FY 2025 SPECIAL REPORT ON IN-REACH AND TRANSITIONS

In the Matter of

UNITED STATES OF AMERICA v. THE STATE OF NORTH CAROLINA

Case 5:12-cv-00557-D

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INTRODUCTION

This is a Special Report describing the status of the State fulfilling its obligation to meet **Section III. (E)(2) Discharge and Transition Processes** and **Section III.(B)(1) and (B)(5) Community-Based Supported Housing Slots** of the Settlement Agreement (SA) in United States v. North Carolina (Case 5:12-cv-000557-F) signed on August 23, 2012.

Where applicable, this Report also includes information pertinent to **(B)(7).** These include six required criteria for community based supported housing. Likewise, there is information applicable to the other **Section III (E) Discharge and Transition Processes** requirements that intersect or are connected to In-reach requirements for individuals residing in Adult Care Homes (ACHs) and Family Care Homes (FCHs), who have been made eligible for Settlement resources.

Section III. (E)(2) Discharge and Transition Processes defines In-reach requirements as the State providing or arranging for frequent education efforts targeted to individuals living in ACHs or State Psychiatric Hospitals (SPH). The requirement includes the State providing information about the benefits of supported housing, facilitating visits in such settings, with their families and with community providers. It also requires that individuals providing In-reach be knowledgeable about community services and supports, including supported housing. **Section III.(B)(1)** is the requirement that the State develop and implement measures to provide individuals access to community based supported housing, including individuals residing in ACHs. **Section III. (B)(5) Community-Based Supported Housing Slots** states the State shall provide 2,000 housing slots to individuals living in ACHs over the course of the Agreement.

In the FY 2024 Annual Report, the Reviewer stated that the State was making discernable progress toward meeting **Section III. (E) Discharge and Transition Processes**. This continues to be the case as reflected in this special report and will be discussed further in the FY 2025 Annual Report.

However, the State only made negligible progress toward transitioning and serving 2,000 Adult Care Home (ACH) residents in supported housing, as required in **Section III. (B)(5).** The State only increased the number of individuals living in supported housing from 957 to 1000 in FY 2024. The same report referenced the State still having challenges meeting **Section III. (B)(1)**, access to community-based supported housing. According to the State's data, only 38% of individuals with a housing slot transitioned to supported housing after receiving a housing slot in FY 2024.

There are clear indicators of the State's progress meeting **Section III. (E) Discharge and Transition Processes** obligations. This report will identify those but also illustrate the challenges that remain for the State to meet those.

The Independent Reviewer (Reviewer) submits an Annual Report each year of this Agreement following the end of the State's Fiscal Year (SFY). The Annual Report references the program the State designed to comply with the obligations of the SA as Transitions to Community Living (TCL). Individuals identified for TCL are eligible for assistance with the Discharge and Transition

Processes, including discharge from ACHs. This report will be added as a supplement to the FY 2025 Annual Report.

The State's Olmstead team contributed immensely to this report, both through their thorough reports and with making staff available for reviews. The Olmstead team maintains a very reliable and informative report, which describes the State's progress and challenges meeting Discharge and Transition Processes and Pre-screening and Diversion requirements with a special emphasis on In-reach requirements. The staff collect meaningful data quickly and consistently, report trends and analyze specific performance issues, at the individual and program level.

However, what has been clear to State staff, and the Reviewer is the difficulty deciphering the number of individuals still residing in ACHs and FCHs who could and want to move to community settings, specifically into Supported Housing slots (SH). At the same time, it is difficult to predict how many more individuals could benefit from additional In-reach, assessments, and other supports. Similarly, it is difficult to predict with certainty how many individuals cannot or will not move based on a firm refusal to consider such a move by a family guardian, who would need to consent. The same is true for an individual repeatedly refusing to move from the home. For these reasons individuals living in ACHs should remain eligible, making it possible for the individual to move to a community setting if in the future they change their minds about moving, or their family guardian changes their mind . Analyzing and making these predictions provides clarity on what is achievable and insight into what additional steps the State needs to take to meet the aforementioned requirements. This also provides insight for the State and LME/MCOs on how best to allocate resources to overcome challenges and meet requirements.

