North Carolina

Transitions to Community Living Initiative

Annual Report for State Fiscal Year 2016

July 1, 2015 – June 30, 2016

Vision Statement

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

DHHS is pleased to present the third annual report for the Transitions to Community Living Initiative (TCLI). Implementation of a comprehensive services system inclusive of TCLI continues to be the main focus for meeting the requirements of the Department of Justice settlement. Some of the accomplishments from the last year include:

- **Provided supportive housing to 334 new individuals in SFY 2015-2016**, bringing the total to 853 individuals since the beginning of TCLI.
- **Funded 10 new Individual Placement and Support – Supportive Employment (IPS-SE) teams and expanded eight teams.**
- **Nine new teams of IPS-SE have reached fidelity this fiscal year**, bringing the total to 22 teams
- **Providing quality Supported Employment (SE) services to 2,089 individuals, of which, 1,755 individuals were served by teams that met IPS-SE fidelity.** Of the 1,755 receiving IPS-SE fidelity services, 708 individuals meet the definition of in or at risk of entry into an Adult Care Home (ACH).
- **Tenancy Supports is now a state-funded service** and the state has committed to developing a similar Medicaid service.
- **Diverted 139 individuals from entry to an ACH.**

Lives Transformed: Comments from Participants in the Transitions to Community Living Initiative

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

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

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

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

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

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

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

1. LME/MCO Totals for Start of SFY2015-16

LME/MCO	In-reach Planning	Transition Planning	Housed	PASRR Screenings Processed	S.E. Total/ In or At Risk/ Teams	ACT Total/ Teams
Alliance Behavioral Healthcare	362	48	46	831	227/64/2	856/10
Cardinal Innovations	713	32	89	1172	99/63/3	796/15
CenterPoint Human Services	180	14	43	290	28/0/0	274/4
Coastal Care	156	24	69	274	85/75/1	43/5
East Carolina Behavioral Health	458	21	35	737	132/12/3	59/2
Eastpointe	245	18	59	426	88/20/3	434/7
Partners Behavioral Health Mgmt.	368	26	40	617	14/0/0	/16780
Sandhills Center	287	22	72	452	48/0/0	416/6
Smoky Mountain Center	551	23	66	882	314/54/1	1108/18
Total	**3320**	**228**	**519**	**5681**	**1035/288/13**	**5054/77**

2. LME/MCO Totals for End of SFY2015-16

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

NOTE: For reporting purposes, there are places in this report where:

- *CenterPoint Human Services is referenced. They are now part of Cardinal Innovations Healthcare.*
- *CoastalCare and East Carolina Behavioral Health are referenced. They merged to become Trillium Health Resources.*

3. LME/MCO Supported Employment Totals for End of SFY 2015-16

LME/MCO	Fidelity S.E. Teams	Teams Working Towards Fidelity	Total Served by Fidelity Teams	Total Served by all teams	Total Served by Fidelity Teams that are in the Priority Population
Alliance Behavioral Healthcare	4	2	349	387	176
Cardinal Innovations	3	1	205	232	142
CenterPoint Human Services	1	1	134	161	77
Eastpointe	4	0	199	199	30
Partners Behavioral Health Mgmt	1	2	66	178	4
Sandhills Center	2	1	110	172	25
Smoky Mountain Center	2	0	445	445	69
Trillium	5	2	247	315	185
Total	**22**	**9**	**1755**	**2089**	**708**

Community Based Mental Health Services

Summary

North Carolina continues to make progress towards fulfilling the promise of TCLI. Our focus continues to be ensuring that our adult mental health service array is person-centered, infused with recovery oriented practices and a community focus. We will continue to broaden our efforts to re-shape the adult mental health service array. Our goal is that all levels of service delivery (from providers, to Local Management Entity-Managed Care Organization (LME-MCO) staff, to state agencies) provide adults with serious mental illness (SMI) access to services that support them in living, working and thriving in the community of their choice.

Assertive Community Treatment (ACT)

In SFY15-16, 41 Tools for Measurement of Assertive Community Treatment (TMACT)s were completed. All were second TMACTs completed on teams that scored at least provisional certification. The table below shows the significant shift in practice between first and second TMACT evaluations:

4. TMACT EVALUATIONS COMPLETED IN SFY 2015-16

Certification Level	Team Score at Baseline Evaluation	Team Score at Second Evaluation	Percent increase/decrease
Full Certification	13	26	50%
Moderate-High Provisional	18	9	50%
Low Provisional	10	3	33%

At the time of this report, three TMACTs were in the process of having consensus calls and do not have final scores. Twelve ACT teams had TMACT rating increases of 0.4, and four teams increased their score by between 0.6 and 0.8, which is a significant shift in practice.

State-level areas of training focus continue to be:

- Implementation of evidence based practices (which includes: integrated dual disorders treatment, IPS-SE, wellness recovery action planning, psychiatric rehabilitation, family psychoeducational and wellness management and recovery)
- Person-centered planning
- Organization and structure (which includes: daily team meeting organization, team scheduling and linking the person-centered plan (PCP) to scheduling)
- Assertive engagement
- Assessments (which includes: integrating mental health and substance use, being comprehensive and ongoing, and directly influencing the treatment provided)

DHHS sponsored and/or facilitated the following trainings during SFY 2015-2016 that focused on quality improvement for Adult Mental Health (AMH) services:

- Integrated Dual Disorder Treatment (IDDT) training kick-off event (9/21/15, Lenoir and 9/30/15, Raleigh)- facilitated Case Western University, open to LME-MCO staff and ACT providers, focus was to build foundation and motivation to improve IDDT services provided by ACT teams
- Tenancy support training (December 2015, February 2016, April 2016, June 2016)- facilitated by NC ACT Technical Assistance Collaborative (TAC) staff, focus was to increase the provision of tenancy supports/psychiatric rehabilitation services provided by both tenancy support teams and ACT teams.
- IDDT Training (2/1/16-2/2/16, Greensboro)- facilitated by Case Western University, focused on working with ACT providers to develop and improve IDDT service delivery
- TMACT Evaluator Summit (3/3/16-3/4/16, Greensboro)- facilitated by NC ACT TAC, focus is to bring all current lead and second TMACT evaluators together, review data trends, provide technical assistance and training on scoring criteria, and obtain feedback on TMACT implementation across the state

- Mental Health and Substance Use 101 training/Crisis Response Training (4/14/16, Raleigh)- developed and facilitated by DHHS AMH staff, focus on entry level mental health professionals for the training to increase understanding of recovery and wellness, Crisis Response Training to focus on increasing knowledge of screening for crisis/suicidal ideation using current evidence based assessments, identifying crisis responsibilities for different levels of community based AMH services
- Person-centered planning for mental health/co-occurring substance use (5/25/16, Greensboro and 5/26/16, Raleigh), focus was exposing both LME-MCO Utilization Management (UM) staff and comprehensive service providers to best practices for AMH/substance use treatment planning. This face-to-face training was preceded by a webinar for LME-MCO staff to discuss their issues and concerns regarding person-centered planning
- IDDT and person-centered planning (6/14/16, Greensboro)-, focus was providing training for LME-MCO staff on how person-centered planning can be done in a way that aligns with IDDT to best support individuals with co-occurring mental health and substance use disorders.

Additionally, NC ACT TAC Consultant and Trainer, Stacy L. Smith, recently became a member of the Motivational Interviewing Network of Trainers (MINT), and has facilitated motivational interviewing trainings with all of the Monarch ACT teams, a training at Alliance LME-MCO (roughly 30 participants representing six teams) and CenterPoint LME-MCO (representation from roughly five ACT teams.)

The ACT training audit tool has been developed to ensure that ACT trainings required by policy meet NC DHHS standards in that they provide information that supports the implementation of high fidelity ACT services. The ACT Training Audit Tool has been reviewed and an implementation plan is in development.

DHHS will continue to address both completion of second/subsequent TMACT fidelity evaluations, completing initial TMACT evaluations on new ACT teams, and continuing to ensure that ACT teams and LME-MCOs have access to training, technical assistance, and learning communities/collaboratives. This will provide LME-MCOs the resources needed to continue to improve quality and improve their fidelity to the model, focus on tenancy supports and supportive employment quality improvements, support recovery and facilitate community integration for adults with severe mental illness.

Supported Employment (SE)

North Carolina has three teams that scored 100 or higher on their most recent fidelity evaluation. One of these teams scored 68 on their first fidelity evaluation and raised their score to 108. This was largely due to intensive technical assistance provided to that specific team by state staff. As a result, we have added five IPS-SE Consultant and Trainer positions to the NC ACT TAC contract to increase the provision of technical assistance to teams.

