informed decision-making; and helps to build trust and rapport. The DHHS provided a refresher training to interested LME/MCOs in February 2021 and continues to offer ongoing support and technical assistance, as needed. In FY21-22, the DHHS intends to develop and launch an on-demand, online IDM training, accessible to all LME/MCO staff and public guardians.

Exploring Engagement

This training was developed to provide an overview to In-Reach Specialists regarding positive engagement for individuals eligible for TCL. Specifically covered are the key components of engagement; getting to know the person; and challenges to engagement. This training was provided as a virtual training in the Fall 2020, due to COVID-19. There are plans to provide an in-person/interactive engagement training in FY 21-22, inclusive of a face-to-face presentation with role-play and interactive exercises.

During FY 20-21, In-Reach Coaches developed a TCL Transition Planning Best Practices for ACHs document and flow chart, as well as a TCL Workflow that includes both the IR/TCL and IDM Tools. These documents have been incorporated into a training which will be offered to LME/MCOs during FY 21-22. In addition, the CTI team collaborated with the Adult Mental Health team to develop an employment training titled, *Employment and Recovery: Working Together*. This training focuses on work as an essential part of recovery, team members' roles, having conversations about work, as well as barriers and challenges. The training will be delivered to LME/MCOs beginning late Summer/Fall 2021.

Monitoring Informed Decision-Making and Guardianship

The IDM tool was first implemented on September 1, 2020. The tool was developed to support a core principle, derived from the *Olmstead* decision: that a person doesn't oppose transition to the community and that their agreement to receiving services in the community is based on an informed choice.[34] The IDM tool helps guide conversations about community living between potential Transitions to Community Living (TCL) participants and In-Reach staff. The tool assists its user in covering such topics as community living options, available resources, and services. Its use assists staff in assessing whether the person's understanding of community living considers life experience, diagnosis and other critical factors. The DHHS developed and implemented the initial training on the IDM tool shortly in after the tool was completed in August 2020. The training defined IDM; engagement in the context of IDM; the use of IDM within the TCL program, specifically during the In-Reach process; and offered a question-and-answer period. Training was provided to all seven LME/MCOs' In-Reach Specialists and Managers.

In the Winter of 2020, the DHHS conducted random, record reviews of those individuals residing in ACHs who had decided not to transition into the community. Reviews indicated several weaknesses in the process in these cases: in many, the IDM tool was not being utilized, nor was assertive engagement occurring consistently and at the frequency necessary to help build trust and rapport with individuals residing in ACHs. An IDM refresher training was conducted in February 2021 to re-educate LME/MCOs about engagement, underlining its fundamental role in an individual making an informed decision about where that person chooses to live, work and play.

[34] In 1999, the US Supreme Court (SCOTUS) held in *Olmstead v. L.C.* that the "unjustified segregation" of people with disabilities in institutional settings was unlawful discrimination under the ADA. Public entities must provide community-based services to people with disabilities when: (1) such services are appropriate; (2) the affected person doesn't oppose treatment that takes place in the community; and (3) providing such services is feasible (services can be "reasonably accommodated, taking into account the resources available… and the needs of others who are receiving disability services...").

The process of engagement, done correctly, is imperative to establishing a rapport with an individual, forming a relationship, and getting to know them before initiating a discussion of community living using the IDM tool. There is no "one-size-fits-all" approach; engagement should occur in the context of an individual's unique social and life circumstances. Individuals need adequate time to engage in face-to-face, meaningful interactions with In-Reach Specialists. Peer services have been shown to enhance engagement in individuals with serious mental illness. These services are founded on key principles of respect, shared responsibility, and mutual agreement on what is helpful.

Ongoing IDM trainings are essential for TCL staff to ensure IDM is understood, engagement occurs consistently with individuals and the IDM tool is completed correctly. When implemented properly, the IDM tool has proven to be beneficial to In-Reach conducted for individuals residing in ACHs and SPHs. The tool is also helpful during Outreach for individuals residing in the community and being diverted from ACHs. The DHHS continue to offer ongoing support and technical assistance on the tool as needed. In FY 21-22, the DHHS will review all completed IDM tools to monitor effectiveness of the tool, ensure completion of the tool and assist DAAS with tracking participation of local Department of Social Services (DSS) guardians and agency guardians in the IDM process.

The DHHS participated in several meetings with the DHHS' Division of Social Services (DSS) and Division of Aging and Adult Services (DAAS) to discuss guardianship and their respective roles in the IDM process. On June 9, 2021, the DHHS discussed TCL and IDM at the Adult Services Committee Meeting, in attendance was the DSS State County Relations group, Adult Services, and Guardianship Corporations. A second presentation was held on June 23, 2021, with DSS guardians, to educate all 100 counties in NC on IDM. When a DSS is the guardian for individuals residing in ACHs and SPHs, TCL encourages them to partner with the LME/MCOs, educating staff on supporting transition; what is required for transitions to succeed; supportive housing; and the process for guardians making an informed decision concerning a ward's participation in TCL.

The DHHS respects DSS guardians' need to balance the individual's goals and rights under the Americans with Disabilities Act (ADA) and *Olmstead* with the guardian's concerns for the safety and welfare of the ward. To ensure all eligible individuals are able to participate fully in the IDM process, DHHS is requiring, prior to DSS guardians' making a choice for a ward about community transition, that the guardian complete the IDM tool, with the ward's desires and preferences in mind. This requirement supports a strengthened collaboration between LME/MCO staff and DSS guardians, respecting both the role and responsibilities of guardians and the LME/MCOs in planning for TCL participants residing in SPHs and ACHs.

Complex Medical Transitions from ACHs

In FY 21-21, the DHHS has partnered with Community Care of North Carolina, Inc. (CCNC) to launch the LME/MCO CCNC Integrated Care Management Pilot for complex medical transitions from ACHs. Cardinal was the first LME/MCO to go live with the pilot across five counties: Cabarrus; Forsyth; Iredell; Mecklenburg; and Rowan. The purpose of the pilot is to enhance support of TCL-eligible individuals as they transition into permanent supportive housing and to reduce separations from housing, while improving transition processes for persons transferring from ACHs to permanent supportive housing. The pilot uses an integrated approach to identify and address

medical and functional needs in a two-phase approach: Phase 1 - Transition and Phase 2 - Pre-Tenancy and Tenancy. The components of the pilot include:

- Pre-Transition Nursing Assessment
- Pre-Transition Self-Care Training
- Integrated Care Transition Plan
- Primary and Specialty Care Connection
- In-home Medical Self-Care and Wellness Training
- 90-day Nurse Care Manager Post-Transition Follow-Along

Desired outcomes of the pilot are: 1) a decrease housing separations, leading to an increase in both housing tenure and community integration; 2) a decrease in emergency department admissions and hospitalizations, leading to an increase in medical self-care, use of in-home medical services, and use of primary/specialty care utilization; and 3) Quality of Life Survey improvements from the baseline. The DHHS is planning to incorporate all LME/MCOs into the CCNC pilot by April 2022.

VII. PRE-ADMISSION SCREENING AND DIVERSION

COMMUNITY INTEGRATION PLANNING

To be clear, successful community living doesn't just happen. It requires intentional, informed support on the part of the Local Management Entity-Managed Care Organization (LME/MCO), providers, natural supports (when available) and DHHS staff. Community Integration Planning (CIP) is the process through which LME/MCO staff assist an individual in developing a plan to achieve those outcomes that promote a person's growth, well-being and independence. Person-centered in nature, the CIP is based on the individual's strengths, needs, goals and preferences, considered in the context of the most appropriate integrated setting, across all domains of the individual's life. As such, the Community Integration Plan is a key component of Transition and Discharge planning.

The conversation that informs the CIP should begin during the Diversion process. For the CIP to be effective, the LME/MCO staff who assist Transition to Community Living (TCL) participants must be adequately trained and knowledgeable about resources, supports, services and opportunities available in the community, including available community mental health service providers and access to mental health supports. Working with knowledgeable staff ensures that individuals are fully informed when making decisions that involve consideration of entry into an Adult Care Homes (ACH).

The Department has been monitoring the CIP process quarterly and has gathered information and documentation from each of the LME/MCOs to assess the CIP and the LME/MCOs' utilization of the revised CIP Guidance document. The LME/MCOs receive a tracking spreadsheet each quarter that requests information and feedback about the CIP process. The State then analyzes responses to ensure that processes promote success and advance substantial compliance with the TCL Settlement Agreement. The State revised the CIP Guidance document and distributed to all LME/MCOs on May 5, 2021 and provided additional Technical Assistance during the LME/MCO Bi-monthly call. In addition, the revised CIP Guidance document was added the to the DHHS TCL webpage, under the TCL database section, to ensure accessibility and transparency.

TECHNICAL ASSISTANCE

Monitoring has allowed the State to continue identifying and addressing training needs regarding the CIP and data errors, as well as concerns regarding, e.g., personal care services (PCS) and the Department of Social Services (DSS) guardianships. Concerning PCS, NC Medicaid and the independent assessment entity, Liberty Healthcare of North Carolina, presented a webinar, titled, *A Review of Medicaid Personal Care Services and the Expedited Review Process*, on September 11, 2020. The webinar training was designed to support the LME/MCO transition coordinators and others who play a vital role in supporting individuals served through the TCL.

Regarding the DSS guardianships, the TCL continues to collaborate with the Division of Aging and Adult Services (DAAS) to secure DSS guardians' participation in TCL's Diversion efforts.

As mentioned in the Community Integration Planning section, the State revised the CIP Guidance document and distributed to all LME/MCOs on May 5, 2021 and provided additional Technical Assistance during the LME/MCO Bi-monthly call. In addition, the revised CIP Guidance document was added the to the DHHS TCL webpage, under the TCL database section, to ensure accessibility and transparency.

RSVP AND DIVERSION

Technical Assistance and Monitoring.

The State continues to provide technical assistance for the Referral Screening and Verification Process (RSVP), as needed, to the LME/MCOs, providers, individuals and referral sources. Training was provided to six of the seven LME/MCOs between February and March of 2021. The State also continues to conduct monthly and quarterly monitoring of the RSVP and Diversion data and processes.

LME/MCO RSVP to Diversion Workflow

On a quarterly basis, the State monitors each LME/MCO's RSVP to Diversion workflow, by requesting information pertaining to their process flow. The State sends a tracking spreadsheet to the LME/MCOs and analyzes responses to identify any gaps or needs.

RSVP Prompt Determination of Eligibility

TCL also monitors for promptness, by means of data reviews, the LME/MCO eligibility determinations. Notification of all RSVPs pending for over 30 days goes to the relevant LME/MCO staff on a monthly basis with a request for response, inclusive of actions taken. State staff review responses and data to ensure that the LME/MCOs are working towards meeting the Settlement Agreement's substantial compliance standard. As a result of the DHHS' training, education and technical assistance with both LME/MCOs and referral sources, the number of individuals in the RSVP "pending" status has been reduced substantially.

Improvements are also evident in processing timeframes, eliminating duplications, and reducing the volume of requests for individuals who are not eligible for TCL. Additionally, the number of "individuals housed" from participants in Category 5, "diversions from institutions," increased significantly from the prior year, primarily due to COVID-19 and the restrictions in accessing individuals in facilities for housing. The number of Category 5 TCL-eligible people housed (with and without a slot), increased from 14% in FY 20 to 25% in FY 21. The data demonstrates that the implementation of RSVP continues to be effective in diverting individuals from restrictive settings. A lack of access to individuals residing in an ACH during the COVID-19 pandemic; RSVP's independent screening function; and RSVP's prompt determination of eligibility are determining factors. As a result, for FY 22, TCL is on track to meet the housing requirement for the Category 5 priority population.

Chart A: LME/MCO Pre-Admission Screening Cumulative Totals from November 1, 2018 through the end of June 30, 2021

The Referral Screening Verification Process (RSVP) database is the source for obtaining Pre-Admission screening data. Data is reported cumulatively.

Totals reflect the number of screenings, not the number of individuals screened.

LME/MCO	Total RSVP Category 5[35] Referrals Submitted	RSVP Screenings Determined TCL Eligible	RSVP Screening Determined TCL Ineligible	RSVP Screenings Pending	RSVP Screenings Withdrawn (duplicate, not considered for admission. other)
Alliance Behavioral Healthcare	2325	628	479	1	1218
Cardinal Innovations	5050	934	579	0	3537
Eastpointe	1280	242	188	0	850
Partners Behavioral Health Mgmt.	2003	227	453	4	1323
Sandhills Center	1429	340	97	12	992
Trillium	2904	483	426	4	1995
Vaya Health	2865	964	594	0	1307
Total	**17856**	**3818**	**2816**	**21**	**11222**

[35] Persons diverted from entry into an Adult Care Home fall into the Transitions to Community Living Category 5 target population if the living arrangement meets the criteria of the Department of Justice (DOJ) Settlement Agreement.

Prescreening Metrics Over Time

- **RSVP Pending referrals decreased (data determined based on RSVP implementation date of 11/1/18):**
    - November 30, 2019: 14 Pending
    - November 30, 2020: 10 Pending
- **TCLD In Process decreased:**
    - June 30, 2020: 986 In Process
    - June 30, 2021: 436 In Process
- **LME/MCO Screening Time Metrics for RSVP (Time from RSVP submission date until RSVP determination of eligibility for TCL date)**
    - 11/1/19 – 6/30/20: LME/MCO average time was 18.48 days
    - 11/1/20 – 6/30/21: LME/MCO average time was 13.58 days

As a result of ongoing technical assistance, training, and monitoring conducted with the LME/MCOs by state staff, DHHS has greatly reduced the number of days it takes to complete a screening ("prompt determination") to determine TCL eligibility.

CHART B: DIVERSION RESULTS FROM JULY 1, 2020 THROUGH THE END OF JUNE 30, 2021

LME/MCO	Diverted (with & w/out slots)	Not Diverted	In Process	Withdrawn/Removed	Total Diversion Attempts
Alliance Behavioral Healthcare	9	22	88	10	129
Cardinal Innovations	42	54	104	17	217
Eastpointe	34	5	12	4	55
Partners Behavioral Health Mgmt.	14	14	12	4	44
Sandhills Center	50	9	40	3	102
Trillium	7	11	39	4	61
Vaya Health	36	12	141	2	191
Total	**192**	**127**	**436**	**44**	**799**

***** Tableau is the data source from which Diversion data is obtained from TCLD

Total Diversion attempts are the screenings that resulted in a determination of TCL Eligible. Withdrawn/Removed includes deaths, moved out of state, or does not meet criteria (Dementia, Alzheimer's, TBI, or I/ DD is the primary diagnosis).

CHART C: DIVERSION RESULTS FROM JANUARY 1, 2013 THROUGH THE END OF JUN 30, 2021

LME/MCO	Diverted (with & w/out slots)	Not Diverted	In Process	Withdrawn Removed	Total Diversion Attempts
Alliance Behavioral Healthcare	651	1016	182	204	2053
Cardinal Innovations	1066	2207	145	400	3818
Eastpointe	416	796	13	60	1285
Partners Behavioral Health Mgmt.	404	1140	23	84	1651
Sandhills Center	362	719	54	36	1171
Trillium	582	1245	59	108	1994
Vaya Health	728	1415	199	159	2501
Total	**4209**	**8538**	**675**	**1051**	**14473**

***** Tableau is the data source from which "Diversion" data is obtained from TCLD. TCLD data clean-up is currently underway and may cause data fluctuations, based on the number of required corrections. Decreases in numbers of overall "Diversion" attempts has occurred due to clean-up. Individuals in all categories. Total "Diversion" attempts are the screenings that resulted in a determination of people who are TCL-eligible. "Diversion" withdrawn/ removed includes deaths, moves out of the State, and those that do not meet criteria for the program (Dementia/Alzheimer's/ TBI/ I/ DD are the primary diagnosis). Withdrawn/ removed no longer includes people referred to Category 4, State Psychiatric Hospital discharges (SPH) that were coded as Category 5 during FY 18-19.

VIII. STATE PSYCHIATRIC HOSPITALS

The State Psychiatric Hospitals (SPH) have continued efforts to increase discharges directly to TCL housing with services and supports available the day of discharge. In FY 2020, 93 people were discharged to TCL housing. This accounts for 19% of the people discharged who qualified for TCL housing. FY 2021 was challenging due to the COVID-19 pandemic. Challenges were met with increased telehealth and a variety of creative solutions to help people with the business and paperwork required for rental assistance and lease signing. Because of this, 122 people were discharged to TCL. This was 17% of the discharges of people who qualified for TCL under the Settlement Agreement for this reporting period.

With the goal to increase discharges to TCL housing, the Division of State Operated Healthcare Facilities (DSOHF) and DHHS have advanced a number of improvements. TCL and SPH leadership, for example, developed a joint training between LME/MCO and SPH staff, based on last year's SPH TCL Discharge Process Flow and Best Practices document. Psychiatric, social work, psychology, and SPH unit staff joined with LME/MCO Lead Transition Coordinators in large scale, joint continuing education specifically designed to improve SPH discharges into TCL settings. This training and flow process has clarified the responsibilities of the LME/MCO in discharge planning for individuals in an SPH and aligned that process with national best practice and the requirements of the Settlement Agreement.

The FY 21 joint trainings and reviews by the DOJ Independent Reviewer and her team of subject matter experts will inform a new, annual desk review of SPH discharges, supporting TCL Category 4 quality assurance. The combined desk review among DHHS Sr. Advisor on the ADA, the DMH/DD/SAS and the DSOHF will mirror the biannual DOJ independent reviews of the SPHs and LME/MCOs, using the tools' weighted items. Findings will be shared with both LME/MCO Lead Transition Coordinators and with SPH social work directors. The reviews will inform more advanced, specific annual joint trainings, urging the replication of positive findings and targeting quality improvement training and projects for negative discharge findings. The goal is an increase not only to the quantity of discharges into TCL Housing or Bridge Housing, but also the quality of the process and plans including, e.g.: early, pre-discharge transition activity; in-hospital, community provider and natural support involvement in transition; *Olmstead*-informed discharge plan services and support detail; and shared TCL discharge plan actions among SPH Continuing Care Plan staff, PCP providers, and TCL transition planners.

To improve community provider engagement for people in the SPHs, State TCL staff met with the DMH/DD/SAS Adult Service Specialists and each LME/MCO TCL leadership team. They gathered information and crafted a plan to enhance use of the state-funded service, Assertive Engagement (AE). These discussions generated unique ideas from each LME/MCO for developing their provider networks to increase AE, both onsite and through telehealth at all SPHs. Trillium Health Services LME/MCO used their own fiscal process to significantly increase existing AE rates. This spurred provider interest and AE activity in a geographically large region with providers often many hours from an SPH. The AE discussions also resulted in proposed FY 20-21 TCL budgetary increases for AE, to be applied both in SPHs and in transition efforts in Adult Care Homes (ACH).

In addition to this pre-discharge, SPH improvement effort, the DSOHF and the DHHS staff began meeting more regularly regarding several Category 4 issues. Both have become more involved in jointly reviewing LME/MCO requests for TCLD removals of Category 4-involved individuals. The DSOHF staff continue participation in State Barriers Committee as well as in SPHs' quarterly staff meetings. Also worthy of note, the DHHS has ad hoc involvement in complex care and discharge situations at each SPH and has enhanced its use of SPH quarterly discharge data to inform decisions delegated to LME/MCO TCL teams.

IX. QUALITY MANAGEMENT

SUMMARY

The State's Quality Assurance and Performance Improvement (QAPI) System is designed to ensure that community-based placements and services, provided through the Transitions to Community Living (TCL) program, are developed and delivered in accordance with the Settlement Agreement with US Department of Justice (DOJ), 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.

The TCL Quality Assurance and Performance Improvement (QAPI) Plan includes compliance and quality assurance data and processes associated with all aspects of the TCL and all substantive provisions of the State's Settlement Agreement with the DOJ. The Plan is designed to ensure that all mental health and other services and supports funded by the State are of good quality and are sufficient to help individuals achieve increased independence and greater community integration; obtain and maintain stable housing; avoid harms; and reduce the incidence of hospital contacts and institutionalization.

The TCL QAPI system is modeled on a Continuous Quality Improvement (CQI) approach. Insights from data collection, analysis, monitoring, reporting and evaluation activities are used to inform process and system changes to address and improve performance, service gaps, the quality of various program elements and, ultimately, the experiences and outcomes of program participants. The system incorporates data from multiple and varied sources to monitor and evaluate progress toward TCL goals, program quality and effectiveness and the impacts of program changes and performance improvement activities.

As demonstrated in the DHHS Annual Reports since SFY 2019, the State has had processes and procedures in place related to Settlement Agreement Quality Assurance and Performance Improvement provisions and has collected data and reported on required outcomes for several years.[36] In February 2021, DHHS contracted with Mathematica to provide technical support to further develop and formalize elements of the TCL QAPI System and the QAPI Plan. The ongoing work with Mathematica includes enhancements to and fuller implementation of existing QAPI System components, as well as development and implementation of new ones.

Mathematica is providing technical assistance and support related to data quality, management, and integration; performance measurement, metrics, and data dashboards; and QAPI Plan enhancements, implementation, and project management. This work will assist the State to integrate Plan processes and the manifold TCL data sources and elements; systematize performance measurement and quality

[36] As noted in the FY 2020 Final Annual Report of the Independent Reviewer, In the Matter Of…Case 5:12-cv-00557-D, "The State did not publish its FY 2020 TCL report prior to the Reviewer sending her draft report to the parties," so the findings in the Independent Reviewer's FY 2020 Annual Report review of the State's progress toward meeting Quality Assurance and Performance Improvement requirements are "not current and thus cannot serve as a review of the [State's] FY 2020 Annual Report." (p. 105)

assurance efforts; improve the accessibility and usability of program data; and more effectively utilize data to evaluate whether intended program outcomes are being achieved and, where needed, to identify, implement, and evaluate the impacts of performance improvement activities.

The State's Senior Advisor on the Americans with Disabilities Act (ADA) oversees implementation of the TCL QAPI System and Plan. Quality assurance and performance improvement activities are planned, carried out and evaluated by agencies, committees and personnel of DHHS; the North Carolina Housing Finance Agency; and the State's Local Management Entities/Managed Care Organizations (LME/MCOs).

State oversight and working committees include the TCL Oversight Committee, chaired by the DHHS Deputy Secretary of Behavioral Health and IDD; the DHHS Transition Team and Barriers Subcommittee, which includes representatives from multiple DHHS agencies and the LME/MCOs; the TCL Quality Assurance Committee, chaired by the State's Special Advisor on ADA; and the Intradepartmental Monitoring Team (IMT), led by NC Medicaid in collaboration with the DMH/DD/SAS, which provides monitoring and oversight of the LME/MCO Pre-Paid Inpatient Health Plan (PIHP)[37] contract functions.

DHHS also contracts with an External Quality Review Organization (EQRO) for annual reviews of LME/MCO contracted functions. The EQRs include comprehensive review and validation of LME/MCO performance and compliance related to TCL functions, policies, and procedures. These include care coordination; program areas, such as housing and In-Reach; quality and timeliness of documentation and progress notes in individual member case records; program manuals and communications; and formal Performance Improvement Projects (PIPs). Review findings are documented in reports for each LME/MCO.

Departmental Monitoring of TCL Service Gaps and Service Quality

Additional, systems-level monitoring of TCL service gaps and quality occurs annually through the DHHS Network Adequacy and Accessibility Analyses (NAAA, "gaps and needs" analysis) and quarterly via joint DHB-DMH/DD/SAS Intradepartmental Monitoring Team reviews.

Network Adequacy and Accessibility Analyses

The LMEs/MCOs are required on an annual basis to analyze and report on service gaps in accordance with their DHHS Performance Contracts. The LME/MCO Network Adequacy and Accessibility Analysis analyses are part of a continuous assessment and action process that drives updates to LME/MCO local business plans and network development plans, and implementation of strategic plans through quality improvement projects and actions.

[37] Prepaid Inpatient Health Plan (PIHP): An entity that: (1) provides medical services to Enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its Enrollees; and (3) does not have a comprehensive risk contract. See https://files.nc.gov/ncdhhs/Provider%20Agency%20Contract.pdf

LME/MCOs report on network availability and accessibility for Outpatient, Location-Based, Community/Mobile, Crisis, Inpatient, Specialized and Waiver services and 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.

The NAAA requirements also include evaluating and describing LME/MCO gaps, needs, obstacles, barriers, and initiatives around community-based supportive housing, community mental health services and supports, participant outcomes, and crisis service for the TCL population. The NAAA requirements for TCL are shown in Table 1.

Table 1: 2020 and 2021 LME/MCO Network Adequacy and Accessibility Analysis Requirements, Transitions to Community Living

COMMUNITY-BASED SUPPORTIVE HOUSING

1. Describe service gaps and needs, obstacles and barriers, and recent initiatives in the LME/MCO to:

a. Identify and engage eligible individuals in the TCL priority population,
b. Transition individuals to community-based supportive housing,
c. Transition individuals within 90 days of assignment to a transition team, and
d. Support the required number of individuals to maintain community-based housing.

INDIVIDUAL PLACEMENT AND SUPPORT-SUPPORTED EMPLOYMENT (IPS-SE)

1. Describe the network adequacy of IPS-Supported Employment services including:

a. Number, locations, and service capacity of fidelity teams,
b. The LME/MCO's total service capacity requirements (including but not limited to the TCL population), and
c. Service gaps and needs. *Discuss discrepancies between service capacity and capacity requirements, and needs for improvement in service quality and outcomes, not only access and choice standards.*

2. Describe obstacles and barriers as well as recent initiatives in the LME/MCO to engage and refer individuals in the TCL priority population, including individuals with SMI living in community-based supportive housing and individuals living in or at risk of entry to adult care homes.

PERSONAL OUTCOMES AND SUFFICIENCY OF COMMUNITY-BASED MENTAL HEALTH SERVICES

1. Describe how the LME/MCO tracks and monitors the following personal outcomes for individuals in supportive housing:

a. Supportive housing tenure and maintenance of chosen living arrangement,
b. Inpatient hospital or psychiatric facility admissions and readmissions,
c. Use of crisis services,
d. Emergency room visits and repeat visits,
e. Incidents of harm,
f. Adult care home admissions and readmissions,
g. Employment,
h. School attendance/enrollment,
i. Community integration and engagement,

j. Natural supports network development and use of natural supports for crisis prevention and intervention, and
k. Other personal outcomes the LME/MCO monitors.
2. Describe how the LME/MCO uses personal outcomes data to determine, plan, and deliver the frequency and intensity of services needed to support individuals in community-based housing.
3. Describe gaps and needs in the community-based mental health services provided to individuals in TCL supportive housing. *Discuss discrepancies between service capacity and service capacity requirements, and the sufficiency of services (array, intensity, frequency, quality, and effectiveness) as indicated by personal outcomes such as those listed above, not only access and choice standards.*
4. Describe obstacles and barriers as well as recent initiatives to address gaps in the array, intensity, quality, and effectiveness of community-based mental health services provided to individuals in supportive housing.

CRISIS SERVICES

1. Describe the network adequacy and sufficiency of the LME/MCO crisis service system including:
a. The service array and geographic availability,
b. The sufficiency to offer timely services of adequate intensity to individuals experiencing a behavioral health crisis,
c. The extent to which services are provided in the least restrictive setting, consistent with an already developed individual community-based crisis plan or in a manner that develops such a plan as a result, and
d. The effectiveness of crisis services for preventing unnecessary hospitalization, incarceration, or institutionalization.
2. Describe gaps and needs in the crisis service system. *Discuss discrepancies between service capacity and capacity requirements, and the sufficiency of services (capacity, array, quality, and effectiveness), not only access and choice standards.*
3. Describe obstacles and barriers as well as recent initiatives to address identified gaps related to crisis service availability, delivery, quality, and effectiveness.

INTRADEPARTMENTAL MONITORING TEAM REVIEWS

Quarterly Intradepartmental Monitoring Team (IMT) meetings have included a representative from the TCL QA Committee and covered enhanced monitoring of TCL program activities, performance, and service gaps and quality since SFY 2020. Additional modifications to the scope of the IMT monitoring process for TCL were implemented in the third quarter of SFY 2021.

IMT monitoring of LME/MCO TCL programs in the first two quarters of SFY 2021 focused on LME/MCO quality monitoring and improvement activities and CST implementation and network requirements and adequacy. Active TCL Quality Improvement Projects and progress were also reviewed. The LMEs/MCOs submitted written responses to TCL agenda items, and questions and issues for clarification or follow-up were discussed with the LME/MCO during the IMT review call. LME/MCO submissions and written summaries of IMT follow-up questions and discussion were

shared with the DHHS Special Advisor to inform Department-level monitoring of LME/MCO performance, challenges, and progress.

IMT deliberations in the first two quarters of SFY 2021 facilitated standardized State monitoring of LME/MCO progress. Monitoring covered varied activities and areas of performance, including provider trainings, learning collaboratives, and consultation activities; provider contract scope of work; quality monitoring activities such as Clinical Quality Reviews and review of PCPs, member outcomes and services/claims data, and provider self-assessments; CST implementation, challenges, network development, and network adequacy; innovative uses of technology to support members in housing; and challenges and strategies for engaging and supporting members and providers during the early months of the pandemic.

Beginning in the third quarter of SFY 2021, the IMT agenda and review team and process for TCL monitoring was expanded significantly to include the following changes:

- IMT TCL agenda included new monitoring items related to Housing, In-Reach, Transition, Employment and IPS-SE, Community Mental Health Services, and Quality Assurance. (See Table 2.)
- The DHHS IMT review team for TCL incorporated representatives from the DHHS Office of the Secretary/TCL Team, including the Special Advisor and subject matter experts in Housing, In-Reach, and Transition. Also included were the DHB and the DMH/DD/SAS Adult Mental Health services and Quality Management subject matter experts, the DHB Contract Managers, and the DMH/DD/SAS LME/MCO liaisons.
- State-level review of the LME/MCO submissions were followed by debriefing meetings among the Special Advisor, DHHS subject matter experts for each major Settlement Agreement provision, and the LME/MCOs.

  These process improvements have resulted in improved communication, coordination, and feedback between DHHS agencies and LMEs/MCOs, along with enhanced, Department-level monitoring of LME/MCO performance and compliance with Settlement Agreement requirements.

Table 2: 2021 Q3 and Q4 Intradepartmental Monitoring Team TCL Agenda Items

Community-Based Supportive Housing
• Housing separation rates, tends, and relationship to member services
• Housing separation causes and LME/MCO strategies to address
• Factors contributing to housing stability
In-Reach
• Strategy and timeline for resuming face-to-face In-Reach in ACHs
• LME/MCO engagement of members residing in ACHs to ensure choice
Transition
• LME/MCO approach to working with SPHs in discharge planning
• LME/MCO methods to increase SPH discharges to bridge or permanent supportive housing
• Use of newly allocated Assertive Engagement funds
• Data and trends related to bridge housing capacity and use

IPS-Supported Employment and Employment Outcomes

- Engagement of members about supported employment and education in ACH In-Reach and person-centered planning
- Engagement of members about supported employment and education in SPH In-Reach and treatment and discharge planning
- Impacts of engagement efforts on IPS-SE enrollments and employment outcomes; challenges and strategies to address obstacles
- TCL competitive employment and IPS-SE follow-along service rates
- Strategies to work with IPS-SE providers to improve employment and follow-along rates
- Strategies to ensure IPS-SE providers maximize utilization of DVR funding
- Methods to ensure improvement of IPS-SE teams scoring in Fair fidelity range

Community-Based Mental Health Services

- Methods of CST provider mentoring and ensuring service quality under the TMS service definition
- Processes and data used to monitor CST service provision and identify and address problems
- ACT recipient IPS-SE service provision and employment rates, processes and data used to monitor, and strategies to improve
- ACT provider strategies to prevent housing separations, LME/MCO methods of monitoring effectiveness and addressing problems
- Methods to ensure improvement of ACT teams scoring in the provisional or fair range
- ACT team low-scoring fidelity areas and LME/MCO monitoring and methods of ensuring quality improvement
- Methods of monitoring and ensuring service sufficiency during member transitional periods
- LME/MCO monitoring of PCPs for community inclusion goals and member progress
- Use of Peer Support Specialists to engage members

Quality Assurance

- Member Quality of Life Survey administration rates and quality assurance processes
- Use of Quality of Life survey in LME/MCO TCL quality improvement systems
- LME/MCO cross-functional efforts to resolve complex clinical situations for TCL members

The quarterly schedule and cyclical nature of IMT reviews also promote and reinforce the State's CQI approach to quality assurance and performance improvement. Areas of improvement are identified through the IMT review process and addressed with the LME/MCO in debriefing, as well as in additional technical assistance activities. The nature and effectiveness of LME/MCO improvement activities then are evaluated and addressed in subsequent quarterly reviews.

The improved effectiveness of the new IMT model has been evident since the first quarter of implementation. As a result of the heightened monitoring, improved communication and feedback, and enhanced technical assistance, the LMEs/MCOs have developed and implemented new data collection and reporting; tracking and trending; monitoring and review; and other quality assurance processes. Examples include the development of new processes for monitoring housing separations in relation to member services; implementation of new systematic methods for tracking member

employment outcomes; more effective incorporation of member survey data into broader quality assurance efforts; adjustments to provider monitoring sampling and data elements and member outcomes reviewed; identification of additional provider training resources; exploration of additional strategies to improve IPS-SE referrals and enrollments; and development of LME/MCO internal and cross-departmental processes to improve data collection, sharing, tracking, and reporting.

Personal Outcome Measures

The State's approach to the measurement of TCL participant outcomes reflects the best practice principle articulated in the TCL Settlement Agreement that services are to "be flexible and individualized to meet the needs of each individual." Rather than taking a utilization management approach to defining standards of sufficiency in, e.g., terms related to service amounts, billing units, or the frequency of service delivery, the State's TCL personal outcomes measures emphasize fundamental objectives related to participant health, safety, and welfare; independence and community integration; housing stability; harm avoidance; and reduced incidence of hospital contacts and institutionalization. Key activities of the State's Quality Assurance System include collecting, monitoring, evaluating, and reporting data on a variety of personal outcomes related to use of institutional settings, quality of life/community integration, housing stability, and incidents of harm.

Use of Institutional Settings

Institutional census tracking and length of stay are monitored through the State Psychiatric Hospital (SPH) Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) data system and the NCTracks claims data warehouse. The SPH census, admissions, and discharge data are reported in other sections of this report. The institutional admissions and readmissions and Emergency Department (ED) visits and repeat visits reported here are based on CY 19 and CY 20 NCTracks Medicaid community hospital and psychiatric facility inpatient and emergency department claims and HEARTS SPH and Alcohol and Drug Abuse Treatment Center (ADATC) admissions data. The institutional claims and encounters and SPH and Alcohol and Drug Abuse Treatment Center (ADATC) admissions records were retrieved for all TCL participants who were in supportive housing for one or more days of CY 20 or who had previously been housed and were subsequently housed through April 2021. For all institutional data reported in this section, admission and visit rates are expressed as percentages of the total number of individuals in these categories, as shown in Table 3.