The State is divided into regions and DHHS contracts with Local Management Entity /Managed Care Organizations (LME/MCOs) in each region to provide In-Reach, discharge and transition processes, assist individuals to access community-based supported housing, and contract for services. The State also makes resources available to the LME/MCOs through incentives and special projects. This includes bridge housing when available. The LME/MCOs have faced a number of challenges providing In-reach and transitions as referenced in recent Annual Reports. Two of these challenges included staff having to work remotely or face-to-face through windows and doors during COVID and challenges presented with LME/MCOs consolidating and individuals needing In-reach and transitions becoming the responsibility of another LME/MCO. This entailed getting records transferred and beginning new relationships in new counties. Staffing, particularly for staff working directly with individuals, has become more of a challenge post COVID.

In March 2022, only 10% of In-reach contacts with individuals living in ACHs and FCHs were face-to-face, 24% of attempted contacts were by letter, and 66% by phone calls to the home. It was not clear to staff whether individuals actually got the letters or calls. On February 13, 2025, the percentage of face-to-face contacts within 90 days had risen to 79.9%. Data from March 17, 2025, showed that Vaya had only missed a 90-day reassessment for two (2) individuals and only seven (7) individuals had not had assessments; there were only 62 individuals with missed 90-day re-

assessments across the other three (3) LMEs. While 90-day re-assessments are important and required, they do not substitute for "frequent visits" as required in the Settlement Agreement.

Staff in ACHs and FCHs are not always helpful and reportedly often discourage individuals from moving. Guardians often limit what staff can discuss or whether they can visit members. Public and agency guardians have the same obligations to meet the Settlement requirements as other entities receiving state funding; family guardians do not. However, public and agency guardians do not always agree to staff or reviewer visits, nor do they always support an individual making a choice. Although limited, several community-based service providers have continued to serve individuals living in ACHs and FCHs for an extended period of time, while not assisting them to move to the community and in a few instances indicating the individual could not move. The State agreed to establish requirements in its contracts with LME/MCOs to limit community providers continuing to serve individuals in ACHs and FCHs for an extended period of time. This requirement would have required LME/MCOs to enforce this change. The State removed this requirement in its last contract with LME/MCOs even though providing community-based services in an ACH for an extended period of time with no indication they are planning for and helping individuals to move. Two providers explicitly refused to assist an individual seen in this review to move to the community.

Lastly, while the frequency of In-reach contacts can result in more individuals getting an opportunity to plan a move to the community, In-reach contacts alone cannot achieve this result. Contacts must be purposeful, respectful, and help individuals feel safe and supported when making the decision to move. Each LME/MCO's transition staff and leadership, community providers, and others who provide support and resources must support each individual's move in a timely and focused manner.

METHODOLOGY

The principal aim of this review was to better determine the number of individuals living in ACHs and FCHs who want to and could move into an SH slot in the community, the number of individuals who could benefit from more In-reach assistance and assessment of an individual's needs if moving to the community, and to verify those individuals who likely cannot successfully move even with supports and who do not want to move to the community.

To get to an accurate number of individuals who could move, need more In-reach, or could not or would not move, the Reviewer chose to conduct a 10% random but stratified sample of individuals across three different groups of individuals living in ACHs and FCHs. There were 2,657 individuals on In-reach status in ACHs and FCHs in September 2024 when we began identifying individuals for this review. We assumed, at the time, we would need to review 260 individuals. In the first round of names pulled, we selected as many individuals as possible not seen by In-reach staff face-to-face in over a year and individuals not seen within the last ninety days. After

our first round of reviews, we also requested individuals seen face-to-face within the past ninety days of when their names were drawn. While it was considered important to balance out the sample across the groups, we also wanted to learn what factors led to individuals not being seen, what barriers exist, and how these relate to the State meeting its obligations for discharge and transition processes.