The IPS-SE Consultant and trainers will be located across the state (two in the east, one in the central region, and two in the west) and will be paired with no more than five IPS-SE teams. They will provide both on-site and virtual training and technical assistance to the IPS-SE model. Higher fidelity scores have resulted in improved outcomes, with IPS-SE teams scoring over 100 (114 is currently the highest score), having more than 40 percent competitive employment rate. Teams scoring in the low fair range (75-80) trend toward more than a 20 percent competitive employment rate.

At this time, 33 teams are providing IPS-SE services across the state. DHHS expects this number to increase. All LME-MCOs recently received allocations to support the development of one or two new IPS-SE teams in their network and to expand at least one existing IPS-SE team.

LME-MCOs are in the process of identifying the teams to receive start-up and expansion funds. The current state-wide capacity is roughly 6,600 individuals (assuming each team pushes to reach the currently identified maximum of 200 individuals receiving services).

Data shows that LME-MCO staff, along with providers, continue to need and benefit from systematic training addressing conversations around employment. The state will continue to identify and provide training and technical support that addresses readiness criteria. That will shift the concept of work from an exception to the expectation for adults with mental illness.

An area of training focus for SFY 2016-2017 will be increasing knowledge and understanding of the IPS-SE model to LME-MCO in-reach staff. Training will also address how employment and housing can support both recovery goals. After the training is complete, DHHS will track the number of individuals working with in-reach staff who also have employment goals on their transition plans or person-centered plans.

In-reach is an engagement, education and support effort designed to accurately and fully inform adults who have an SMI or a serious and persistent mental illness (SPMI) about community-based mental health services and supportive housing options. This includes, but not limited to, the availability of tenancy support services and rental assistance.

In SFY 2015-2016 trainings for SE included:

- Foundations of SE and recovery
- Employment peer mentor
- Benefits counseling for recovery
- Job development

North Carolina will continue collaboration with the Dartmouth Psychiatric Research Center, and participate in the Dartmouth Learning Collaborative. This collaboration will continue to provide funding, training and technical assistance to support the state in developing a sustainable infrastructure for the IPS-SE model. The Division of Vocational Rehabilitation (DVR) will partner with other divisions within the DHHS.

The state has five Dartmouth sites:

- University of North Carolina Center of Excellence in Community Mental Health in Carrboro/Pittsboro (Cardinal Innovations Healthcare)
- Meridian Behavioral Health in Sylva (Smoky Mountain LME-MCO)
- Easter Seals UCP in Wake (Alliance Behavioral Healthcare)
- RHA Howell in La Grange (Trillium Health Resources)
- Physicians' Alliance Behavioral Health in Wilmington (Trillium Health Resources)

Critical Time Intervention (CTI)

In 2014, DHHS began piloting Critical Time Intervention (CTI) with four LME-MCOs across the state. Funding was provided to:

- Phoenix House in Gastonia (Partners Behavioral Health Management)
- UNC in Chapel Hill/Carrboro (Cardinal Innovations Healthcare)
- Fellowship Health Resources in Fayetteville (Alliance Behavioral Healthcare)
- RHA in Greenville (Trillium Health Resources)
- Coastal Horizons (Trillium Health Resources)

State staff have received training from the model developers at the Silberman School of Social Work in New York and have started facilitating CTI trainings for providers.

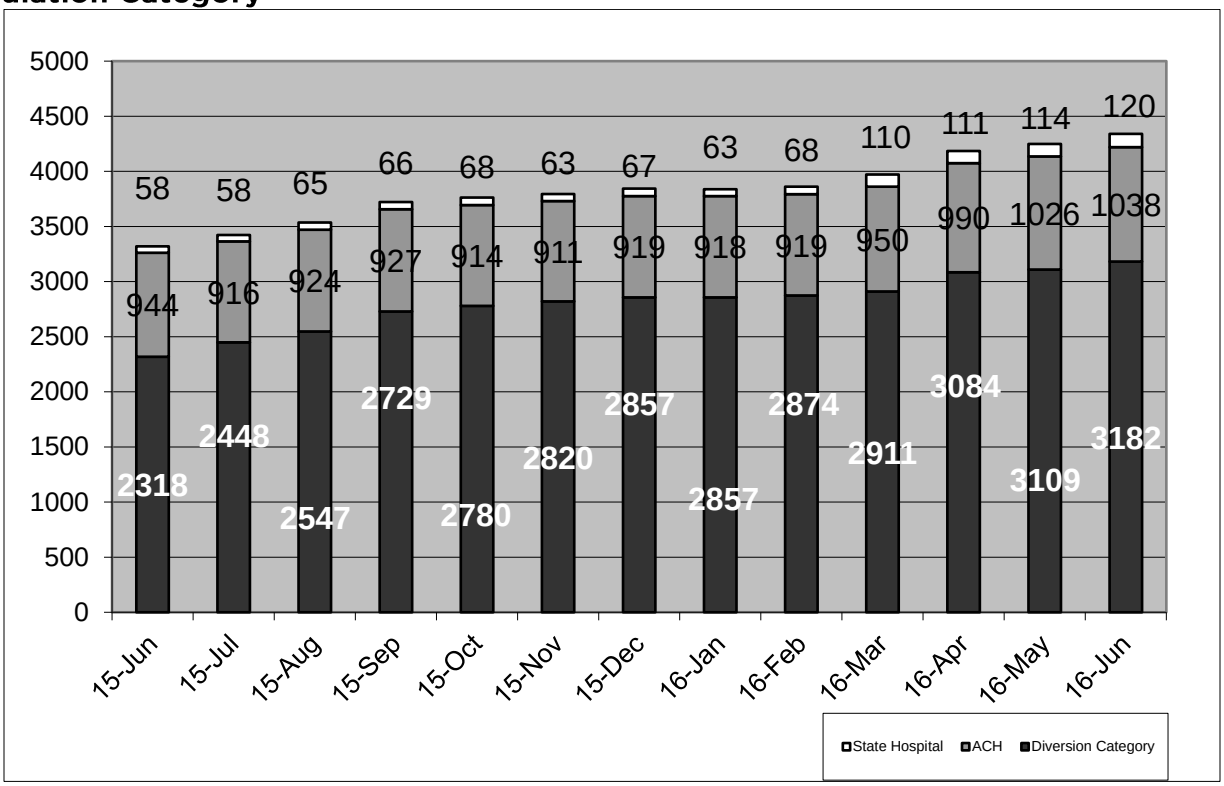
In SFY 2015-2016, funds were allocated through an Invitation to Apply for LME-MCOs to develop CTI teams that focus specifically on individuals who are part of TCLI. Funds were awarded to Easter Seals (Partners Behavioral Health Management), Carolina Outreach (Eastpointe) and Daymark (CenterPoint LME-MCO). These teams are required to work with individuals that are part of the priority population. We expect these teams to be operational and tracking outcome data by the beginning of SFY 2016-2017.

Tenancy Supports

Tenancy supports was redesigned as a behavioral health service called transition management services. This redesign has brought coordination of the service to the local MCOs and their community service providers. This also allows each LME-MCO better supervision of the service to assist individuals with their transition back to the community.

The LME-MCO has authority to contract with a qualified provider and obtain reports on the effectiveness of the service being provided. Quality management of the service should be greatly improved by bringing the service to the local systemresulting in improved consumer service. Several LME-MCO TCLI staff have already expressed satisfaction with this change.

Figure A: End of June 2016 Monthly Totals of Individuals in in-reach Status by Population Category



2015							2016					
June	*July*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Apr*	*May*	*Jun*
3320	3422	3536	3722	3762	3803	3843	3838	3861	3971	4185	4249	4340

This year, six trainings were provided to the Department of Social Services (DSS) guardians and private guardians contracted through Division of Aging and Adult Services (DAAS). Training targeted new guardians working within the system and provided education on aspects of working with individuals with mental illness. A review of the history of guardianship was conducted, explaining how it moved to the DSS system after the development of the LME network.

Trainers discussed recovery and how individuals with mental illness are best served to be successful living in the community. A detailed description of the supportive community housing model and review of housing were presented.

An LME-MCO also participated to supplement the training and reinforce the importance of services for the success of a transition to the community. The LME-MCO provided information on accessing services and addressed any concerns that the DSS system maybe experiencing in coordinating services with the LME-MCOs.

DHHS provided written guidance in December of 2015 regarding LME-MCO collaboration when an individual with SMI lives outside of thesponsible LME-MCO's catchment area or an individual with an approved housing slot requests to move to a county outside of the responsible LME-MCO's catchment area.