Table 3: Individuals in Housing in Calendar Year 2020

LME/MCO	N (Percentage Housed Denominators)
Alliance	444
Cardinal	878
Eastpointe	269
Partners	371
Sandhills	330
Trillium	476
Vaya	395
Statewide Total	**3,163**

STATE PSYCHIATRIC HOSPITAL ADMISSIONS AND READMISSIONS

Table 4 shows numbers of individuals with SPH admissions and readmissions during 2020 while housed, and numbers with readmissions while housed after having one or more 2019 or 2020 pre-transition admission or 2019 admission while housed. Less than 2% (1.2%) of individuals had SPH admissions while housed in 2020, and 27% of those had two or more admissions during that period. Of 37 individuals with SPH admissions, 57 % had a previous admission prior to transitioning to supportive housing in 2019 or 2020 or while housed in 2019.[38]

Table 4: Calendar Year (CY) 2020 SPH Admissions and Readmissions While in Housing

Repeat Admissions I					
	N with SPH Admits	**% of Housed**	**N with >1 Admission**	**% of N with SPH Admits**	**% of Housed**
Alliance	6	1.4%	1	16.7%	0.2%
Cardinal	3	0.3%	0	0.0%	0.0%
Eastpointe	10	3.7%	6	60.0%	2.2%
Partners	5	1.3%	2	40.0%	0.5%
Sandhills	6	1.8%	0	0.0%	0.0%
Trillium	7	1.5%	1	14.3%	0.2%
Vaya	0	0.0%	0	N/A	0.0%
Total	**37**	**1.2%**	**10**	**27.0%**	**0.3%**
Repeat Admissions II					
	N with SPH Admits	**% of Housed**	**N with Prior Admits**	**% of N with SPH Admits**	**% of Housed**
Alliance	6	1.4%	4	66.7%	0.9%
Cardinal	3	0.3%	1	33.3%	0.1%
Eastpointe	10	3.7%	6	60.0%	2.2%
Partners	5	1.3%	2	40.0%	0.5%
Sandhills	6	1.8%	4	66.7%	1.2%
Trillium	7	1.5%	4	57.1%	0.8%
Vaya	0	0.0%	0	N/A	0.0%
Total	**37**	**1.2%**	**21**	**56.8%**	**0.7%**

Table 5 shows, among individuals in supportive housing in 2020 who had prior SPH admissions, the number and percent who had readmissions in 2020 while in housing. Less than 7% of all individuals in housing had an SPH admission in 2019 or 2020 prior to their transition or in 2019 while in housing. These individuals were far less likely (10%) to experience an SPH admission in 2020 while in supportive housing. Notably, SPH admissions for 90% of individuals were reduced to zero during this period.

[38] Administrative re-admissions following direct discharges or transfers to and from medical visits or other facilities are excluded.

Table 5: CY 2020 SPH Readmissions for Individuals with Prior Admissions

	Total N with Prior Admits	Percent of Housed	Subset with Readmissions	% with Readmissions	% of Housed
Alliance	66	14.9%	4	6.1%	0.9%
Cardinal	25	2.8%	1	4.0%	0.1%
Eastpointe	29	10.8%	6	20.7%	2.2%
Partners	9	2.4%	2	22.2%	0.5%
Sandhills	34	10.3%	4	11.8%	1.2%
Trillium	39	8.2%	4	10.3%	0.8%
Vaya	4	1.0%	0	0.0%	0.0%
Total	**206**	**6.5%**	**21**	**10.2%**	**0.7%**

INPATIENT PSYCHIATRIC ADMISSIONS AND READMISSIONS

Table 6 shows numbers of individuals with inpatient psychiatric and community hospital admissions and readmissions during 2020 while housed, and numbers with readmissions while housed, after having one or more 2019 or 2020 pre-transition admission or 2019 admissions while housed. Less than ten percent of individuals had inpatient admissions while housed in 2020. Approximately one-third (32%) of those had two or more during that period, and 45% had a previous inpatient admission.

Table 6: CY 2020 Inpatient Admissions and Readmissions While in Housing

Repeat Admissions I					
	N with Inpatient Admits	**% of Housed**	**N with >1 Admission**	**% of N with Inpatient Admits**	**% of Housed**
Alliance	53	11.9%	21	39.6%	4.7%
Cardinal	83	9.5%	25	30.1%	2.8%
Eastpointe	29	10.8%	7	24.1%	2.6%
Partners	20	5.4%	11	55.0%	3.0%
Sandhills	40	12.1%	13	32.5%	3.9%
Trillium	53	11.1%	15	28.3%	3.2%
Vaya	23	5.8%	5	21.7%	1.3%
Total	**301**	**9.5%**	**97**	**32.2%**	**3.1%**
Repeat Admissions II					
	N with Inpatient Admits	**% of Housed**	**N with Prior Admits**	**% of N with Inpatient Admits**	**% of Housed**
Alliance	53	11.9%	29	54.7%	6.5%
Cardinal	83	9.5%	35	42.2%	4.0%
Eastpointe	29	10.8%	14	48.3%	5.2%
Partners	20	5.4%	9	45.0%	2.4%
Sandhills	40	12.1%	16	40.0%	4.8%
Trillium	53	11.1%	22	41.5%	4.6%
Vaya	23	5.8%	9	39.1%	2.3%
Total	**301**	**9.5%**	**134**	**44.5%**	**4.2%**

Figure 1 shows estimated numbers of participants with between one and four or more admissions. Seventy percent of individuals with any admissions had a single admission, while one-fifth (20%) had two, and the remaining 13% had three or more.

Figure 1: CY 2020 Estimated Inpatient Psychiatric Admissions While Housed (N = 301)

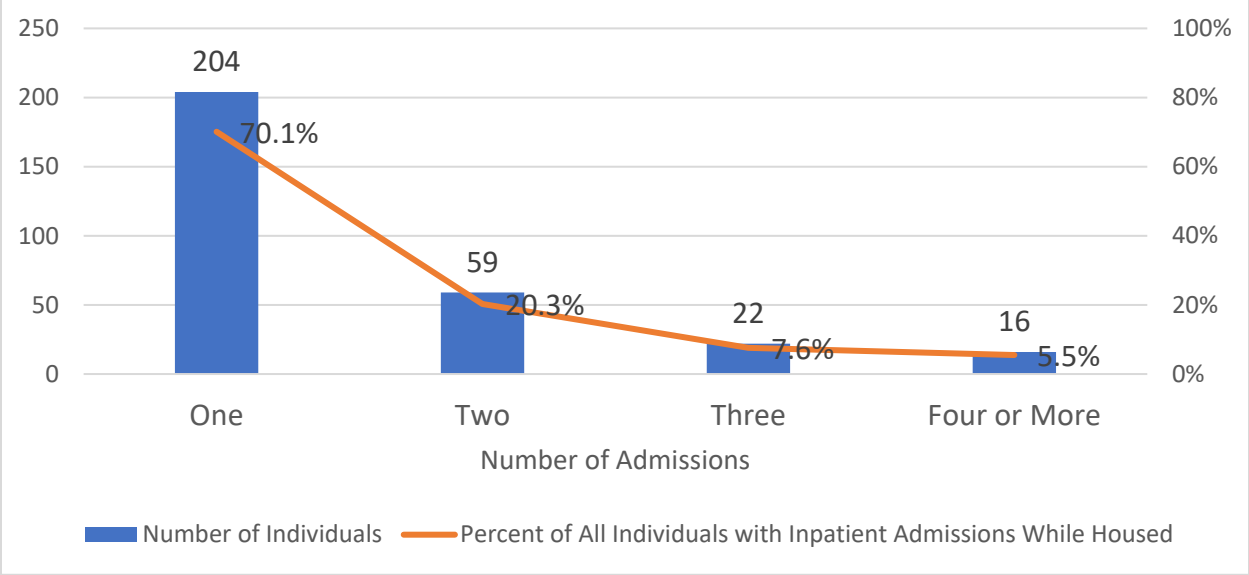


Table 7 shows, among individuals in supportive housing in 2020 who had prior inpatient admissions, the number and percent who had readmissions in 2020 while in housing. Sixteen percent of all individuals in housing had an inpatient admission in 2019 or 2020 prior to their transition or in 2019 while in housing. These individuals were far less likely (27%) to experience a readmission in 2020 while in supportive housing. Admissions for 73% of individuals with previous admissions were reduced to zero during this period.

Table 7: CY 2020 Inpatient Admissions for Individuals with Prior Admissions

	Total N with Prior Admits	Percent of Housed	Subset with Readmissions	% with Readmissions	% of Housed
Alliance	90	20.3%	29	32.2%	6.5%
Cardinal	100	11.4%	35	35.0%	4.0%
Eastpointe	48	17.8%	14	29.2%	5.2%
Partners	40	10.8%	9	22.5%	2.4%
Sandhills	52	15.8%	16	30.8%	4.8%
Trillium	97	20.4%	22	22.7%	4.6%
Vaya	73	18.5%	9	12.3%	2.3%
Total	**500**	**15.8%**	**134**	**26.8%**	**4.2%**

EMERGENCY DEPARTMENT VISITS AND REPEAT VISITS

Table 8 shows numbers of individuals with emergency department (ED) visits and repeat visits during 2020 while housed, and numbers with repeat visits while housed after having one or more 2019 or 2020 pre-transition visits or 2019 visits while housed. Eleven percent of individuals had ED visits while housed in 2020. Approximately one-third (37%) of those had two or more during that period, and 48% had a previous ED visit.[39,40]

Table 8: CY 2020 ED Visits and Repeat Visits While in Housing

Repeat Visits I					
	N with ED Visits	**% of Housed**	**N with >1 ED Visit**	**% of N with ED Visits**	**% of Housed**
Alliance	46	10.4%	11	23.9%	2.5%
Cardinal	99	11.3%	45	45.5%	5.1%
Eastpointe	31	11.5%	9	29.0%	3.3%
Partners	41	11.1%	16	39.0%	4.3%
Sandhills	42	12.7%	13	31.0%	3.9%
Trillium	67	14.1%	27	40.3%	5.7%
Vaya	35	8.9%	13	37.1%	3.3%
Total	**361**	**11.4%**	**134**	**37.1%**	**4.2%**
Repeat Visits II					
	N with ED Visits	**% of Housed**	**N with Prior Visits**	**% of N with ED Visits**	**% of Housed**
Alliance	46	10.4%	22	47.8%	5.0%
Cardinal	99	11.3%	40	40.4%	4.6%
Eastpointe	31	11.5%	10	32.3%	3.7%
Partners	41	11.1%	19	46.3%	5.1%
Sandhills	42	12.7%	20	47.6%	6.1%
Trillium	67	14.1%	41	61.2%	8.6%
Vaya	35	8.9%	20	57.1%	5.1%
Total	**361**	**11.4%**	**172**	**47.6%**	**5.4%**

[39] Emergency Department claims with consecutive service dates are counted as single visits. 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 service end date. 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. Completeness of ED visit claims data also may be affected by timely filing limits.

[40] This analysis is limited to stand-alone behavioral health-related ED visits that do not overlap or immediately precede psychiatric inpatient admissions reported in the previous section.

Figure 2 shows estimated numbers of individuals with between one and four or more ED visits. Nearly two-thirds (63%) of individuals with any ED visits had a single visit, while just over one-fifth (21%) had two, and the remaining 16% had three or more.

Figure 2: CY 2020 Estimated ED Visits and Repeat Visits (N = 361)

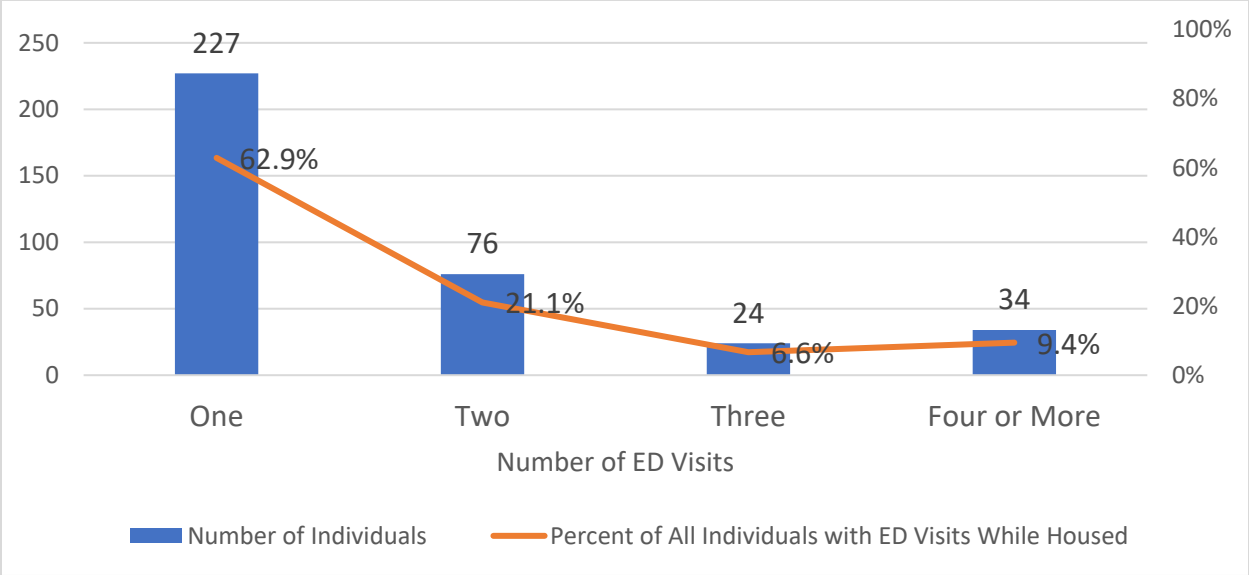


Table 9 shows, among individuals in supportive housing in 2020 who had prior ED visits, the number and percent who had repeat visits in 2020 while in housing. Eighteen percent of all individuals in housing had an ED visit in 2019 or 2020 prior to their transition or in 2019 while in housing. These individuals were far less likely (30%) to experience a repeat visit in 2020 while in supportive housing; ED visits for 70% of individuals were reduced to zero during this period.

Table 9: CY 2020 ED Visits for Individuals with Prior ED Visits

	Total N with Prior ED Visits	Percent of Housed	Subset with Repeat Visits	% with Repeat Visits	% of Housed
Alliance	71	16.0%	22	31.0%	5.0%
Cardinal	131	14.9%	40	30.5%	4.6%
Eastpointe	57	21.2%	10	17.5%	3.7%
Partners	75	20.2%	19	25.3%	5.1%
Sandhills	58	17.6%	20	34.5%	6.1%
Trillium	96	20.2%	41	42.7%	8.6%
Vaya	90	22.8%	20	22.2%	5.1%
Total	**578**	**18.3%**	**172**	**29.8%**	**5.4%**

OTHER CRISIS BED USE

As reported in the Services section of this Annual Report, NCTracks claims analysis indicated that 4% of housed individuals in CY 2020 received crisis services while housed during the year. Not reported in that section, a total of 41 individuals, 1.3% of the total housed population, received Facility-Based Crisis services.

Table 10 shows ADATC admissions for 18 individuals (0.6%) while housed, and few readmissions within or across calendar years. Of those with ADATC admissions while housed in 2020, 14 (78%) had one admission, and four (22%) had more than one admission.

Table 10: CY 2020 ADATC Admissions and Readmissions While in Housing

Repeat Admissions I					
	N with ADATC Admits	**% of Housed**	**N with >1 Admission**	**% of N with ADATC Admits**	**% of Housed**
Alliance	1	0.2%	0	0.0%	0.0%
Cardinal	4	0.5%	0	0.0%	0.0%
Eastpointe	1	0.4%	0	0.0%	0.0%
Partners	1	0.3%	0	0.0%	0.0%
Sandhills	1	0.3%	0	0.0%	0.0%
Trillium	6	1.3%	4	66.7%	0.8%
Vaya	4	1.0%	0	0.0%	0.0%
Total	**18**	**0.6%**	**4**	**22.2%**	**0.1%**
			Repeat Admissions II		
	N with ADATC Admits	**% of Housed**	**N with Prior Admits**	**% of N with ADATC Admits**	**% of Housed**
Alliance	1	0.2%	0	0.0%	0.0%
Cardinal	4	0.5%	0	0.0%	0.0%
Eastpointe	1	0.4%	0	0.0%	0.0%
Partners	1	0.3%	0	0.0%	0.0%
Sandhills	1	0.3%	1	100.0%	0.3%
Trillium	6	1.3%	1	16.7%	0.2%
Vaya	4	1.0%	0	0.0%	0.0%
Total	**18**	**0.6%**	**1**	**5.6%**	**0.0%**

Table 11 shows, among individuals in supportive housing in 2020 who had prior ADATC admissions, only two individuals (6%) had a readmission in 2020 while in supportive housing, while admissions for 94% were reduced to zero during this period.

Table 11: CY 2020 ADATC Admissions for Individuals with Prior Admissions

	Total N with Prior Admits	Percent of Housed	Subset with Readmissions	% with Readmissions	% of Housed
Alliance	8	1.8%	0	0.0%	0.0%
Cardinal	2	0.2%	0	0.0%	0.0%
Eastpointe	1	0.4%	0	0.0%	0.0%
Partners	0	0.0%	0	N/A	0.0%
Sandhills	6	1.8%	1	16.7%	0.3%
Trillium	5	1.1%	1	20.0%	0.2%
Vaya	11	2.8%	0	0.0%	0.0%
Total	**33**	**1.0%**	**2**	**6.1%**	**0.1%**

Community Integration and Quality of Life

Transitions to Community Living (TCL) participant quality of life is assessed through structured interviews administered to individuals during the transition planning period and again at 11 and 24 months after transition. In each full state fiscal year (SFY) of the TCL, participants surveyed in follow-up interviews, after 11 and 24 months in supportive housing, have reported improvements in quality of life. They also reported more positive assessments of their life circumstances than did individuals who had not yet transitioned from congregate living facilities and other settings to supportive housing. These patterns are observed across LME/MCO catchment areas as well as over time.

Appendix A to this Annual Report is an updated summary of results for surveys administered through SFY 2021. The Quality of Life Survey report includes detailed results related to members' pre- and post-transition reports of community integration; choice and control in daily activities; and satisfaction with housing and other community resources. Most individuals report improvements in community integration and engagement, natural supports networks, and quality of life after transitioning to supportive housing. Quality of life gains from the initial transition are largely maintained through the second year in housing. Results related to some members' continuing challenges--associated with unmet needs, physical and mental health, obstacles to community integration, engagement of natural supports, and housing problems--are also described. (See Appendix A.)

Time Spent in Congregate Day Programming

Calendar Year (CY) 2020 rates of Psychosocial Rehabilitation (PSR) services among individuals in housing are shown in the Services section of this Annual Report. Results of additional analysis of paid NCTracks claims for PSR are shown in Table 12.

Table 12: CY 2019 Time Spent in Congregate Day Programming (Psychosocial Rehabilitation)

	N with PSR	% of Housed	Average Duration[a] (Weeks)	Average Hours/ Week
Alliance	20	5%	24.5	9.9
Cardinal	51	6%	26.9	7.5
Eastpointe	11	4%	29.4	12.6
Partners	28	8%	36.3	6.2
Sandhills	30	9%	29.8	16.2
Trillium	15	3%	29.5	5.4
Vaya	18	5%	28.9	7.8
Total	**173**	**6%**	**29.0**	**9.3**

Duration is calculated as the length of the interval between the earliest and latest PSR service claim dates of service within the calendar year, and during the period the individual was in TCL supportive housing. Hours per week is expressed as the average number of PSR hours per week for the duration of the service while in housing.

COMMUNITY TENURE AND SEPARATIONS

For the life of the program, 67.8% of individuals who transitioned to supportive housing were in supportive housing at the end of SFY 2021, with an average of 785 days from their initial transition dates. Table 13 shows numbers and percentages of individuals in housing three months to two years after the initial transition date. Table 14 shows attrition rates by year. Table 15 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 (ACH) or other facilities.

Table 13: Life of Program Maintenance of Housing

Threshold	Total Possible	Number Housed This Long	Percent Meeting Threshold
Not applicable (housed less than 3 months)	180	N/A	N/A
3 Months	4,393	4,180	95%
6 Months	4,098	3,700	90%
1 Year	3,699	3,009	81%
1.5 Years	3,387	2,400	71%
2 Years	3,066	2,050	67%

Table 14: Housing Attrition Rates by State Fiscal Year and Year Housed

SFY Housed	Number Housed	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17	SFY 18	SFY 19	SFY 20	SFY 21
2013	46	2%	15%	11%	11%	8%	9%	11%	9%	13%
2014	201	-	10%	21%	11%	9%	9%	4%	3%	2%
2015	210	-	-	7%	16%	11%	14%	10%	5%	5%
2016	331	-	-	-	10%	16%	14%	11%	7%	6%
2017	600	-	-	-	-	10%	21%	14%	10%	7%
2018	692	-	-	-	-	-	8%	21%	10%	7%
2019	971	-	-	-	-	-	-	8%	14%	11%
2020	836								7%	15%
2021	852									7%

Table 15: Life of Program Housing Separation Outcomes and Destinations

Outcome or Destination	Number	Percent
Adult Care Home	341	21.10%
Alternative Family Living (Unlicensed)	8	0.50%
Adult Living Facility	18	1.15%
Deceased	396	24.50%
Family/Friends	237	14.60%
Hospice	3	0.20%
Independent	364	22.50%
Jail/Prison	76	4.70%
Medical Hospital	39	2.40%
Mental Health Group Home	36	2.20%
Skilled Nursing Facility	31	2.00%
State Psychiatric Hospital	29	1.80%
Substance Use Facility	30	1.85%
Unknown	8	0.50%
Total	**1,616**	**100.00%**

INCIDENTS OF HARM

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

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, and Medication Error; Allegation of Abuse, Neglect, or Exploitation; Consumer Behavior (including suicide attempt, inappropriate sexual, aggressive, destructive, illegal, and unplanned absence); Suspension/Expulsion from services; and Fire.

Incidents involving TCL participants are retrieved, reviewed, and reported in aggregate on a monthly basis and at the end of the full fiscal year. Table 16 summarizes by LME/MCO the number of incidents reported in SFY 2021 by the reported month of the incident.[41]

Table 16: Aggregate Number of Incidents Reported in IRIS, SFY 2021

LME	July 2020	Aug. 2020	Sep. 2020	Oct. 2020	Nov. 2020	Dec. 2020	Jan. 2021	Feb. 2021	Mar. 2021	Apr. 2021	May 2021	June 2021	Total
Alliance	1		4	1	2	1	2			2			**13**
Cardinal	1	1		3									**5**
Eastpointe			1	2	2		4	1	2		1	1	**14**
Partners													**0**
Sandhills	2	2	2	4	4	6	4	1	5	5	6	4	**45**
Trillium	1			1						1		1	**4**
Vaya	1	6	2	3	5	4	4		3	5	2	3	**38**
Total	**6**	**9**	**9**	**13**	**13**	**11**	**14**	**2**	**10**	**13**	**9**	**9**	**119**

[41] Table 16 values may differ from previous monthly report values, which reflect the month each incident was reported rather than the month of the incident. Table 16 values also may differ from monthly reported values due to end-of-year housing event date reconciliation. For example, end-of-year totals may include additional incidents not previously included in monthly reports for individuals who had left housing at the time of the incident and who were rehoused later in SFY 2021. End-of-year totals also may exclude previously reported incidents that occurred after an individual's permanent separation from the TCL program. SFY 2021 incidents that occurred before individuals' initial transition dates are excluded. Incidents that occurred within seven days after an individual's permanent separation from TCL are included.

X. OLMSTEAD PLAN INITIATIVE

SUMMARY

The United States Supreme Court case, *Olmstead v. L. C.*,[42] is often compared, within the disability community, to another Supreme Court case, *Brown v. Board of Education*, and with good reason. Like *Brown*, *Olmstead* is a transformative driver of cultural and systemic change. The *Olmstead* case, which derives from the Americans with Disabilities Act (ADA), provided the country with a sweeping interpretation of the ADA's "integration mandate." Writing for the Court, Justice Ruth Bader Ginsburg stated: the "unjustified segregation" of people with disabilities in institutional settings is unlawful discrimination under the ADA. The high court's ruling established that public entities, such as North Carolina's Department of Health and Human Services (DHHS), must provide community-based services to people with disabilities when: (1) such services are appropriate; (2) the affected person doesn't oppose treatment that takes place in the community; and (3) providing such services can be "reasonably accommodated, taking into account the resources available… and the needs of others who are receiving disability services..."[43] Since the ruling, the country's work to implement *Olmstead* has brought thousands of people with disabilities into the mainstream of American life. The State's Olmstead Plan, due to be completed in December of 2021, will build on the firm foundations set by Transitions to Community Living and Money Follows the Person and chart the future course for community living for North Carolinians with disabilities, beginning in calendar years 2022 – 2023.

BACKGROUND. WHAT IS AN OLMSTEAD PLAN?

Generally, Olmstead plans offer a description of a state's current system of providing publicly funded, community-based services and supports to people with disabilities; an assessment of the strengths and weaknesses of that system; a description of the state's plan and goals for expanding opportunities for providing community-based services and supports to people with disabilities; and baseline data/ targeted measures.[44] Ingredients of an Olmstead plan include populations to be addressed; data; housing; employment; wellness and healthcare; transportation; supports and services; funding; policies, rules and regulations; outcomes; and training and workforce development.[45][46] North Carolina's Olmstead Plan will build on this framework, adapting it to the State's unique strengths, gaps in services and barriers to service delivery. In its first two years, the plan will reflect an approach determined by the State, informed by expert analyses and diverse stakeholder input from those with lived experience and families to policy makers, systems managers, and providers.

[42] 527 U.S. 581 (1999).
[43] Ibid.
[44] Kevin Martone, Technical Assistance Collaborative. Presentation to Olmstead Plan Stakeholder Advisory, July 8, 2020.
[45] Ibid.
[46] In North Carolina, this workforce includes Peer Specialists.

SCOPE AND TIMELINE

In late 2019, the Secretary for North Carolina's Department of Health and Human Services charged the Office of the Senior Advisor on the ADA with the development of the State's Olmstead Plan. The plan is designed to be a "living, breathing document" that will be reviewed and updated regularly. It covers all eligible individuals with disabilities, whether served directly by the DHHS, in public facilities, or indirectly through, e.g., Local Management Entities/Managed Care Organizations (LME/MCOs) and the private provider networks they operate. The Plan's target populations cross the life span, covering such populations as those with intellectual and other developmental disabilities (I/DD); Traumatic Brain Injury (TBI); serious mental illness/severe and persistent mental illness (SMI/ SPMI); and conditions that result in medically fragility or medically complex treatment needs. Many within in Olmstead Plan's target populations reside in publicly funded, congregate settings; others are at risk of entering such settings.

In 2021, DHHS committed to a Plan that will serve as a lens for policy, program and budgetary decisions. Much of the year was spent in discussions with policymakers and external stakeholders, determining what work, relative to Olmstead's goals, was already underway and what structures and policies could best bolster these efforts. The DHHS reiterated that the Plan, once completed, will be reviewed, and updated on a regular basis, with the advice of external stakeholders.

DHHS MISSION AND OPSA VISION STATEMENTS

Shortly after the first meeting of the Olmstead Plan Stakeholder Advisory (OPSA; see below), the DHHS adopted as its mission for the Olmstead initiative the following statement: "In collaboration with our partners, the NC DHHS provides essential services to assist people with disabilities to reside in and experience the full benefit of inclusive community." After discussion with its membership, the OPSA also crafted a vision statement: "North Carolina champions the right of all people to choose to live life fully included in the community."

In remarks to the Olmstead Plan Stakeholder Advisory in August of 2021, Secretary Mandy K. Cohen described the Plan as a "blueprint" for the way that DHHS and its state government partners will make decisions central to improving the lives of people with disabilities. She noted that the document rests on the *Olmstead*-based implementation of both Transitions to Community Living (TCL) and Money Follows the Person (MFP); expands the social determinants work at the heart of DHHS' Healthy Opportunities initiative; incorporates efforts well underway, across the DHHS, to refine and re-define policies and programs to align with *Olmstead's* imperative of community integration; and commits North Carolina to a future where all people with disabilities can access the services that they need to live "an everyday life—even, an enviable life--side-by-side with friends, family and neighbors."

OLMSTEAD TECHNICAL ASSISTANCE CONTRACT WITH THE TAC

In 2020, the Office of the Senior Advisor on the ADA awarded a technical assistance contract to the Boston-based Technical Assistance Collaborative (TAC). DHHS extended that contract to March of 2021 and renewed it for Phase II of the Plan development.

As reported in the 2020 Annual Report, the TAC initiated its analysis of information for the Olmstead Plan by hosting 15 listening sessions, all held online due to the pandemic. The TAC complemented the sessions with a two-week, online survey, creating yet another opportunity for the public to input into the planning process. In 2021, the TAC augmented its qualitative analysis with a cross-departmental, quantitative data pull and analysis, focusing in large part on data sets from NC Medicaid and the DMH/DD/SAS. Among other issues, this portion of the analysis covered population data (e.g., numbers served, numbers waiting); workforce shortages and pay rates; budgetary comparisons between community-based and facility-based services; length of stay in various facilities; housing capacity and service array; policies and regulations; and gaps in services. On April 30, 2021, the TAC and its subcontractor, Human Services Research Institute (HSRI), presented findings to the DHHS in a report titled, *An Assessment of the North Carolina Department of Health and Human Services' System of Services and Supports for Individuals with Disabilities.* On May 12, the TAC reviewed the assessment with the OPSA.

The TAC report is a foundation for development of the State's Olmstead Plan. It includes both an assessment and an analysis of how the DHHS's and other agencies' systems, funding, services, and housing options function to serve people with disabilities in integrated settings. The report provides a framework for subsequent phases of the initiative, specifically, Olmstead Plan development; technical assistance for implementation activities; and development and implementation of a system for performance evaluation and outcome measurement. Offering an extensive analysis of strengths of systems and services, system weaknesses and gaps in the service array and barriers to accessing services, the assessment concluded with the following recommendations, by topic area:

Ensure that individuals with disabilities have access to the community-based services and supports they want and need to live as integrated members of their communities

- Recommendation 1: Build on the Strengths of the Current System: Use the components of Transitions to Community Living (TCL) as a framework for community inclusion and adopt lessons learned from the Money Follows the Person (MFP) program.
- Recommendation 2: Increase the Use of Evidence-Based and Promising Practices: DHHS should target Medicaid and non-Medicaid funding to support best practices, promising practices and evidence-based services, based on data that shows their effectiveness, and strengthen contractual language regarding the use of evidence-based practices in the Tailored Plans.
- Recommendation 3: Eliminate Gaps in Community-based Services: Strengthen services for children with behavioral health disorders, enhance crisis response, improve services for adults with serious mental illness (SMI), address issues with residential services for individuals with intellectual and other developmental disabilities (I/DD), improve services for individuals with autism, and provide coverage for services to meet the needs of individuals with traumatic brain injury (TBI).

- Recommendation 4: Increase Access to Affordable Housing for Individuals with Disabilities: Increase the amount of funding for the Key Rental Assistance program; explore opportunities and eliminate service barriers to increase utilization of the available housing units in rural communities; increase the use of assistive technology in an effort to make housing units more fully accessible; and add housing indicators to the Tailored Plans performance criteria.
- Recommendation 5: Increase Competitive, Integrated Employment Opportunities: Strengthen employment opportunities for youth, adults and older adults with disabilities; inform individuals and families about available resources and services.

Increase access to integrated housing and community-based services through new resources and repurposed funding from institutional and segregated settings.

- Recommendation 6: Reduce Reliance on Institutional Settings: Define the role of institutional settings in the State's service array. Reduce state-operated health care facility capacity as supported by declining census. Promote diversion strategies. Repurpose existing funds to further expand community-based service capacity.
- Recommendation 7: Request Targeted Bridge Funding: Identify the need for additional funding, based on an assessment of individuals' needs for services. Include a strategy for repurposed funding as part of request for additional funding. Commit savings from reduced institutional or congregate care settings to further expand community-based service capacity.
- Recommendation 8: Reduce Reliance on Community-Based Congregate Care and Segregated Day Service Settings: Reduce reliance on congregate care settings. Phase out day service settings that segregate individuals with disabilities from the community.
- Recommendation 9: Adopt Policy Strategies to Address Financing Challenges and Gaps: Increase access to affordable health care. Examine implications of transitioning from LME/MCOs to Tailored Plans to maximize the outcomes and efficiencies of the new approach, while mitigating disruptions in services. Enforce DHHS contract requirements. Introduce alternative payment approaches.

Address systemic challenges and eliminate barriers to accessing the services that can help individuals to live meaningful lives as integrated members of their communities.

- Recommendation 10: Include Input from All Stakeholders: Support efforts to enhance meaningful participation and strengthen the roles of all stakeholder groups, targeting efforts to stakeholders that are currently underrepresented in the Olmstead planning process.
- Recommendation 11: Create a Culture that Supports the Voices of Individuals with Lived Experience
- Incorporate Supported Decision-making and Person-centered Planning into All Applicable Service Definitions. DHHS should provide support to individuals and groups with lived experience for self-advocacy.
- Recommendation 12: Address Workforce Capacity and Shortages: Utilize state staff expertise to strengthen community-based provider competencies. Promote the employment of individuals with lived experience. Incentivize employment through competency-based training of direct service staff and "professionalizing" these roles.
- Recommendation 13: Use Data for Evaluation and Quality Improvement: Take measures to expand quality improvement efforts. Explore whether the Quality Assurance and Performance

Improvement system designed to support TCL can serve as a model for a statewide, cross-disability approach. Ensure that the Olmstead Plan's outcome, performance, and quality measures align with Patient-Reported Outcome Measures (PROMs) and other relevant program measures.

- Recommendation 14: Eliminate Barriers to Accessing Services: Reduce the number of people on the I/DD Registry of Unmet Needs. Right-size the Innovations Waiver waitlist. Expand the TBI waiver statewide while funding additional TBI waiver slots. Continue to assess all Medicaid authority options to further expand community-based service capacity. Rethink guardianship.

Engaging Stakeholders: The Olmstead Plan Stakeholder Advisory[47]

In the early summer of 2020, the DHHS Secretary announced appointments to the Olmstead Plan Stakeholder Advisory (OPSA). The OPSA experienced some turnover in 2021 but continues to be comprised of a diverse mix of stakeholders from the disability advocacy community, including individuals with lived experience and their families; providers; managers of provider networks (e.g., LME/MCOs); professional associations; policymaking leadership within the DHHS; and legislators from both sides of the aisle. Most members represent statewide organizations and agencies. The OPSA is co-chaired by the recent past chair of The Coalition and the current chair of the NC Coalition on Aging. These Community Co-Chairs are joined by a Departmental Co-Chair, in 2021, the Deputy Secretary for Medicaid. The Deputy Secretary ensures that the Department stays abreast of and engaged in OPSA's deliberations, while its Community Co-Chairs provide dynamic leadership for a large, representative body. The OPSA held its first, quarterly meeting on July 8, 2020. Since that time, the OPSA has held a total of five, quarterly meetings, the most recent on August 23, 2021. The Advisory's sixth meeting of 2021 will occur in November, following its members' and the public's review and comment of the draft plan in October.

OPSA Meetings Advance Policy Innovations

In 2021, the OPSA continued to host presentations from national experts, spotlighting key policy issues and innovations. As reported in the 2020 Annual Report, the OPSA heard from the TAC President Kevin Martone on Olmstead Plan development; Burton Blatt Institute Senior Director for Law and Policy Jonathan Martinis on Supported Decision Making; and Executive Director of the National Alliance for Direct Support Professionals (NADSP) Joe Macbeth and Director of the Institute for Community Integration (ICI) Amy Hewitt, Ph.D. on workforce development. This year saw a new spate of guest presentations. These included The Lewin Group's Leigh Ann Kingsbury (December 8, 2020 and May 14, 2021) on, respectively, person-centered systems and aging with disabilities; High Impact's Allan I. Bergman on competitive, integrated employment (January 13, 2021); former Secretary of the Pennsylvania Department of Public Welfare and former Senior Advisor to the Secretary of Housing and Urban Development, Estelle Richman, on effective system change strategies (March 11, 2021); Mathematica's Jessica Ross and Carey Appold on quality measurement (March 16, 2021); the TAC's Jim Yates on the Center for Medicare and Medicaid's (CMS) Home and Community Based Services (HCBS) Final Settings Rule (June 2, 2021); and TCL

[47] For details on the OPSA and Olmstead Plan developments generally, see the DHHS Olmstead website at NC Olmstead | NCDHHS.

Independent Reviewer Marti Knisley on supportive housing (June 28, 2021). All presentations were well received and all attracted guests well beyond OPSA's 46 members.