In order to get a proportional and accurate statewide sample, the Reviewer intended to pull names based on the number of individuals on In-reach status in ACHs and FCHs in each LME/MCO catchment area. However, this review began several weeks after Hurricane Helene devastated western North Carolina, principally in counties in the Vaya catchment area. Therefore, we limited the number of Vaya reviews to include only individuals living in eastern counties outside the disaster recovery area. We limited the number in the Trillium area given that they had only recently assumed responsibility for the Sandhills and Eastpointe catchment areas. We added reviews in the Partners area at their request as they were engaging in a more focused review themselves which raised the number of reviews to 289. This also provided the opportunity to increase the sample size. Given those considerations we divided reviews according to those numbers as illustrated in Figure 1 below:

Figure 1: Total Individuals Reviewed by LME/MCO

	Alliance	**Partners**	**Trillium**	**Vaya**
Total Reviewed	72	117	67	33

After names were pulled for the review, each LME/MCO attempted to meet with each individual to prepare for the review. They quickly learned, especially for individuals not seen regularly, that not everyone was still living in an ACH or FCH, including individuals who could not be located even after checking records to see if they were using services elsewhere. Others were deceased, had moved to a skilled nursing facility (SNF), were incarcerated or hospitalized, had moved to a group home, had recently switched to another LME, or had moved as a result of Hurricane Helene and had not been seen at the time of the review.

Figure 2: Individuals Reviewed

Review Types	**Reviews**
Total Reviews	289
In-Person Interviews with a Desk Review[1]	151
Phone Call, Record Review or LME/MCO Report[2]	138

[1] Six individuals in this category refused an interview after the reviewer arrived at their home

[2] Individuals in this category included those with family guardians who refused the visit or agreed to a phone call only, individuals who the LME/MCO could not locate, individuals who were withdrawn either before or at the time they were referred for a review, individuals who were deceased or had moved to skilled nursing facilities (SNFs), individuals who had moved because of Hurricane Helene, and individuals who were hospitalized or in jail and not available at any point during the review timeframe.

As widely recognized, the best source for capturing primary source data for this type of review is through individual interviews. The Reviewer and her team conducted individual interviews in the individual's home or at a location of the individual's choice.

Reviewers attempted to visit individuals who were hospitalized and one individual who was homeless. One reviewer met one individual at a psychosocial rehabilitation program (PSR) for the day. Several reviews were delayed until an individual was available. A desk review, phone call, and/or record review were conducted for each individual not seen as referenced in Figure 2 above.

The protocol was similar to the standard protocol used each of the past 10 years, including individual, staff and key informant interviews, record reviews, and a series of questions tied to requirements in the Settlement Agreement. This review though was more limited in scope with more focus on the key requirements and questions tied to who in In-reach status could move into the community and less on transition processes and community services. However, since there is a connection across multiple requirements, this report will reference those connections in the individual findings and recommendations sections below.

To achieve this aim, and assure the validity of the sample, the team and the Reviewer did not determine each finding based on a single data point but on a body of information, including documentation, assessment results and whether or not the review could reasonably predict the possibilities given the State's adherence to the Settlement requirements, individual choice, and possible outcomes. The sample was drawn from individuals living in ACHs and FCHs for a range of timeframes but weighted initially towards individuals who had been living in homes for a long time, including one woman who had been living in the same ACH for 30 years. The team assumed older individuals would be less likely to say yes to a move.

However, we interviewed 16 individuals over the age of 70, including a 90-year-old individual, who indicated who wanted to move. One individual over the age of 70 had already moved and another was in the transition phase. Individuals in this age group were interested in a move and the two who either moved or in the process of moving. This was 42% of the total number of individuals in the sample over the age of 70. It was assumed ahead of time that many of these individuals would be withdrawn or say no to a move. Including each individual whose name was drawn, provided for a more accurate account of individuals in TCL living in an ACH. Withdrawing and adding new names of individuals who could be seen would have potentially invalidated the results. In retrospect, this decision to leave individuals names in was correct.

Reviewers met the test for reliability based on their experience and common view of their understanding of challenges individuals face moving to community living. The Independent Reviewer case-judged each review, read each set of documents when available, attended follow-up desk reviews, and had numerous follow-up discussions with LME and DHHS staff. Each of the

assigned reviewers submitted a written review that included a summary of their interviews and information to support their findings.

We also asked In-reach staff for their view of the likelihood an individual could move and live successfully in the community based on their understanding of community living and weighed their impressions based on their experience and understanding of community living.