Guidance was provided through *Joint Communications Bulletin #J172 - New Procedure for In-Reach and Transitions across Different LME-MCOs*. The bulletin is available at: http://jtcommunicationbulletins.ncdhhs.gov/post/135252052959/j172-new-procedure-for-in-reach-and-transitions

The state has hired a new lead for in-reach who will focus on data integrity and ongoing quality improvement and support for staff in the LME-MCOs. DHHS will fund additional in-reach and Transition Coordinator positions at the LME-MCOs for this past fiscal year.

Total allocations for In-Reach staff are now 86 statewide and 97 for Transition Coordinators. LME-MCOs have initiated heavy recruitment for these positions during the past year. . It is DHHS's goal that these new positions will increase the number of individuals receiving in-reach in Adult Care Homes in the new fiscal year in SFY 2017.

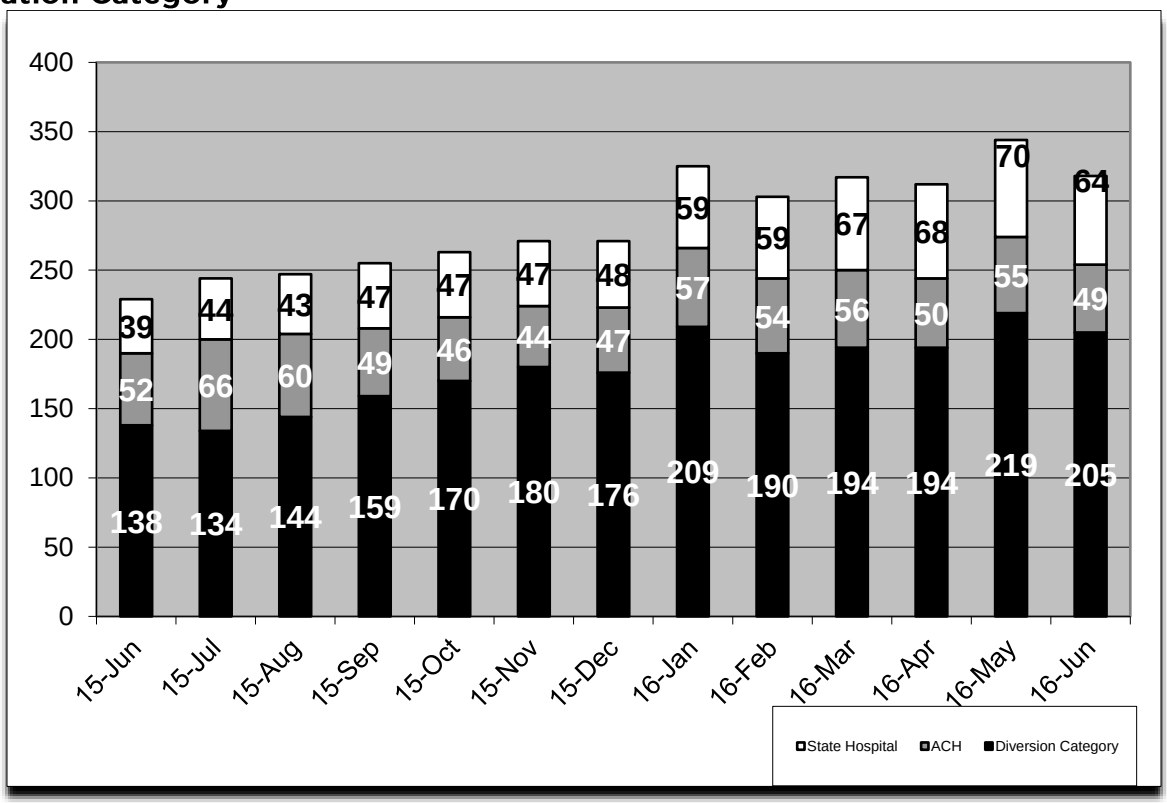
5. LME/MCO STAFFING

LME/MCO	Allocated FTE in-reach (effective 10/1/15)	Allocated FTE Transition Coordinators (effective 10/1/15)
Alliance	**9.64**	**12.0** (11 Medicaid and 1 State funded)
Cardinal	**15.28**	**17.0** (16 Medicaid and 1 State funded)
CenterPoint	**7.64**	**8.0** (7 Medicaid and 1 State funded)
Eastpointe	**7.64**	**9.0** (8 Medicaid and 1 State funded)
Partners	**7.64**	**9.0** (8 Medicaid and 1 State funded)
Sandhills	**7.64**	**9.0** (8 Medicaid and 1 State funded)
Smoky	**15.28**	**17.0** (16 Medicaid and 1 State funded)
Trillium	**15.28**	**16.0** (14 Medicaid and 2 State funded)

In SFY 2015-2016 there were more than 15,000 in-reach interventions. With the number of individuals requiring in-reach constantly on the rise, LME-MCOs developed a tiered system of in-reach in SFY 2015-2016, which follows the rules of the Settlement Agreement, but allows LME-MCOs to focus in-reach on individuals who seem most interested.

In SFY 2016-2017 it is DHHS's goal to have more in-reach visits for individuals in population categories 1-3. DHHS is developing methods to increase the percentage of individuals who agree to in-reach. Additionally, in SFY 2016-2017 DHHS will encourage LME-MCOs to have housing slots available immediately for individuals that agree to in-reach.

Figure B: End of June 2016 Monthly Totals of Individuals in Transition Status by Population Category



2015							2016					
June	*July*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Apr*	*May*	*Jun*
217	244	247	255	263	271	271	325	303	317	312	344	336

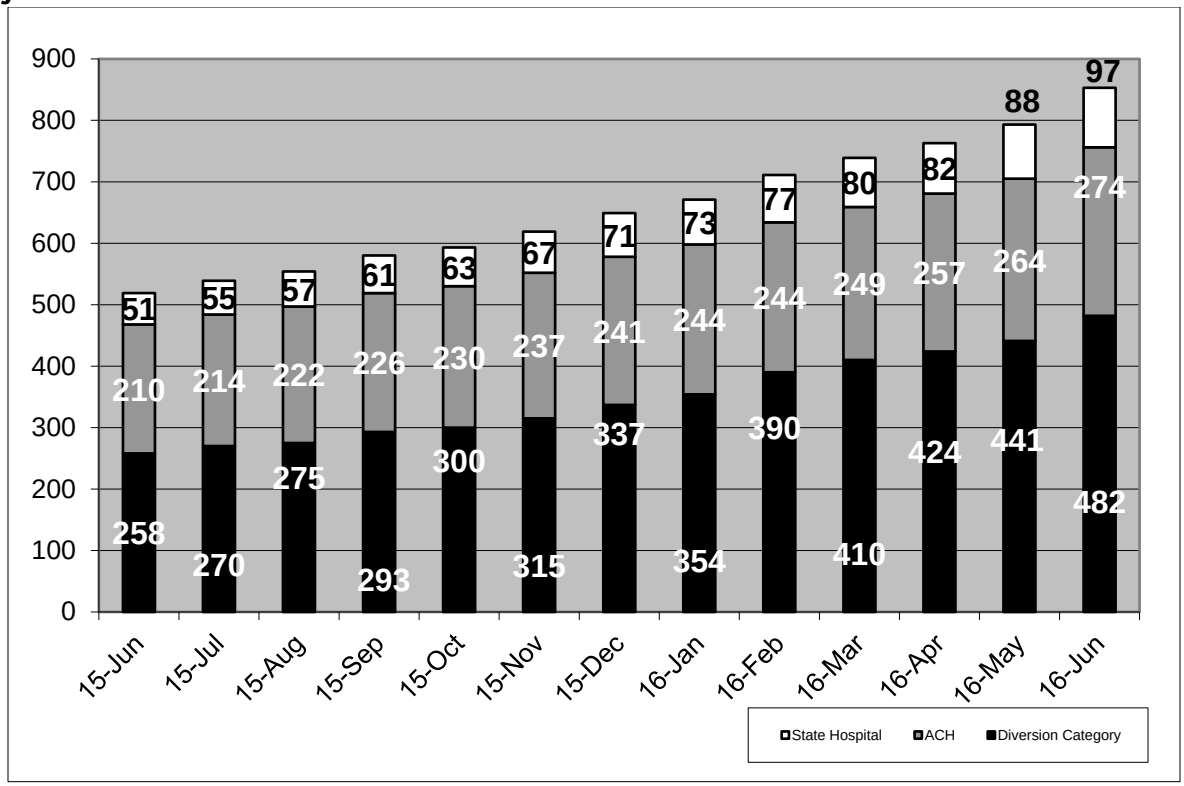
Notes: Diversion category includes individuals who were screened for ACH admission and may or may not have been diverted from ACH admission.