OPSA COMMITTEES

The OPSA continued in 2021 to conduct the bulk of its work through eight committees: Housing; Employment; Community Capacity Building; Transition to Community; Children, Youth and Families; Workforce Development; Older Adults; and Quality Assurance and Quality of Life. These committees are supported by staff from six DHHS divisions and three offices (Division of Medical Assistance (DMA)/NC Medicaid; the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS); Division of State Operated Healthcare Facilities (DSOHF); Division of Vocational Rehabilitation (DVR); Division of Social Services (DSS); Division of Aging and Adult Services (DAAS); NC Council on Developmental Disabilities (NCCDD); Money Follows the Person (MFP); a provider and/or LME/MCO representative; Office of the Secretary/Office of the Senior Advisor on the ADA; and Office of the General Counsel. In 2021, the Olmstead Staff Work Group assisted OPSA's committees to produce recommendations for incorporation into the Olmstead Plan. The committees' work prepared the way for its review, in early October of 2021, of the draft Plan.

THE CONTINUED ROLE OF TRANSITION TO COMMUNITY LIVING IN THE OLMSTEAD PLAN

Olmstead's vanguard in North Carolina is Transition to Community Living (TCL). TCL, the implementation of a settlement agreement, was born out of an *Olmstead*-driven case that was brought by the Department of Justice on behalf of people with serious or severe and persistent or serious mental illness (SMI, SPMI). As the Olmstead Plan moves into its implementation phase, much of State's policy and practice infrastructure will be adapted from the work done under TCL. Significantly, TCL's approach to community integration—and it follows, that of the DHHS' Olmstead Plan--is architected into the State's Tailored Plan.[48] This approach promotes the adaptation of systemic changes, initially effected for one population, to other populations.

[48] As North Carolina transitions its Medicaid and NC Health Choice programs' care delivery system from predominately fee-for-service (FFS) to Medicaid managed care, the DHHS is committed to advancing integrated and high-value care, improving population health, engaging and supporting providers and beneficiaries, and establishing a sustainable program with more predictable costs. While Standard Plans will serve the majority of Medicaid and NC Health Choice beneficiaries enrolling in Medicaid managed care, Behavioral Health and Intellectual/Developmental Disability (Behavioral Health I/DD) Tailored Plans will serve populations with more significant behavioral health conditions—including mental health and substance use disorders (SUD)—I/DD, and traumatic brain injury (TBI). For more information, see *North Carolina's Design for State-Funded Services Under Behavioral Health and Intellectual/Developmental Disability Tailored Plans* at https://files.nc.gov/ncdhhs/State-funded-Services-Policy-Paper-20191230.pdf

NEXT STEPS

In 2022, the NDHHS plans to continue the work of implementing and oversighting the Olmstead Plan. It will do so in conjunction with a second iteration of the OPSA, selected to advise the State on new and emerging needs, as defined by the Plan. The NDHHS has committed to the identification of staff specific to Olmstead Plan oversight. It has pledged to use the Plan as a lens for making policy, budgetary and programmatic decisions for the affected populations. As implementation proceeds, DHHS will, through its Secretary and senior leadership, reach out to sister agencies within the Administration, e.g., Department of Public Instruction and the Division of Community Corrections, strengthening the State's infrastructure for realizing the *Olmstead*'s promise of community integration, inclusion and, ultimately, belonging.

XI. BUDGET

For SFY20-21, TCL continued the following activities for ongoing monitoring and optimization of the TCL funding:

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

With an annual budget of 52.3 million, expenditures continue to increase as housing placements increase each year. Last year, the following primary increased allocations were expended to help achieve the TCL goals for SFY20-21.

TCL Allocation	Increase Percentage	Increase Amount
TBRA	33%	~$6.7Million
Mental Health Services	35%	~$1.4 Million
Community Living Assistance (CLA)	55%	~$1 Million
Bridge Housing	44%	~$660K
TYSR	8%	~$100K
Diversion	5%	~$100K

Also, a new service, Assertive Engagement, was introduced to augment services to individuals in the Settlement Agreement; this service supports tenancy and fosters reduced separations.

With the increased expenditures and new service added, TCL estimated an additional need of at least $10 Million. As a result, in October 2020, the Office of State Budget and Management approved realignment of additional funds from DHB to address program needs.

Table 1: Breakdown of funds expended by LME/MCO

TCLI Service	Partners	Cardinal	Vaya	Alliance	Sandhills	Eastpointe	Trillium
Transition Year Stability Resources	$120,842	$439,757	$173,048	$235,715	$141,258	$100,777	$178,245
lnReach Collaborative				$10,719		$36,742	
Community Living Assistance (CLA)	$310,545	$396,628	$308,640	$515,528	$482,920	$337,714	$482,360
Emergency Housing Funds	$52,132	$103,682	$14,537	$8,196	$19,742	$16,152	$19,332
MCO Transition Coordinators	$90,000	$159,305	$90,000	$90,000	$90,000	$87,627	$180,000
Bridge Housing	$132,955	$485,323	$74,903	$131,982	$130,000	$265,699	$116,000
Mental Health Services	$428,757	$2,142,444	$239,566	$921,536	$514,128	$446,870	$928,516
Supported Employment	$232,361	$1,309,172	$144,114	$372,942	$383,620	$526,264	$276,136
Alliance ADANC Pilot				$43,965			
Subsidy Administration	$90,000	$425,000	$90,000	$90,000	$90,000	$90,000	$90,000
Diversion	$359,064	$692,361	$697,775	$478,410	$100,276	$252,724	$238,237
Assertive Engagement				$60	$1,914		$18,930
Total	**$1,816,655**	**$6,153,671**	**$1,832,583**	**$2,899,052**	**$1,953,858**	**$2,160,569**	**$2,527,757**

XII. CONCLUSION

As we conclude about FY 20/21, we acknowledge that despite valiant efforts across our State, we were unable to meet substantial compliance by the end of June of 2021, as agreed, and the Settlement will continue until June of 2023. Despite the ravages of COVID, we were able to end the year with 2,957 people in housing, just 43 people short of the established benchmark of 3,000; however, far short of the 2,000 persons who were to be housed coming out of adult care homes. There are many reasons why this occurred, but largely, the virus made it difficult to move people out of a congregate setting and into a community of their choice. This is mainly due to working around visitor restrictions in these facilities.

However, we would be remiss if we didn't talk about some of the important system change accomplishments that Transitions to Community Living (TCL) has produced to date. In housing, the July report indicates that 2.963 people are now living in permanent supportive housing. Over the life of the program, over 4,500 people with serious and persistent mental illness have experienced the pride of having an address, being a part of the community, and steering their lives toward recovery. In services, over 5,000 people have benefitted from the stabilizing work of ACT teams across our State. Community Support team (CST) now includes a tenancy support component and can now be accessed as long as a person needs the service. Transition Management Services, largely provided by peers, helps people continue to manage their housing and community integration as an initial service or to continue their recovery journey even after ACT or CST are no longer medically necessary. Individual Placement Supports (IPS), evidenced based supported employment service, not only helps people pursue meaningful employment but socially redefines them as co-worker, teammate, and friend.

The State created an Informed Decision- Making tool (IDM) so people fully understand their rights to live and receive services in the community. The tool has now been updated so that guardians and the person can document their desires, decisions, or concerns about community living, When Guardians express concerns about community transition for the person In-reach Specialists, who administer the tool, can then address the concerns with individualized strategies for overcoming any barriers to community living. If concerns cannot be addressed at the local level, they can be elevated to the State's own Barriers Committee made up of cross-Divisional subject matter experts who set out to address the barriers that inhibit community life. If the Barriers Committee cannot resolve a systemic issue, it is raised to the Transition Oversight Committee, along with recommendations for resolution. Many systemic barriers have been overcome in this manner.

Discharges from State Hospital protocols are in place and training across all hospitals and LMEs was conducted this year. Nearly twenty percent of discharges from the hospital are now leaving to go into housing or bridge housing. Transition times are improving, and we continue to monitor movement from Adult Care Homes.

One of the barriers to community living that was addressed in the last two years, was the need for improved transition planning and focused complex medical support. Again, done with a cross-Divisional team, we now have created a Complex Medical Care Management (CMCM) pilot whereby occupational therapists and registered nurses develop a plan of care before the person leaves an institution. In addition, when needed, training can also be provided so that a person can better manage his/her own health status once in their own home. Before the person leaves the institution, they are introduced to medical care managers who will follow them into their homes to help further train a person around making healthy decisions, understanding medications, how to perform at-home medical care, and more. The Complex Medical Care pilot will be rolled out to all of the six LME/MCOs before April 2022. This pilot is a critical component of our work to move people out of Adult Care Homes, with the typical age much

higher than with any other priority population often with multiple medical conditions and ongoing care needs.

We have made great strides in reducing reliance on institutions and expanding the array of services and supports for people to lead successful lives in the community. We have developed and are tracking an action plan for the next 18 months to meet compliance by the June 2023 deadline, and we are in the countdown. Our LME/MCO partners have developed plans to ensure their own success as well as the success of their members. Elements of TCL are now housed within Medicaid Transformation Tailored Plans, our Olmstead Planning, and its incorporation of elements of both TCL and Money Follows the Person (MFP). The intention of moving forward with the elements of TCL and MFP with all disability groups was recently made clear with a presentation made by the DHHS Secretary Mandy Cohen who spoke to all of our Olmstead Committees and to stakeholders and the public at large on August 23rd of 2021, she noted:

> *The Plan serves as a "blueprint" for the way that DHHS and its state government partners will make decisions central to improving the lives of people with disabilities. She noted that the document rests on the Olmstead-based implementation of both Transitions to Community Living (TCL) and Money Follows the Person (MFP); expands the social determinants work at the heart of DHHS' Healthy Opportunities initiative; incorporates efforts well underway, across the DHHS, to refine and re-define policies and programs to align with Olmstead's imperative of community integration; and commits North Carolina to a future where all people with disabilities can access the services that they need to live "an everyday life—even, an enviable life--side-by-side with friends, family and neighbors."*

Transitions to Community Living is no longer a stand-alone initiative. It is a way of approaching all of our work for individuals with disabilities who deserve the opportunity to live and thrive with us in communities throughout North Carolina.

XIII. APPENDIXES

Appendix A: TCL Quality of Life Survey Summary Report

Appendix B: 2021 TCL Network Adequacy and Accessibility Analysis Excerpts

Appendix C: Permanent Supportive Housing Habitability Checklist

APPENDIX A: TCL QUALITY OF LIFE SURVEY SUMMARY REPORT

"I am just trying to get back up the mountain." TCL participant, pre-transition

The NC Transitions to Community Living (TCL) Quality of Life (QOL) Surveys assess the extent to which individuals who transition to supportive housing in the community experience improvements in the quality of their daily lives, as well as areas in which they experience obstacles and challenges to community integration, housing stability, and harm avoidance. A component of State and LME-MCO Quality Assurance and Performance Improvement (QAPI) monitoring systems, the surveys help to ensure participants receive the services and supports they need for health, safety, and welfare.

LME-MCO staff and community mental health services providers administer the surveys during the transition planning period and again 11 and 24 months after the individual transitions to supportive housing.[1] Together with regular provider-facilitated interviews administered through the NC Treatment Outcomes and Program Performance System (NC-TOPPS)[2], TCL QOL Surveys are used to monitor key participant outcomes, including community integration, natural supports network development, and other factors vital for maintaining stable housing and avoiding harms.

The surveys utilize a structured interview format and are designed to directly assess participant perceptions, satisfaction, and outcomes related to housing and daily living, community supports and services, and well-being. Approximately 30 survey questions are presented with defined response options. At twelve points throughout the interview, individuals are invited to provide additional information, elaborate on earlier responses, discuss what they would like to change, and identify and discuss unmet needs, factors limiting daily choice and control, and obstacles to community integration and receiving needed services.

Defined-response questions allow for data tracking and trending over time at both state and regional LME-MCO levels and are the primary focus of this annual summary report. The surveys are also used in LME-MCO TCL quality assurance and performance improvement activities.

At the member level, providers and LME-MCO staff are able to identify obstacles and problems that require immediate follow-up and solutions. Open-ended survey questions provide a structured opportunity for service providers and LME-MCO contacts to assess individual preferences, needs, and goals during transition planning, and to identify, explore, and discuss with individuals in supportive housing any factors related to their services and supports, daily activities, and housing that need attention, adjustment, or intervention. For example, open-ended questions address and encourage

[1] In general, 24-month surveys are administered two SFYs after the transition year, such that 24-month surveys for individuals who transitioned in 2019 occurred in 2021. Follow-up surveys may be administered substantially later than 11 and 24 months after the initial transition for individuals who leave and later return to supportive housing.

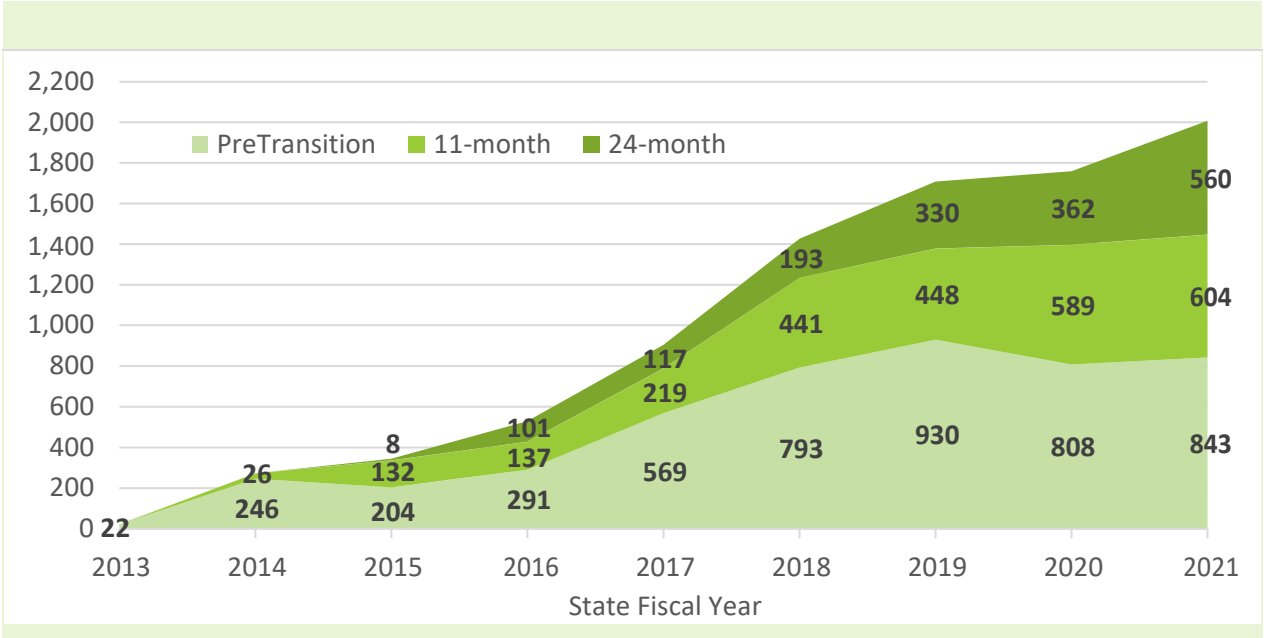
[2] NC-TOPPS interviews are administered upon initiation of services, at 3-month and 6-month follow-ups, and every six months thereafter until the individual is discharged from services.

deeper exploration and discussion of member obstacles to community integration, impediments to self-direction, additional service and support needs, and problems and sources of dissatisfaction with the current living situation.

The State also encourages LME-MCO to conduct quantitative analysis of survey data to evaluate system-level performance and aspects of member experiences that require systematic action and improvement. For example, LMEs-MCOs are encouraged to identify for targeted performance improvement efforts survey areas with low relative percentages of positive member reports compared to other areas assessed, low percentages compared to statewide percentages, areas for which decreases in satisfaction or quality of life are noted between 11-month and 24-month follow-ups, and any areas for which member satisfaction remain low or decrease over time.

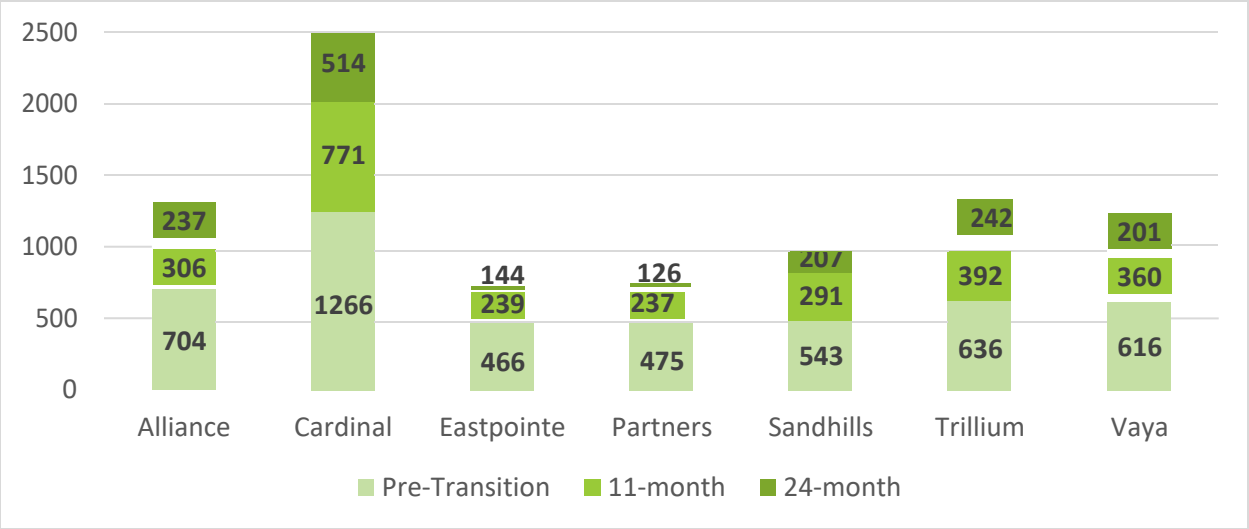
Survey responses are submitted by the LME-MCO or service provider through the State's secure, web-based survey application. As of June 30, 2021, almost 9,000 surveys for nearly 5,000 TCL participants have been submitted or administered. With this annual report, responses to a total of 4,706 Pre-Transition surveys; 2,596 11-month surveys; and 1,671 24-month surveys have been analyzed.[3] (See Figures 1 and 2.)

Figure 1: Participant Surveys by State Fiscal Year



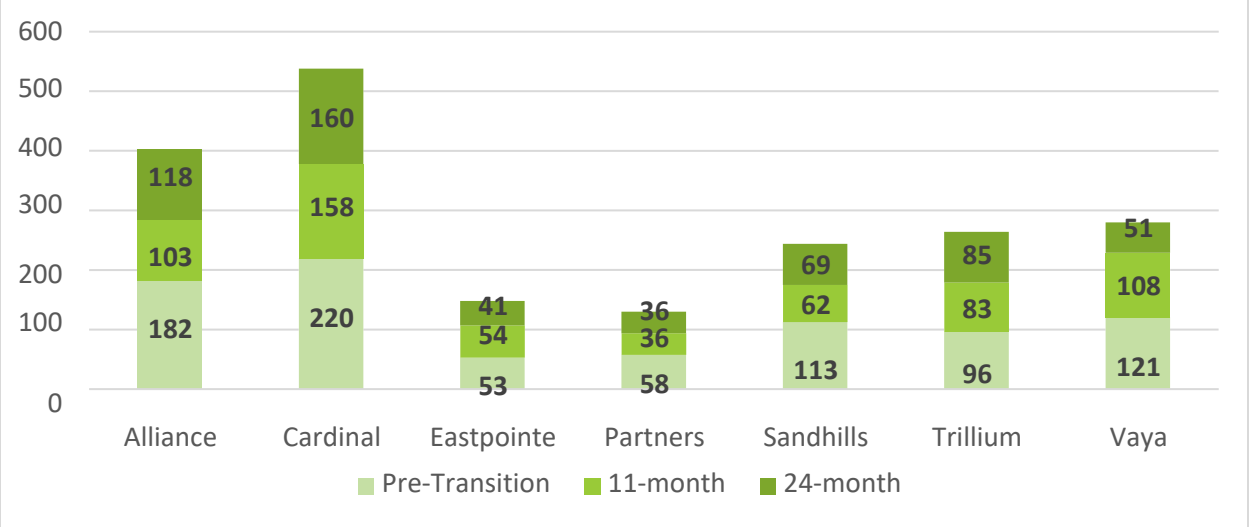
[3] Per Section III.G.5 of the State's Settlement Agreement (SA) with U.S. DOJ, the State implemented Quality of Life surveys in 2013. The SA requires surveys for individuals transitioning out of adult care homes or state psychiatric hospitals. The State extended the survey requirement for LMEs-MCOs to include all five priority populations who transition to supportive housing, including individuals diverted from adult care home admission.

Figure 2A: Completed Participant Surveys by Submitting LME-MCO, SFY 2013-2021



Analyses of SFY 2021 data reported in this annual update are based on 2,120 surveys, including 843 pre-transition, 604 11-month, and 560 24-month surveys, as shown in Figure 2B.

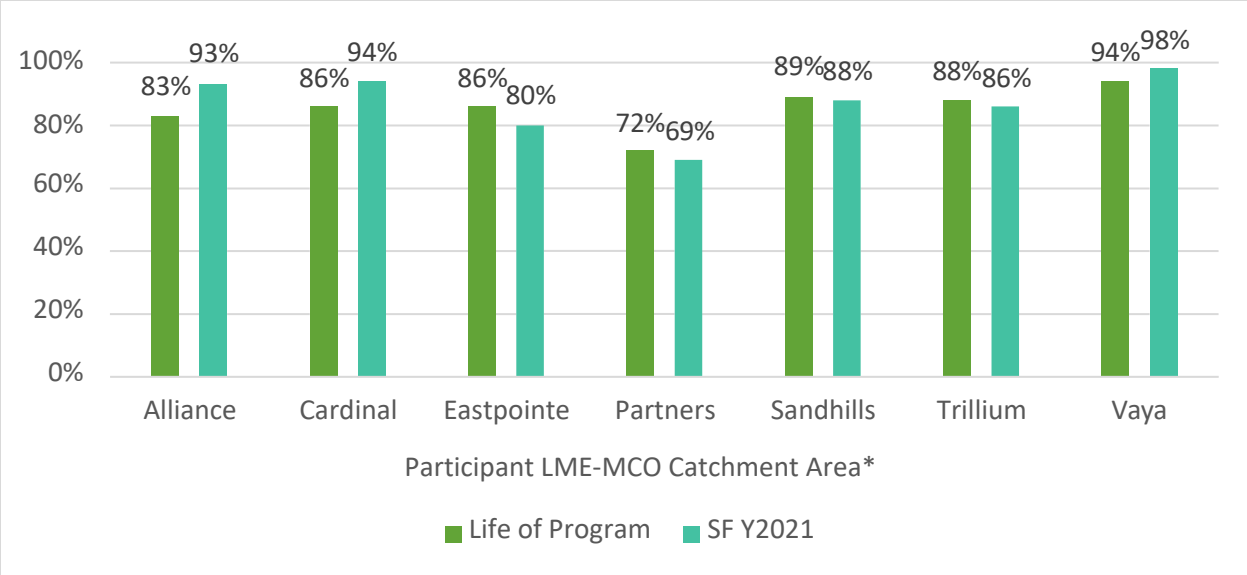
Figure 2B: SFY 2021 Completed Participant Surveys by Submitting LME-MCO



LME-MCO compliance with the Quality of Life survey requirement is an area of ongoing State team performance monitoring. Over the life of the TCL program, 85% of surveys for individuals housed and/or reaching 11 or 24 months in housing have been submitted. This includes pre-transition surveys for 93% of individuals housed and follow-up surveys for 79% of individuals in housing at 11-month and 24-month follow-ups. Because individual survey participation is voluntary, a 100 percent submission rate is not expected.

The overall submission rate for surveys due in the 2020-2021 State Fiscal Year was 89 percent and included surveys for 94 percent of all individuals who transitioned to supportive housing during the year, and 86 and 85 percent, respectively, of individuals in housing at 11 and 24 months. Life of program and SFY 2021 survey submission rates by current LME-MCO catchment area are shown in Figure 3.[4]

Figure 3: Percentage of Expected Surveys Submitted, Life of Program and SFY 2021



*May include surveys submitted by legacy LMEs-MCOs that later merged and surveys administered by a different LME-MCO or its contracted provider prior to a member transfer to a different catchment area.

Although positivity bias is a well-documented phenomenon in self-report satisfaction surveys in general, TCL member Quality of Life Surveys have proven effective for identifying individual and system-level challenges to member satisfaction and the quality of their experiences in supportive housing. The State's annual TCL Quality of Life Survey Summary Reports also demonstrate system-level progress in addressing and reducing these challenges over time (see, for example, Figure 11 of this report).

Over the life of the program, members on average have responded to 9 of 38 (24%) defined-response survey questions with an answer other than the one that indicates the most positive experience or level of satisfaction. In more than one-third of all surveys, both pre- and post-transition, 11 or more of these "flags" are present, with 17 or more in approximately one-tenth of surveys.

In surveys administered in SFY 2021, the average number of defined-response questions with responses indicative of less than the most positive experience or level of satisfaction was 10.1 for pre-transition

[4] Aggregate annual and life of program submission rates presented here are not precise estimates of LME-MCO compliance or performance. Submissions reported under each LME-MCO reflect each participant's most recent LME-MCO on record. They may include surveys submitted by legacy LMEs-MCOs that later merged and surveys administered by a different LME-MCO or its contracted provider prior to a member transfer to a different catchment area. Approximately five percent of TCL participants have transferred across LME-MCO catchment areas since the initial transition to supportive housing.

surveys, 7.3 for 11-month follow-up surveys, and 6.4 for 24-month follow-ups. Approximately one-quarter of surveys of members in supportive housing included two or fewer flags, and approximately one-quarter included 10 or more. A plurality, approximately 50 percent, included responses that could indicate between three and nine potentially actionable issues, problems, or concerns.

Participant Voices, Pre-Transition: What would you change about your living situation?*
If I was by myself, I would do like I want and be free. I would be free and wouldn't feel like I have to walk on eggshells.
I want a place of my own. I would prefer to live around less drama and around sober minded people.
I would have a place of my own to share with my son and dog.
I would like to have my own apartment somewhere close to my mom so I can check in on her and help her out.
Having more independence, my own kitchen, not having to constantly set boundaries with people, having my own space and not community spaces, less noise, I can play my own music.
I want to live by myself so I can use my kitchen and bathroom anytime I like.
I would change to me living in my own house with my sanity and peace.
I would have my own place and…just handling my own stuff my own way.
I am tired of moving around trying to find somewhere to stay.
I would not sleep in a vehicle, I know that much.
I'd probably have more kind people around me. I'd like to have my own house.
I'd…get back to going to church, fix up my place and just be happy with my gospel music.
I'm ready to move to another chapter of my life.
Not to sleep on the floor. It is really tearing my body up.
I just want a fresh start.
I don't to want to be in the cold anymore. I want to live in my own place.
I would like to not sleep on couch. I want my own place to live and relax.
I am homeless and currently been in between hotel, woods, and homeless shelter. I am too old to live like this.
By the Grace of God, I have been in assisted Living facilities for over 19 years and ready to start over.
I want my own place, so I can have power and water with access to transportation as needed.
I want to walk to the store and go out to eat. I need some clothes. I am excited about starting over.
Being in a house by myself, being able to have someone help me with food and transportation, someone to help keep me from being depressed.
I choose to be around better people, people that will bring me up and not pull me down.
I want to have my own place and I want to have employment so I can have the things I need.
I want to live on my own and decorate my own place and possibly get a dog.
I would like to live in a safer environment. My current environment is unsafe physically and emotionally.
Would like to be on my own, prepare my own meals, live closer to my daughters.
I need my own place for privacy and autonomy. I would move!
My own place, with my own bed, and a place to cook.
I wouldn't be underneath someone's thumb.

*Pre-transition participants surveyed in SFY 2021

PARTICIPANT QUALITY OF LIFE

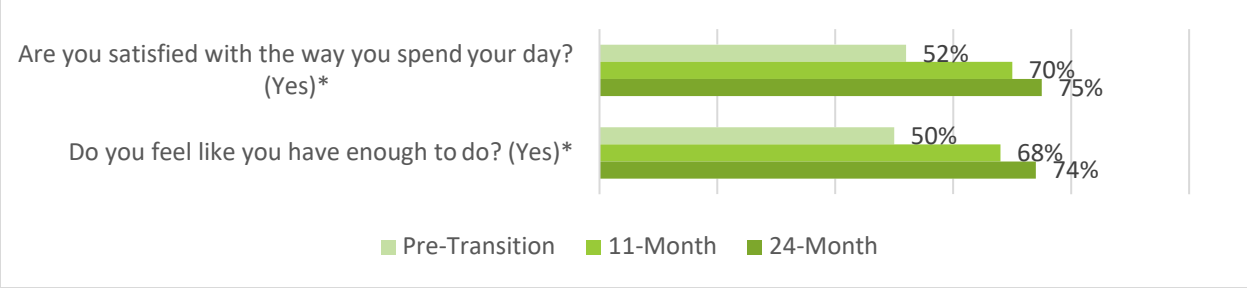
"I am learning how to live a little better each day. Right now I am taking baby steps. But I have a good team around me." TCL participant at 11-month follow-up

Figures 4A through 4H show percentages of participants surveyed in SFY 2021 who reported positive experiences related to eight Quality of Life domains.[5,6] "Participant Voices" exhibits throughout this section feature quotations from individuals in supportive housing who participated in 11-month and 24-month follow-up surveys.[7]

Pre-transition, 11-month and 24-month responses follow the same general pattern from previous years, with similar percentages of individuals in housing selecting the response that indicates the most positive experiences and satisfaction. Significantly larger percentages of post-transition respondents reported positive experiences related to Meaningful Day, Choice and Control, Natural Supports, and Safety.

In Staff Support and Satisfaction with Services, Service Planning, and Service Sufficiency domains, post-transition percentages were nonsignificantly higher or did not differ from pre-transition responses. Related to the Health and Wellness domain, a significantly lower percentage of post-transition respondents reported feeling lonely during the past week. However, post-transition respondents were significantly more likely than the pre-transition group to report having needed to go to the doctor unexpectedly or having gone without needed medications.

Figure 4A: Meaningful Day



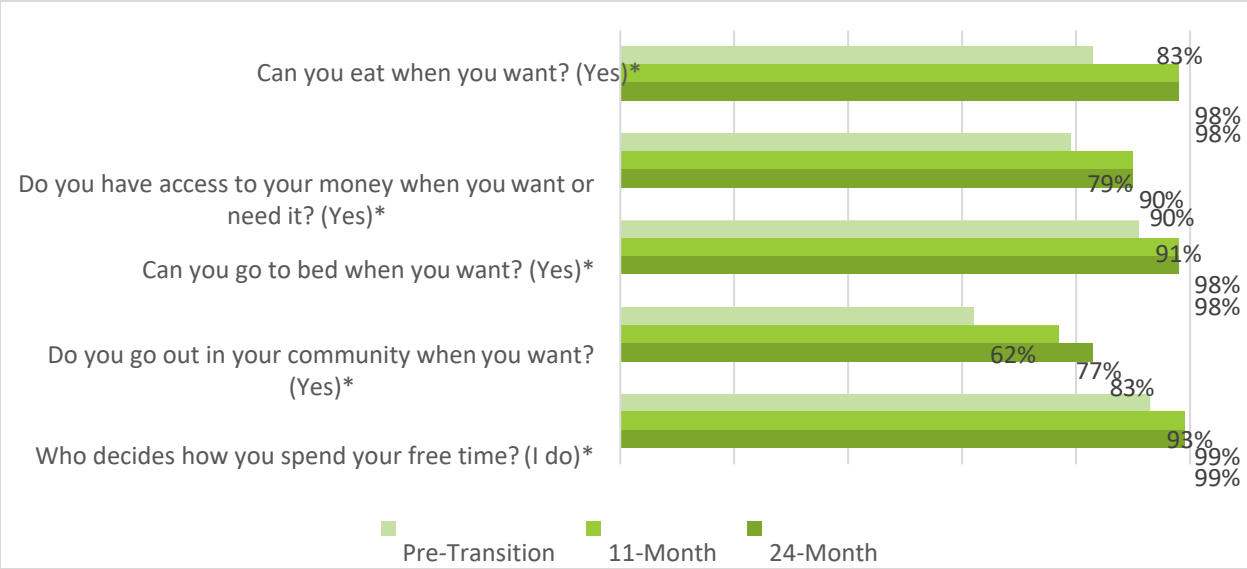
*Pre-transition and post-transition percentages are significantly different.

[5] The eight Quality of Life facets are defined by correlated groups of survey items. In general, responses to items within each domain are more related to one another than they are to responses in other domains.

[6] "No Response" and "Unsure" responses are excluded from all percentage denominators.

[7] Open-ended survey questions are designed to bring out and explore in greater depth problems and sources of dissatisfaction with housing, obstacles and challenges to community integration and obtaining needed services, and unmet needs that require attention and intervention. Many individuals provide responses indicating they are very satisfied with their housing and community and are receiving all needed services and supports. The quotations featured in Participant Voices exhibits are less representative of this common responses pattern and instead are selected to illustrate the range of concerns respondents express.

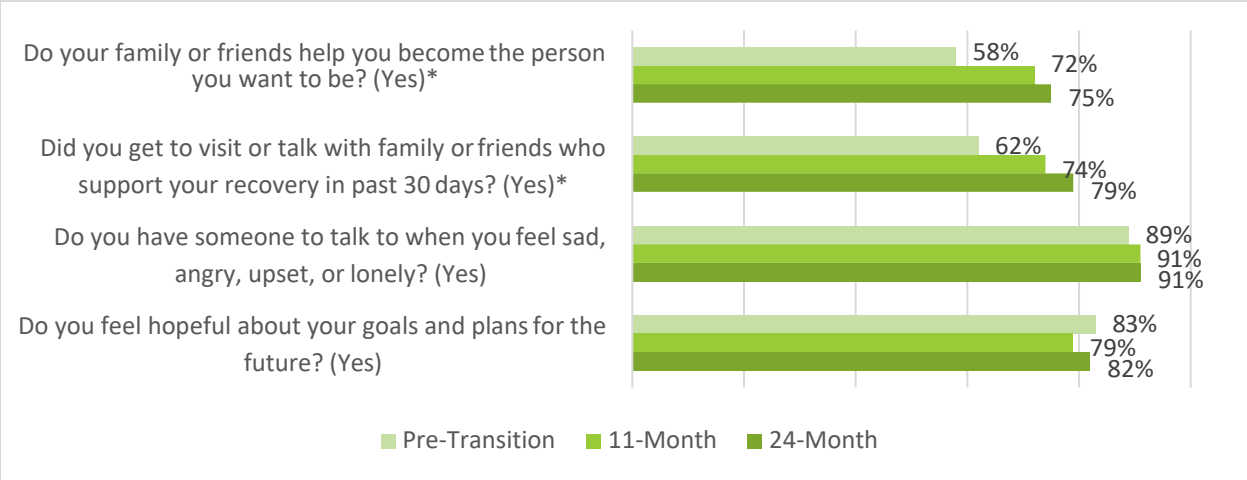
Figure 4B: Choice and Control



*Pre-transition and post-transition percentages are significantly different.

Participant Voices: Meaningful Day, Choice and Control
I am getting out more in the community and I am not as paranoid.
I am writing a book…I will be talking with my provider about getting a computer/laptop.
I have found Christ and my life is better. One day I would like to own a house.
I have informed my workers and added it as a goal that I would like to return to school to get my GED.
I have purchased my own car.
I would like a job. My ACTT is helping me.
I am not satisfied with my life but I love the Lord and that is what keeps me strong.
It is like a box, I do the same things every day, I come out of the box, [there's] more to my life than that.
I need to find more positive things to do but everybody working with me is great.
I am working on getting medical transportation and going to school online. I am interested in being a computer technician.
I want to work on becoming a Peer Support and become a motivational speaker.
I would like to volunteer somewhere but ACTT doesn't think I am ready.
I'm in the process of getting my GED through…Technical College.
Would like to get back to trout fishing.
I would like to get out of the house more.
I would like to have my own house where I can work in my own yard and plant flowers.
I would like to get a degree in culinary arts and eventually work.