INDIVIDUAL REVIEW FINDINGS

Individual findings highlight various opportunities and barriers, such as frequency or lack thereof of in-reach visits or family support, age, physical disabilities, chronic medical conditions, desire for change, guardianship, ,and personal history. Below is information related to those indicators.

Figure 3: Demographics and Guardian Information[3]

Categories	Alliance	Partners	Trillium	Vaya	State Totals
Average age	56	57	59	65	58
Female	22	49	33	13	117
Male	52	69	34	18	172
Has a public guardian	15	22	6	4	48
Has a family guardian	3	16	9	4	32
Total reviewed	72	117	67	33	289

As referenced in Figure 3 above, 172, or 59% percent of the 289 individuals in the review sample, were men and 117, or 41%, were women. The number of public and family guardians was twice that reported in Annual Reports for the past five years, reflecting this review's focus on individuals living in ACHs. The average age of the individuals in the individual reviews was 58, which is on average 4-5 years older than if the review had included individuals living in the community. The number of individuals under the age of 50 decreased by 55%, from the percentage reviewed in FY 2024 and the number of individuals between 51-70 increased by 54%, as shown in Figure 4 below. These differences are likely the result of only reviewing individuals living in ACHs and FCHs, excluding individuals on transition status in those homes, and individuals living in the community.

Figure 4: Percentage Age Distribution

	21-30	31-40	41-50	51-60	61-70	0ver 70	Total
FY 2024 Report	13%	20%	23%	21%	20%	.02%	85
In-reach 2025	2%	4%	17%	23%	41%	12%[4]	289

Physical Disabilities and Chronic Health Conditions: There were a higher number of individuals with chronic health conditions and/or physical disabilities in this review, as seen in previous reviews. The sample size of individuals for a review of physical disabilities and/or chronic health

[3] The average age and guardian numbers are based on a subset of numbers based on availability of data

[4] One individual was 80 and another was 90 years old

conditions only included individuals if sufficient information was available for individuals who indicated they wanted to move and could move and individuals needing additional In-reach. In the 2024 Annual Review, 77% of the sample for whom information was available had at least one serious physical disability, chronic health condition, or deafness/blindness. In this review, 190 individuals or 84% of the individuals for whom information was available had at least one serious physical disability, chronic health condition, or deafness/blindness. The higher percentage in this ACH In-reach review was expected given that for the review the sample was only drawn for individuals living in ACHs or FCHs. This sample included fewer younger individuals by percentage than the 2024 sample and nearly all of the individuals in this review with no serious conditions listed were younger.

Seventy-four percent (74%) of the individuals had 2 or more chronic illnesses and/or physical disabilities. Eight individuals had five or more conditions. Two individuals in this group who wanted to move were blind, another individual had glaucoma causing a serious vision loss, and one individual was deaf.

This strongly suggests a significant number of individuals could benefit from services that recognize medical and behavioral health factors as important for overall health and their stability in their own home should they choose to move to the community. This can be done by blending or integrating behavioral health and primary care services together in one team or setting with a focus on health care and wellness in addition to tenancy support and behavioral health interventions. As stated in previous reports, a significant number of individuals will need daily assistance, home health and/or health care management, specialty care, accessibility features or equipment, and/or a unit with easier physical access (location of the building or in the building). Healthy lifestyle management, often provided by peers, could add value if utilized more regularly.

Three individuals suffered significant physical injuries, resulting from accidents, and 16 individuals had major physical disabilities requiring either a wheelchair, prosthesis, or other adaptive equipment and accessibility features. This includes four individuals who had amputations.

There was completion information available for an analysis of 100 individuals in this review to determine their number and types of physical disabilities and chronic medical conditions. This may not be a complete list as records did not always reveal medical conditions and physical disabilities. There were 30 different diagnostic categories or descriptions of medical problems and/or physical disabilities. Twenty-seven (27) individuals were reported to have high blood pressure, congestive heart failure, or another type of heart disease or failure followed closely by Type 2 diabetes, COPD, osteoarthritis, GERD, asthma, high cholesterol, and seizure disorders. There were 12 individuals reported to have diabetes, and seven (7) individuals reported to have COPD. Nine individuals had high cholesterol. Seven individuals were non ambulatory, either because of a single or double amputation or other spinal injuries, requiring some type of assistance. Five (5) individuals had either a degenerative disc disease or back injury. Two (2) individuals have had a stroke, and two (2) individuals have had heart attacks. Three (3) individuals

had, or current have cancer. Seven (7) individuals had a traumatic brain injury, and three individuals were blind in one eye. Three individuals were diagnosed with metabolic syndrome.