In SFY 2015-2016, LME-MCO staff made a significant effort to increase the number of individuals engaged in the transition process. Many of the same staff were also assisting a significant number of individuals leaving transition for placement in the community through supportive housing. This work is evident by the fact that more initial housing slots were granted in SFY 2015-2016 than any other year of the Settlement Agreement. In SFY 2014-2015, 385 slots were released. In SFY 2015-2016, 555 slots were released.

Transition efforts have been increased in two key areas, ACHs and state-operated phychiatric hospitals. A significant effort has been made to improve in-reach and education for individuals residing in ACHs to allow more individuals to become educated about the opportunity of choices in the community for housing services.

In SFY 2015-2016, the largest number of individuals in the state hospital system become involved with the transition process due to the close collaboration between LME-MCO staff and hospital social workers. Working together, many new eligible participants were identified.

Figure C: End of June, 2016 Monthly Totals of Individuals in Housing by Population Category



2015							2016					
June	*July*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Apr*	*May*	*Jun*
519	539	554	580	593	619	649	671	711	739	763	793	853

In SFY2015-2016, 334 individuals were placed in supportive housing. Throughout the life of the initiative, 853 individuals have been placed in supportive housing while 203 individuals left supportive housing. Only 47% left housing for a higher level of medical care or for a more congregate setting.

To ensure safe housing, all units are all inspected using U.S. Department of Housing and Urban Development (HUD) Quality Standards (HQS). The state will continue inspections of units, and re-inspections at times to make sure all housing provided is of sufficient quality. In SFY 2015-2016, DHHS staff started visiting individuals in the community and following up with the LME-MCO to make sure individuals have well-furnished apartments.

In SFY 2015-2016 the North Carolina Housing Finance Agency amended their Qualified Allocation Plan (QAP) to include points for projects that will be especially helpful to TCLI individuals, and have attempted to incentivize one bedroom units. The winning applications in 2016 all scored the points that favor TLCI.

In SFY 2015-2016, the targeted transition pilot continued to give individuals who need immediate placement a location to stay while services are wrapped around the invididual and the housing search takes place. For the life of the pilot, 16 individuals have participated. Six of those moved into Target/Key units, nine into other TCLI supportive housing and one person decided to enter a group home.

In SFY2015-16 higher Housing Assistance Payment (HAP) payments were authorized in the state's two toughest rental markets - Charlotte and Raleigh. To-date, this higher HAP has aided seven individuals in accessing quality housing.

North Carolina Housing Finance Agency (NCHFA) was able to expand the stock of more than 1,100 units that will participate in the Target/Key key program. These units will be available upon turnover. However, as they open, TCLI individuals will have preference.

In SFY 2015-2016, the state, in coordination with NCHFA, analyzed the stock of housing with tax credits, analyzed gaps,and asked LME-MCOs to complete a survey showing whether or not they found these units accessible. Regional housing coordinators are working closer with transition coordinators, resulting in a higher percentage of housing slots being paid for through the Key program, instead of the TCLI subsidy.

NCHFA, DHHS and the NC Justice Center collaborated to formulate a model criminal background policy for Targeted/Key units to improve accessibility for the priority population. This policy aligns with the recent guidance issued from HUD. The new model criminal background policy was presented to Target/Key property managers, and they are expected to implement this policy by November 1, 2016.

NCHFA utilized their Enhanced Asset Management information system for payment automation of tiered (enhanced) Key paymnent standards at expansion properties in high-cost counties and used the same information system to streamline workflow.

NCHFA and DHHS redesigned Targeting Agreements, Property Profiles, and Pre-leasing notifications with NCHFA, taking on roles previously handled by DHHS. NCHFA and DHHS also instituted bi-weekly operational meetings and monthly strategic meetings.

In SFY 2015-2016, each LME-MCO developed and submitted a housing plan for their entire catchment area.

In SFY 2015-2016, DHHS and NCHFA contracted with TAC for a statewide housing plan, which will be completed in SFY 2016-2017.

DHHS contracted with NCHFA for housing administration and partnered to re-evaluate how subsidy administration was implemented. NCHFA has committed additional staffing as part of subsidy administration and other housing functions within TCLI.

DHHS and NCHFA continue to work toward implementation a new system for Subsidy Administration, which is expected to go-live in SFY 2016-2017. NCHFA will act as the Subsidy Administrator.

NCHFA Sponsored 16 Fair Housing Trainings for service and housing providers.

DHHS is planning to offer HQS inspection training to LME-MCOs in SFY 2016-2017. It is expected that empowering LME-MCOs to perform this function will result in losing fewer units due to the lengthy wait for inspections to be completed.

Throughout SFY 2015-2016 DHHS has worked towards a master leasing pilot which is scheduled to begin in SFY 2016-2017. This will allow individuals who need to transition immediately to have an option if needed.

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

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

The state collaborated with Socialserve (NCHousingSearch.com) to update the housing search tool with more qualitative information, identify NCFHA and Targeted properties, and increase involvement with landlords.

In SFY 2016-2017, the same risk mitigation tools utilized by the Target/Key program will be made available to landlords that rent to TCLI individuals,. This is intended lead to a greater acceptance rate of the TCLI population in the landlord community.

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

LME/MCO	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5	Total
Alliance Behavioral Healthcare	3	15	0	24	35	**77**
Cardinal Innovations	6	41	5	9	105	**166**
Centerpoint Human Services	15	7	0	0	48	**70**
Eastpointe	1	24	3	14	45	**87**
Partners Behavioral Health Mgmt	16	6	9	18	54	**103**
Sandhills Center	1	30	10	13	54	**108**
Smoky Mountain Center	19	8	7	4	62	**100**
Trillium	33	11	4	15	79	**142**
Total	94	142	38	97	482	**853**

Note. Population categories are defined as follows:

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

7. Diversion Status of Individuals with PASRR Screenings Processed from January 2013 to the end of June 2016

LME/MCO	Diverted	Not Diverted	In Process*	Total PASRR Screenings Processed
Alliance Behavioral Healthcare	236	411	449	1096
Cardinal Innovations	263	670	610	1543
CenterPoint Human Services	56	271	52	379
Eastpointe	268	616	85	969
Partners Behavioral Health Mgmt	134	461	259	854
Sandhills Center	155	459	10	624
Smoky Mountain Center	224	782	146	1152
Trillium	157	527	209	893
Total	**1493**	**4197**	**1820**	**7510**

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

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

Prescreening and Diversion

Since January 2013, individuals seeking admission to ACHs must first complete a pre-admission screening to determine if the individual has an SMI or SPMI. The state implemented this requirement through the use of a Pre-admission Screening and Resident Review (PASRR) as the prescreening tool.

Once an individual is determined through the PASRR as having an SMI, the person is referred to an LME-MCO and is provided options of services, supports and a choice of where they would like to live through a community integration planning process.

8. Diversion Status of Individuals with PASRR Screenings Processed for end of June 2016

LME/MCO	Diverted	Not Diverted	In Process*	Total PASRR Screenings Processed
Alliance Behavioral Healthcare	3	16	240	259
Cardinal Innovations	17	79	287	383
CenterPoint Human Services	7	49	36	92
Eastpointe	29	156	52	237
Partners Behavioral Health Mgmt	5	38	180	223
Sandhills Center	38	141	4	183
Smoky Mountain Center	27	151	96	274
Trillium	13	38	149	200
Total	**139**	**668**	**1044**	**1851**

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

The total number of individual PASRRs submitted for review in SFY 2015-2016 declined from past fiscal years.

In May 2015, reconciliation of the PASRR database and the TransITions database began in an effort to ensure data reliability. Errors were identified and solutions were developed to ensure data entry accuracy in the PASRR database.

Once the PASRR database was reconciled and accurate, new reporting measures and methods were developed in order to begin pulling data from TransITions and merging the data with PASRR. This allowed DHHS to provide datato LME-MCO's monthly regarding errors, corrections and missing information in the TransITions database.

Technical assistance was provided as needed to LME-MCO's and onsite technical assistance was provided when requested. Technical assistance focused on data compliance within the diversion area of the TransITions database and responding to questions regarding diversion and PASRR.

Prior to this effort, there was a large amount of missing and/or incorrect data entered into the TransITions database pertaining to diversion. By the end of December 2015, there was a substantial decrease in errors and missing individuals in the TransITions database.

The reconciliation and clean-up efforts have resulted in more accurate and meaningful data for reporting. In addition, Community Integration Plans (CIP) have improved significantly since the Earthmark contract began in early 2015. The amount of missing CIP's has significantly decreased and LME-MCO's are working to complete CIPs with individuals prior to 2015.