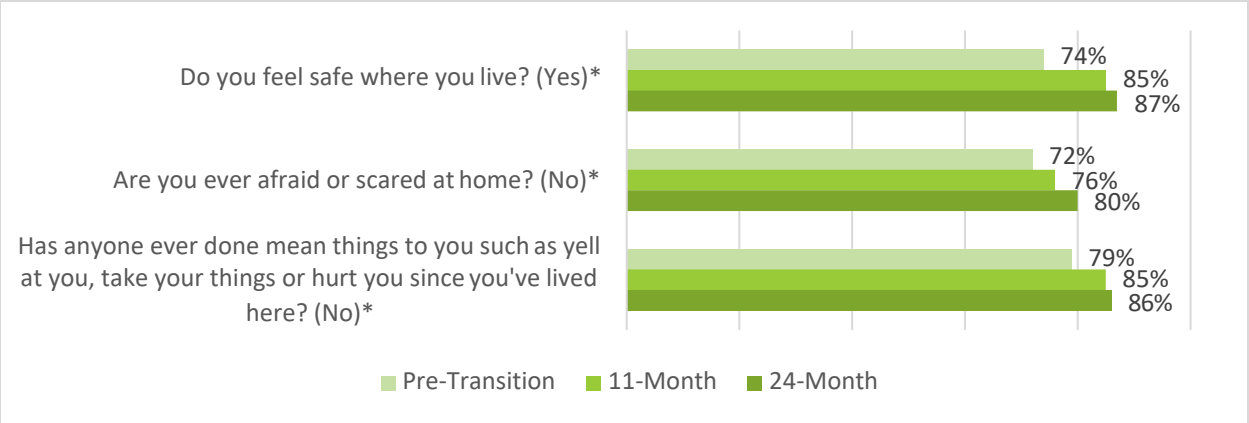
Figure 4C: Natural Supports



*Pre-transition and post-transition percentages are significantly different.

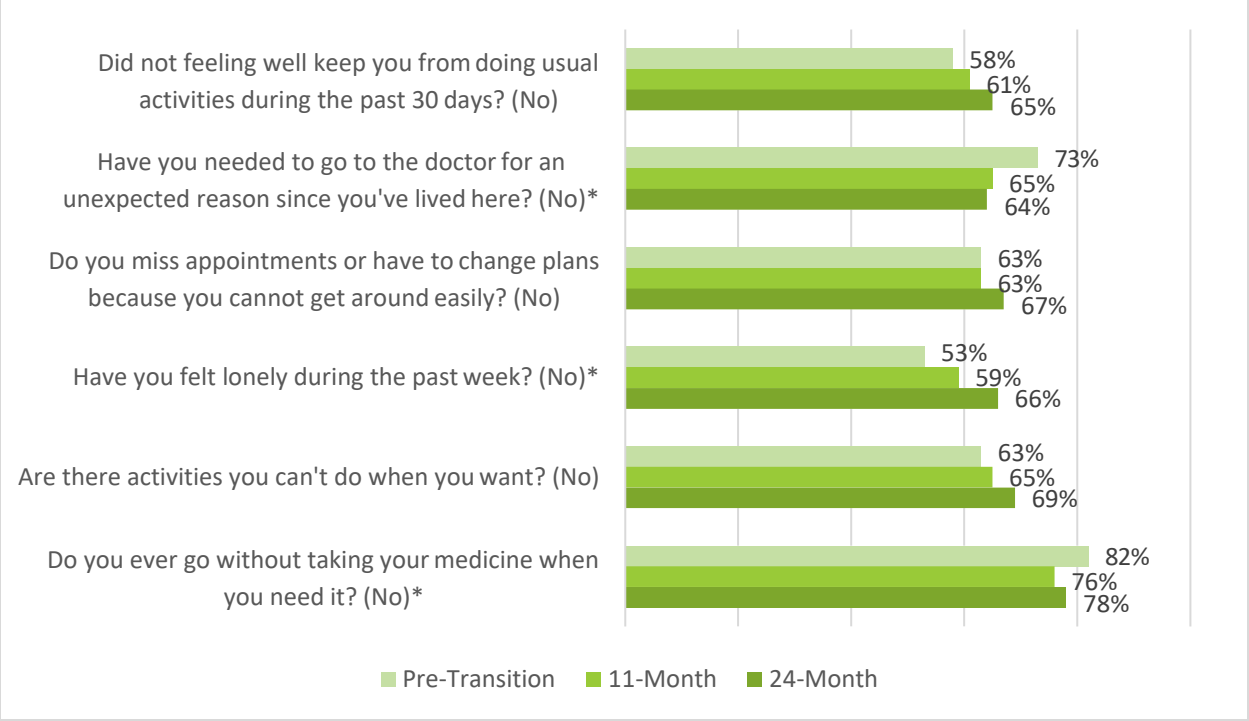
Participant Voices: Community Integration and Natural Supports
I would like to connect to people to help them know about what I been through, to be involved with the political process.
I do not have a good relationship with my mom. I have someone I consider as my adoptive mom.
I talk and get along with my neighbors.
I want to reconnect with my daughter and a female friend. I have a lot of support from my family.
I would like to help during hurricane times, but I don't know where to help.
I have been doing very good on my own and happy to have my daughter back in my life.
I want to get into a relationship.
I am grateful for the opportunity to have my own place. My life is better. My relationship with my mother is better. I am more independent.
I am involved with my church Young Adult group. I attend church on Wednesday and Sunday. I read a Bible chapter a day to my grandpa.
I want a wife or girlfriend so I can stop being lonely.
I don't like being by myself all the time.
I would change my single status. I would like to have a family.
Would like to have company to come over, like my son and daughter.
I wished I lived closer to my friend or brother who lives out of town.
I would like to meet new people.
I wish I was closer to where I could walk, like to a store where I would not feel so isolated.

Figure 4D: Safety



*Pre-transition and post-transition percentages are significantly different.

Figure 4E: Health and Wellness



*Pre-transition and post-transition percentages are significantly different.

Participant Voices: Safety, Health, and Wellness
I am living in a bad area with drugs.
I still have a suitcase packed for fear of being homeless.
I am severely depressed.
I have some anxiety and a little depression at times. Besides that I am all right.
I have been lonely due to the COVID 19 but I am staying in. The team talks with me and helps me get through those days.
My anxiety is bad.
My house was involved in drive-by shooting…I am frightened to live here. [LME-MCO Transition Coordinator] is helping me find safer housing.
Everything is going better than they were a few months ago. I feel like I'm doing well.
I am doing better about taking my medication.
I feel so much better since I have a place to stay. I feel secure and not afraid.
My mental health is difficult to deal with. I really feel like I have no control. I've been without my nightmare medicine for 30 days now.
Some crime in my neighborhood leaves me feeling a little unsafe.
I would move to an area where no one gets shot in front of your mailbox.

Figure 4F: Satisfaction With Services and Staff Support

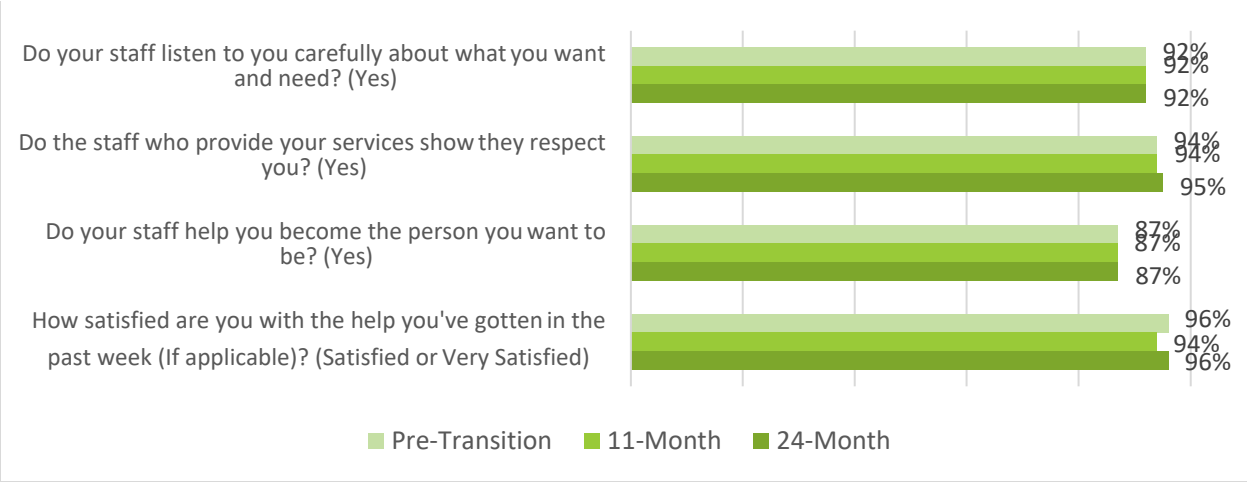


Figure 4G: Service Planning Contacts

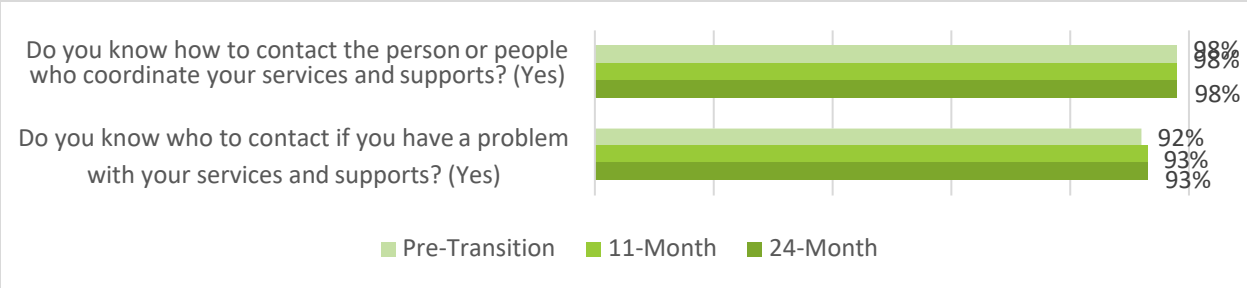
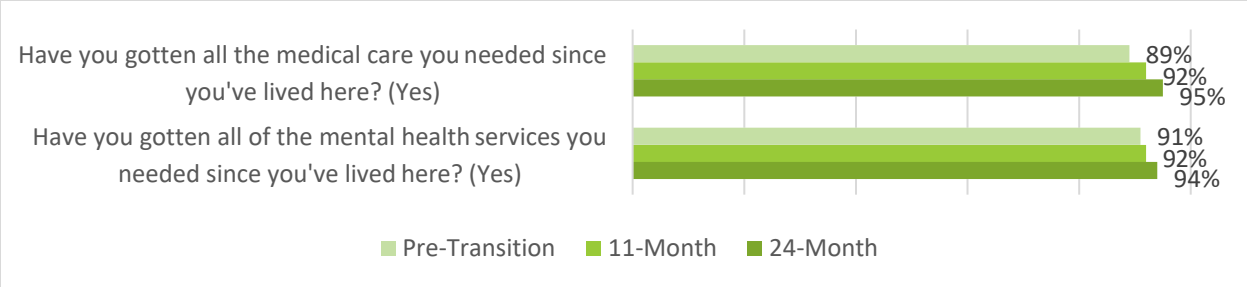


Figure 4H: Service Sufficiency



Participant Voices: Services and Supports
I don't know what to do. I feel like I am in a trap in certain services or jail.
I have left messages for members on my ACTT Team I am only getting a recording.
I am not happy with the Personal Care Services and the RN that comes here.
One provider has been very helpful and I have indicated they are very understanding. However, the other provider, I fired them and refused to sign a form indicating the staff was at my unit offering services when he was not.
ACTT changes QPs quite often and that's frustrating.
Things have been better since [Provider] switched things around and got me on a different caseload with a different caseworker.
Everything is smooth. The staff meets me where I am at.
I am still growing. I have two workers that care about the people they work with. It is not just a paycheck.
I did not like the new provider not showing up when they were scheduled. I requested they call me if they are not coming and reschedule not just show up.
My workers…don't seem to care. They show up maybe once or twice a month.
I need a better [Provider]. There is a high turnover with provider's staff. They are quitting or going on leave.
I do not know who my [Provider] team is. It is hard to get up with anyone. I do not know what is going on or what services I am getting.

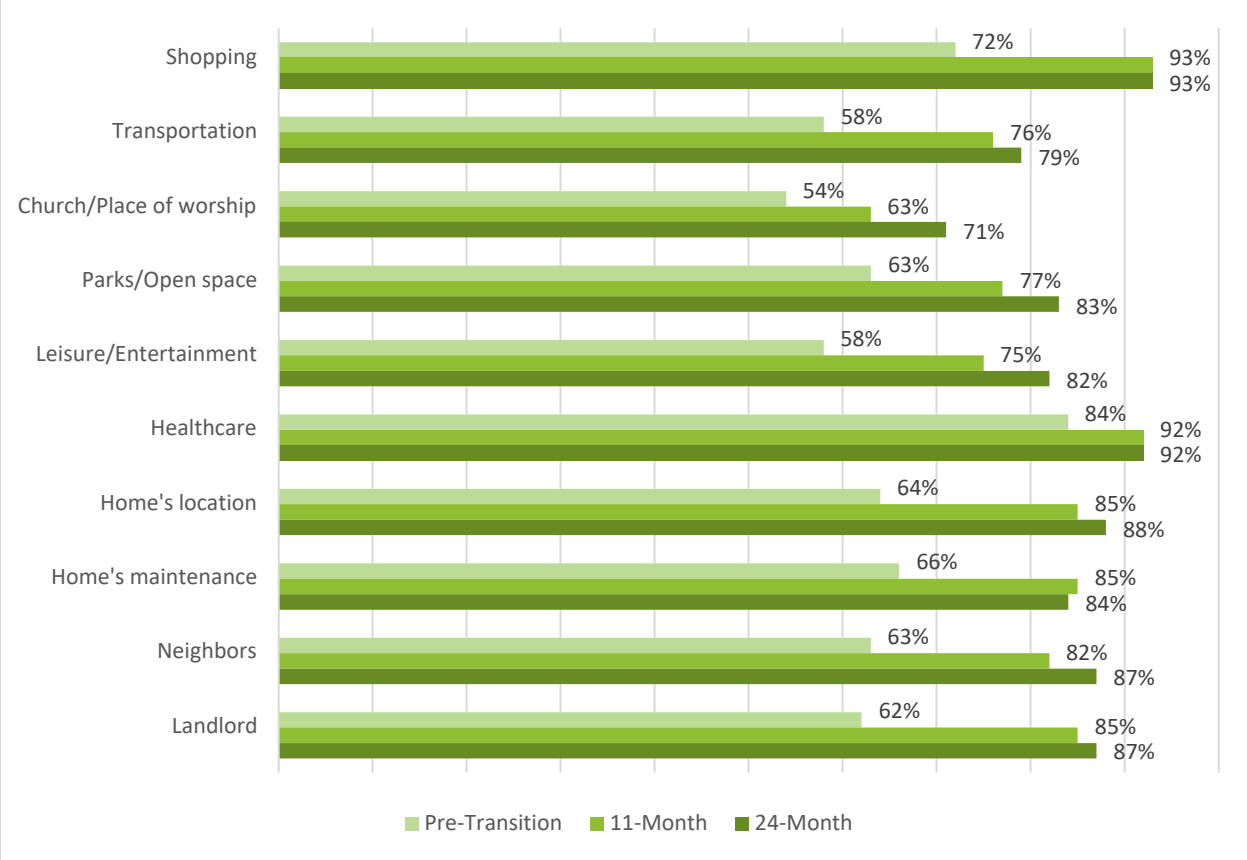
SATISFACTION WITH HOUSING AND COMMUNITY

"I am just glad to have a place to call mine." TCL participant at 24-month follow-up

Figure 5A shows percentages of SFY 2021 survey respondents who reported being satisfied with various resources in their communities and aspects of their housing. "Participant Voices" exhibits feature quotations from individuals in supportive housing who participated in 11-month and 24-month follow-up surveys during SFY 2021.

As in previous years, significantly larger percentages of individuals in supportive housing reported satisfaction in each of the ten areas compared to individuals who had not yet transitioned. Also as in past years, at all three points respondents were most likely to report satisfaction with their Healthcare. Compared to the pre-transition group, post-transition respondents were approximately 20 percent or more likely to report satisfaction in all other areas assessed.

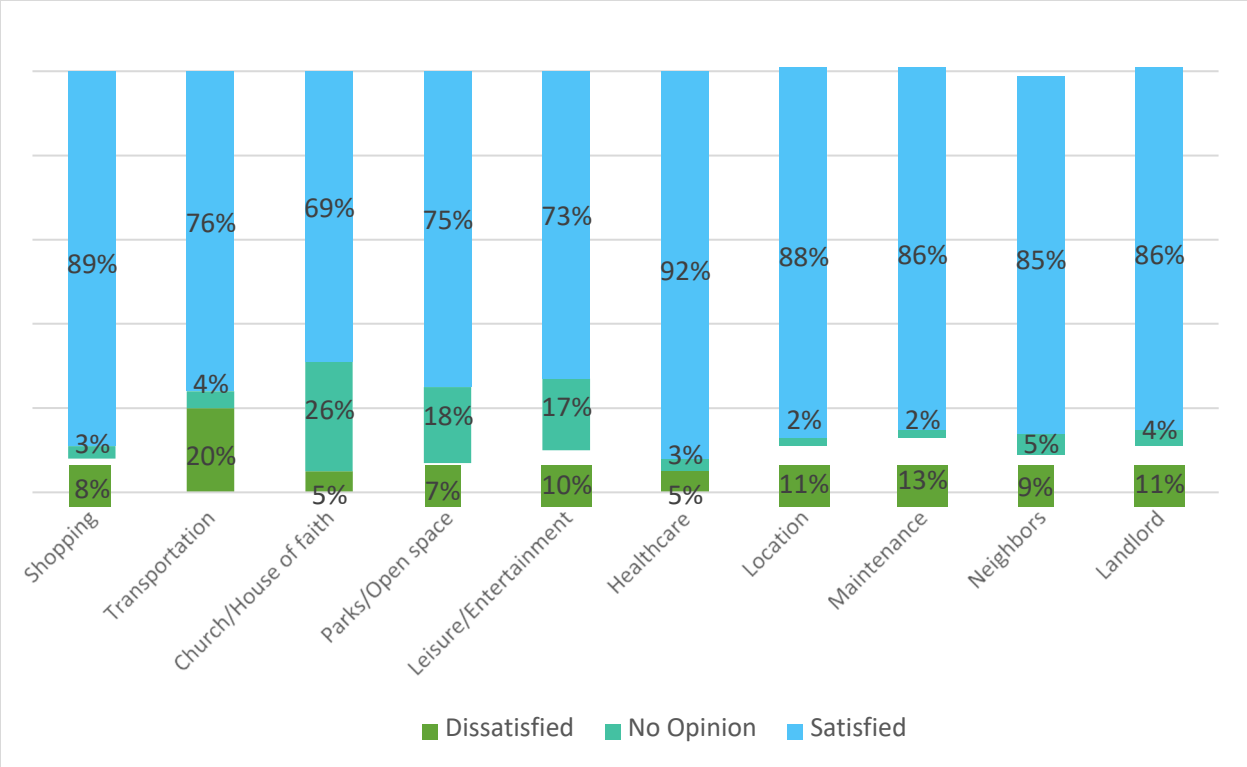
Figure 5A: Satisfaction with Housing and Community Resources



Values shown are percentages of respondents who selected "Satisfied" rather than "Dissatisfied" or "No opinion." Non-responses are excluded from percentage denominators. Significantly larger percentages of post-transition respondents reported being satisfied with all ten aspects of housing and community resources.

As shown in Figure 5B, Transportation continues to have the highest rate of post-transition dissatisfaction, followed by Home Maintenance, Location, and Landlord. Relatively lower rates of reported satisfaction with Church, Parks, and Leisure reflect in part the percentages of participants who reported No Opinion.

Figure 5B: Satisfaction vs. Dissatisfaction in Supportive Housing



Includes all SFY 2021 11-month and 24-month follow-up surveys.

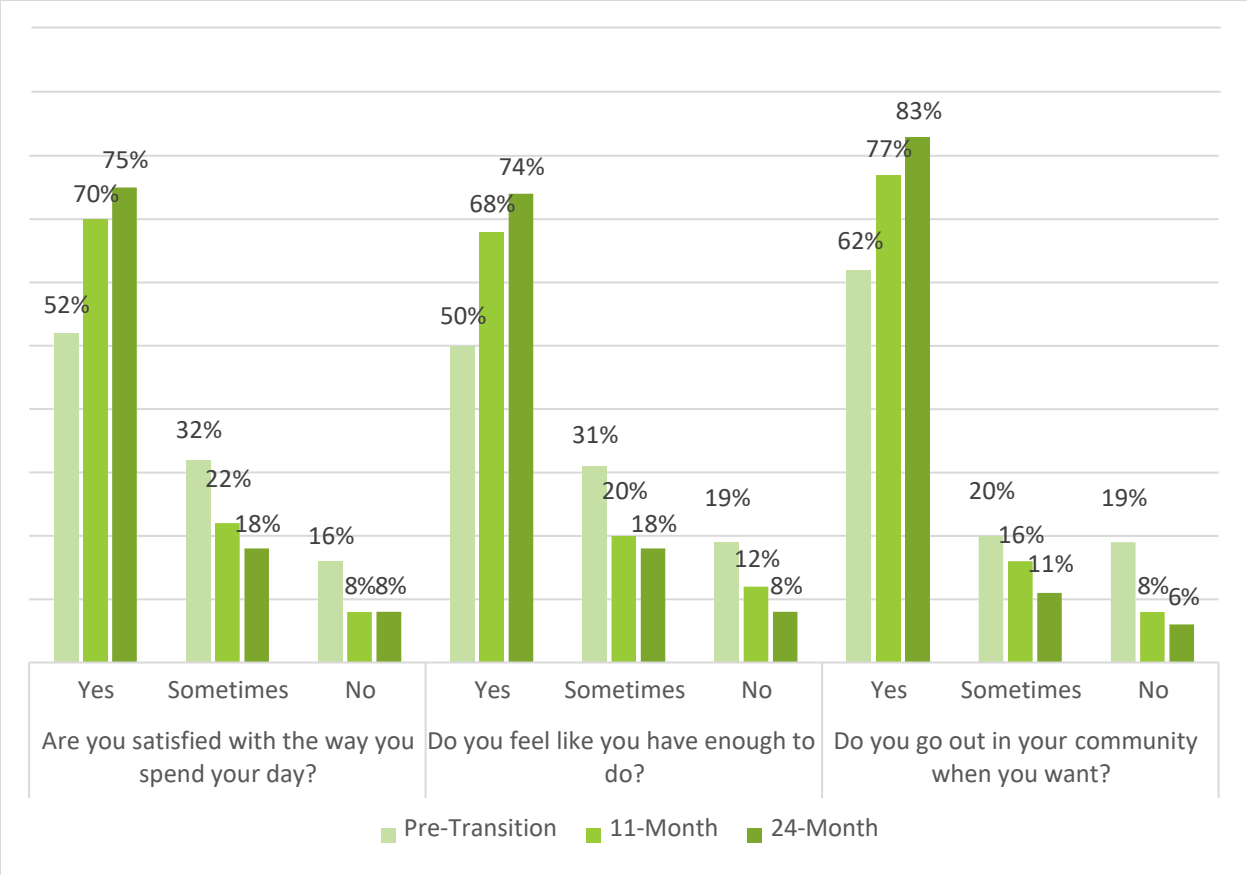
Participant Voices: Satisfaction with Housing & Community/What would you change?
I would change where I live. The house would not be old and broken down.
I'm happy and very satisfied and I'm very pleased with the maintenance of all the units.
I am concerned about having mold in this apartment.
I really like new apartment. It's cleaner than the last one.
The landlord would be more responsive when work orders are submitted. There is a leak in the washroom and it was reported 3 weeks ago.
I would like for my landlord to be more proactive regarding maintenance concerns and maintenance requests including returning my phone calls to address these issues (broken window, loose access ramp to front door).
I would like to be in a more updated facility with access to a computer, gym, garden and a better manager you can get along with.

Participant Voices: What would you change about your current living situation? (cont.)
Safety measures need to be improved: elevator needed, lighting, walkways, security and door locks.
The Landlord needs to talk with tenants, not just stuff items in the mailbox. I understand not talking face to face, but he could at least make a phone call.
I would like a more responsive landlord who would have my lease to me before the renewal date.
I would have a considerate landlord who is not racist.
I would like my neighbor to be respectful to the community and not be loud or threatening.
I have wonderful neighbors.
I want a house that has central heat and A/C and has the floors insulated.
I wish I lived in a house or on one floor.
I would have an outdoor space attached to my apartment and washer and dryer in my apartment.
I want to get a place with a front and back yard because I have dogs.
I would live on the first floor so my mother who is wheelchair bound could visit me at my apartment.
The left side of my body is paralyzed, I would be on the bottom floor instead of the third floor. It is difficult walking up the stairs.
I wish I had more room when my kids come and stay.
I wish I could have a roommate.
I would have a pool and a play area closer to the apartment.
I would have a house with more trees and a patio. I enjoy sitting outside.
I would like a second bedroom so my grandchildren could visit overnight.
I would like to be able to smoke on my porch.
I would live closer to a bus line and in a quieter place.
Would like to move. Wheelchair gets stuck in the yard on rainy days.
I wish I could have a pet.
I would live in a much quieter place so I can hear the birds.
Move to a quieter place way out in the country where I can grow a garden and have plenty of space to be outdoors and exercise without neighbors. And be able to take a bath or shower every day without water problems.
I would rather live out in the country with less neighbors so it would be quieter.
I love my community. Everything is within walking distance.
I want to be in a more mixed community…The racial tension has the stress level to the max.
I would like to live in a community with people my age.
I want to move where there is not a lot of loud noise. The park is in front of me and the children get on my nerves.
I would live in a different safer place. I am in a wheelchair and people are coming in my apartment without me knowing.
I would move out of this environment. There is a lot of drug activity going on. This does not help my recovery.
Sometimes I wish there was more to do in my area as far as entertainment goes, but overall I'm very satisfied where I live.

COMMUNITY INTEGRATION AND NATURAL SUPPORTS

Figure 6 shows detailed response distributions to survey questions related to participant community integration and engagement. Pre-transition and post-transition respondents differed substantially in their reports of satisfaction with daily activities, having enough to do, and going into the community when desired. On average, 55 percent of individuals responded affirmatively to these questions prior to transition, compared to 74 percent on average at 11-month and 24-month follow-up surveys.

Figure 6: Community Integration and Engagement at Pre-Transition, 11 and 24 Months



Pre- and post-transition respondents also differed in their reports of typical daily activities. Participants in supportive housing selected 3.6 activities on average, significantly greater by ten percent than the 3.3 activities selected on average by individuals in congregate living and other pre-transition settings.[8] As shown in Figure 7, participants in supportive housing were significantly more likely to select Cooking/Cleaning, Physical activity/Exercise, and Computer activities.

[8] This pattern is the reverse of that observed in SFY 2020, when the average number of activities selected by pre-transition respondents was approximately 15 percent higher (M = 4) compared to post-transition respondents (M = 3.5). This trend may reflect a disproportionate impact of COVID-19-related precautions and restrictions on facility residents.

After Watching TV, which was the most commonly selected activity for both groups, the only activity selected by more than 50 percent of individuals in supportive housing was Cleaning/Cooking. The only other activity selected by more than 50 percent of individuals who had not transitioned to supportive housing was Listening to Music.[9]

Figure 7: How do you usually spend your day?

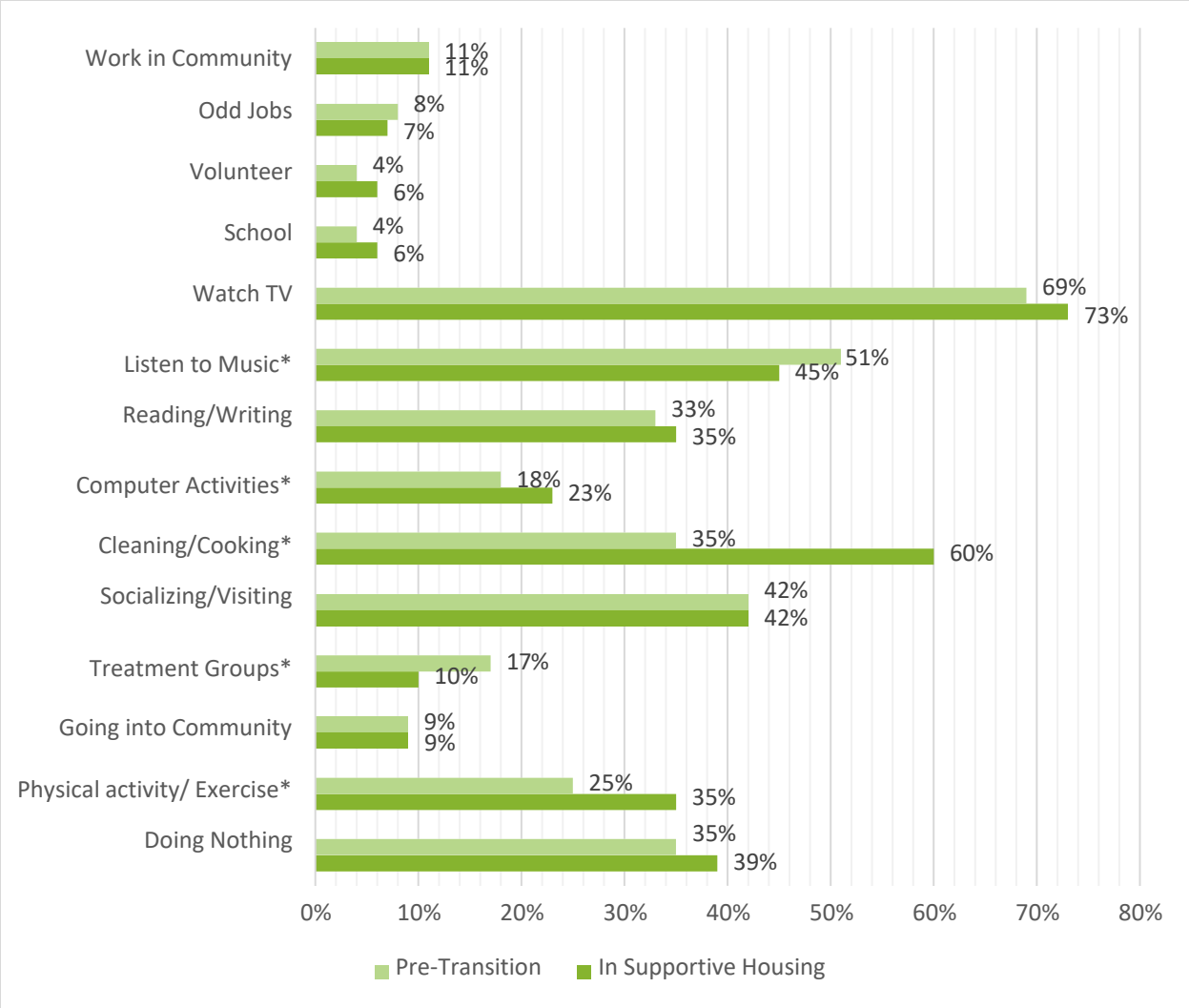
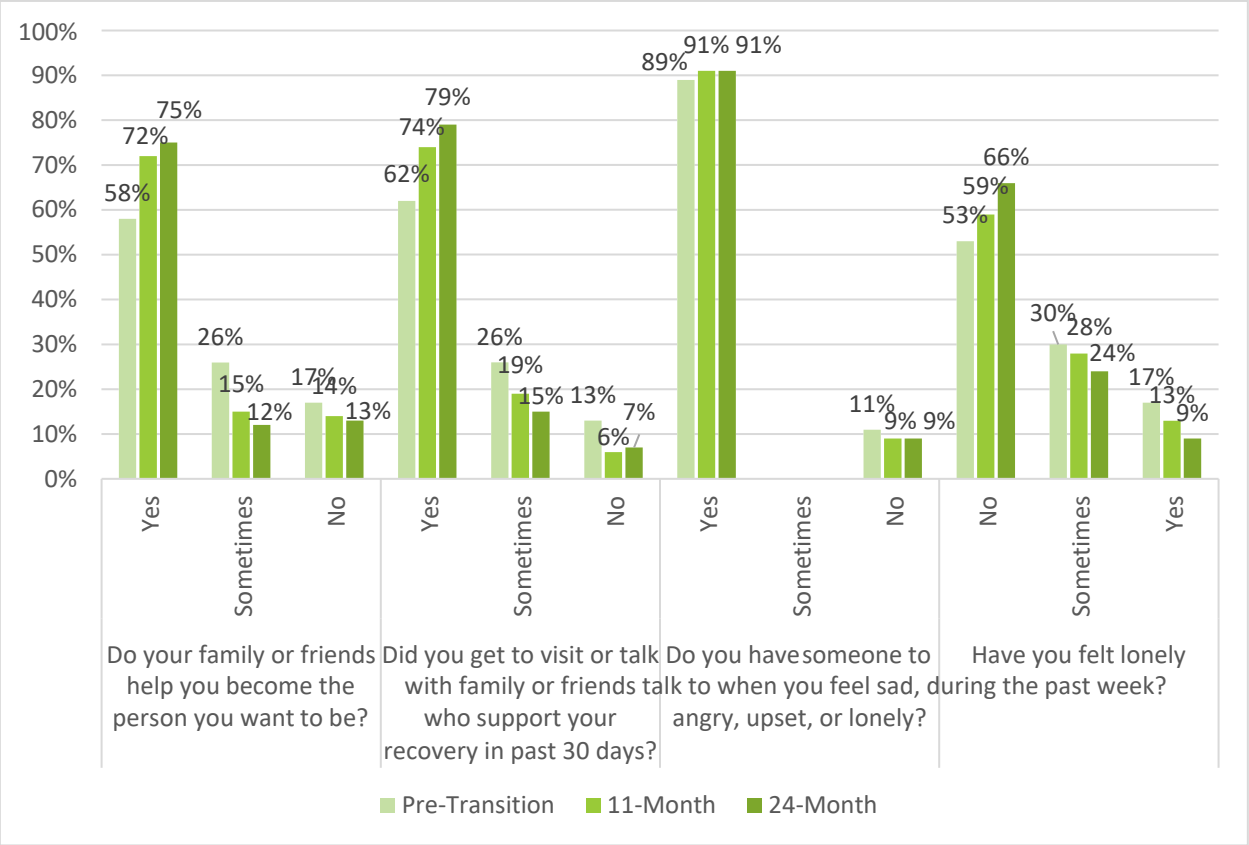


Figure 8 shows detailed response distributions to survey questions related to participants' natural support networks and relationships with friends and family. Pre-transition and post-transition respondents differed substantially in response to these questions. On average, 66 percent of individuals

[9] At 9% for both groups, reports of going into town or the community during the COVID-19 emergency in SFY 2021 were dramatically lower compared to the previous year for pre-transition (47% in SFY 2020) as well as post-transition (51% in SFY 2020) respondents.

selected the answers most indicative of positive support networks prior to transition, compared to 76 percent on average at 11-month and 24-month follow-up surveys, although these percentages varied substantially across different survey questions.

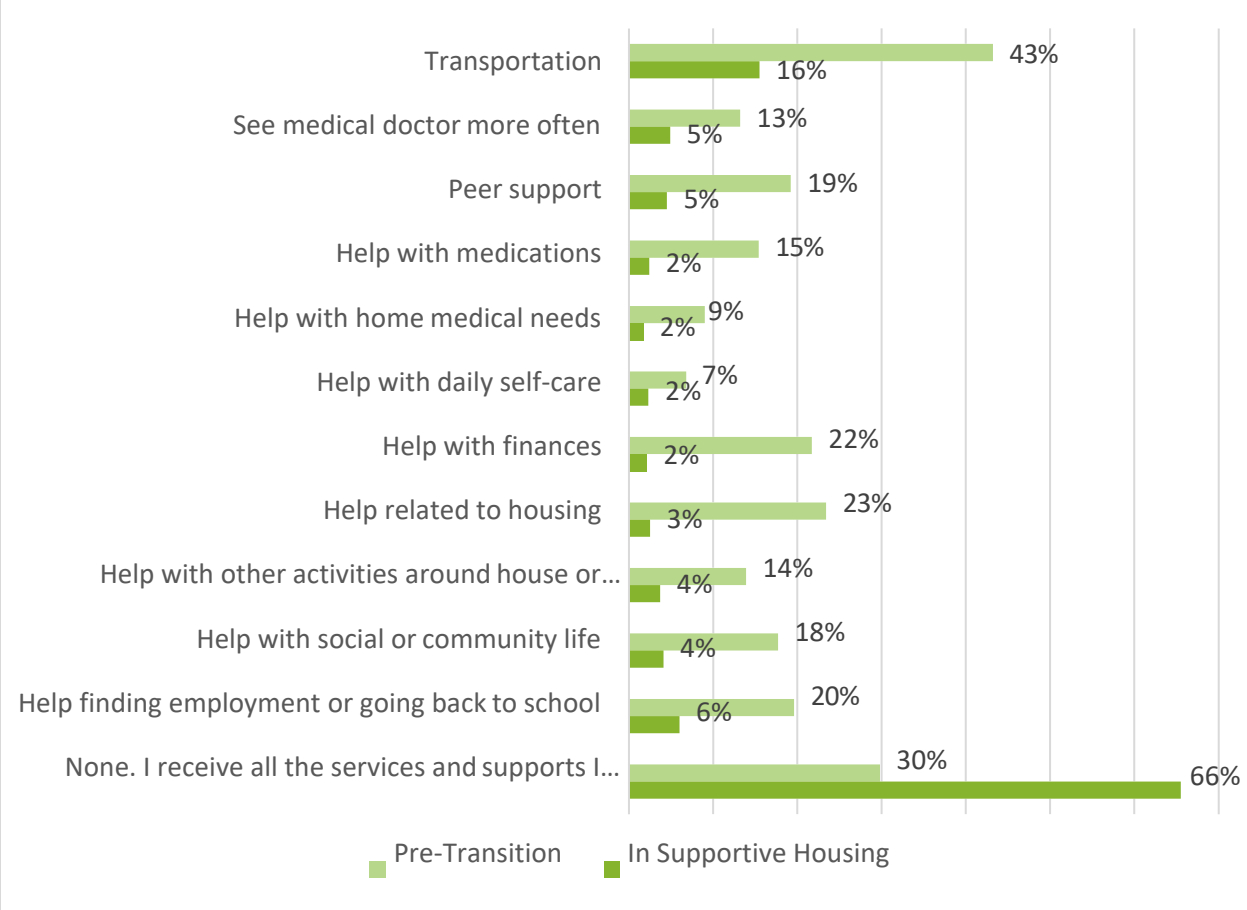
Figure 8: Natural Supports at Pre-Transition, 11 and 24 Months



UNMET NEEDS AND CHALLENGES TO COMMUNITY INTEGRATION IN SUPPORTIVE HOUSING

Compared to their peers in congregate living facilities and other pre-transition settings, individuals in supportive housing were more than twice as likely to report that they receive all of the services and supports they need. Sixteen percent of individuals in supportive housing reported at their 11-month or 24-month follow-up surveys that they needed additional help with transportation, a need identified by nearly half of individuals surveyed prior to transition.

Figure 9: Other Needed Services and Supports



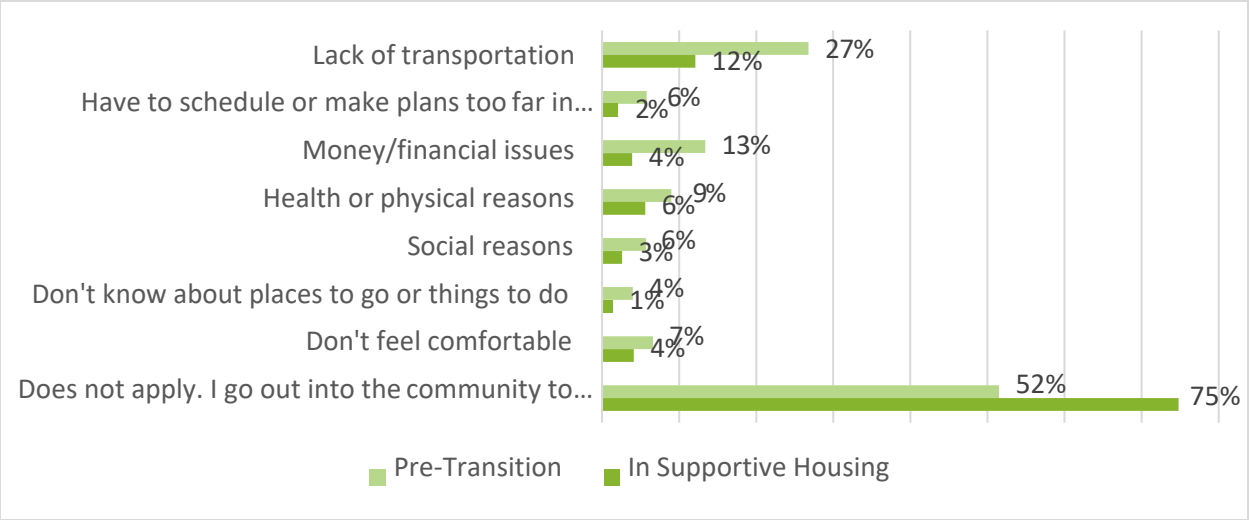
In addition to defined response options shown in Figure 9, respondents cited other need services and supports. These included physical health needs such as dental and vision care, physical therapy, and nutritionist and other specialist services. Additional behavioral health service needs included therapy, grief counseling, support groups, and 12-step programs for drug or alcohol use. Some participants reported needs for benefits assistance including SNAP, payee services, Medicaid, guardianship resources, and SSI or other financial assistance. Additional needs included assistance with physical exercise or obtaining a gym membership; obtaining an emotional support animal, animal training, and veterinary services; home modifications and supports; computer equipment; assistance obtaining a driver's license; childcare; day program or activities; and information about COVID-19.

Participant Voices: Additional Needed Supports
I need help getting off weed and cigarettes. I need to get clean and off drugs. I want emotion therapy.
I need Medicaid or some type of insurance.
I want to make a better life for my two-year-old. The system is backward- you have to have a job or be in school before you can receive childcare. I take care of my child 24 hours a day, 7 days a week.
I will be talking with my ACTT team about needing a doctor for my knees and back. I am taking care of this issue by going to the ER.
I am trying to get my food stamps straightened out.
Need a walker.
Want to start back NA meetings.
Do y'all help with getting a black recliner? The one I got broke. It helps me get up easier.
Exercise- would like to see about a physical trainer.
My teeth are worn out and brittle.
I have questions about my SA In-Home and Section 8.
I need new furniture, my grass cut, phone bill needs to be paid by the end of the month.
Would like an in-home nurse.
I am having pains in my knees. I need physical therapy and to see my doctor. I have been out of vitamins for months.
I have not received help with broken down appliances.
I need dental work. Since I've had a stroke I forget to call about getting glasses. I need a new foot doctor.
I need counseling. I am trying to attend an AA meeting but I will not have bus transportation after the meeting and it is too far to walk.
I would like to receive therapy sessions but my provider…is understaffed and they told me they need to hire another therapist. I have not been receiving therapy but would like to.
Learning more things about getting around being blind.
I need some grab bars in both bathrooms.
I wish I had a car and I could just go where I need to go and not have to plan every outing ahead to be at the bus stop and be out all day

As previously shown in Figure 6, individuals in supportive housing were significantly more likely than the pre-transition group to report that they go out into the community when they want. Figure 10 shows that higher percentages of individuals who had not yet transitioned to the community also cited each of several obstacles as reasons they do not go out into the community when they want.

Lack of transportation was again the most commonly identified obstacle to going out into the community when desired. Approximately six percent of pre-transition respondents also referred to COVID-19 or the pandemic as an obstacle, compared to three percent of 11-month and two percent of 24-month respondents.

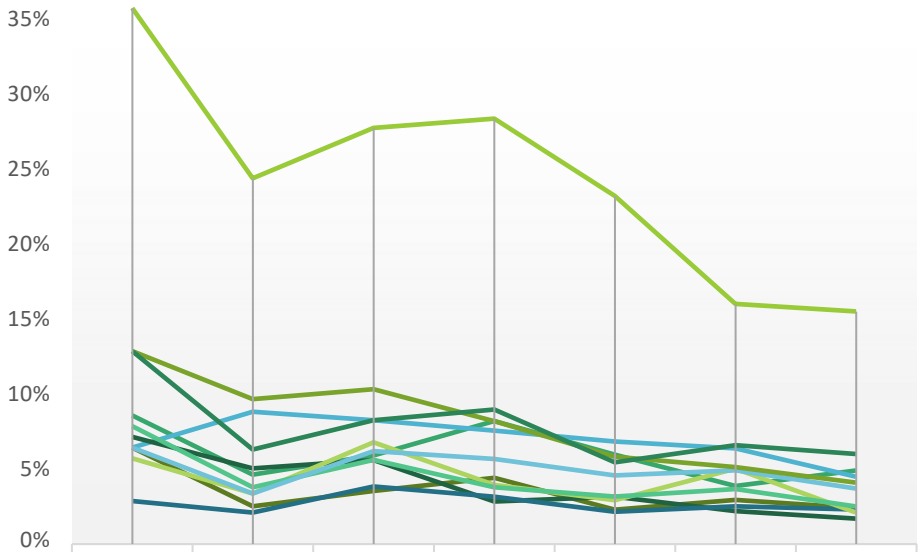
Figure 10: Obstacles to Community Integration



Participant Voices: Obstacles to Community Integration
Due to transportation issues I cannot go to work or play disc golf in the park. The walk is about an hour away.
I cannot go to the mall when I want to due to my bad knee and ankle. I cannot walk far.
I cannot go in my backyard or sit in my front yard because of dogs and drug traffic.
I have COPD and I am not able to go out in the community and exercise like I use to.
I want to go swimming. I do not know of any swimming pools that are wheelchair assessable.
I can't work due to disabilities.
I was trying to save money for vehicle. Something always became between me and my transportation needs, like cigarettes, household supplies.
Can't go to the doctor or the grocery store or the post office, or shopping or clothes shopping when I want because of transportation.
I want to go fishing, but I don't want to go by myself.
Panic attacks are too overbearing sometimes.
Sometimes I can't walk due to my back hurting if I don't have medicine.
Can't go visit family out of town due to not having money for it.
I can't eat out when I want to because I don't have money.
I want/need outdoor exercise every day. The neighborhood is not good for that.
I want to go to church but transportation is difficult.
Sometimes I can't get out of the house due to anxiety with leaving the house and interacting with others.
I am not able to drive, clean and other activities due to my medication.
I am not able to drive because I need a license.
I would like to work but sometimes I get tired and my mobility is not steady
I can't do some of my hobbies that I used to do prior to my stroke. I used to play billiards and the drums and now I am not able to do these things.

Although transportation continues to be the most cited obstacle, as Figure 11 shows, the percentage of individuals in supportive housing reporting this difficulty has steadily declined to less than half the SFY 2015 rate. The trend of decreasing percentages of participants reporting the problem applies to a majority of obstacles cited.

Figure 11: Annual Trends in Reported Obstacles to Community Integration in Supportive Housing



	2015	2016	2017	2018	2019	2020	2021
Transportation	36%	24%	28%	28%	23%	16%	16%
See MD more often	9%	5%	6%	8%	6%	4%	5%
Peer support	6%	9%	8%	8%	7%	6%	5%
Medication assistance	6%	3%	4%	4%	2%	3%	2%
Home medical needs	7%	5%	6%	3%	3%	2%	2%
Daily self-care	3%	2%	4%	3%	2%	3%	2%
Finances	6%	3%	7%	4%	3%	5%	2%
Housing	8%	4%	6%	4%	3%	4%	3%
Other daily living activities	6%	3%	6%	6%	5%	5%	4%
Social or community life	13%	10%	10%	8%	6%	5%	4%
Employment or school	13%	6%	8%	9%	5%	7%	6%

TRENDS IN QUALITY OF LIFE AND SATISFACTION BY LME-MCO AND TRANSITION YEAR

Aggregate Quality of Life (QOL) Index and Satisfaction (SAT) Index scores are based on the 28 survey questions listed in Figures 4A through 4H and the ten housing and community satisfaction ratings in Figure 5. Scores are calculated as the average score of the applicable items (positive experience/satisfied = 3, neutral/middle/no opinion = 2, negative experience/dissatisfied = 1) and rescaled to a zero to 100 scale. Score interpretation is comparable to a percentage. A score of 50 would indicate that respondents reported the most positive experience or satisfaction in response to about half of the questions.

As in previous years, quality of life and participant satisfaction reports were higher among respondents surveyed after the transition to supportive housing. While differences between pre- and post-transition respondents are significant in both areas, the difference in satisfaction with housing and community resources was more than three times as large as the between-groups difference in QOL. Differences between 11-month and 24-month survey groups were smaller but also statistically significant, with 24-month respondents reporting greater quality of life and satisfaction with home and community resources on average. (See Table 1).

Table 1: SFY 2021 TCL Participant Quality of Life and Satisfaction Index Score Means

	Pre-Transition	11 Month Follow-Up	24-Month Follow-Up
Quality of Life	81.8 (13.1)	85.2 (12.6)	86.7 (11.9)
Participant Satisfaction	72.5 (24.9)	85.2 (17.8)	88.2 (16.5)

Quality of Life and Participation Satisfaction Index scores may range from 0 to 100. Numbers in parentheses are standard deviations, which indicate on average how many points individual respondent scores differed from the overall mean.

Among pre-transition respondents, QOL scores were again higher than SAT scores. That pattern is reversed for 24-month survey respondents, for whom satisfaction scores are slightly higher than QOL. Within each survey group, index scores vary considerably across respondents, and more so in satisfaction than in quality of life indicators.[10]

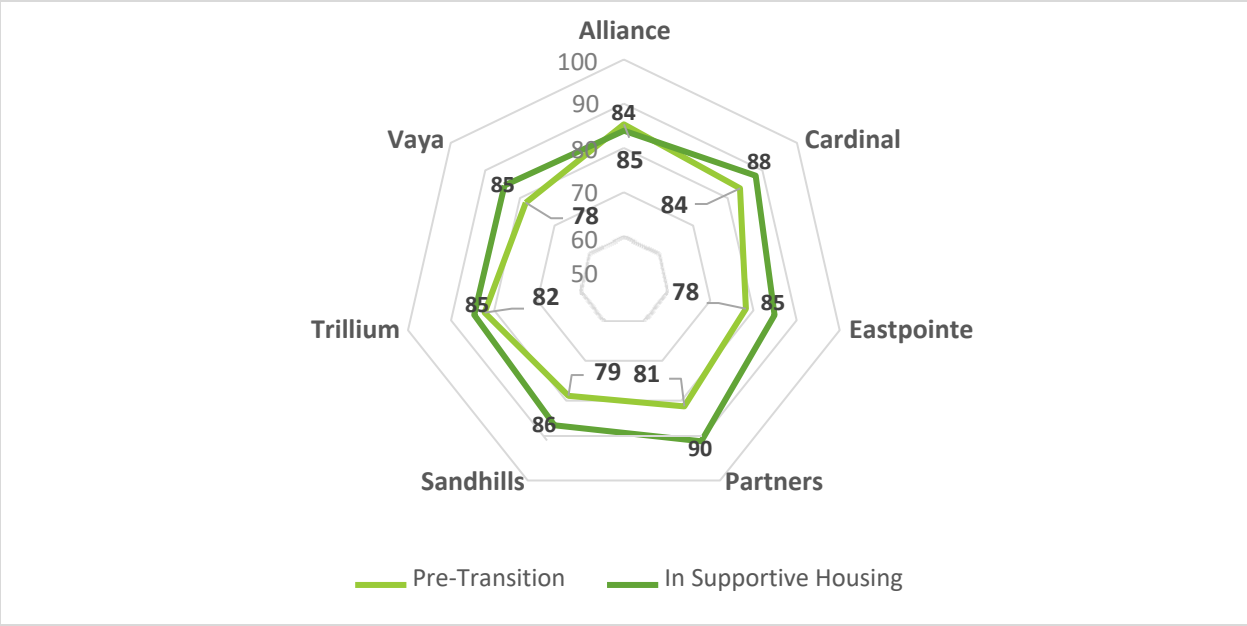
Together with trends shown in the figures below, these results demonstrate that the QOL and SAT Indexes derived from participant survey responses are sensitive to differences between individuals, both within and between survey groups, across aspects of the same individuals' experiences, across LME-MCO catchment areas, over program and survey years, and in individual experiences over time.

Both Index scores were somewhat more variable across LME-MCO catchment area pre-transition than post-transition respondents.[11] In catchment areas in which differences between pre- and post-transition participants were smaller, pre-transition scores tended to be higher compared to other catchment areas. (See Figures 12 and 13.)

[10] This is indicated by the standard deviations, which express the average variation in each set of scores.

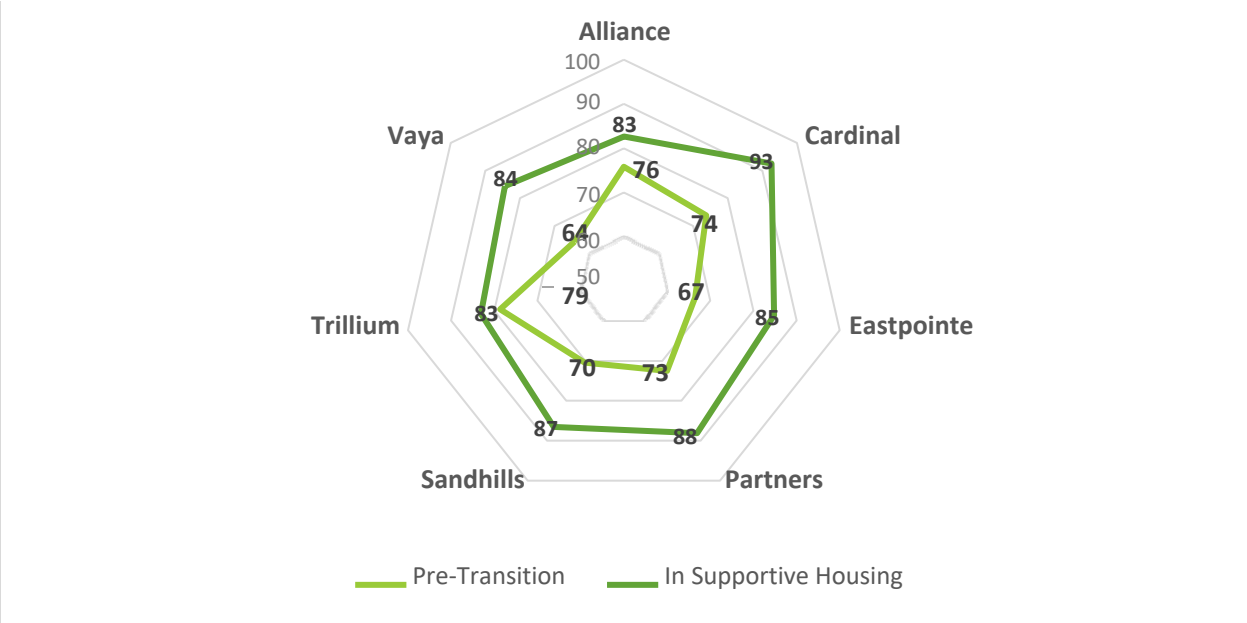
[11] For analyses reported by LME-MCO catchment area, each survey is assigned to the LME-MCO that submitted it or to the LME-MCO with which the submitting LME-MCO later merged.

Figure 12: Quality of Life by LME-MCO Catchment Area, Individuals in Supportive Housing, SFY 2021



Index scores may range from 0 to 100.

Figure 13: Satisfaction Index by LME-MCO, Individuals in Supportive Housing, SFY 2021

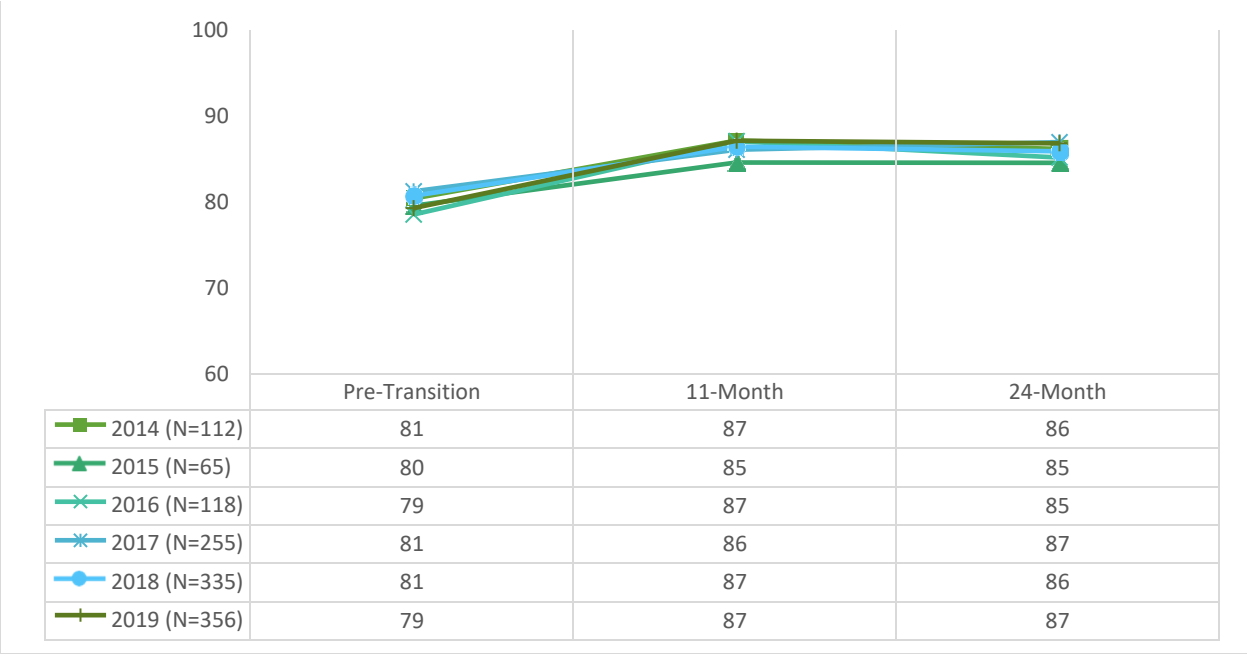


Index scores may range from 0 to 100.

To assess individual change over time, QOL and SAT Index scores for 1,254 individuals who transitioned to supportive housing over the life of the program and completed all three surveys by the end of SFY 2021 were compared in a series of repeated measures analyses. Results of these analyses confirm the interpretation of significant increases in reported quality of life and satisfaction after participants transitioned to supportive community housing.

For both measures, the same individuals' scores were higher on average at both the 11-month and 24-month follow-ups compared to pre-transition, and 11-month and 24-month scores generally did not differ significantly. Changes from the 11-month to the 24-month survey are relatively small and the direction varies by transition SFY and LME-MCO catchment area. (See Figures 14, 15, 16, and 17.)

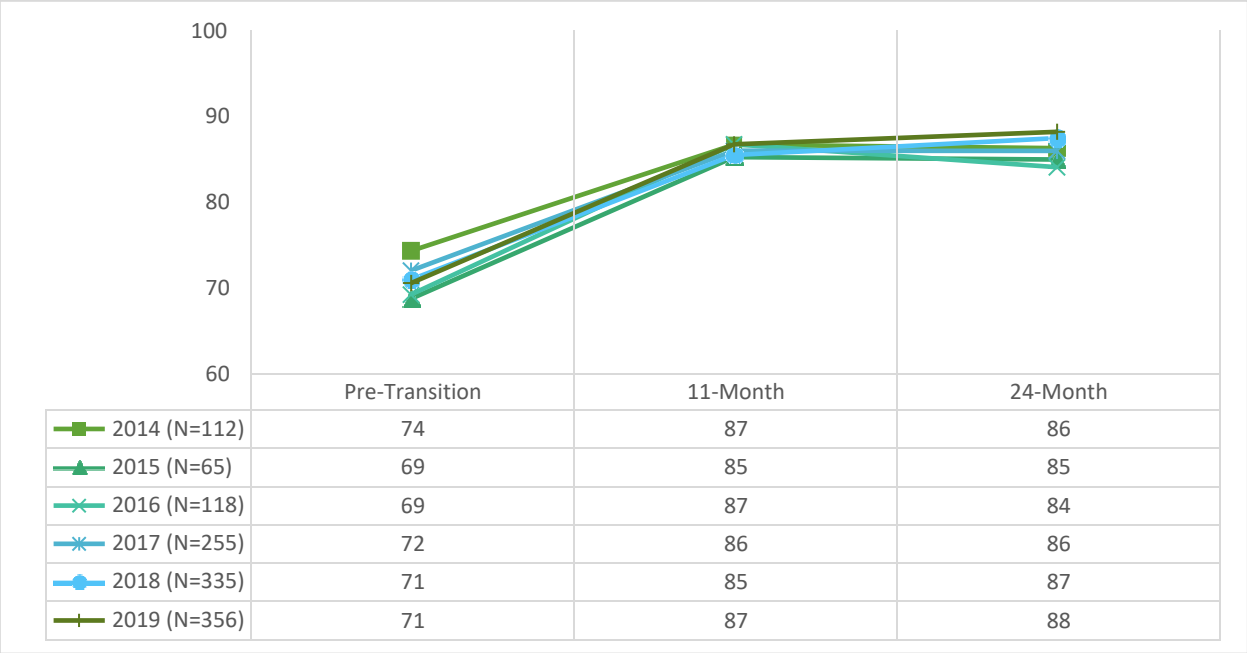
Figure 14: Individual Change in Quality of Life by Transition Year



	Pre-Transition	11-Month	24-Month
2014 (N=112)	81	87	86
2015 (N=65)	80	85	85
2016 (N=118)	79	87	85
2017 (N=255)	81	86	87
2018 (N=335)	81	87	86
2019 (N=356)	79	87	87

Index scores may range from 0 to 100; vertical axis is truncated to show detail.

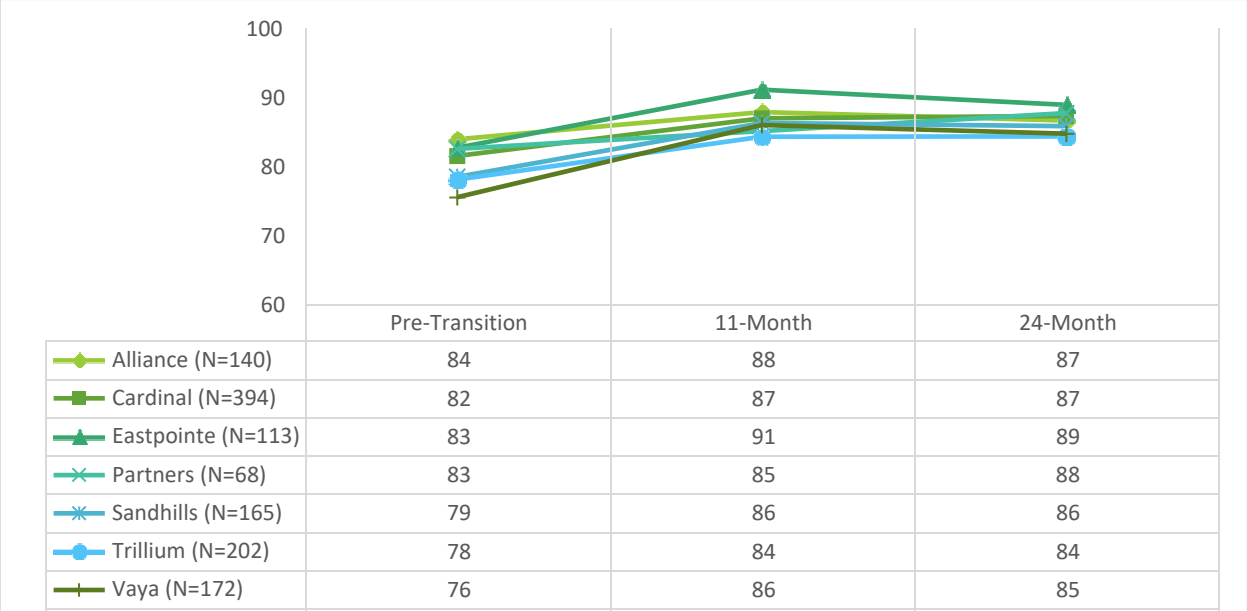
Figure 15: Individual Change in Satisfaction by Transition Year



	Pre-Transition	11-Month	24-Month
2014 (N=112)	74	87	86
2015 (N=65)	69	85	85
2016 (N=118)	69	87	84
2017 (N=255)	72	86	86
2018 (N=335)	71	85	87
2019 (N=356)	71	87	88

Index scores may range from 0 to 100; vertical axis is truncated to show detail.

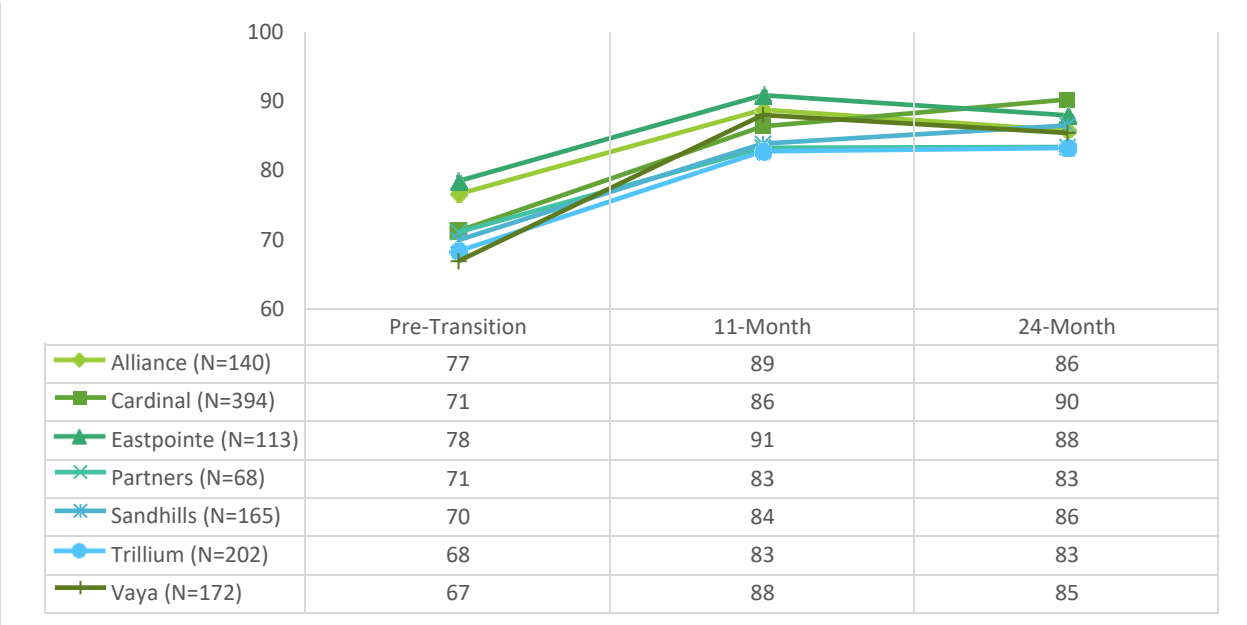
Figure 16: Individual Change in Quality of Life by Participant LME-MCO



	Pre-Transition	11-Month	24-Month
Alliance (N=140)	84	88	87
Cardinal (N=394)	82	87	87
Eastpointe (N=113)	83	91	89
Partners (N=68)	83	85	88
Sandhills (N=165)	79	86	86
Trillium (N=202)	78	84	84
Vaya (N=172)	76	86	85

Index scores may range from 0 to 100; vertical axis is truncated to show detail.

Figure 17: Individual Change in Satisfaction by Participant LME-MCO



	Pre-Transition	11-Month	24-Month
Alliance (N=140)	77	89	86
Cardinal (N=394)	71	86	90
Eastpointe (N=113)	78	91	88
Partners (N=68)	71	83	83
Sandhills (N=165)	70	84	86
Trillium (N=202)	68	83	83
Vaya (N=172)	67	88	85

Index scores may range from 0 to 100; vertical axis is truncated to show detail.

Pre-transition scores on both measures are approximately twice as variable across LME-MCO catchment areas than after the transition to supportive housing. Pre-transition scores are also strongly inversely correlated with reported gains; individuals in catchment areas with the least positive perceptions prior to transition experienced the largest reported gains after transitioning to supportive housing.

SUMMARY

"…I'm glad I'm here. I want to keep living on my own and not go back to a facility." TCL participant at 24-month follow-up

Participants surveyed in follow-up interviews after transitioning to supportive housing reported improved quality of life and significantly greater satisfaction with housing and community. Initial gains observed at 11-month follow-up surveys are largely maintained or increased through the second year in housing. These patterns hold for individuals housed each year of the TCL program and across LME-MCO catchment areas.

The transition to supportive housing in the community is associated with reports of substantially greater choice and control in daily activities, community integration, and satisfaction with housing and other community resources. The percentage of individuals reporting satisfaction with daily activities and having enough to do is nearly 50 percent higher among individuals in supportive housing compared to participants surveyed pre-transition.

Larger percentages of individuals report positive engagement with family and friends supportive of their recovery, not feeling lonely in the past week, and feeling safe where they live after the transition to supportive housing. They are less likely to report restrictions in their daily activities, including limitations due to not feeling well or being able to get around.

While pre-transition and post-transition survey respondents report about equal levels of satisfaction with provider staff and the services they have received, individuals in supportive housing are slightly more likely to report receiving all needed medical and mental health services, and more than twice as likely as their pre-transition counterparts to report receiving all needed services and supports.

As in previous years, transportation is the most frequently cited additional support needed and the most frequently cited obstacle to community integration, both before and after the transition to supportive housing. Compared to pre-transition, post-transition survey respondents are approximately one-third as likely to report transportation as an additional needed service and less than half as likely to report lack of transportation as an obstacle to community integration and doing the activities they want.

Annual trends show that significant progress in meeting participants' transportation needs were maintained in SFY 2021. The percentages of program participants reporting most other categories of additional needed supports declined compared to the previous year.

Participant experiences in supportive housing are not uniformly positive, and aggregate QOL and SAT Index scores are sensitive to differences between individuals, across pre- and post-transition settings, over time, and by LME-MCO catchment area. On average, six or seven concerns or potential problem per participant can be identified through defined-response survey questions among individuals in supportive housing who were surveyed in SFY 2021.

The State's TCL Quality of Life Survey continues to be a useful tool for identifying individual and system level challenges and obstacles. The survey offers a valuable opportunity for LME-MCO and service provider staff to engage with participants in discussion of their goals and of obstacles to those goals and to address challenges to participant health and safety, well-being and wellness, community integration, and housing stability.