Continued monitoring is planned to ensure compliance with the diversion process and provide technical assistance to LME-MCO's. SFY 2016-2017 efforts will continue to focus on training and data compliance with LME-MCO's. With the development of a new TCLI database and continued planning efforts regarding process changes for prescreening and diversion, reporting data and compliance is expected to greatly improve.

Quality Management

In SFY 2015-2016, the state made enhancements to improve quality management of work done by LME-MCOs and DHHS TCLI program administration.

To ensure individuals were getting necessary services, DHHS has reviewed and insisted on changes to PCPs before the start of subsidy payment. Root Cause Analysis has continued in SFY 2015-2016 and will be submitted to DHHS in aggregate form in SFY 2016-2017.

In SFY 2015-2016, DHHS began a more comprensive reporting process to increase the accuracy and timeliness of SE information reported monthly by LME-MCOs and providers. DHHS sends a monthly report to the independent reviewer.

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

Level II includes any incident which involves a consumer death due to natural causes or terminal illness, or results in a threat to a consumer's health or safety or a threat to the health or safety of others due to consumer behavior.

Level III includes any incident that results in (1) a death, sexual assault or permanent physical or psychological impairment to a consumer, (2) a substantial risk of death, or permanent physical or psychological impairment to a consumer, (3) a death, sexual assault or permanent physical or psychological impairment caused by a consumer, (4) a substantial risk of death or permanent physical or psychological impairment caused by a consumer or (5) a threat caused by a consumer to a person's safety.

Incident types:

- Death
- Restrictive intervention
- Injury
- Medication error
- Allegation of abuse, neglect, or exploitation
- Consumer behavior (including suicide attempt, inappropriate sexual, aggressive, destructive, illegal, unplanned absence)
- Suspension, expulsion from services
- Fire

From July, 2015 to June 2016, 61 category 2 and 3 incidents were documented in DHHS's Incident Response Improvement System (IRIS), or about five per month. Level 2 and 3 incidents are documented below

9. Incident Response Improvement System Report for SFY2015-16

LME Name/ County	Date of Incident	Incident Level	Incident Type
Partners	8/7/2015	2	Consumer Behavior
Trillium	8/7/2015	2	Consumer Behavior
Trillium	8/7/2015	2	Consumer Behavior
Sandhills	8/16/2015	2	Injury
Partners	8/18/2015	2	Consumer Behavior
Partners	8/22/2015	2	Consumer Behavior
Trillium	8/24/2015	2	Injury
Cardinal	8/25/2015	2	Consumer Behavior
Trillium	9/2/2015	2	Consumer Behavior
Cardinal	9/4/2015	3	Death
Smoky	9/9/2015	2	Consumer Behavior
Partners	9/16/2015	2	Consumer Behavior
Trillium	10/9/2015	2	Consumer Behavior
Trillium	10/19/2015	2	Consumer Behavior
Smoky	10/20/2015	3	Other

Sandhills	10/23/2015	2	Consumer Behavior
Sandhills	11/5/2015	2	Consumer Behavior
Partners	11/26/2015	2	Consumer Behavior
Sandhills	11/28/2015	2	Consumer Behavior
Smoky	12/7/2015	2	Consumer Behavior
Eastpointe	12/15/2015	2	Consumer Behavior
Smoky	12/19/2015	2	Other
Partners	1/1/2016	2	Injury
Smoky	1/14/2016	2	Consumer Behavior
Partners	1/16/2016	2	Consumer Behavior
Smoky	1/21/2016	2	Consumer Behavior
Trillium	1/29/2016	2	Consumer Behavior
	2/23/2016	2	Consumer Behavior
Sandhills	1/31/2016	3	Death
Partners	2/2/2016	3	Consumer Behavior
Partners	2/9/2016	2	Consumer Behavior
Partners	2/20/2016	2	Injury
Partners	2/24/2016	2	Injury
Sandhills	3/3/2016	2	Consumer Behavior
Alliance	3/3/2016	2	Other (Arrest)
Smoky	3/9/2016	2	Consumer Behavior
Trillium	3/11/2016	2	Consumer Behavior
Partners	3/11/2016	2	Consumer Behavior
Partners	3/23/2016	2	Other (EMS medical intervention)
Smoky	4/1/2016	2	Consumer Behavior

Partners	4/4/2016	2	Injury
Alliance	4/6/2016	2	Consumer Behavior
Eastpointe	4/12/2016	2	Consumer Behavior
Smoky	4/15/2016	2	Consumer Behavior
Smoky	4/21/2016	2	Abuse
Alliance	5/5/2016	2	Abuse
Trillium	5/5/2016	2	Medication Error
Partners	5/6/2016	2	Injury
Partners	5/13/2016	2	Consumer Behavior
Eastpointe	5/18/2016	3	Death
Sandhills	5/18/2016	2	Consumer Behavior
Partners	5/18/2016	2	Consumer Behavior
Smoky	5/25/2016	3	Death
	6/3/2016	2	Other
Partners	6/22/2016	2	Other
Smoky	6/7/2016	2	Consumer Behavior
Eastpointe	6/10/2016	3	Death
Partners	6/15/2016	2	Consumer Behavior
Alliance	6/21/2016	2	Injury
Partners	6/23/2016	2	Consumer Behavior
Partners	6/23/2016	2	Injury

In SFY 2015-2016, DHHS developed and began releasing a dashboard to LME-MCOs. The goal of this dashboard is to drive improvement in key settlement areas, including: housing, supported employment, in-reach, transition and services.

LME-MCOs have responded diligently to the dashboard. As certain dashboard goals are achieved, DHHS will replace them with new benchmarks. Goals in the dashboard are tied to contract expectations.

In SFY 2015-2016 DHHS utilized the data warehouse to send monthly reports of data discrepancies to LME-MCOs. Most of LME-MCOs have used these reports to correct errors and identify which individuals served by TCLI need more attention. For example, LME-MCOs are informed of individuals who are overdue for an in-reach visit, allowing the LME-MCO to either update the database or to contact the individual.

DHHS provided several database training sessions in SFY 2015-2016, and additional trainings will be offered in SFY 2016-2017. This will help ensure all existing and new LME-MCO staff have the ability to take the training.

The state collects data documenting where individuals go when leaving supportive housing. By the end of June 2016, 203 individuals left supportive housing. The below table shows these destinations.

10. Individuals who moved from Supportive Housing

Where	Number of People
ACH	56
AFL	3
Family/Friends	29
Independent/Left State	35
Jail/Prison	9
Medical Hospital/Hospice	3
MHGH	6
S.U. Facility/Oxford House	4
Passed Away	42
Psychiatric Hospital	1
SNF	6
State Hospital	7
Hospice	2
Total	203

Of the 203 individuals who have left TCLI housing, 108 did not leave housing for a more restricted level of care. Individuals who have left housing averaged 327 days in supportive housing prior to exiting. The individuals that move to a facility remain eligible for TCLI, and several are eventually rehoused. Those individuals discharged to ACHs are re-engaged with in-reach services.

For SFY 2016-2017, there are several quality management goals. One goal is to move from the difficult-to-use database to a new database that will work more seamlessly, and will also include the Target/Key database, which should improve both systems.

Another goal for SFY 2016-2017 is to conduct an analysis of common factors among people who leave housing by searching for patterns and making changes to the program if applicable. In SFY 2016-2017 the Housing Plan, Services Plan, and SE plans will be carefully monitored and followed (if accepted).

The LME-MCOs documented 25 individuals that spent 258 days in crisis beds. Seventy-one individuals spent 120 days in the emergency department. Forty-six individuals have spent 743 days in community hospitals, including one individual who spent 339 days in a community hospital.

By the end of SFY 2016-2017, 650 of the 853 individuals transitioned into supportive housing remained in supportive housing. This represents 76 percent of all individuals placed since the inception of the program. Of the 853 individuals placed, 751 did not go to a more restrictive setting, which represents 88 percent of all individuals placed since the inception of the program.