Participant Voices: "*I'm glad I'm here*."
It took me a long time to get to my own apartment and I'm glad I'm here. I want to keep living on my own and not go back to a facility.
Y'all was great with the transition and that it's been a great two years.
I am thankful that TCLI has given me a chance to have stable housing. Because of housing I have a job.
Everything is going better than they were a few months ago. I feel like I'm doing well.
I appreciate everything [LME-MCO] and [Provider] has done. It has helped me go a long way than I was.
I am just glad to be alive today.
I have the freedom of living in my own place. I want to get my record expunged.
I'm proud of myself for staying in treatment and working with great people who understand and have never judged me. It keeps me in great spirits.
I am happy to have [LME-MCO] helping me. Where I am at now is so much better than the place I had to stay in before.
How thankful I am. How much I love this home.
I am happy to have my place considering I lived in my car for almost 7 years and was very sick.
Thank you TCLI for my apartment. This has truly made a difference in my life. It has been an answer to my prayer. It's a blessing. I am married now, I have a 14 month old baby and an emotional support dog.
I love my house. I love the TCLI program!

Appendix B to the Annual Report on North Carolina Supportive Housing Program: 2020 and 2021 LME-MCO Network Adequacy and Accessibility Analysis Submissions, TCLI Excerpts[1]

The excerpts included in this Appendix are from the combined 2020-2021 Network Adequacy and Accessibility Analysis LME-MCO submissions. The Analysis is part of a process in which LMEs-MCOs assess service adequacy and accessibility, plan and implement strategies to address inadequacies and areas of inaccessibility, and evaluate progress and outcomes. The Analysis is an annual, joint initiative led by N.C. Medicaid and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS).

[1] The DHHS extended deadlines and modified requirements for the 2020 and 2021 DHHS NAAA due to the COVID-19 pandemic. As of the time of the development of this report, combined 2020-2021 reports had been submitted by five of seven LMEs-MCOs.

Section Four
Special Populations

The following section provides an update on Alliance activities regarding two statewide initiatives that are the result of legal settlements: Transitions to Community Living Initiative (TCLI) and Children with Complex Needs. For each topic, answers are provided to specific questions from DHHS about the overall status of Alliance activities, the sufficiency of our service array, gaps and needs, obstacles and barriers encountered, and actions being taken.

I. Transitions to Community Living Initiative (TCLI)

A. Community-Based Supportive Housing Slots

The following summarizes service gaps, obstacles, and recent activities and projects for the primary TCLI requirements for Community-Based Housing:

a. **Identification and engagement of eligible individuals**: Alliance continues to have a steady volume of referrals through RSVP who are category 4 and 5. Referrals for Category 2 and 3 are lower which makes it difficult to increase transitions from ACH's. TCL staff caseloads are high or at capacity so there is a barrier for individual assignment. Additional staffing is being pursued to address this concern. Alliance is also seeing an increase in referrals of members with barriers in cognitive functioning or with recommendations from discharge for 24/7 supervision. These members with complex support needs are challenging and require significant assessment, documentation, and interview information to determine eligibility status. This is not a fast process.

b. **Transition of individuals to community-based supported housing:** Especially with the pandemic, Alliance has experienced a harder time with assisting members in obtaining their vital documents, especially while at the SPH's. The absence of an ID card makes it difficult to access hotels and of course sign leases and delays the process. This year, Alliance started three bridge housing programs that provides support during community transition and also gives us the flexibility to work on securing vital documents. Two programs are located in Durham County and one in Wake County. A fourth program is expected to open the first quarter of FY22 in Cumberland County. Currently, there are seven dedicated beds for TCLI; however, TCLI has access to additional beds as needed. One program, Community Transition Recovery Program (CTRP), is for members with high and complex behavioral health needs who are transitioning from psychiatric hospitals, crisis centers or have rehousing needs after hospitalization. CTRP is a comprehensive program with nursing, case management, peer support, and

clinical staff. Housing availability is extremely limited in Wake/Durham counties.

Access to "targeted units" is difficult due to the lack of a real-time inventory availability. While we have made tremendous strides in accessing private units through the TCL Voucher, we are at capacity with current vendors and the inventory is very low or non-existent in some of our Counties. Alliance has increased access to mainstream vouchers. There are 33 in Durham County, 62 in Cumberland County, and 15 Housing Choice Vouchers in Wake County all with an Olmstead preference. There have been challenges with utilization and transferring those on the TCLV. A few reasons are: the extensive documentation; some TCLV units are over fair market rents; and the lack of housing inventory willing to take vouchers. Nevertheless, Alliance continues to prioritize moving members from the state to the federal subsidies. Another challenge is the dual responsibilities of the transition coordination staff. They are faced with the challenge of balancing new moves and rehousing individuals who have separated from housing – especially those evicted from their units due to lease violations. As the number of members requiring rehousing increases over the settlement it decreases housing options. Alliance is working in many ways to decrease separation rates as well as address tenancy concerns with rehousing. Additionally, Alliance has been working on connecting members with services which can sometimes pose as a challenge. This is still a barrier with providers being able to conduct CCA's in institutionalized settings. This creates a delay in getting individuals assesses and referred to the appropriate level of service. Alliance has added Assertive Engagement to provider contracts to help address this concern but CCA's continue to pose a barrier.

c. **Transition of individuals within 90 days of assignment:** The pandemic has posed new barriers to transitioning but Alliance is continuing to assist individuals to moving into PSH during this past fiscal year. Barriers to 90 day transitions continues with individuals with significant criminal histories/needs for private housing, past evictions, the increasing need for accessible and first floor units, increasing need for medical/physical/health supports, acquiring vital documents, individuals seeking housing outside Alliance's catchment area, and connectivity to providers and services. Alliance continues to address these barriers on an individual basis and works closely with the providers and all departments within Alliance to create positive outcomes. Alliance continues to work diligently to find housing for all TCL members even when the 90 day benchmark is not attained.

d. **Support of individuals' housing tenure and ability to maintain supportive community-based housing:** Alliance Transition/Care Coordination is required (per DMH/DMA contracts) for 90 days post-transition. The TCL & Care Coordination team steps back and the expectation is that ongoing support services are delivered by provider agencies. However, this presents many challenges and as of late we are experiencing housing separations. TCL Team needs staff capacity to provide ongoing support and monitoring of the contracted TCL providers as it relates to tenancy supports in housing, negotiating and troubleshooting issues with landlords, and rehousing individuals. Alliance TCL staff also routinely have to check in with providers to get updates on members and there are usually tenancy issues that have been occurring unbeknownst to us. Ideally, Alliance TCL staff should be informed immediately when serious tenancy issues are occurring so we can assist the member or the provider, or intervene with the landlord. Just getting updates and concerns about members from providers has been a recurring challenge for Alliance TCL staff.

   In response Alliance created a Supportive Housing department to address challenges with separations and to build provider competency surrounding tenancy. The program offers regular trainings and technical assistance to the providers. A round table discussion is held each month with the clinical leadership to address barriers and develop training strategies to support providers. Bi-monthly, office hours are held so providers have an opportunity to ask questions of the Supportive Housing team as they work through housing and rehousing members. Although this is a start, having additional staff would create capacity needed to do monitoring and provide better ongoing technical assistance to the providers. Another need is for onsite staff at the ISHP in hopes of reducing the separations on those properties. To help increase community tenure Alliance is also developing ways to utilize the new Care Team model to increase communication with private landlords and continues to refer to ADANC to help identify and connect members for opportunities to increase Community Inclusion. Additionally, service definitions such as Peer Supports and Individual Supports are currently being reviewed by a work group at Alliance to help engage individuals with appropriate levels of support to maintain housing.

B. IPS-Supported Employment

a. **Network capacity of IPS-SE services**: Alliance contracts with seven teams through five IPS-SE Supported Employment providers. Three providers are located in Wake County and one provider each in Cumberland and Johnston counties. Teams are distributed to cover all Alliance counties, and several teams cover multiple counties. Of the seven teams, three cover Wake, two cover Johnston, two cover Cumberland, and two cover Durham. There is a sufficient number of providers for current service need.

IPS Providers	**Community Partnerships (CPI)**	**Johnston County Industries**	**Easter Seals UCP Wake**	**Easter Seals UCP Durham**	**Easter Seals UCP Cumberland/ Johnston**	**Service Source**	**Monarch**
Counties Served	Wake Durham	Johnston	Wake	Durham	Cumberland Johnston	Cumberland	Wake
Team Composition	1 FTE Team Lead 1 FTE EPM 3 FTE ESP's	1 FTE Team Lead 1 FTE EPMs 3 FTE ESPs PA is also Benefits Counselor	1 FTE Team Lead 2 FTE EPMs 3 FTE ESPs	1 FTE Team Lead 1 FTE EPM 1 PT EPM 2 FTE ESP's 1 PT ESP	1 FTE Team Lead 1 FTE EPM 3 FTE ESPs Benefits Counselor is shared between teams	1 FTE Team Lead 1 PT EPM 1 FTE ESP 1 PT PA	1 FTE Team Lead 1 FTE EPM 2 FTE ESPs 1 PT PA
Waitlist	No	No	No	No	No	No	No
Fidelity	Fair	Fair	Fair	Fair	Fair	Good	Good

When we look at additional capacity of our IPS teams, we know that all of our teams are able to take referrals. Providers confirm that they are able to add FTEs to their team as caseloads reach capacity per the service definition in order to meet the need for new referrals.

b. **Service capacity requirements:** Alliance has increased the number of individuals newly enrolled in IPS-SE that meet the in/at risk of ACH over the past couple of years. Ongoing focus this year has been increasing the number of TCLI eligible individuals (all phases – In-Reach, Transition, Post-Transition) among the number of in/at-risk individuals newly served. Eligibility for State funded IPS has been limited to individuals who meet in/at-risk criteria due to continued decreases in funding availability. However, due to decreased spending in FY21, we were able to open up eligibility for State funded service to individuals who do not meet in/at-risk criteria. While we were able to expand eligibility for FY21, funding for the service remains a concern.

c. **Service gaps and needs:** We are hopeful that more of our IPS-SE providers will reach "good" fidelity. We have two of seven teams in this category – the others are in the "fair" fidelity category. We have uncoupled the rate from fidelity score and have standardized the rate at the 'good fidelity' level in an effort to provide all teams with sufficient funding to improve quality of services. There will be an alternative payment model implemented for FY22 that will be more outcome focused. Staff turnover continues to be a challenge, and FY21 has seen additional challenges around hiring staff. Some of these challenges are competition with providers of enhanced services that have higher rates of pay and effects of the pandemic—decrease in member comfort with engagement and contact, decrease in job market, and disruption of scheduling due to new limitations and needs around childcare for staff and members. Providers also cite transportation, differences between service definitions and fidelity model, uncertainty around funding availability, and developing and maintaining relationships with clinical partners as barriers to service delivery.

d. **Obstacles, barriers and initiatives.** The ability of IPS teams to bill for meeting with individuals to discuss IPS prior to authorization would be beneficial. This would increase IPS staff outreach and engagement to members who are still unsure about IPS services. TCL members often perseverate on the decision to receive IPS services, which results in the need for ongoing conversations to get connected to service. There is still significant fear regarding the potential for loss of benefits and continuous education is required. Recent, or ongoing, initiatives to increase referral of TCLI population include:
    - TCL staff have ongoing discussions regarding employment, education, and benefits counseling opportunities with all TCL members throughout the process.
    - Ongoing monthly IPS and CST Collaboratives. Members from the TCL Team continue to attend these collaboratives to provide education and updates regarding TCL in efforts to increase TCL referrals.
    - Alliance has also coordinated IPS provider presentations to CST and TMS providers to describe referral process and increase awareness of the IPS service.
    - Continued use of a TCL Referral form to identify TCL members as part of the priority population for providers.
    - Partnership with VR to create a universal referral form for direct referral from TCL team to VR and IPS provider simultaneously.
    - VR training provided to TCL team to increase awareness of all DVR

services.

- Proposed alternative payment model for IPS includes an incentive outcome payment for members who are TCL.
- This past fiscal year, Alliance continued with its quality improvement plan to increase referrals from TCL staff to IPS services.

C. Personal Outcomes and Sufficiency of Community-Based Mental Health Services

- ***Describe how the LME/MCO tracks and monitors the following personal outcomes for individuals in supportive housing:***

  At the end of May 2021 there were 443 individuals in supportive housing. Since the beginning of the Transitions to Community Living Initiative Alliance has transitioned a total of 632 individuals. The overall community tenure rate is 70%.

  Not all of the requested information for individuals living in supportive housing is readily available or currently tracked or requested. TCLI follows the individual for the first 90 days the individual is in housing, but we do not have a "post-transition" team. The provider agencies are responsible for providing tenancy support and behavioral health services once the individual moves in to their own place.

  - ***Supportive housing tenure and maintenance of chosen living arrangement*** is tracked through regular communication from the providers of tenancy support (ACTT, CST, TMS) via a monthly tenancy checklist. We do have problems obtaining checklists from all providers for all the individuals they support in TCLI supportive housing. We have recently designated one staff member to review the tenancy checklists for any areas indicated as high risk and to obtain additional information so we can assess needed interventions. In addition, we have a monthly separations deep dive to review reasons for housing separations and to review individuals at very high risk for separation. The separation reviews are helpful as the providers develop rehousing plans.
  - ***Inpatient hospital or psychiatric facility admissions and readmissions:*** we receive a report from the State psychiatric hospitals regarding all admissions regularly. We have the ability to review the information as Alliance staff work with the SPH to develop discharge plans. We are not regularly notified of psychiatric facility admissions/readmissions unless the individuals housing is in jeopardy. We rely upon our provider network to provide support to the individuals upon discharge back to their supportive housing unit.

- ***Adult care home admissions and readmissions***: individuals seeking entry into an adult care home, whether for the first time or for a readmission, are entered in the RSVP system. They must be screened for TCLI eligibility so we would know if an individual is/was currently in TCLI supportive housing. Upon entry they would be separated from housing and would enter/re-enter the In-Reach phase.
- ***Employment:*** ACTT: provider reports quarterly to LME-MCO & NCTOPPS; IPS: copy of reports that providers submit to DHHS; CST: not currently tracked but we are planning have CST submit quarterly reports as required for ACTT.
- ***School attendance/enrollment***: same as above
- ***Community integration and engagement***: this is only tracked by ACTT through NCTOPPS
- ***Natural supports network development and use of natural supports for crisis prevention and intervention***: some but not all of this data is tracked by ACTT through NCTOPPS

Use of crisis services, ***Emergency room visits and repeat visits***, and incidents of harm are not currently tracked specifically for individuals in supportive housing

2. Describe how the LME/MCO uses personal outcomes data to determine, plan, and deliver the frequency and intensity of services needed to support individuals in community-based housing.

Alliance requires that ACT and Community Support Teams use the DLA-20, and we are working to develop a plan for how to use DLA-20s to look at progress. Goals and interventions, including frequency and intensity of services, are developed as part of the person centered planning process which is completed by providers working with individuals, natural supports, and others who are supporting the individual.

3. Describe gaps and needs in the community-based mental health services provided to individuals in TCLI supportive housing. Discuss discrepancies between service capacity and service capacity requirements, and the sufficiency of services (array, intensity, frequency, quality, and effectiveness) as indicated by personal outcomes such as those listed above, not only access and choice standards.

Staff turnover and vacancies continue to be challenges, and the pandemic has exacerbated this. Providers report that there are fewer qualified applicants for open positions across the board. FY21 has also seen additional barriers to member

engagement that are pandemic related, i.e. decrease in member comfort with contact and limitations in ability to interact in the community.

Provider staffing challenges have impacted network capacity. IPS-SE providers have maintained ability to accept referrals and can meet capacity requirements. ACTT, CST, and TMS providers have had increasing difficulty with capacity due to staff vacancies and trouble hiring staff to expand teams if necessary.

Service gaps, obstacles and actions taken to resolve them

Primary service gaps for the TCLI population are community engagement, development of natural supports, and choice in daily living. We continue to emphasize the importance of tenancy, employment and community inclusion. When reviewing housing separations, the ACTT providers are included in this discussion to examine and identify contributing factors and areas of improvement. While provision of behavioral health and tenancy focused services is essential, these services do not fully address all of the needs an individual has in order to be engaged in the community. One approach to address these gaps is our pilot project with the Alliance of Disability Advocates NC (ADANC). This pilot is funded by DHHS to provide community inclusion supports and benefits counseling to TCLI recipients in the Alliance catchment area. Community inclusion Supports are provided to support individuals in identifying activities, events and opportunities for individuals to increase participation in their communities, and provide direct support to individuals so they can successfully become involved in community activities. Benefits counseling is designed to inform the individual (and guardian, payee representative, and/or natural support, if applicable) of the multiple pathways to ensuring individualized competitive and integrated employment or self-employment which results in economic self-sufficiency (net financial benefit) through the use of various work incentives.

Our challenges are two-fold – funding and provider engagement. Adequate funding is critical to support our providers in the delivery of services – primarily with TMS and IPS-SE. We plan to develop strategies to have performance based payment for providers who are supporting our TCLI individuals, and we also plan to increase provider accountability.

The expansion of TMS teams has not been extensive, in part due to the implementation of the revised CST service definition. The current TMS teams continued growth, and the need for TMS continues as individuals step down from higher levels of care. Due to funding restrictions, there is a need to further reduce reliance on TMS.

We are hopeful that more of our IPS-SE providers will reach “good fidelity”. We only have two of seven teams in this category – the others are in the “fair fidelity” category. The IPS-SE rate was uncoupled from provider fidelity score, so all

providers are now paid at the "good fidelity" rate. With additional funding, the agencies may be able to reach a higher fidelity level.

Additional steps taken to address service-specific gaps include:

- IPS-SE – Alliance is working with UNC Center for Excellence to develop an alternative payment model that will increase the use of VR milestones and provide an outcome based structure for payment. This is scheduled to launch in the first quarter of FY22. We continue to host and facilitate monthly IPS Learning Collaborative meetings to address challenges and barriers and to share successes and lessons learned.
- ACT –During FY21, we have continued to host and facilitate monthly ACT Collaborative meetings and TCL staff members attend the meetings to continue educating providers about TCLI. We have emphasized the importance of tenancy and employment, and we work with the teams to develop strategies to improve in these areas. For FY20, we used data collected via NC TOPPS. Analyzing data will help us look at trends, consider alternative methods of payment, and evaluate the impact of increased Community Inclusion, especially as it relates to community tenure.
- CST – We host and facilitate a monthly CST Collaborative that operates in similar fashion to the ACTT Collaborative.
- Tenancy Support - Development of alternative services to provide tenancy support – We are in the process of developing a scope of work for Individual Support and a scope of work for Peer Support with a Tenancy focus for FY22 that will decrease the reliance on TMS and clearly delineate the TMS and Peer Support services.

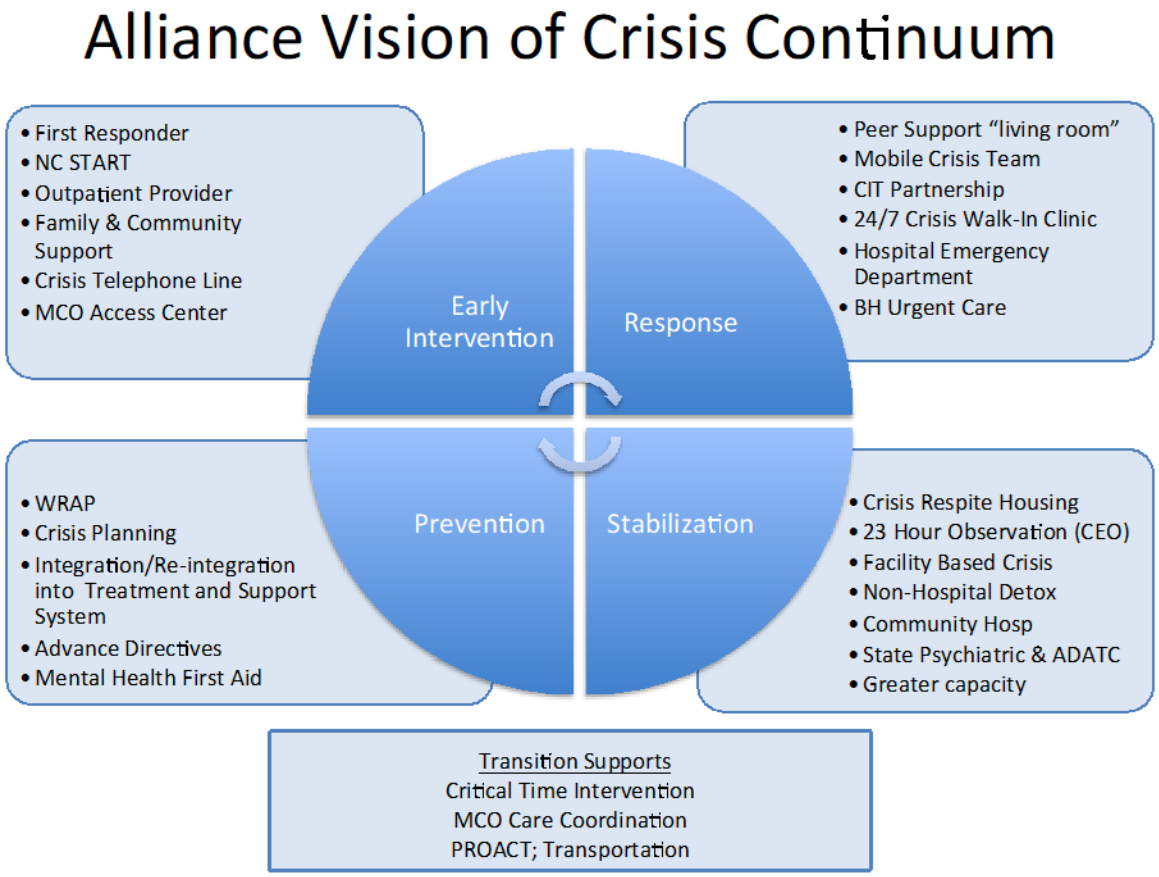
D. Crisis Services

Alliance continues to invest significant resources to expanding the crisis continuum to avoid unnecessary hospital utilization, incarceration and institutionalization. Like most other communities, ours are challenged with maintaining enough services to meet the needs. In each of our four counties, there is an active crisis collaborative that consists of hospitals, community partners, law enforcement, and crisis facilities and service providers who regularly gather to discuss and address challenges in our crisis continuum. We work together to identify needs and how to meet those needs. The current crisis continuum is organized in such a way that it provides services at the right place, right time, and with the right amount. The goal is to address crises in the least restrictive setting while ensuring that people receive the appropriate treatment to avoid future crises and/or unnecessary utilization of services that do not meet their needs. At each level, within each service, it is the expectation of the provider to consider the individual's crisis plan. As part of the contracting process, Alliance develops scopes of work for crisis services that provide detailed expectations for engagement, clinical treatment, and follow-up.

The following provides an update on the network adequacy of the LME/MCO crisis service system and its capacity to offer timely and accessible services and supports to individuals experiencing a behavioral health crisis. This scope of this summary applies both to the TCLI population as well as all individuals covered by the Alliance network. Additional information is provided about identified crisis continuum gaps and barriers, as well as actions taken to address identified gaps and barriers

<u>Network adequacy of the Alliance crisis continuum</u>

Alliance is committed to developing a comprehensive, accessible and effective crisis continuum within each of its communities, and is working to develop a crisis continuum that includes service and support components in each of four levels of care: 1) Early Intervention, 2) Response, 3) Stabilization, and 4) Prevention. The services within each level are listed in the chart below, and a more detailed overview of the Alliance crisis continuum is included in **Appendix E**.



As the tables in **Appendix E** show, there continue to be challenges with offering consistently timely response and stabilization services to all individuals experiencing a behavioral health crisis in each Alliance community. Areas of highest need include:

- Lack of inpatient psychiatric beds
- High volume at local crisis facilities
- Lack of state and county funding to expand walk-in crisis services in each county
- Frequent utilizers/familiar faces utilizing the ED for primary behavioral health care.

A continued key consideration as it relates to providing adequate and effective crisis services in the least restrictive setting is the availability of services at every point of the crisis continuum in each county. For example, individuals without insurance who face a crisis are generally able to access immediate crisis services, yet, the lack of funding for additional outpatient therapy capacity may keep them from accessing the appropriate follow-up care.

Actions taken to address gaps and barriers

During FY20 and FY21, Alliance continued to develop the crisis continuum through the initiatives described below. These actions were priorities for the Alliance Network Access Plan, and additional information is available in **Section Five** below.

- Tier III Behavioral Health Urgent Care (BHUC): this is an innovative model and increases community walk-in capacity and has expanded hours of operation. Services include brief assessments and on-site prescribers for the duration of operating hours. This service is available in Durham and Wake counties.
- Tier IV BHUC: this level of crisis care provides 24/7 services, and is now available in Cumberland, Durham and Wake counties. Recovery Innovations opened the Cumberland Recovery Response Center (CRRC) in May, 2020
- Several hospitals have added psychiatric beds during the past two years, including Holly Hill and Cape Fear Valley, which also plans to open an adolescent psychiatric unit in December, 2021.
- Alliance plans to add Mobile Outreach Response Engagement and Stabilization (MORES) to all counties in 2021. This model is a replication of Mobile Response Stabilization Services in New Jersey and elsewhere in the country, as well as in NC, Partners has been providing the service since 2018.
- Crisis residential programs for youth involved with Child Welfare, 8 boys and girls beds with Thompson's Youth and Family Focus in Charlotte (open now), and a plan for Thompsons to open a 6 bed crisis residential program in Cumberland County. The building, formerly licensed, is under renovation currently.
- Alexander Youth Network (AYN) adding 6 crisis beds for child welfare involved members on their Charlotte campus, and adding beds in Greensboro in 2022. Property has been purchased.
- The Hope Center for Youth and Family Crisis, an Alliance facility run by KidsPeace will be opening in the fall of 2021 as a Tier IV BHUC and Facility Based Crisis, with 10 adolescent beds and 6 beds for Children in Fuquay-Varina, NC.

The gaps and needs became heightened during the pandemic. There became a shortage of available psychiatric beds for youth and adults, community based crisis options, which was exacerbated by shortage of available beds at lower levels of care and youth not in school. This resulted in extraordinary numbers of youth in

emergency departments (statewide tracking in April 2020 averaged 20 youth in Emergency Departments, by November 2020 that average climbed to 70), and for those not acute enough for Emergency Departments, and involved with Child Welfare, these youth were simply dropped at DSS for them (and us) to find appropriate treatment services. This resulted in the effort to build out the child crisis system.

II. Children With Complex Needs

"Children with Complex Needs" are defined as Medicaid eligible children ages 5 to 21 with a developmental disability (including Intellectual Disability and Autism Spectrum Disorder) and a mental health disorder, who are at risk of not being able to enter or remain in a community setting due to behaviors that present a substantial risk of harm to the child or to others. The following summarizes Alliance network service gaps, access barriers, and initiatives taken to address gaps and barriers.

A. Identification & Engagement

1. **Describe service gaps and needs to identify and link CWCN to appropriate levels of service.** Based on anecdotal data many families would like to see more programs for transitional age children with autism who are leaving high school as Medicaid does not fund ABA after 21. Based on the previous report appropriate residential options, psychological services, ABA and day programs were noted as service gaps. All network remains open for ABA and psychological services. Due to limitations as a result of COVD-19 there has been an increase in families seeking NC START services. These families are being informed that NC START does not have a respite program for children as they do for members over 18. Families with young children are seeking options for planned breaks and it appears that there are limited respite options.
2. **Describe obstacles and barriers to identifying kids and linking CWCN to appropriate levels of service.** Children are identified based on the process flow attached. There are no barriers with the identification of the children. Because of how the data is collected it is established that there might be some false positives being reported. These children are showing up on the report based on claims data but not specifically because there is an official diagnostic criteria that they have met. The barrier is locating and making contact with children on the quarterly report with no billable claims. Letters are being drafted to be mailed out to these families with information on Alliance Health 24 hour access line as well as information on the I/DD eligibility process. Once a child is deemed I/DD eligible they are placed on the waitlist and a provider list is mailed with all the eligible services that are available. This is the focus of the next fiscal year to link children who are not currently engaging in services.

Intervention to be Completed- Workteam will meet and plan next steps for those providers without available appointments on the calendar. *Meeting scheduled for Oct 2020*

Member perceived improvement

Utilization of advanced technology to communicate text/app- need to educate on the use of the app

Intervention to be Completed- Repeat education with providers on the app and share additional information with social media. *Target Date-4/2021*

Train Providers on importance of reviewing the PCP with members. Marketing provider meetings and offering incentive to attend training.

Intervention Completed: Network Operations, Monitoring, Clinical, and Quality Management, and the Medical Director created a Provider Enrichment Training related to Member Experience and presented to Provider Meeting. This information was also posted to the Eastpointe website for those who could not attend. *Completed virtually March 20, 2020.*

Development of training video in collaboration with Provider Council to address member areas of concern specific to communication that would be utilized by providers within the network for member annual review.

Intervention Completed Complete Initial PowerPoint and Share with Provider Council for feedback. *Completed July 2020.*

Intervention to be Completed- Complete video with provider council volunteers- target date 12/31/20.

Measuring Effectiveness

At least annually the Eastpointe Member Experience Workgroup re-measures and analyzes this data to evaluate the implemented interventions and assess whether they had the desired effect. FY 2019 and FY 2020 data show consistent attainment of goal performance for all measures related to member experience. In FY 2020 Eastpointe chose to implement interventions related to specific satisfaction questions even though content areas met the goal. These interventions will continue in FY 2021 and their effectiveness will be measured based on the results of the 2020 survey which will be available in first quarter of 2021.

Section 4: Special Populations

4.1 Transitions to Community Living (TCL) Initiative

A. Community-Based Supportive Housing Slots

Transitioning members into a community living program presents multiple challenges. Obstacles and barriers exist that limit the TCL population size, constrain program capacity, and hinder the transition process. Eastpointe engages with members, stakeholders, and its communities to understand root-causes and to address these obstacles and barriers.

The barriers that exist around identifying eligible individuals in the TCL priority population stem from a lack of understanding around eligibility requirements, as criteria to identify eligibility is

sometimes inaccurate. There is a quality improvement project in place to educate members and providers about TCL eligibility requirements. A focal point for Eastpointe involves efforts to educate community stakeholders and assisted living facility providers on the eligibility requirements and benefits to members of TCL.

Eastpointe's educational outreach programs are directed to staff and member residents of group living facilities such as adult care homes (ACH). Not all group living facility staff and ownership are aware of the eligibility requirements and the important benefits of TCL. ACH providers in particular express concern over the loss member residents who transition into the community via TCL. This lack of understanding of TCL eligibility requirements and benefits may lead to a lack of cooperation by the ACH staff with Eastpointe staff. An ACH may, for example, decline to allow Eastpointe staff to enter the facility to meet with member residents. Because of COVID-19, many long-term care homes were unable to let additional members in. Many of the long-term care hospitals also did not let staff enter.

Throughout the COVID-19 pandemic, Eastpointe's TCL department team continued to see members in person. Eastpointe was the only LME-MCO to continue face-to-face contact with TCL members to ensure continuity of care. Eastpointe's TCL department team came up with many innovative ways to assist members in recognizing signs of COVID-19, protecting themselves from the virus, and proactively staying healthy. For example, TCL members were sent protective gear, including N-95 and cloth masks, along with instructions for how to properly wear and take care of the masks. Additionally, Eastpointe's Transitions Support Supervisor created, developed, and distributed a COVID-19 Workbook for TCL members. The COVID-19 Workbook included 12 pages of educational materials on COVID-19, how to best protect yourself from the virus, and general safety precautions. It also provided educational material about the COVID-19 vaccine. Eastpointe made sure that the readability level was suitable for all ages over the 8th grade. The Workbook was designed and developed by Eastpointe staff and follows CDC recommendations with respect to COVID-19 and the vaccine. At the end of the COVID-19 Workbook, there is a certificate that members can get upon completion of the Workbook.

Eastpointe may require the assistance of a Long-Term Care Ombudsman, employed by the state, who protects the rights of members at ACHs and with whom Eastpointe works closely to determine the best outcomes for the member. In addition to working closely with the Ombudsman, Eastpointe routinely reaches out to the state's In-Reach Specialist. This approach helps to establish cooperation and critically leads to a more informed choice for the member. Eastpointe also reaches out and coordinates with the DHHS Barriers Committee to address barriers on a systematic macro scale.

Eastpointe additionally faces environmental obstacles and barriers. The Eastpointe catchment area suffered multiple hurricanes and other natural disasters during FY2018 and FY2019. The aftermath of these natural disasters presented a number of challenges for the TCL population in terms of community-based supportive housing slots. Many rental properties in the Eastpointe catchment area were badly damaged or destroyed, forcing people out of their homes either permanently or temporarily while repairs were made. Due to the large number of homes in need of repair, the lack of developers and repair companies in the area, and difficulties in securing funding, many people were either unable to get the repairs they needed to be able to live in their homes or were forced to find housing elsewhere. Additionally, much of the Eastpointe catchment area is close to rivers and is very flood prone. There were floods in CY2020 that damaged existing structures and caused additional anxiety for members who feared losing their homes. The housing market still hasn't recovered and continues to limit options for TCL members.

In CY2020, an additional reason for limited housing options is the COVID-19 moratorium on evictions as well as the government stimulus checks that went to eligible adults.

Other obstacles and behaviors may hinder providing access and transitioning individuals to community-based supported housing. Delays can be attributed to lengthy assessments completed by the providers and/or a lack of referral documentation. The North Carolina Department of Health and Human Services implemented the Referral Servicing Verification Process (RSVP) as of November 1, 2018. It includes new mandates on documentation required for referrals. With the new system, providers, family members, and members often fail to provide the accurate referral documentation needed. Adoption of the new referral system is slow as providers train and learn how to use RSVP. The lack of education and awareness on how to use the new referral system necessitates individual referral guidance and follow-ups that impede transitions. Because the system allows anyone to make a referral, Eastpointe staff are required to screen every referral. Those referrals that do not meet criteria slow down the process for those who are qualified. Since inception of RSVP, the state has either updated or changed guidance for MCOs in at least four different occasions. Providers who have a conflict of interest who provide ancillary services to TCL are increasing bad referrals in the hope of increasing the services they provide. Sometimes people misunderstand the TCL program as a program for the homeless, which leads to additional confusion. In 2020, Eastpointe began to form a TCL Housing Advisory Group, which started to meet in February 2021. Partners and stakeholders involved in this group include DSS, landlords, the American Red Cross, Southeastern Family Domestic Violence Center, CFAC, Vocational Rehab, the ombudsmen, the Housing Authority, and other community partners. Eastpointe wanted to utilize this group to make sure the community understands the TCL program and how they go about integrating members into housing and into the community.

Finding housing to match member preferences presents another set of obstacles and barriers to the transition process. Eastpointe provides TCL members choice in the housing selection process. Members can decline all housing options offered for any reason, including reasons not necessarily unrelated to the appropriateness and/or quality of the housing options. Members provide unique challenges especially if personal barriers are present such as poor credit history, eviction history, criminal history, or sex offender status.

Family members also influence member housing choices. This is an additional challenge to promptly transitioning members into community-based supported housing. Family members may disagree that it is in the best interests of the TCL participant to rejoin the community. Family members dissuade the member from transitioning into the community by encouraging the member to decline housing options. This can occur if family doubt the capacity of the member to live independently in the community. Sometimes family members face financial incentives for members not moving and this can negatively affect the transition process.

Of those members who do transition into community-based supported housing, stability is a persistent challenge. This challenge is greater for dual-diagnosed individuals, particularly those with a substance use disorder and those who face loneliness and isolation. These high-risk individuals have a difficult time maintaining stability and independence in a home. Behavioral issues stemming from the substance use disorder contribute to discord with neighbors and community members. These behaviors can lead to further isolation and relapse. The leading cause of separations that Eastpointe has identified through data is loneliness and isolation that members face after transitioning out of adult care homes or family care homes.

Additional obstacles and barriers exist in the management of the TCL program. Fragmented data sourcing inhibits comprehensive, accurate, and timely data analysis. Currently, Eastpointe enters TCL data into three disparate databases. The state-initiated development of system enhancements to reduce redundancies, streamline processes, and to centralize data sources.