11. Community Engagement/Readmissions/Congregate Day Programming

Engagement	Activity
Activities/Hobbies	94
Volunteering	8
School	12
Working	8
Total	112

12. Readmissions

Number of days in crisis beds	Number of ER Visits	Number of days in community hospitals
83	49	170

13. Time spent in Congregate Day Living

Payments	924
Individuals Served	659
Total Amount Paid	$4,030,887.50
Total Units	1,498,471
Total Hours Spent	374,618

***Based on all individuals in Inreach, Transition planning, Diversion and in Supportive Housing usage of PSR in Fiscal year 15-16.**

14. Hospital Census for SFY 2015-16

Fiscal Year 15-16	Admits	Discharges	Average Daily Census
Broughton	**404**	**408**	**255.4**
Adult Admissions	350	305	110.9
Adult Long Term	4	38	87.7
Geriatric	12	18	37.7
Medical Unit	17	22	9.3
Deaf Unit	21	25	9.8
Cherry	**470**	**488**	**164**
Adult Admissions	419	348	63.5
Adult Long Term	9	78	77.8
Geriatric	34	40	20.7
Medical Unit	8	5	1.9
CRH	**1038**	**1056**	**341**
Adult Admissions	860	863	212.6
Adult Long Term	0	8	7.1
Geriatric	53	58	37.6
Medical Unit	41	46	6.2
Forensic Unit	84	81	77.7
Grand Total	**1744**	**1770**	**761**

Notes:

- Adult admissions units are acute care units with typical length of stays around 30-60 days. Length of stay on the adult admissions units may be less than one month. Adult admissions units admit people 24/7/365, taking many individuals waiting in community emergency departments for psychiatric hospitalization.
- Adult long-term units are for individuals who need longer term care at the hospital level. Often individuals on long-term units have SMI complicated by legal problems, poor response to treatment, co-occurring intellectual/developmental disabilities, chronic illness and cognitive deficits.
- Geriatric units typically serve people 64 and older, but may include people in younger age ranges who have needs similar to older individuals.
- Individuals in need of care for a medical condition that can be treated at the state-operated psychiatric hospital are admitted to the medical units.
- All of these units may have individuals who qualify for TCLI therefore individuals on all units are referred to the MCO for in-reach.
- Discharge numbers are higher in the data compared to the following discharge destination table because transfers out for medical care cannot be removed from this data.

15. Hospital Discharge Data for SFY2015-16

Fiscal year 15-16 Discharge Destination	Broughton	Cherry	CRH	Grand Total
Private Residence	173	214	451	**838**
Correctional Facility	49	68	103	**220**
Adult Care Home	61	77	33	**171**
Group Home 5600	11	34	108	**153**
Homeless Shelter	11	5	92	**108**
Hotel	12	6	22	**40**
Halfway House	5	8	19	**32**
Alcohol and Drug Abuse Treatment Center	8	6	14	**28**
Psychiatric Hospital	4	6	19	**29**
Boarding House	3	4	21	**28**
I/DD Group Home	7	7	9	**23**
Alternative Family Living	7	0	17	**24**
Neuro Medical Treatment Center	2	6	15	**23**
Skilled Nursing Facility	5	3	10	**18**
TCLI Housing	7	8	4	**20**
Developmental Center	2	0	4	**6**
Therapeutic Home	2	0	3	**5**
Expired	0	1	4	**5**
Therapeutic Community	1	0	3	**4**
Supervised Apartment Living	1	0	3	**4**
Oxford House	0	2	3	**5**
Veteran Administration Hospital	0	1	1	**2**
Intermediate Care Facility	0	0	2	**2**
Community Detox Center	1	0	0	**1**
Cross Area Service Provider	0	0	1	**1**
Whitaker	0	0	1	**1**
Hospice	0	0	1	**1**
Group Home ICF	1	0	0	**1**
Community Respite	1	0	0	**1**
Grand Total	**353**	**413**	**867**	**1633**

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

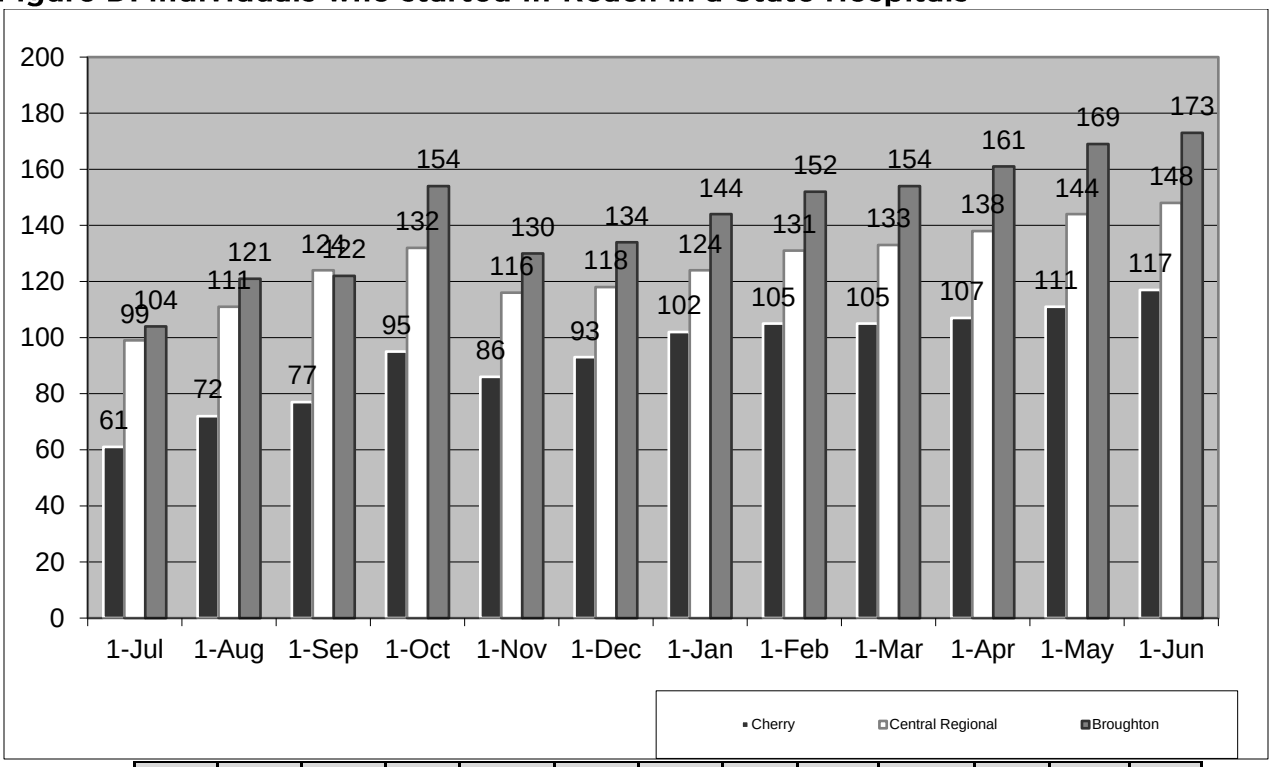
Of the 1,633 people discharged from state-operated phychiatric hospitals in SFY 2016, 47 percent were discharged to a private residence, defined as any private home in the community. ACH accounted for nine percent of the discharge locations in SFY 2016.

The total number of individuals who started in-reach services while in a state psychiatric hospital increased from 179 (reported last year) to 438 during SFY2015-2016. In-reach begins when an LME-MCO makes contact with an individual and/or guardian to talk about TCLI while the individual is a patient of a state-operated psychiatric hospital.

State-operated psychiatric hospitals send each LME-MCO a list of referrals each month that provides details about the individuals referred. This includes discharge and guardian contact information to assist LME-MCOs in following-up. During SFY 2016, state-operated psychiatric hospitals have referred 552 individuals, 316 of whome have been discharged since referral, and 236 remain in the hospital.

DHHS plans to continue working with LME-MCOs to refer people who qualify for TCLI and increase the number of people in state-operated psychiatric hospitals who start in-reach and/or transition, including direct discharges to TCLI housing.

Figure D: Individuals who started In-Reach in a State Hospitals



15-Jul	15-Aug	15-Sep	15-Oct	15-Nov	15-Dec	15-Dec	16-Jan	16-Feb	16-Mar	16-Apr	16-May	16-Jun
40	42	50	51	49	51	57	57	63	64	69	76	80
32	41	47	52	45	46	49	49	49	49	52	53	55
26	27	31	33	28	28	29	29	31	31	32	33	33
21	26	29	35	35	39	40	40	41	42	42	45	48
22	27	27	34	28	28	30	30	33	34	36	38	38
27	31	31	36	30	33	33	33	33	33	33	33	34
57	65	65	69	69	70	78	78	83	84	87	92	94
39	45	45	48	48	50	54	54	55	55	55	54	56
264	304	323	358	332	345	370	370	388	392	406	424	438

Note: Totals are cumulative.

External Quality Review

The Balanced Budget Act of 1997 (BBA) requires that a state which contracts with a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) conduct an External Quality Review (EQR) of each entity. The state is also required to prepare an annual technical report that describes the manner in which data for activities conducted, in accordance with 42 C.F.R. § 438.358, were aggregated and analyzed.

To comply with these regulations, the DHHS Division of Medical Assistance (DMA) contracted with The Carolinas Center for Medical Excellence (CCME), an external quality review organization, to aggregate and analyze the data, and prepare an annual technical report. The contract between CCME and DMA stipulates that a compliance review be conducted for the PIHPs yearly.

The process used for each review activity was based on the protocols for external quality review of Medicaid MCOs and PIHPs developed by the Centers for Medicare & Medicaid Services (CMS).

The review included a desk review of documents submitted by the health plan, a two-day onsite visit for the compliance review, a teleconference to discuss the validation findings and a review of any corrective action plans submitted.

All seven LME-MCOs have been reviewed by CCME and the Mercer Group (a contractor employed by the DMA to perform audits of the LME-MCOs) for compliance with the required TCLI areas:

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

Findings

To determine the state's PIHP's compliance with state and federal requirements, CCME developed and DMA approved standards which address access, quality and timeliness of care and services received by enrollees by LME-MCO. Areas of review were identified as either meeting a standard (Met), acceptable but needing improvement (Partially Met), failing a standard (Not Met), Not Evaluated, or Not Applicable. The findings for each LME-MCO, as will be outlined in the compliance findings, are listed as follows:

- Alliance Behavioral Healthcare --developed desk procedures addressing requirements for TCLI. Review of the desk procedures and client files confirmed that overall, appropriate processes are being followed and documented for each client.
- Cardinal Innovations Healthcare Solutions--has not developed policies to address requirements. Cardinal developed a detailed task list for use by staff, which addresses requirements, timeframes, pre-requisites, forms needed, etc. This task list addresses all functions and tasks required to meet the requirements of the settlement agreement. In addition, a reference binder containing detailed documentation of the specifics of the settlement was created as a central source of information for staff.
- CenterPoint--developed procedures to address requirements for TCLI. However, the requirements for Quality of Life survey completion at 11 and 24 months post-transition to community living were not addressed in the procedures. Onsite review of the TCLI files confirmed that appropriate processes are being followed and documented for each client.

- Trillium (CoastalCare&ECBH)-- developed two policies relating to in-reach activities for TCLI. Detailed case management/care coordination processes and eligibility requirements are found in policy 1001, care coordination and in the PowerPoint presentation titled Care Coordination. All files contained appropriate documentation that included: PCPs, completed Quality of Life surveys, in-reach tool completion, transition meetings, and progress notes following transition. ECBH demonstrated their dedication to these individuals by remaining involved several months following transition. Individuals received peer support, tenancy support, ACT, community support, and medication management services when indicated. ECBH has several policies which guide the provision of care coordination for individuals, including those with complex health needs and high-risk behavioral health conditions.
- Eastpointe: Descriptions are found for case management / care coordination programs related to intellectual developmental disabilities, mental health and substance use. Eastpointe included TCLI in their 2013-2016 Business Plan and formulated goals and a strategy. Three draft policies that address TCLI services were presented. Eastpointe had not developed a program description for how these services will be handled for the TCLI population.
- Partners Behavioral Health Management developed internal processes to comply with requirements of TCLI. However, no formal policy or procedure has been developed. CCME recommended that a policy that addresses all requirements, as well as Partner's processes to ensure compliance, be developed. Some of the requirements and processes are found in the care coordination program description. Review of the selected TCLI files onsite confirmed that activities are being performed to meet the requirements. Crisis plans and PCPs are being developed as required, and members are frequently contacted during the transition process.
- Smoky Mountain LME-MCO developed detailed and thorough policies to guide staff through TCLI requirements. Review of files for three enrollees in TCLI confirmed that Smoky is following appropriate processes for pre-transition, transition and post-transition for these enrollees. The files confirmed that contacts with these members, both in person and by telephone, exceed the frequency requirements of TCLI and are well-documented.
- Sandhills Center developed a Care Coordination Departmental Operations and Procedures document which includes a summary of the activities required the TCLI population. All files demonstrated face-to-face contact met or exceeded contract requirements. Sandhills Center has a large number of TCLI individuals who remain successfully transitioned. During the onsite visit, Sandhills Center submitted three policies and procedures related to TCLI. Generally speaking, these policies addressed most requirements. However, they did not address the requirement of pre-transition, and 11-month and 24-month Quality of Life Survey completion. TCLI members should be identified as a new required "Special Healthcare Population" in policies.

Monitoring of Service Gaps

LME-MCOs are required to annually conduct and submit provider capacity, community needs assessment and gaps analyses in accordance with their DHHS performance contracts. The gaps analyses are part of a continuous assessment and action process. This drives development of and updates to LME-MCO local business and network development plans, and implementation of strategic plans through quality improvement projects and actions.

DHHS distributed gaps analyses process and report guidelines in November, 2014 for LME-MCO SFY 2014 reports to be submitted in April 2015. LME-MCOs were required to address the following in their gaps analyses:

- Analyses by service type of the capacity and adequacy of the provider network to serve and offer consumers with a choice of providers;
- Needs and service capacity assessments for each age-disability group and special population, including successes and challenges in implementing TCLI;
- Identification of service gaps, underserved populations and unmet needs in the LME-MCO catchment area; and
- Priorities and strategies for the coming fiscal year to address identified service gaps, including strategies to ensure progress on TCLI.

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

All LME-MCOs were required to evaluate the full service array in their assessments and gaps analyses. They also identified and described service gaps, priorities and initiatives of special relevance to TCLI in areas such as housing and services. Other areas LME-MCOs identified service gaps, priorities and initiatives include: co-occurring mental health and intellectual developmental disability services, increased access to substance use disorder services, integrated healthcare, prevention, provider/service outcomes, psychiatric capacity, technology resources and traumatic brain injury.

LME-MCO strategies to ensure progress on TCLI described in the April, 2015 gaps analyses reports include:

- Providing education to ACH administrators through training and meetings
- Contracting with a provider and using a case rate model to provide individual peer support to individuals interested in supportive housing
- Holding forums and meeting individually with apartment complexes to increase partnerships with potential landlords
- Addressing housing barriers through the use of reasonable accommodation
- Developing short-term transitional housing slots and housing units
- Including Tenancy Support Specialists in staff and transition planning meetings to improve support for individuals' success in the community
- Increasing collaboration between transition and care coordination departments to identify barriers and link members with resources
- Increasing emphasis on life and community integration as consumers transition
- Working with the quality management department to ensure quality of individuals' PCPs
- Collaborating with service providers to further program development and referrals
- Establishing an enhanced service provider learning collaborative
- Dedicating staff positions to promoting and working toward SE goals

- Providing SE benefits training to transition staff and SE providers covering methods for educating members
- Educating the community and individuals about the benefits of SE
- Contracting with additional peer support service providers
- Implementing enhanced peer support service rate for providers working with TCLI consumers
- Improving the quality and accessibility of ACT teams
- Contracting with CTI providers to meet the needs of individuals moving into supportive housing
- Collaborating with the quality management department to develop an LME-MCO formal monthly TCLI dashboard and benchmarks

The state continues to monitor crisis services and community-based mental health services required to enable the successful transition of adults with SMI to supportive housing. Services and identified gaps, as well as the implementation and success of LME-MCO strategies to address service gaps, are monitored by the DHHS.

Monitoring activities include the annual gaps analysis review process, review and monitoring of LME-MCO Local Business Plans, review of LME-MCO Network Development Plans and Quality and Performance Improvement Plans and Projects and Intradepartmental Monitoring Team (IMT) review of LME-MCO performance relative to contract requirements and performance standards.

Quality of Life Survey

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

As of December 31, 2015, initial surveys of 523 TCL participants, 11-month follow-up surveys of 202 individuals, and 24-month follow-up surveys of 45 individuals have been administered and submitted by LME-MCOs. Participant survey responses continue to indicate most individuals' positive transition planning experiences:

- Nearly all (94 percent) individuals reported positive perceptions about their level of participation in transition planning.

After transitioning to the community, more participants reported positive personal choice and control, and satisfaction with varied aspects of housing, community and services:

- More individuals reported satisfaction with daily activities (17 percent), housing location (10 percent) and community activities (14 percent) 11 months after transition.
- More individuals reported access (11 percent) and satisfaction (12 percent) with services 11 months after transition.

Survey results, including areas of need and lower reported satisfaction and descriptive follow-up survey response summaries by LME-MCO, are presented in the attached Appendix, N. C. Transitions to Community Living Initiative Quality of Life Survey 2015 Summary Results (June, 2016).