Eastpointe identifies and engages TCL-eligible individuals via multiple approaches. Eastpointe presents at provider forums. Provider forum presentations build awareness and help to educate the provider network about eligibility requirements. TCL staff are part of the Eastpointe Motivational Interviewing (MI) Champions Program in partnership with a National MI Trainer from UNC. Eastpointe staff use this evidence-based approach to engage members in the transition process to assess readiness, and to assist members dealing with ambivalence related to life changes. Eastpointe TCL staff use this internally as well to combat burnout and compassion fatigue. The MI Trainer conducts MI training sessions yearly for internal staff as well as opportunities for provider network staff. The MI Champions and MI Champions leadership have regular meetings with the trainer to assist with the consistency of the application of MI.

Eastpointe utilizes quarterly conference calls with provider network supports. Provider network supports include providers who provide Assertive Community Treatment Team (ACT), Community Support Team (CST), and IPS-Supportive Employment. Eastpointe also utilizes monthly calls for providers providing Transition Management Services (TMS). Specifically, for TMS, Eastpointe and providers work collaboratively to identify those individuals who are at high risk for separation to prevent recidivism. During these calls, we also provide updates on communications from the state to ensure there's an understanding about service definition changes, and any policy changes. Staffing and communications changes are discussed on all calls and Eastpointe gives providers the opportunity to air any grievances about Eastpointe staff or provide input on what processes are working well. Eastpointe staff and providers also use these calls to make sure they have the same understanding about community resource linkages. The quarterly conference calls are inter-departmental and include Eastpointe's Director of Network Operations, the Director of Provider Monitoring, and the Director of Quality Improvement. Another way Eastpointe supports providers and the TCL program is through a two-part collaboration with other internal departments in our provider network to gather data related to training, staffing requirements, employment status, and utilization of vocational rehab. From the initial data submission reviews, the cross-functional team provides technical assistance to help with ensuring provider compliance. In CY2020, the cross-functional team provided technical assistance webinars for CST and IPSSE providers. These trainings are ongoing.

Eastpointe additionally hosts housing presentations and housing collaborative meetings as needed. The target audience is adult care homes. The housing presentations and housing collaborative meetings help improve communication and understanding. The goal of this approach is to improve collaboration to better identify and transition TCL eligible individuals.

Eastpointe employs a focused task group to coordinate these efforts. The task group identifies and monitors implementation. They are able to clarify questions about the TCL program and the RSVP referral process. The task group directs members to the RSVP frequently asked questions on the DHHS website and DOJ settlement. Stakeholder engagement is a priority. Eastpointe aims to expedite the member transition once a provider is identified via a closer collaboration between all stakeholders. Efforts to develop more direct relationships and lines of communication with providers support this priority.

When transitioning individuals within 90 days of assignment to a transition team, Eastpointe takes multiple steps to give members choice and access. Staff help by physically showing members different properties as well as maintaining a dashboard to track activities and statuses.

Regarding supporting individuals' housing tenure and ability to maintain supportive community-based housing, Eastpointe has one of the lowest separation rates as found by a federal auditor. According to the dashboard, in FY19, Eastpointe had a community retention rate of 97.5 percent. Staff follow up with members, even past the 90-day mark, with personal phone calls and hold routine meetings with providers to ensure proper service. This includes maintaining communication with providers to ensure they continuously check-in with members.

B. IPS-Supported Employment

Eastpointe delivers IPS-Supported (Individual Placement and Support) Employment via five teams in the Eastpointe network. The Eastpointe network avails adequate total IPS-Supported Employment service capacity. Total network IPS-Supported Employment concurrent capacity stands at 132 members. All teams accepted new referrals continuously in FY20.

IPS-Supported Employment Capacity:

Team	Location	Member Capacity
Client First	Goldsboro	63
Family First	Mount Olive	19
Monarch	Lumberton	25
New Dimension	Rose Hill	New Dimension Group, LLC has ended the service effective 6/1/21.
Monarch	Rocky Mount	0 members. Agency just got the letter of approval on May 25th and have not implemented the service yet.

The barriers related to IPS-Supported Employment include a general lack of understanding of the service definition and eligibility requirements, as teams may not identify members that meet the criteria. There is a need for increased referrals to sustain the IPS-Supported Employment program.

Eastpointe attends the IPS-SE steering committee meetings hosted by providers. During these meetings, the IPS-SE providers provide updates on members who have entered the workforce, including what type of jobs they obtained and competitive pay. A company reached out to these providers to inform them that they might be able to help additional members with employment opportunities. The UNC IPS-SE Trainer agreed to participate in Eastpointe's quarterly IPS-SE meetings to provide additional technical assistance.

Another barrier is the conflict of interest between employment and receipt of benefits as members are often choosing between being employed and fearing ineligibility to continue to receive benefits if they make more money than is allowed. All members are supposed to receive benefits counseling but sometimes the member does not receive the appropriate counseling services, and/or they fail to understand the work constraints to which they need to abide in order to continue receiving benefits. Employers of members should be aware of the constraints in which the members are under in order to continue to receive their benefits. However, sometimes the member's employer is not aware of or does not care about the time and salary

constraints, so they allow the employee to work additional hours, thereby disqualifying them from receiving benefits.

Additionally, more jobs are needed in the community to fit the unique needs of members. Currently, there are not enough job opportunities that meet the unique needs of TCL members. There are vocational and job training support programs but not enough of them exist in the catchment area. All employers need to be more aware and respectful of the unique job constraints that members face in order to continue to be eligible for benefits.

Another barrier related to IPS-Supported Employment is the lack of incentives and training for employers who can work with members. TCL members have unique needs, which presents a challenge for employers.

Transportation is another barrier, as transportation limitations in rural communities, lack of public, low-cost transportation, and ride services are too expensive relative to job wages for members.

TCL members also face family pressure to not work for risk of losing benefits, as there is misinformation related to benefit eligibility and employment.

As the TCL population can be a difficult population to serve, engaging providers is a priority. Quarterly TCL meetings with the supported employment team and provider monitoring staff are held. The benefits counseling team works with this population to encourage stability during this time of major life transitions.

Eastpointe developed a work group to provide additional comprehensive training and technical assistance to IPS-SE fidelity providers. Eastpointe submits in-risk (already in ACH placement or in TCL) and at-risk (potential for placement ACH or TCL) checklists that are required to be submitted to the state, compliance with the service definition, contract requirements, quality improvement, and provider monitoring.

Eastpointe TCL has joined the IPS-SE steering committees of multiple providers (Monarch and Client First), which is a work group of stakeholders and community partners to improve services, discuss barriers for communication, and provide technical assistance Eastpointe also participates in the IPS-SE coalition meetings, hosted by DMH. They request all IPS-SE providers be in attendance, including vocational rehab providers. And there are incentives to link members with IPS-SE services. DMH hosts IPS-SE vocational rehab services utilization meetings, in which all IPS-SE providers should have a contract for vocational rehab. MCO's are using too much IPRS funding, and IPS-SE funding is available at VR (at state) and DMH prefers IPS-SE VR funding to allow for Medicaid federal match.

Many additional tasks involve monitoring, and direct engagement with providers, which increases the complexity of administering an IPS-SE program, as it requires cross-functional coordination and understanding of service delivery.

C. Community-Based Mental Health Services

Eastpointe delivered services to 287 TCL members living supportive housing in CY 2020. Eastpointe completed 103 move-ins or lease signings for members in CY2020. Eastpointe deploys a service array that emphasizes development of natural supports, community engagement, evidenced-based treatment and support, and support for competitive employment. This service array is designed to help drive improvement in key personal outcomes for members, including:

- supportive housing tenure and maintenance of chosen living arrangement;
- hospital, adult care home, or inpatient psychiatric facility admissions;

- use of crisis beds and community hospital admissions;
- emergency room visits;
- incidents of harm;
- time spent in congregate day programming;
- employment;
- school attendance/ enrollment; and
- engagement in community life.

Eastpointe offers multiple wraparound services. Wraparound services directly support improvements in these personal outcomes. Wraparound services include: Transition Management Services (TMS), Community Support Team (CST), Assertive Community Treatment Team (ACTT), Psycho-social Rehabilitation (PSR), Supportive Employment (IPS-SE), and Peer Support. Eastpointe's service array is designed to comprehensively address key personal outcomes. Members in TCL have access to any of the benefit plans for Eastpointe members, both IPRS and Medicaid. Eastpointe has a community inclusion pilot, which is currently the only one of two that exists in the state of North Carolina. Based on the success of Eastpointe's community inclusion pilot, the state expanded the pilot to another LME-MCO. Eastpointe has a contract with ADANC, which includes a specific allocation for TCL members to find different community inclusion activities. For example, TCL members were able to access freedom funds to do different community inclusion activities. In order to access these funds, TCL members had to submit a plan for how they planned to use the funds as it has to be used toward healthy integrative activities. There were some funds added back at the end of the FY20 for Eastpointe to utilize.

Transition Management Services (TMS) is a service provided to individuals participating in the Transition to Community Living Initiative (TCL). TMS is a rehabilitation service intended to increase and restore an individual's ability to live successfully in the community by maintaining tenancy. TMS focuses on increasing the individual's ability to live as independently as possible, managing the illness, and reestablishing his or her community roles related to the following life domains: emotional, social, safety, housing, medical and health, educational, vocational, and legal. TCL had 88 members enrolled into TMS services FY2019.

Eastpointe continues to excel in community retention for the TCL population. Personal outcomes indicative of greater integration in the community for Eastpointe's TCL population include a higher than average retention rate of 98 percent for CY2019. Eastpointe had 39 members separate in CY2019. Eastpointe closely monitors TCL members who are admitted to the hospital, return to adult care homes, or are admitted to inpatient psychiatric facilities. Eastpointe works closely with state hospitals to be notified faster when members are admitted to the hospital. In CY2019, four people returned to adult care homes. Eastpointe takes a more collaborative approach to the member's care by increasing the numbers of face-to-face treatment team meetings with members and the hospital team.

With respect to the use of crisis beds and community hospital admissions, Eastpointe has an effort to identify TCL members in authorized settings, including inpatient, facility-based, detox, and state facilities. An Eastpointe licensed care coordinator and a member of the QP staff normally go over to the facilities multiple times a week to work on engaging and discharge planning earlier. However, due to COVID-19 protocols, Eastpointe had to alter their visits and communicate virtually. Eastpointe receives reports that list whether or not there is a TCL member in the system and if they've been assigned to a care coordinator.

Eastpointe continues to make an effort to increase contact with community partners to increase education and awareness about TCL. Eastpointe has increased referrals for Peer Support services due to an increased provider capacity and options for member's choice. All TCL members are offered the following services: Peer Support, Transition Management Services, CST, ACTT, Supported Employment, and Community Inclusion. Other specialized services are offered such as trauma focused therapy. Eastpointe added a registered nurse to their staff. The nurse is addressing primary care, mental health, and substance use needs. The nurse is pivotal with assisting with linking the member to personal care services and service animals. In the past 4 years, the data has shown members to be more likely to leave housing due to deaths versus going back to an Adult Care home. Eastpointe had 43 inpatient admissions over the last fiscal year.

Overall, there has been a reduction in instances of intentional self-harm among the TCL population, with only one incident of accidental self-harm within CY20. Substance use is a root cause of the incidences of harm that Eastpointe sees among its members. For CY20, for example, Eastpointe had two instances where a member relapsed/used substance and had an accidental overdose and passed away. Relapse and substance use issues contribute to the spread of communicable diseases so there is a new initiative in which Eastpointe is working with the local health department in Wayne County to offer screening and immunizations to TCL members.

4.2 Children with Complex Needs

"Children with Complex Needs" are defined as Medicaid eligible children ages 5 to 21 with a developmental disability (including Intellectual Disability and Autism Spectrum Disorder) and a mental health disorder, who are at risk of not being able to enter or remain in a community setting due to behaviors that present a substantial risk of harm to the child or to others.

With respect to service gaps and needs to identify and linking Children with Complex Needs (CWCN), Eastpointe continues to focus on the expansion of Applied Behavioral Analysis (ABA) network capacity, however there is still a shortage of ABA providers. Efforts to expand capacity apply to all Eastpointe counties. Education with Eastpointe's call center has increased the number of family referrals to CWCN.

The Eastpointe population frequently cites transportation as a need. Members, especially in rural locations, may have difficulty finding transportation or may have to travel far distances to access care, including ABA services. Providers that offer in-home ABA services may limit travel to an area that does not address extended travel for all CWCN.

Eastpointe providers additionally offer State-funded services to the CWCN population. State-funded services are available to address the needs of the Eastpointe CWCN population. Efforts to expand State-funded services require additional network capacity. The Innovations Waiver Registry of Unmet Needs is lengthy, and some families may be reluctant to utilize alternate services while waiting to be approved for the Innovations Waiver. ABA services often have a waitlist or lack of capacity.

With respect to additional training for providers and other stakeholders, Eastpointe and NC DHHS have a partnership with the University of North Carolina Chapel Hill's Behavioral Health Springboard through the UNC School of Social Work's Springboard. The Springboard provides access to a website that provides information, training, and resources for parents, caregivers, primary care physician offices, community members, and others who live with and care for people with intellectual and developmental disabilities who are experiencing mental illness. The

SECTION 4.1: TRANSITION TO COMMUNITY LIVING INITIATIVE (TCLI)

Access to safe and affordable housing greatly impacts health and well-being. Our Community Collaborative in Burke County is targeting housing and homelessness through efforts to create a community-wide plan of action. Partners is an active partner in the HUD permanent supportive housing grant. We are the leader in four housing Continuum of Care groups across our service region. Through these groups, we work with cities and counties to increase access to affordable housing and collaborate with housing authorities when applying for grants. As a result, Partners has earned more housing vouchers than any other LME/MCO.

Partners uses county and Medicaid funds to help members secure and retain housing though rental deposit support, utility payments and credit repair. When a member who was previously homeless moves into a new home, Partners provides $5,000 in Medicaid funds for furniture, first month's rent, utilities, etc., to create a comfortable and stable home. We provide short-term fund housing applications and utility payments. Partners uses county funds to provide mattresses, box springs and sofas.

Partner's dedicated housing manager and housing specialist assist members in identifying, securing and retaining community-based housing. These positions provide education and assistance to member-facing staff regarding housing options. They assess members' eligibility for programs and subsidies and connect them to available supports to achieve permanent housing. They help members complete forms such as HUD applications and connect them to housing resources and community-based organizations that offer support. Our housing manager participates in local programs focused on increasing access to affordable housing, such as the Transitions to Community Living Initiative.

COMMUNITY-BASED SUPPORTIVE HOUSING

1) Describe service gaps and needs, obstacles and barriers, and recent initiatives in the LME/MCO to:

a. *Identify and engage eligible individuals in the TCLI priority population:*
Partners Transitions to Community Living Initiative (TCLI) program has not experienced issues with the identification and engagement of eligible individuals in the TCLI priority population. Our TCLI program has continued to be successful in their efforts by working with the state hospital, visiting individuals in Adult Care Homes, and reaching out to individuals through the diversion process.

b. *Transition individuals to community-based supported housing:*
As of April 2021, Partners TCLI program has successfully transitioned 450 individuals (over the life of the program) into the community with no problems. Education and training opportunities have been provided to landlords and improved access to Targeted Key Units continues to be offered by NCDHHS. Collaborative efforts with Partners and NCDHHS staff assist in providing easier access to available units. This partnership also supports increasing housing capacity more quickly. Partners' TCLI program routinely provides education and training for members, providers, and employers on employment options that are available for individuals with mental health, intellectual/developmental disability, and substance use disorder diagnoses. Bridge Housing is supporting TCLI program activities by providing a place for members to transition when they are ready for discharge from SPH. Partners currently has one four (4) bed facility in Cleveland County at 927 Tom Street, Shelby, NC. Partners is projected to add two (2) additional facilities by the Spring of 2021, which will increase the capacity in Catawba County by six (6) beds. Based on feedback from the federal reviewer, Partners is doing well with transitioning members to supported housing from SPH.

c. *Transition individuals within 90 days of assignment to a transition team:*
Barriers experienced by the Partners TCLI team within the first 90 days include: criminal history, financial problems, medical problems, finding places to live in the individuals chosen area, and not enough handicapped accessible units. In 2018, Partners hired an additional housing coordinator to assist TCLI staff in locating housing and making referrals, including reducing housing barriers, such as limited housing resources,

inspections, and background checks and that position has supported the efforts over the past year. Partners staff have also worked very hard to develop a network of landlords that are willing to accept members with either criminal background or financial challenges. Partners staff have also worked to prevent members from going into adult care homes by utilizing temporary housing programs.

d. *Support the required number of individuals to maintain community-based housing:* Partners has identified concerns and issues with members maintaining housing and have met with providers to discuss ways to better support our members. Some of the identified concerns and issues include the following: members allowing friends/family members who are not on the lease to move in; members becoming involved in drug use; member's ability to maintain safe/clean household; and member's lack of personal hygiene. To combat these challenges in maintaining housing, Partners TCLI program has implemented post-transition coordinators who will work with members throughout their time in the program. The individual has care coordination for 90 days after transition then could be closed to care coordination. Now, Partners TCLI program has developed weekly or biweekly calls with service providers to discuss concerns and resolve any problems with members that are in housing so that permanency can be supported.

IPS-SUPPORTED EMPLOYMENT

1) Describe the network adequacy of IPS-Supported Employment services including:

a. *Number, locations, and service capacity of fidelity teams:* 4-Partners currently has four approved fidelity Individual Placement Services-Supported Employment (IPS-SE) providers; Monarch Inc. (Cleveland, Gaston, and Lincoln counties), PQA Healthcare (Iredell, Surry and Yadkin counties), Family Preservation Services (Rutherford County) and Coastal Southeastern United Care (Cleveland, Gaston and Lincoln counties). All four providers meet fidelity and are approved IPS-SE providers. A Caring Alternative (Catawba and Burke counties) and Easter Seals UCP (Surry County) have implemented pre-fidelity IPS-SE teams.

b. *The LME/MCO's total service capacity requirements (including but not limited to the TCLI population):* 446.

c. *Service gaps and needs. Discuss discrepancies between service capacity and capacity requirements, and needs for improvement in service quality and outcomes, not only access and choice standards.* In years past, it was difficult to meet the service capacity requirement as Partners only had two approved fidelity IPS-SE providers, Monarch Inc., and Coastal Southeastern United Care, located within our catchment area. In 2019, Partners gained two approved fidelity IPS-SE providers, PQA Healthcare Inc. and Family Preservation Services, bringing the current total to four providers located within our catchment area. Coastal Southeastern United Care serves members in Cleveland, Gaston and Lincoln counties and has served 53 members to date. Monarch Inc. provides this service in Cleveland, Gaston and Lincoln counties and has served 98 members to date. PQA Healthcare serves members in Iredell, Surry, and Yadkin counties and has served 51 members to date. Family Preservation Services serves members in Rutherford County and has served 172 members to date. Easter Seals UCP has a pre-fidelity team that provides this service in Surry County and has served 31 members to date. A Caring Alternative began a pre-fidelity team that served 18 members in Catawba and Burke counties; however, their program ended due to the lack of referrals and the numbers of members needed to maintain the service.

2) Describe obstacles and barriers as well as recent initiatives in the LME/MCO to engage and refer individuals in the TCLI priority population, including individuals with SMI living in community-based supportive housing and individuals living in or at risk of entry to adult care homes.

Obstacles and barriers to sustainability of this service include concerns about the rates and how fidelity scoring is implemented. Providers express concerns about being able to maintain the service with the current payment structure and individuals are concerned about changes to the benefits they receive. We have continued to focus on the recruitment of additional IPS-SE providers and as such, Easter Seals UCP has started a new team. Partners initiated a Root Cause Analysis (RCA) involving our interdepartmental team, current IPS-SE providers, and A Caring Alternative. Partners staff will consult with and utilize technical assistance from the Supportive

Employment/Enhanced Services Learning Collaborative on an ongoing basis. We increased our focus on the referral management process for TCLI consumers at an individual level and increased members engagement with Supported Employment services. This resulted in reaching the total of 450 engaged members by the end of April 2021. Additionally, we have built IPS-SE incentives for adding members of the in/at risk population into provider contracts to increase IPS-SE service utilization. The feedback received from the providers who do deliver this service across the state and meet fidelity is that this service needs to start at the good fidelity rate for baseline and then move up from there to be viable. This feedback has been shared with and is being assessed by the fidelity reviewers.

PERSONAL OUTCOMES AND SUFFICIENCY OF COMMUNITY-BASED MENTAL HEALTH SERVICES

1) Describe how the LME/MCO tracks and monitors the following personal outcomes for individuals in supportive housing:

On a monthly basis, Partners provides personal outcomes data for individuals in supportive housing through the Quality of Life (QOL) survey. This information is then analyzed and compiled by NCDHHS to develop their TCLI Annual Report. Per Section III.G.5 of the State's Settlement Agreement with U.S. Department of Justice, Partners' staff members must administer the surveys in person at the following checkpoints: transition planning period, 11 months after the member transitions to supportive housing; and 24 months after the member transitions to supportive housing.

According to the NCDHHS website, the QOL surveys assess whether, to what extent, and in which areas individuals who transition to supportive housing in the community experience improvements in the quality of their daily lives. The surveys are designed to assess member perceptions and satisfaction related to housing and daily living, community supports and services, and personal well-being.

Additionally, the numbers below were gathered three ways: (1) They are reflective of individuals that were participating in TCLI and Supported Housing. The total number of surveyed individuals = 1,682. Personal Outcomes are not tracked specifically for the TCLI population after 90 days; therefore, some of the items below do not solely reflect the TCLI population; (2) Claims CY20 data where an individual received a service with the DJ modifier. There were 253 individuals tracked this way during CY20; and, (3) the State's Incident Response and Improvement System (IRIS).

a. *Supportive housing tenure and maintenance of chosen living arrangement:* Partners' TCLI Department, which is required to track *this* data and report to the state monthly, reports that 450 individuals have been successfully transitioned into their chosen living arrangement in the community.

b. *Inpatient hospital or psychiatric facility admissions and readmissions:* CY20 claims data shows out of 253 individuals, 14.6% (n = 37) had a psychiatric inpatient hospitalization and 11.1% (n = 28) had an initial hospital visit. Of the individuals with *either* a psychiatric inpatient hospitalization and/or initial hospital visit claim during the 2020 calendar year, 35 had another visit within 30 days of another.

c. *Use of crisis services:* CY20 claims data shows out of 253 individuals, 7.1% (n=18) received a crisis service; 3.2% (n = 8) had a crisis intervention – facility based and 6.3% (n = 16) had a mobile crisis service. This shows six individuals received both services (crisis intervention – facility based & mobile crisis) at least once.

d. *Emergency room visits and repeat visits:* CY20 claims data shows out of 253 individuals, 16.6% (n =42) had ER visits during the calendar *year*. Of the 42 who visited the ER, 26 had more than one visit during the calendar year and 11 had a repeat visit within 30 days of another visit.

e. *Incidents of harm*: 3, *as* reported by IRIS.

f. *Adult care home admissions and readmissions:* Partners' TCLI Department, which is required to track this data and report to the state monthly, reports that 20 individuals had ACH admissions and 18 had readmissions in CY20.

g. *Employment:* CY20 claims data reports, of the 253 individuals 10.3% (n = 26) received supported employment *services*.

h. *School attendance/enrollment:* This information is not currently tracked, reported, or monitored by Partners.

i. *Community integration and engagement:* Specifically, the following QOL survey items are related to the community integration and engagement for individuals: *Are you satisfied with the way you spend your day? Do you feel like you have enough to do?* and *Do you go out in your community to do things when you want or choose?* As reported in the state's 2019 TCLI Annual Report, 54% of the 1,682 individuals surveyed responded positively prior to transition while an average of 73% responded positively at the 11 and 24 months follow up checkpoint.

j. *Natural supports network development and use of natural supports for crisis prevention and intervention:* Specifically, the following QOL survey items are related to the natural supports network development and use of natural supports for crisis prevention and intervention for individuals: *Do your family or friends help you become the person you want to be? Did you get to visit or talk with family or friends who support your recovery in the past 30 days? Do you have someone to talk to when you feel sad, angry, upset, or lonely?* and *Have you felt lonely during the past week?* As reported in the state's 2019 TCLI Annual Report, 64% of the 1,682 individuals surveyed responded positively prior to transition while an average of 74% responded positively at the 11 and 24 months follow up checkpoint.

k. *Other personal outcomes the LME/MCO monitors:* N/A

2) Describe how the LME/MCO uses personal outcomes data to determine, plan, and deliver the frequency and intensity of services needed to support individuals in community-based housing.
Partners relies on our network service providers to monitor the personal outcomes of the TCLI members they serve on an ongoing basis through member treatment. It is also our expectation that the providers establish appropriate treatment plans that will include the development of goals needed to support the members achieving permanency in housing. These determinations, plans, and subsequent delivery of services by our providers are established at the appropriate frequency and intensity suitable for everyone based on their unique levels of need.

3) Describe gaps and needs in the community-based mental health services provided to individuals in TCLI supportive housing. Discuss discrepancies between service capacity and service capacity requirements, and the sufficiency of services (array, intensity, frequency, quality, and effectiveness) as indicated by personal outcomes such as those listed above, not only access and choice standards.
In the past, members have reported difficulty in receiving their respective service(s) at a frequency sufficient to their satisfaction. In response to this concern, Partners has prioritized initiatives to work with and educate providers on meeting the individual needs of each member; however, it is important to note that for the Assertive Community Treatment Teams (ACTT) service, the team has such a large high intensity caseload that sometimes they cannot respond as quickly as the TCLI member may need or want. In response to this issue, Partners has implemented a process where each member is contacted monthly by TCLI staff to discuss any problems, issues, or concerns that they may be experiencing. Additionally, Partners facilitates weekly and/or biweekly teleconferences with ACTT and Transition Management Service (TMS) providers to identify, troubleshoot and resolve member issues as they arise.

Another concern that has been noted are TCLI individuals who are unfortunately allowing their buddies to sleep on their couch, or they bring pets in without adding them to their lease. This failure to comply with the terms of their rental contract could result in a lease violation that leads to their eviction. In response to this issue, Partners has communicated with and educated our providers about our network compliance requirements for TCLI member home inspections (at a minimal monthly frequency), and most especially when the individual is resistant to the providers entering their homes.

4) Describe obstacles and barriers as well as recent initiatives to address gaps in the array, intensity, quality, and effectiveness of community-based mental health services provided to individuals in supportive housing.
One obstacle that has been reported is related to situations where conflict exists between provider staff and TCLI individuals. Generally, when these situations occur, individuals will no longer engage with the provider and will eventually disengage from their treatment. Member decisions such as these could ultimately lead to their eviction. In some other cases, members engaged in services lose their housing due to firing their providers. Partners' plan to address this challenge was the implementation of a formal process for Assertive Community Treatment Team (ACTT), Community Support Team (CST) and other high intensity service providers to notify Partners Access to Care Department when they have been terminated from providing services for our TCLI members. Another obstacle that has been noted is a lack of medication adherence for TCLI members, which can result in housing problems due to psychiatric instability. Partners' recent initiatives to address this issue include resolving member medical transportation issues, as well as providing psychoeducation to members that will increase the likelihood of their commitment to medication treatment plans, improve overall treatment engagement, and encourage compliance with appointments to renew medications. Improving the quality of members' daily living skills and increasing the number of provider face to face visits should also positively impact this issue. Provider treatment teams are tasked with the implementation of this initiative and this process appears to successfully address these issues. Lastly, (b)(3) peer service funding is extremely limited and therefore, limits peer engagement.

CRISIS SERVICES

1) Describe the network adequacy and sufficiency of the LME/MCO crisis service system including:

a. *The service array and geographic availability*: The comprehensive crisis service array is available to all TCLI individuals throughout the nine-county catchment area. This includes, but is not limited to, mobile crisis, facility-based crisis, psychotherapy for crisis, Assertive Community Treatment Teams (ACTT), Community Support Team (CST), and Transition Management Service (TMS).

b. *The sufficiency to offer timely services of adequate intensity to individuals experiencing a behavioral health crisis:* Members with Medicaid and those appearing to meet criteria for State Funded target populations are linked through Screening Triage & Refer (STR) to providers for an initial assessment/evaluation and treatment. This applies to TCLI members as well as individuals across the catchment area. Members who do not appear to qualify for any benefits under State Funds are linked to community resources. Standardized screening, triage and referral protocols focus on timely access to the most needed level of care. Triage is a brief process aimed at determining the intensity of the member's need and results in prioritizing their level of care into the following categories: Emergent Care members will be seen face-to-face within two hours or directly linked to 911 depending on severity due to medical needs. Members presenting with moderate risk or incapacitation in one or more area(s) of physical, cognitive, or behavioral functioning related to MH/IDD/SA problems. Urgent care is provided within 48 hours of initial contact if the member is experiencing a more slowly evolving crisis and a catastrophic outcome is not imminent. Members presenting with mild risk or incapacitation in one or more area(s) of safety, or physical, cognitive, or behavioral functioning related to MH/IDD/SA problems. Routine Care will be provided to members within 14 calendar days of initial contact.

c. *The extent to which services are provided in the least restrictive setting, consistent with an already developed individual community-based crisis plan or in a manner that develops such a plan as a result:* A crisis plan is developed prior to crisis episodes and assists with providing community supports that are helpful to each individual during a crisis to prevent hospitalization. These plans are made available to mobile crisis providers and/or ACTT team staff.

d. *The effectiveness of crisis services for preventing unnecessary hospitalization, incarceration, or institutionalization*. Wraparound services are provided for all TCLI participants within our catchment area with a purpose to provide each member with the unique clinical or community supports necessary to prevent unnecessary hospitalization, incarceration, or institutionalization. These services are determined by the

provider's *assessment* of the individual and adjusted as needed throughout client treatment. As each TCLI participant works with their providers to develop and manage their individual crisis plan, the providers are tasked with effective implementation of the plan to prevent any future elevation of crisis experiences. Additionally, as a supporting strategy to ensure provider compliance with our provider crisis service requirements, Partners routinely and randomly conducts mystery shopper programs within our network to continually monitor and assess the effectiveness of provider crisis services.

2) Describe gaps and needs in the crisis service system. Discuss discrepancies between service capacity and capacity requirements, and the sufficiency of services (capacity, array, quality, and effectiveness), not only access and choice standards.

Partners has not observed significant crisis service system gaps or needs within our catchment area. Our provider network maintains the following crisis service array at sufficient levels of capacity, quality and effectiveness: mobile crisis, facility-based crisis, psychotherapy for crisis, Assertive Community Treatment Teams (ACTT), Community Support Team (CST) and Transition Management Service (TMS). The only concern that has been noted to date is related to the fact that Transition Management Services (TMS) is not a clinical service. The issue with this *constraint* is that the TMS service providers typically are not adequately trained to conduct assessments during a member's crisis experience. In November 2019, however, a new Community Support Team-Permanent Supportive Housing (CST-PSH) service definition went into effect that now increases the amount of clinical support available to TCLI members that are transitioning to the community. This recent change in the service definition appears to be providing a suitable resolution to the aforementioned concern with TMS.

3) Describe obstacles and barriers as well as recent initiatives to address identified gaps related to crisis service availability, delivery, quality, and effectiveness.

Partners has not observed obstacles and barriers related to crisis service availability, delivery, quality and effectiveness within our provider network. Additionally, the state's recent changes to the CST service definition has allowed for more appropriate clinical intervention during member crises. Although we still have members receiving TMS services, these members can receive crisis intervention through Mobile Crisis Management, which provides a timely and effective support to the member's crisis experience.

SECTION 4.2: CHILDREN WITH COMPLEX NEEDS

"Children with Complex Needs" are defined as Medicaid eligible children ages 5 to 21 with a developmental disability (including Intellectual Disability and Autism Spectrum Disorder) and a mental health disorder, who are at risk of not being able to enter or remain in a community setting due to behaviors that present a substantial risk of harm to the child or to others.

IDENTIFICATION & ENGAGEMENT

1) Describe service gaps and needs to identify and link CWCN to appropriate levels of service.

Identification of service gaps and unfulfilled needs for Children with Complex Needs (CWCN) and linking them to appropriate levels of service are key objectives for Partners staff. An outstanding issue is the need for more Intensive Alternative Family Treatment (IAFT) or Therapeutic Foster Care (TFC) for our CWCN members; however, we have also identified critical needs to increase CWCN residential capacity for Level II-III Residential, PRTF, Transitional Living Residential, Crisis Respite and Facility Based Crisis. Additional CWCN residential care needs indicate specialized services are needed to treat sexually aggressive behaviors, highly aggressive behaviors, transitional age youth, and victims of sex trafficking. Providers have also cited a reduction in the number of foster families who are properly trained to work with CWCN. In some instances, those families who are interested have limited time availability due to their own parenting responsibilities.

trending analysis is also performed and shared. Each year, a workgroup is formed to address the items identified as needing improvement. In the past, Sandhills Center has contracted with outside training consultants and/or developed their own materials to address these topics and presented them at Provider Forums. It is also important to note that if issues are identified as area's needing improvement, they are then included in the interventions developed. There have been some instances specifically related to access that Sandhills Center has addressed at Clinical Leadership, Clinical advocacy and Quality Management Committee, to determine provide capacity, gap, etc.

2020 presented many challenges for surveys due to the COVID-19 Pandemic. LME/MCO's did not receive a report for the Consumer Perception of Care results as the number of responses were too low, but they did receive a data file. Sandhills Center did not receive any Provider Satisfaction data or reports. Only ECHO results were reported to the LME/MCO's. This year's workgroups made a decision to develop a presentation showing trending on the area's needing improvement and asking Sandhills Center providers for input on how to get better results. This is targeted for Sandhills Center's August Provider forum. In previous Sandhills Center external quality reviews (EQR), the Carolinas Center for Medical Excellence (CCME) has noted that this process is "best in class." Additionally, the State was impressed with Sandhills Center's plan to reach out to providers for feedback on how to improve future survey response rates.

Sandhills Center reviewed survey data from the ECHO surveys and the Perception of Care survey data specific to their membership. There are comparison charts for barriers and challenges, social determinants, special populations and needs and gaps, located in the Appendix.

Section IV – Special Populations

Transitions of Community Living Initiative (TCLI)

A. Community-based Supportive Housing Slots:

1. Describe service gaps and needs, obstacles and barriers, and recent initiatives in the LME/MCO to:

a. ***Identify and engage eligible individuals in the TCLI priority population.***

During fiscal year 2020-2021, Sandhills Center has been able to successfully identify a sufficient number of candidates to participate in the TCL program. However, the inability to interact with individuals face-to-face and concerns about contracting COVID-19 outside of facilities for individuals residing in Adult Care Homes (ACH) has likely led to a decrease in participation in the TCLI program. During In-Reach contacts, staff address these concerns by informing individuals that ACHs have higher rates of COVID-19 cases, and that they may be safer living in the community. Also, a weekly TCLI Supervisors meeting was implemented this fiscal year for the purpose of identifying challenges/barriers more timely and working together to identify a solution, which in some instances entails bringing the issue to the monthly DOJ/TCLI Workgroup or other entity for further assistance. In addition, Sandhills Center recently approved the purchase of smart phones for completing face-to-face In-Reach visits for the purpose of increasing participation of individuals residing in ACHs.

b. ***Transition individuals to community-based supported housing.***

Overall, Sandhills Center has been successful in transitioning TCLI participants to the community despite the barriers/challenges related to the COVID-19 shutdown restrictions.

As of May 30, 2021, a total of 84 members have been transitioned into supportive housing via a TCLI housing slot. It should be noted that the face-to-face component of the transition activities have been temporarily suspended due to COVID-19 restrictions. Staff are meeting their obligations towards these efforts via assistance from providers, phone, and email and, US mail communications. The inability to interact with individuals face-to-face and complete tasks directly has led to some delays in completing timely transitions.