Crisis Solutions Initiative Update

DHHS established priorities for improvement in crisis services and began working on those priorities in 2014. The crisis solutions initiative, established in November, 2013, focuses on identifying and implementing the best known strategies for crisis care throughout the continuum of prevention, intervention, response and stabilization.

Initiative projects are intended to support the development of appropriate levels of intervention for individuals in behavioral health crises and to reduce avoidable visits to emergency departments and involvement with the criminal justice system. The initiative is built upon two key strategies:

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

The Crisis Solutions Coalition meets every six to eight weeks to focus on developing solutions leading to better crisis care options. Client advocates, along with leaders from healthcare, government, law enforcement and magistrates, schools, healthcare providers, paramedics, emergency departments, community health centers, LME-MCOs and others learn about emerging innovative practices from different parts of the state. They also discuss options and advise DHHS team on priorities for implementation.

The following are areas of need identified at the meeting on March 21, 2016:

- Increase funding for additional behavioral health urgent care locations and services
- 24/7 crisis services need to be child-friendly and have child-focused care
- Continue the work with Emergency Medical Services (EMS) to address CIT across the state. Consider methods to incorporate it into the standard educational curriculum offered to all levels of EMS
- Appreciating (as a system) the incredible work and value of the crisis worker
- Mobile crisis needs to be redefined with new training and service definitions, a different level of mobile crisis provider expectations – currently ineffective at two hour response time
- Strengthen outpatient treatment to keep people with SMI/SPMI out of crisis. The outpatient clinics are not financially viable. The focus on clinician productivity instead of quality team-based care leads to crisis/ emergency department boarding.
- Consider increased rates for facility-based crisis centers
- More funding for bi-directional integrated care in facility-based crisis centers is essential to decrease visits back to the emergency department for primary care needs
- More high-intensity beds needed are in state hospitals
- Timely access to the current state hospital beds needed to be addressed/funded
- Reduction of: suicide deaths, suicide attempts, self-injury – use this data to inform intervention and prevention
- Non-unified data rules
- Local hospitals/crisis services partnering with agencies that foster natural supports in the community (e.g. local collaboratives, NAMI, AA, etc.) and peer services/groups

- Need service definitions and funding for behavioral health services in the emergency department
- Development/training/recruitment of Peer Support Specialists is fragmented. This area needs some simplification and streamlining.
- Consultation centers for families who are in crisis with the emergence of mental illness

The Crisis Solutions Coalition met again in late July to prioritize and finalize the list of areas of need and gaps within our crisis service array.

Implement policy direction and funding for four behavioral health urgent care and facility-based crisis programs

The NC General Assembly appropriated funds to build crisis response services that will divert individuals in behavioral health crisis from the unnecessary use of emergency departments into settings staffed with behavioral health specialists connected to other community-based services.

Behavioral Health Urgent Care Center - An alternative to a hospital emergency department for individuals in behavioral health crisis for:

- Specialized assessment
- 23-hour observation
- Barrier-free gateway to facility-based crisis centers
- A partner in the jail diversion partnership with CIT programs

Facility-Based Crisis Center - An alternative to inpatient psychiatric hospitalization for some individuals

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

A behavioral health urgent care workgroup, which also concentrates on facility-based crisis services, was established in April 2014 with DHHS leadership and crisis provider agency representatives, and later expanded to include representation from the LME/MCOs. The workgroup was initially charged withproviding guidance for existing and new behavioral health urgent care centers. Since then, the workgroup has also included facility-based crisis services in its scope.

The workgroup is finalizing a DMA-sponsored “in lieu of” service definition, and the requirements for implementing services within a behavioral health urgent care center. Accomplishments of the behavioral health urgent care workgroup in SFY2015-2016 include:

- Defined standard components of a behavioral health urgent care center
- Drafting staffing expectations, policy and service definitions for behavioral health urgent care
- Completed standardization data collection report
- Currently drafting staffing expectations, policy, and service definitions for behavioral health urgent care centers

- Completed administrative work needed to include facility-based crisis for children and adolescents in the state-funded and Medicaid-funded service array.

The NC General Assembly appropriated $2,200,000 in recurring funds in SL 2014-100, Section 12F.5.(b)

- To increase the number of co-located or operationally linked behavioral health urgent care and facility-based crisis centers.
- To increase the number of facility-based crisis centers designated by the Secretary as facilities for the custody and treatment of involuntary clients pursuant to G.S.122C-252 and 10A NCAC 26C .0101. The department shall give priority to areas of the state experiencing a shortage of these types of facilities.
- To provide reimbursement for services provided by facility-based crisis centers.
- To establish facility-based crisis centers for children and adolescents.

Noted below are accomplishments made relative to each LME-MCO and its behavioral health urgent care center:

- CenterPoint had a groundbreaking ceremony for the Highland Avenue Center on April 5, 2016.
- Smoky Mountain LMe-MCO had a ribbon cutting ceremony for the C3-356 center on April 21, 2016.
- Eastpointe finalized its renovation schedule. There will be three phases, allowing for minimal disruption on use of the current 11 beds at the Tanglewood Arbor Center. Phase I has begun, and renovation completion is scheduled for October, 2016.
- Cardinal Innovations Healthcare Solutions had a groundbreaking ceremony May, 2016 for its facility-based crisis centers in Mecklenburg County.

If similar behavioral health urgent care centers could be made available statewide as an alternative to emergency departments, North Carolina could see up to 30,000 fewer emergency departments visits for this population per year. Estimates of potential cost savings and population density required to support these 24/7 facilities are currently being developed.

Explore and Pilot Community Paramedicine Behavioral Health Crisis Response

DHHS and the Office of Emergency Medical Services (OEMS) are collaborating on an innovative strategy that will improve care for individuals in a behavioral health crisis. Local EMS personnel are frequently the first responders providing assessment and intervention for a person in a behavioral health crisis.

Some EMS departments have developed advanced training for paramedics and partnerships with community providers that specialize in treating mental illness and substance use. This helps divert individuals in crisis from unnecessary visits to hospital emergency departments, especially when partnering with behavioral health urgent care centers.

16. LME/MCO and & EMS County Contracts fiscal year 15-16

LME/MCO & EMS COUNTY	Start date for contracted service event reimbursement	Projected Events for SFY2016
Alliance/Durham	3/1/2016	70
Alliance/Wake	7/1/2015	500
Cardinal/Halifax	9/1/2016	20
Cardinal/Orange	11/1/2016	0
CenterPoint/Forsyth	5/1/2016	100
CenterPoint/Rockingham	5/1/2016	50
CenterPoint/Stokes	5/1/2016	20
Partners/Lincoln	7/1/2016	125
Sandhills/Guilford	9/1/2016	20
Smoky/McDowell	12/15/2016	20
Trillium/Brunswick	7/1/2016	0
Trillium/Onslow	7/1/2016	200
ADDITIONAL LME/MCO & EMS COUNTIES RECEIVING CAPACITY BUILDING MINI-GRANTS		
Alliance/Johnston	7/1/2016	0
CenterPoint/Davie	7/1/2016	0
Smoky/Buncombe	7/1/2016	0

Fund are available from SFY 2016 to assist these counties with the continuation of this service in SFY 2017.

Mental Health First Aid

Mental Health First Aid is an evidence-based eight-hour curriculum that helps the public identify, understand and respond to signs of mental illnesses and substance use disorders. People trained in Mental Health First Aid have greater confidence in providing help to others and are more likely to advise them to seek professional help.

As of May 1, 2016 there are 20,763 North Carolinians trained in Mental Health First Aid and more than 400 instructors.

Psychiatric Advance Directive

A contract was completed with NAMI of NC for the deliverables of promoting long term strategies for increasing the awareness about Psychiatric Advance Directives (PADS), their utilization and a sustainable model for facilitators to assist individuals in the completion of a PAD. Highlights of this project include:

- An informational flier was developed for distribution at various stakeholder sites across the state.
- Alliance Behavioral Healthcare will sponsor and host for a training for a six hour curriculum led by Marvin Swartz – to be completed in September, 2016.
- A second PAD training will take place at the Fall NAMI conference in October, 2016.
- A workplan was developed to address all training groups that will have a connection with PADs. It will also address the need for more user -riendly access and completion of the current template on the Secretary of State's website.

Closing Statement

DHHS continues to be strongly committed to meeting requirements of the settlement agreement while building a system that assures the vision of a community based system is in place for people with mental illness. We are working closely with all partners and stakeholders, adjusting our strategies as we identify opportunities to improve. DHHS is confident that this approach will result in successful implementation of the settlement.