The primary challenges/barriers experienced in transitioning participants to the community during the 2020-2021 fiscal year are as follows:

i. delays in referrals to Targeted Key Units
ii. shortage of housing stock as a result of the moratorium on evictions and property managers refusing to work with TCL participants due to issues with previous extremely challenging TCL tenants
iii. difficulty identifying housing in a participant's preferred area (e.g. county, section of town, apartment complex) and for members with extensive criminal and poor credit backgrounds

Sandhills Center's DOJ/TCLI Workgroup that meets monthly, which consists of Sandhills Center's department leaders (e.g. Network, Finance, Care Coordination, TCL Supervisors, Legal Counsel, QM, Associate Medical Director, Chief Member Services). The purpose of this monthly meeting is to keep workgroup members abreast of the progress of the TCL program each month, to provide updates/changes provided/issued by DHHS, and to request feedback/recommendations on any issues/barriers encountered. Sandhills Center also meets monthly with its Transition Management Services (TMS) provider to discuss member-related issues and identify ways in which participants can best be supported and ensure their needs are being met by providers as well as TCLI staff. In addition, a weekly TCLI Supervisors meeting was implemented so that challenges/barriers could be discussed timely and a solution identified, which sometimes entails bringing the issue to the monthly DOJ/TCLI Workgroup or other entity for further assistance.

To address and resolve the challenges related to the Targeted Key units, TCLI supervisors have reached out to our internal DOJ/TCLI Workgroup for recommendations and have brought the issue to the DHHS Barriers Committee for assistance. In an effort in increase our housing resources, Sandhills Center's Housing Supervisor and Transition Coordinators have been reaching out to other properties who might be willing to accept the TCLI voucher. In some cases, TCLI staff have to be realistic with participants regarding housing availability in their preferred area or how their criminal/credit/eviction histories have limited their options; as a result, they might consider expanding their preferred area or modifying their expectations.

c. Transition individuals within 90 days of assignment to a transition team.

The following barriers have been experienced during FY 2020-2021 regarding timely transitions to the community:

i. locating housing for registered sex offenders and for individuals with a significant criminal records.
ii. delays in referrals to Targeted Key units
iii. shortage of housing stock as a result of the moratorium on evictions and property managers refusing to work with TCL due to issues with previous extremely challenging TCL tenants
iv. difficulty identifying housing in a participant's preferred area (e.g. county, section of town, apartment complex) and for members with extensive criminal and poor credit

backgrounds

Despite the barriers listed above, as of March 31, 2021 TCLI staff demonstrated an average transition period of 51 days. This has resulted from a QIP related to Days to Transition that was implemented on February 27, 2018. At the time of implementation, the average number of days to transition was 115 days. Recently, a request was submitted to close the QIP due to the success of the project[70].

d. Support the required number of individuals to maintain community-based housing.

Maintaining members in the community has been the greatest challenge for Sandhills Center TCLI staff during FY 2020-2021 as our separation rate is approximately 52%. Unfortunately, almost one-forth of these separations resulted from the death of the individual.

To address the separation issue, TCLI staff make contact with all housed TCLI participants each week for a check-in and ensure the individuals are getting their basic needs met, including food, supplies, and medications. Staff also inquire about their behavioral/physical health services and discuss any COVID-19 concerns as well as safety precautions. For any member who reports information that leads staff to be concerned about their wellbeing or possible housing loss, TCLI staff convene clinical team meetings so that all involved parties can come together to discuss the member's issues and brainstorm/develop additional interventions and strategies to better support these members in maintaining their community-based housing. This fiscal year, there have been approximately 30 clinical team meetings convened each month; it is believed that this strategy has improved the level of support for the identified members and has prevented the loss of supported housing for these individuals.

In addition, Sandhills Center's Medical Director and Associate Medical Director conduct reviews of members who have been identified for the TCLI program and those already in housing who are struggling to maintain their living arrangements or have had multiple evictions. The documents reviewed include the CCA, PCP, Transition Tool, and any other pertinent document/information. All recommendations regarding how these members might best be supported in the community are shared with the providers who are asked to incorporate the recommendations into their PCPs.

B. IPS-Supported Employment:

1. ***Describe the network adequacy of IPS-Supported Employment services including:***

   a. ***Number, locations, and service capacity of fidelity teams:***

   Sandhills Center has six (6) IPS-SE providers, all of which have met fair fidelity, with some scoring very close to good fidelity status during their most recent reviews. Four (4) of the providers are located in Guilford County (some also cover Randolph), and one (1) covers the Lee/Harnett county area. Through an RFP process in 2016, an IPS-SE provider was identified to provide IPS-SE services to Sandhills Center's remaining five (5) rural counties. However, this provider has struggled in their provision of IPS-SE services in the Sandhills Center area. UNC Institute for Best Practices has been working with this provider in an effort to assist them with the challenges they have experienced establishing a behavioral health partnership.

[70] See Appendix G

b. ***The LME/MCO's total service capacity requirements (including but not limited to the TCLI population):***
Based on paid claims from July 1, 2020 to May 31, 2021, 148 individuals received IPS-SE services. Currently only eight (8) TCLI members are receiving this service. Therefore, there is more than sufficient capacity based on the number of IPS-SE providers/teams for additional members to be served, including TCLI participants.

c. ***Service gaps and needs. Discuss discrepancies between service capacity and capacity requirements, and needs for improvement in service quality and outcomes, not only access and choice standards:***
See (b) above regarding service capacity/service requirements. Regarding quality of service and outcomes, Sandhills Center holds regular IPS-SE LME-MCO Collaborative meetings to provide technical assistance, emphasize the importance of identifying/reporting TCLI/at-risk members and partnering with the Division of Vocational Rehabilitation (DVR) for the purpose of accessing milestone payments and the additional services/supports offered through DVR. Due to the strong focus on IPS-SE providers partnering with DVR and accessing the milestone payments, Sandhills Center has collaborated with Marcia Gibson from DVR to work directly with the IPS-SE providers to address some of the barriers/challenges experienced. This has resulted in increased access to the milestone funding available through DVR. In an effort to increase the quality of IPS-SE services provided, Sandhills Center has collaborated with UNC Institute for Best Practices to provide pertinent IPS-SE trainings as well as a training series designed to assist IPS-SE providers in increasing their fidelity scores.

2. ***Describe obstacles and barriers as well as recent initiatives in the LME/MCO to engage and refer individuals in the TCLI priority population, including individuals with SMI living in community-based supportive housing and individuals living in or at risk of entry to adult care homes.***
Sandhills Center continues to experience challenges regarding connecting individuals agreeing to participate in the TCLI program to employment services. There continues to be members who fear losing their benefits if they go to work and/or they have been told they would never be able to work. In addition, many guardians and stakeholders still discourage participants from working.

In July 2020, Sandhills Center developed a TCLI IPS-SE Engagement Process that involved offering all individuals an IPS-SE presentation during their In-Reach contact (includes individuals residing in ACHs as well as those identified for Diversion). The purpose of the presentation is to allow the "experts" to share information about the IPS-SE services offered to include employment, education, benefits counseling. For individuals who agree to a presentation, they are offered a choice of providers in areas where choice is available. Whenever an individual agrees to participate in the TCLI program and they have not yet heard a presentation or agreed to IPS-SE services, the same process occurs at the time of the first transition meeting. As of April 30, 2021, the IPS-SE Engagement Process has achieved the following outcomes:

- 41 IP-SE presentations offered
- 30 IP-SE presentations accepted
- 23 IPS-SE referrals made
- 5 IPSE referrals made into enrollments

There are currently eight (8) TCLI participants actively receiving IPS-SE services. Of these eight (8), five (5) members are competitively employed, and three (3) are receiving follow-along services.

C. ***Personal Outcomes and Sufficiency of Community-Based Mental Health Services:***

1. ***Describe how the LME/MCO tracks and monitors the following personal outcomes for individuals in supportive housing:***

a. ***Supportive housing tenure and maintenance of chosen living arrangement:*** Designated Sandhills Center TCLI staff maintain a spreadsheet to track transitions and separations for each month of the fiscal year so that net gain requirements can be tracked/monitored. The reasons for all housing separations are included on the spreadsheet for tracking purposes and so that trends can be identified and discussed. In addition, a running list all transitions and separations from the outset of the TCLI program has been maintained so that the total number of housed participants can be easily identified. This list tracks a variety of other data elements including housed/separation date, date the Transition Coordinator was assigned, transition status, county of residence, subsidy type, and TCLI category.

b. ***Inpatient hospital or psychiatric facility admissions and readmissions:*** See below (b-d are combined)

c. ***Use of crisis services:*** See below (b-d are combined)

d. ***Emergency room visits and repeat visits: See below (b-d are combined)*** Data is received and reviewed daily regarding psychiatric inpatient/ED admissions and access to crisis services. In instances in which a TCLI participant has been found to have had multiple hospital admissions, Root Cause Analysis meetings are convened to include the member's provider, TCLI staff, QM Director, and any other involved parties for the purpose of identifying precipitating factors leading to the member's crisis events and brainstorming ways in which the member can be better supported going forward. All such meetings are documented in the member's Electronic Health Record in Sandhills Center's information management system. In situations in which a member has been determined to have accessed any combination of 3 crisis services within the past 12 months (inpatient, ED, Mobile Crisis Team, Facility-Based Crisis) the member is assigned to a MHSA Licensed Care Coordinator who collaborates with the TCLI team to assist in connecting to traditional medically necessary services and to work with any existing provider to offer technical assistance regarding interventions, goals, and crisis plans to reduce crisis incidents.

e. ***Incidents of harm*** Providers are encouraged to notify TCLI staff of all incidents of harm involving TCLI members. These incidents are tracked and Root Cause Analysis meetings are convened to include the member's provider, TCLI staff, QM Director, and any other involved parties for the purpose of identifying precipitating factors leading to the member's self-harm behavior events and brainstorming ways in which the member can be better supported going forward.

f. ***Adult care home admissions and readmissions*** Clinical Treatment Team Meetings are held prior to any TCLI member returning to an adult care home. Once a member enters an ACH, Root Cause Analysis meetings are convened to include the member's provider, TCLI staff, QM Director, and any other involved parties for the purpose of identifying precipitating factors leading to the member's expressed desire to return to an ACH and brainstorming ways in which the

member can be better supported going forward in a way that they would want to continue living in the community. The admissions are tracked, Exit Interviews are completed, and the information is submitted to the State.

g. ***Employment; h. School attendance/enrollment***
TCLI staff engage with members during In-Reach, Transition Planning, and Post Transition Follow-Along activities regarding employment and education. Providers are encouraged to notify TCLI staff when members are employed or enrolled in school. (See attached[71] IPS-SE TCLI Engagement Process)

i. ***Community integration and engagement***
The vast majority of TCLI members participate in community life. This includes going to the park, gym, church, Walmart/grocery store, senior center, library, visiting friends/family members, as well as various other community activities of the members' choosing. During their transition meetings, the transition coordinators assist members in identifying their community-related interests and help to get them connected with these activities upon their transition. Ongoing engagement and participation in community life is the responsibility of the service provider to which TCLI members are connected. This topic may be revisited during a Clinical Team Meeting if it is determined that a member is having difficulties living independently due to issues related to social isolation, loneliness or not having meaningful activities in which to engage.

j. ***Natural supports network development and use of natural supports for crisis prevention and intervention:***
Natural supports are identified prior to and during the transition meetings. With the TCLI member's permission, natural supports are included in the participants' crisis plan as a contact during a potential crisis and to assist with any needed intervention be it as simple as talking with the individual during a crisis to calm and help de-escalate the crisis situation. Unfortunately, many TCLI members do not have natural supports for a variety of reasons. In such cases, TCLI staff and providers must work with the members to identify alternate supportive resources. This topic may be revisited during a Clinical Team Meeting if it is determined that a member is having difficulties living independently due to issues related to social isolation and loneliness.

k. ***Other personal outcomes the LME/MCO monitors:***
N/A

2. ***Describe how the LME/MCO uses personal outcomes data to determine, plan, and deliver the frequency and intensity of services needed to support individuals in community-based housing:***
TCLI supervisors communicate with Sandhills Center's Training Coordinator to identify areas of deficiency regarding service provision and any other identified training needs for Network providers in order to improve the quality of services provided to TCLI participants. Sandhills Center has collaborated with UNC Institute for Best Practices for the past four (4) years to provide various trainings as well as some training series for ACTT, CST, and IPS-SE providers. The focus this fiscal year was on trainings for IPS-SE providers, with one series specifically designed to assist providers in increasing their fidelity scores. In addition, in recent months TCLI staff have collaborated with our Network Operations department to develop a TCLI Provider Monitoring

[71] ibid

Review Tool, which includes the most important elements for maintaining members in their supportive housing arrangements in the community. It consists of 3 components: housing maintenance/stability, clinical, and employment. The implementation of this tool is still in the planning phase as the logistics are being defined.

3. ***Describe gaps and needs in the community-based mental health services provided to individuals in TCLI supportive housing. Discuss discrepancies between service capacity and service capacity requirements, and the sufficiency of services (array, intensity, frequency, quality, and effectiveness) as indicated by personal outcomes such as those listed above, not only access and choice standards***
   The vast majority of TCLI members are connected to either ACTT or CST services. For those who are not eligible for either ACTT or CST services, they are connected to TMS services. Also, TCLI participants are stepped down to TMS services once they no longer meet medical necessity for CST services. Other behavioral health services received are: Psychosocial Rehabilitation, Peer Support Services, Individual Supports, IPS-Supported Employment, Individual Psychotherapy, and Medication Management. At this time, the ACTT provider covering five (5) of Sandhills Center's rural counties (Richmond, Anson, Montgomery, Moore, Hoke) oftentimes has a waitlist. Care Coordination has been in communication with the Network Operations Director to assist in communicating with this provider to inquire about adding another team to meet the current demand. In addition, although there are sufficient CST providers in the Network, some are not accepting referrals at this time, which then makes the service unavailable to our members. This concern has also been brought to the attention of the Network Operations Director who is looking into this issue further.

4. ***Describe obstacles and barriers as well as recent initiatives to address gaps in the array, intensity, quality, and effectiveness of community-based mental health services provided to individuals in supportive housing.***
   In recent months TCLI staff have collaborated with our Network Operations department to develop a TCLI Provider Monitoring Review Tool, which includes the most important elements for maintaining members in their supportive housing arrangements in the community. It consists of three (3) components: housing maintenance/stability, clinical, and employment. The implementation of this tool is still in the planning phase as the logistics are being defined. Also, Sandhills Center met with DHHS staff to discuss and develop a strategy for supporting one of our IPS-SE provider's resolve the challenges they are experiencing in the provision of IPS-SE services. We hope this issue will be resolved in the near future.

D. ***Crisis Services: See below for responses to questions 1-3-no changes from FY19-20 report***
   1. ***Describe the network adequacy and sufficiency of the LME/MCO crisis service system including:***
      a. ***The service array and geographic availability,***
      b. ***The sufficiency to offer timely services of adequate intensity to individuals experiencing a behavioral health crisis,***
      c. ***The extent to which services are provided in the least restrictive setting, consistent with an already developed individual community-based crisis plan or in a manner that develops such a plan as a result, and***
      d. ***The effectiveness of crisis services for preventing unnecessary hospitalization, incarceration, or institutionalization.***
   2. ***Describe gaps and needs in the crisis service system. Discuss discrepancies between service capacity and capacity requirements, and the sufficiency of services (capacity, array, quality, and effectiveness), not only access and choice standards.***
   3. ***Describe obstacles and barriers as well as recent initiatives to address identified gaps related***

to crisis service availability, delivery, quality, and effectiveness.

Sandhills Center's crisis continuum includes services, providers, and stakeholder collaborations that offers adequate crisis intervention coverage for members in the Transitions to Community Living program. Across the service area Sandhills Center offers Mobile Crisis Management, enhanced service providers that act as first responders to their members, default crisis providers, and hospital emergency departments within 30 miles and /or 45 minutes of all members residing in the service area.

Sandhills Center engages regularly with stakeholders that work in collaboration with the Center and its crisis providers. To ensure ongoing engagement and transparency between the Center, providers, and stakeholders, Sandhills Center facilitates regularly scheduled crisis collaborative meetings in Anson, Guilford, Harnett, Lee, Randolph, and Richmond counties. Additionally an emergency crisis services meeting that includes Call Center operations, an after-hours assessment team and, representatives from the counties where a collaborative is not established convenes quarterly at the Center.

A comprehensive Community Crisis Services Plan was developed in 2019/2020 at the behest of the NC Division of Mental Health. The Local Sheriff's Departments, local law enforcement agencies, hospital emergency departments, magistrate's offices, mobile crisis management teams, and default crisis and outpatient providers were included in the process. The development of the community crisis services plan enhanced the transparency and systemic expectations among members of the continuum.

The majority of TCLI members have Medicaid funding. Approximately 50% of TCLI members receive ACTT services. Daymark Recovery Services is contracted to provide ACTT coverage in Anson, Harnett, Hoke, Lee, Randolph, Montgomery, and Moore Counties. Easter Seals is operating out of Harnett County, and three (3) other ACTT Teams are operating out of Guilford County offering coverage in Guilford and Randolph County. ACTT service providers are "first responders" and are available 24/7. The service includes crisis response and the development of a crisis management plan with TCLI recipients.

Sandhills Center meets 100% access standard for ACTT services. In addition to the ACTT services referenced above, additional services available during crisis situations include:

- Walk-In Crisis Units in all nine (9) counties of the catchment area.
- Mobile Crisis coverage across the catchment area.
- Emergency Department coverage.
- Inpatient hospitalization
- Transition Management Services that include personal crisis management and relapse prevention plans for TCLI members and,
- Community Support Team services.

A Walk-In Crisis Unit is open 24/7 in Guilford County and is available 8:00 am – 5:00 pm in the remaining eight (8) counties of the catchment area. Mobile Crisis response to a crisis in the community is available for a face-to-face assessment within 2 hours of the initial screening call and the mobile crisis team makes referrals and facilitates 911 transport to Emergency Departments and hospitals as needed.

Emergency Department and inpatient coverage is available 24/7. 23- Hour Behavioral Health "chairs" will be available in the Sandhills Center service area in two (2) locations within the next several months.

Sandhills Center contracts with three (3) hospitals within our service area that offer inpatient psychiatric treatment. Inpatient admissions are available outside of the service area with contracted providers that offer easy access for members throughout the service area.
Sandhills members also are admitted to state hospitals as deemed appropriate. Transition Management Services that include personal crisis management and relapse prevention plans for TCLI members is a service option for the target population.

Community Support Team (CST) services are available 24/7, and this service includes crisis management, crisis planning, and prevention. Sandhills Center meets 100% access standard for CST services.

TCLI members receiving an enhanced service have a crisis plan to be followed when the member is experiencing a crisis situation. Daymark is contracted to provide Walk-In/Crisis Units in Anson, Harnett, Hoke, Lee, Montgomery, Randolph, and Richmond Counties. RHA Behavioral Services and Cone Health are contracted to provide Walk-In/Crisis Units in Guilford County. Therapeutic Alternatives provides Mobile Crisis services in all of Sandhills Center's nine (9) counties. There are currently no obstacles or barriers related to crisis services available to TCLI members. With regards to access and availability, 100% of Sandhills Center members (both Medicaid and IPRS funded) have easy access to at least two (2) providers in the catchment area for crisis services for adults.

Children with Complex Needs

"Children with Complex Needs" (CWCN) are defined as Medicaid eligible children ages 5 to 21 with a developmental disability (including Intellectual Disability and Autism Spectrum Disorder) and a mental health disorder, who are at risk of not being able to enter or remain in a community setting due to behaviors that present a substantial risk of harm to the child or to others.

A. Identification & Engagement

1. ***Describe service gaps and needs to identify and link CWCN to appropriate levels of service.*** There continues to be a need for programs developed specifically for the dually diagnosed child with mental health diagnoses and intellectual/developmental disability. There is also a need for programs that have been modified for delivery to this population with evidence-based research that validate these modifications are effective for the population. Many of the identified "Children with Complex Needs" (CWCN) have recommendations for therapy, enhanced services and residential treatment that is available to children with mental health diagnoses, but with very few programs developed or modified for the dually diagnosed child. Three (3) issues occur causing denials of their applications to mental health programs:
    a. The current milieu in the placement is not appropriate for the child;
    b. The treatment is not evidence based for the child's dual diagnoses;
    c. There is minimal training and experience for the dual diagnosed needs of the child.

Individuals with developmental disabilities are at a higher risk of experiencing trauma and then later being re-traumatized through the response they receive to the problematic behavior they have

SECTION FOUR: SPECIAL POPULATIONS

Transitions to Community Living

Community-based Supported Housing Slots

How does the TCL team identify and engage eligible individuals in the Transitions to Community Living (TCL) priority population?

Vaya's TCL team provides In Reach to eligible individuals in the community. This includes individuals who have been identified via the Referral, Screening, Verification Process (RSVP), the DHHS In Reach list, and by a State Psychiatric Hospital. Since 2018, Vaya has employed a TCL community liaison who works in the community, hospitals, and county Departments of Social Services (DSS) and with other providers and stakeholders to provide education about TCL and the RSVP process. The TCL community liaison provides training and resources to community hospitals, legal guardians, ombudsmen, service providers and county DSS agencies to help identify individuals who may be eligible for TCL. Vaya's Call Center staff screen RSVP referrals and work with the TCL team to identify TCL eligible individuals. TCL in-reach and diversion staff notify eligible individuals, offer options counseling, and develop an individualized Community Integration Plan.

How does the TCL team provide access and transition individuals to community-based supported housing?

For SFY 20-21, TCL housed over 120 people in the community with tenancy supports. TCL works in collaboration with Vaya's Housing, Member Services and Provider Network Operations departments, as well as DHHS Regional Housing Coordinators, to help identify the housing inventory available in each county. Each TCL participant who agrees to move forward with transition planning receives a Comprehensive Clinical Assessment (CCA) to help identify necessary services to maintain supported housing in the community. Every TCL participant transitions into supported independent living with a tenancy support service in place.

How does the TCL team ensure an individual is transitioned within 90 days of assignment to a transition team?

During the transition planning process, barriers to housing are identified and addressed to help promote a smooth transition into housing within 90 days. Staff help resolve past issues such as late fees or when applicable, write letters requesting reasonable accommodation. schedule utilities, help purchase household items, and coordinate the lease signing and move in date. In SFY 20-21, 88% of individuals transitioned within 90 days.

How does the TCL team support individuals' housing tenure and ability to maintain supportive community-based housing?

Our transition coordinators ensure that each participant receives tenancy support services while in TCL supported living by requesting monthly updates from providers. To help maintain community-based housing tenure, TCL collaborates with the tenancy support provider and the rest of the transition team to support an individualized person-centered plan, regular team meetings to evaluate goal progress, and necessary plan updates that collectively promote timely, meaningful support for the individual throughout their tenancy.

IPS-Supported Employment

How does the TCL team ensure network adequacy of IPS-Supported Employment services?

Vaya has worked with our network of providers to develop IPS-Supported Employment across our region:

- RHA Health Services – Contracted to serve Buncombe and McDowell counties
- Family Preservation Services – Contracted to serve Buncombe, Henderson, and Polk counties
- Meridian – Contracted to serve Haywood, Jackson, Macon, Graham, Cherokee, Clay, Transylvania, and Swain counties
- Daymark – Contracted to serve Alleghany, Ashe, Avery, Watauga, and Wilkes counties
- Appalachian Community Services – Contracted to serve Graham, Cherokee, Transylvania, and Clay counties

If a waitlist occurs with any provider, TCL participants are placed at the top of the waitlist for the team serving that county and will get the first available opening.

What are the obstacles and barriers that the TCL team has encountered as well as recent activities and projects to engage and refer individuals in the TCL priority population?

Barriers include private and paid guardians' lack of understanding about the TCL process and available wrap-around supports and concerns about the risks of independent living for their ward. Other barriers include lack of available housing stock in desired counties and insufficient natural supports for individuals in communities.

Community-Based Mental Health Services

What is the array and intensity of community-based mental health services provided to individuals living in supportive housing?

Based on the recommendations of their Comprehensive Clinical Assessment (CCA), TCL participants can access Assertive Community Treatment (ACT), Community Support Team (CST), Transition Management Services (TMS), Peer Supports, Outpatient Therapy, Medication Management, Psychosocial Rehabilitation (PSR), Group Therapy, Substance Abuse Intensive Outpatient Program (SAIOP) and IPS-SE. The Crisis Service Continuum is also available 24/7. Available service frequency ranges from daily to monthly.

How does the TCL team provide supportive housing tenure and maintenance of chosen living arrangement?

TCL participants receive ongoing tenancy supports when housed. Tenancy support providers provide TCL with a monthly update on each housed member. Based on the update, the provider and TCL proactively address potential issues to promote continued housing. TCL participants can access funds for housing-related expenses, which if not resolved, will result in the individual being unable to maintain housing.

How does the TCL team support members after hospital, adult care home, or inpatient psychiatric facility admissions?

If a TCL participant is admitted to a hospital, adult care home, or inpatient psychiatric facility, our team collaborates with the transition team to orchestrate the individual's return to supported living, if that is the desire of the participant. The transition team includes care management (Acute Response/MHSU), tenancy support provider, guardian, transition coordinator, and natural supports. If the participant is inpatient and desires to return to their home, the TCL team works to maintain the home by ensuring that necessary bills are paid and tenancy is maintained during the stabilization period. If the participant returns to a care home, then TCL resumes in reach.

How does the TCL team address the use of crisis beds and community hospital admissions?

TCL encourages individuals to reach out to their behavioral health provider and follow their crisis plan. When individuals are admitted to crisis beds or community hospitals, TCL ensures that rent is kept up to date and can access emergency funding for other needs that will help maintain housing.

How does the TCL team address emergency room visits?

When a participant utilizes the ED, TCL staff reach out to the participant's provider to inform and request that the TCL participant connects with their medical home. The provider is instructed to contact TCL if housing is at risk so that a plan can be developed.

How does the TCL team address incidents of harm?

If there are incidents of harm, TCL ensures the member contacts their behavioral health and medical providers. If stabilization needs to occur outside of the home, TCL coordinates maintaining the home and lease in conjunction with the tenancy support provider.

How does the TCL team address time spent in congregate day programming?

TCL promotes connecting or reconnecting a participant with natural and paid supports. TCL works to identify and pair the individual with community engagements that match their interests. Participants can take advantage of Psychosocial Rehabilitation, Peer Living Rooms, as well as other community resources.

How does the TCL team address employment?

Each TCL participant is presented with information about IPS-SE and the value it may bring to their life. TCL connects individuals who express a desire to volunteer, pursue education or work with an IPS-SE provider in their local community who will help them gain meaningful employment, volunteer work or education.

How does the TCL team address school enrollment and attendance?

When TCL participants express a desire to pursue further education their Tenancy Support provider is notified and will support them in enrollment and attendance. Educational goals are included in the person-centered plan.

How does the TCL team address engagement in community life?

TCL encourages and helps the provider link the participant to community resources based on the participant's interests, which are listed on their community integration plan. TCL promotes connecting or reconnecting a participant with natural and paid supports. Often, participants take advantage of IPS-SE, Peer Living Rooms, connecting with faith communities, volunteer work, as well as other community resources.

What gaps and needs exist in community-based mental health services provided to individuals in community-based supportive housing?

There are continued gaps in services for our most rural counties, which limit service choice. Rural counties with small populations may only support having either a CST or ACT team. Vaya's TCL team is working in conjunction with Vaya's Provider Network team to strengthen service array in all counties. Other barriers include access to transportation and accessing dentists who accept Medicaid.

Describe the obstacles and barriers as well as recent activities and projects to address gaps in the array, intensity, and sufficiency of services for the TCL population.

The North Carolina Collaborative for Ongoing Recovery through Employment (NC CORE) Pilot was started to overcome the challenges of delivering IPS-SE entirely through the Medicaid fee-for-service modality. NC CORE braids funding from Vaya and the Division of Vocational Rehabilitation (DVR) as members reach milestones built into IPS-SE. This has proven to be a financially sustainable model that has stabilized IPS-SE provider-based teams. As of Apr. 1, 2021, 187 members were receiving IPS-SE in the Vaya catchment.

Crisis Services

Describe the availability and array of crisis service system.

In coordination with RHA, Meridian, FPS, Daymark and ACS, we support 26 comprehensive care walk-in centers, which provide crisis prevention, early intervention, response, and stabilization services and supports as an alternative to emergency department visits or institutionalization. Services are provided based on triage protocols for emergent, urgent, and routine needs. Comprehensive care center practices are based on a trauma-informed, recovery-oriented system of care and may include:

- Mobile Crisis Management (MCM), Assertive Community Treatment Team (ACTT) and Community Support Teams (CST) that dispatch for all ages, behavioral health and IDD needs. This service is available to any individual regardless of Medicaid status and is available 24/7. Vaya meets the 100% benchmark for MCM, ACTT, and CST by offering a choice of at least two provider agencies within the MCO catchment area.
- Facility-based Crisis (FBC) for adults and children with behavioral health, substance use, and intellectual and developmental disability needs. This service is available 24/7 to any Vaya beneficiary. There are four FBCs serving adults in the Vaya catchment: The Neil Dobbins Center (C3356) in Buncombe County (16 bed capacity), Caldwell C3 Comprehensive Care Center in Caldwell County (16 bed capacity), The Balsam Center in Haywood County (16 bed capacity), and Synergy Recovery at the Shirley B. Randleman Center in Wilkes County (12 bed capacity). Vaya meets the 100% benchmark for FBC by offering a choice of at least one provider agency within the MCO catchment area.
- Outpatient Behavioral Health Services. These services are available throughout the week, with enhanced service (CST, ACTT, SAIOP, etc.) providers having 24/7 on call staff available for any crisis that may emerge.
- Assessment and diagnosis for mental health, substance abuse, and/or intellectual/developmental disability issues as well as crisis planning and referral for future treatment. Members can walk into any comprehensive provider Monday through Friday during normal business hours to receive an assessment.
- Medication management is available Monday through Friday during normal business hours and can be accessed through enhanced services (ACTT, CST, etc.) for any crisis or PRN need 24/7.
- The Peer Living Room at C3356 is open from 8 a.m. to 6 p.m., Monday through Friday, with a maximum capacity of 20 participants at any time.
- Recovery Education Centers are available Monday through Friday in Haywood, Jackson, Macon, and Transylvania counties.

Describe least restrictive setting and consistency with individual crisis plans.

Each TCL participant has a comprehensive community-based crisis plan. The Vaya Health TCL team works closely with the member and providers of tenancy supports to create these plans. The principles of recovery, housing first, employment first, person-centered practice, and full community inclusion, guide the implementation of the crisis plan. Each TCL participant has wraparound services and supports in place (e.g., Individual Supports, IPS-SE, PSR, Peer Supports, ACTT, Transition Management Services, MCM, Home Health, Primary Care Physician, etc.). These services are in place to help prevent unnecessary hospitalizations, incarceration, or institutionalization. Providers of these services follow the crisis plan to help ensure that the member can continue in the least restrictive setting. Providers strive to provide crisis response in the home or community. If a higher level of care is needed, the member can use a non-inpatient facility, such as Facility-based Crisis, to avoid unnecessary hospitalization, incarceration, or institutionalization.

What are the obstacles and barriers to crisis service availability and what are the recent activities and projects to address these gaps?

At times, TCL participants go to Emergency Departments when lower levels of care could be appropriate. Vaya is working to address this by providing education about our FBC centers and encouraging providers to show members these facilities. ACS in Haywood, RHA in Buncombe, Caldwell and the Daymark Child Facility Based Crisis units are designated as IVC drop off locations. Vaya is actively working with Synergy FBC to ensure that this facility becomes a designated involuntary commitment (IVC) drop off location. FBCs also help members receive care in the least restrictive setting.

In 2017, Vaya Health was selected to lead a pilot project that focused on addressing social determinants of health that contribute to high ED and hospital inpatient utilization. The pilot has been in operation since 2017. At times, TCL participants present to Mission Health ED with a primary behavioral health concern and become a part of the project. A collaborative effort among Vaya, RHA and Mission Hospital, the project – called the Comprehensive Case Management (CCM) for Adults with Mental Health Treatment and Substance Use Disorder Treatment needs – places staff in the ED to provide immediate linkage to services, as well as case management services post discharge. Following discharge, Vaya care managers link individuals to community supports that can prevent future ED visits and potential institutional placements. The pilot is currently funded through SFY 2022. Using pre and post admission data, ED utilization decreases over 40% and inpatient utilization decreases over 50% for individuals engaged in the program.

Describe how TCL operated during the COVID pandemic and any accomplishments over the past year.

As the COVID-19 pandemic escalated in the spring of 2020, TCL staff quickly adapted business processes, allowing work which typically was conducted face to face to occur virtually. Vaya provided participants smartphones to maintain communication with TCL during shelter-in-place and stay-at-home orders and utilized virtual meeting platforms to conduct care plan and team meetings. Despite Adult Care Homes (ACHs) being closed to outside visitors for many months, TCL continued to transition members out of these facilities by working with tenancy support providers, local housing resources, and DHHS to facilitate lease signings and documentation completion for members living in ACH/FCH settings. As front-line workers, TCL staff worked in the community to complete necessary functions such as lease signings, shopping for household goods, and to help on move-in days. Vaya TCL is proud to have helped transition over 120 members into permanent supported housing during SFY 2021.

Minimum Standards for Permanent Housing

Instructions: Place a check mark in the correct column to indicate whether the property is approved or deficient with respect to each standard. The property must meet all standards in order to be approved. A copy of this checklist should be placed in the client file.

Approved	Deficient	Standard *(24 CFR part 576.403(c))*
		1. *Structure and materials*: The structure is structurally sound to protect the residents from the elements and not pose any threat to the health and safety of the residents.
		2. *Space and security*: Each resident is provided adequate space and security for themselves and their belongings. Each resident is provided an acceptable place to sleep.
		3. *Interior air quality*: Each room or space has a natural or mechanical means of ventilation. The interior air is free of pollutants at a level that might threaten or harm the health of residents.
		4. *Water Supply*: The water supply is free from contamination.
		5. *Sanitary Facilities*: Residents have access to sufficient sanitary facilities that are in proper operating condition, are private, and are adequate for personal cleanliness and the disposal of human waste.
		6. *Thermal environment*: The housing has any necessary heating/cooling facilities in proper operating condition.
		7. *Illumination and electricity*: The structure has adequate natural or artificial illumination to permit normal indoor activities and support health and safety. There are sufficient electrical sources to permit the safe use of electrical appliances in the structure.
		8. *Food preparation*: All food preparation areas contain suitable space and equipment to store, prepare, and serve food in a safe and sanitary manner.
		9. *Sanitary condition*: The housing is maintained in sanitary condition.
		10. *Fire safety*: a. There is a second means of exiting the building in the event of fire or other emergency. b. The unit includes at least one battery-operated or hard-wired smoke detector, in proper working condition, on each occupied level of the unit. Smoke detectors are located, to the extent practicable, in a hallway adjacent to a bedroom. c. If the unit is occupied by hearing-impaired persons, smoke detectors have an alarm system designed for hearing-impaired persons in each bedroom occupied by a hearing-impaired person. d. The public areas are equipped with a sufficient number, but not less than one for each area, of battery-operated or hard-wired smoke detectors. Public areas include, but are not limited to, laundry rooms, day care centers, hallways, stairwells, and other common areas.
		11. Meets additional recipient/subrecipient standards (if any).

CERTIFICATION STATEMENT

I certify that I have evaluated the property located at the address below to the best of my ability and find the following:

Minimum Standards for Permanent Housing

Instructions: Place a check mark in the correct column to indicate whether the property is approved or deficient with respect to each standard. The property must meet all standards in order to be approved. A copy of this checklist should be placed in the client file.

☐ Property meets all of the above standards.

☐ Property does not meet all of the above standards.

COMMENTS:

LME-MCO Name: _____

TCLV Participant Name: _____

Street Address: _____

Apartment: _____

City: _____ State: _____ Zip: _____

Evaluator Signature: _____

Date of review: _____

Evaluator Name: _____

Approving Official Signature (if applicable): _____

Date: _____

Approving Official Name (if applicable): _____