Individuals repeatedly expressed concern about their health conditions, particularly those with physical disabilities who need regular and frequent scheduled personal assistance or support, home health, and/or care management for their physical disabilities and chronic medical problems. The State has taken major steps to increase nursing and occupational therapy assessments. The State previously added funds to LME/MCOs' Medicaid payments for their Complex Care Initiative. This review also revealed individuals continue to be concerned about their health and challenges they would face moving to the community but likewise other individuals being adamant about their ability to move regardless of their physical disabilities and keenly aware of what help they would need. One woman summed up this determination, stating that if she could not stand at the stove, she would get a microwave.

REVIEW RESULTS

The major purpose of this review was to derive a sample of individuals living in ACHs and FCHs, eligible for TCL, to report the following: 1. individuals who reported choosing to move to the community; 2. those who need more In-reach either by self-report or reviewers' observation; and 3. those individuals and/or their family guardian who are choosing to remain living in the facility or wanting to move to another facility.

This was a point in time review. Circumstances often change for individuals, especially across the first two groups. This ranges from individuals no longer being able or wanting to move, especially when individuals cannot conceive of being provided assistance to move, not being able to conceive of a new life in the community or not having spoken with anyone to develop a plan that would enable them to move.

Individuals in the "needing more In-reach" category have even more health challenges, sometimes legal issues, pressure from families, other family circumstances, or facility owners that make it difficult for them to move. Conversely, individuals provided more In-reach and opportunities to visit with individuals in the community, as required in the Settlement agreement, and/or seeking out opportunities with peers and community inclusion specialists may decide to move. Experience shows it is possible individuals who have said no previously may change their mind.

For these reasons, the numbers listed below will fluctuate. Nonetheless, they provide the Parties with information about a range of possibilities and challenges in meeting both III. (B) Community-Based Supported Housing and III. (E) Discharge and Transition Processes requirements. It also provides LMEs with their information to establish priorities and allocate time for required tasks accordingly.

As the reviews began, it became clear that many individuals had not been seen "frequently" as required in the Settlement Agreement and, in a few situations, were not seen at all before the review was scheduled. Although "frequently" is not defined in the Agreement, regular interactions can help staff develop relationships with individuals who are considering whether to move or stay and who need support in making their decision. The Settlement requires individuals have an assessment at least every 90 days. An assessment is important but only part of the in-reach process. Frequent In-reach staff turnover makes it difficult to build lasting relationships, as new staff must repeatedly introduce themselves and establish trust before individuals feel confident about moving to supported housing. It was also evident as the reviews began that information regarding where an individual was living and other information regarding an individual's health status and eligibility had not been updated recently, in some instances for months or years.

The review began approximately one month after the Helene hurricane and flooding with several homes damaged and individuals relocated. Even though DHHS had several individuals listed as living in an ACH or FCH, the assigned LME did not have any information on the individual and two individuals had moved and were being served by another LME.

In this review, only three (3) public/agency guardians verbally supported a move out of 48 individuals with public or agency guardians. One of those guardians appeared to support the individual moving but would not take action because his mother was negative about the move. Eight (8) public/agency guardians did not allow anyone, including the In-reach worker, to visit the individual; several others indicated the In-reach worker could visit but was not allowed to talk about housing. Nine (9) individuals with public/agency guardians requested more IR visits and three (3) were living in the community. One public guardian told a reviewer "his time had passed (to move)."

In-reach workers noted, and it was confirmed, that public and agency guardians rarely visited, with one guardian needing directions to the ACH to attend a review. The Reviewer met with or talked with one public and four (4) agency guardian agency staff and agency leadership in separate meetings. One DSS leadership staff, Mecklenburg, was supportive of working with Alliance to continue to build a strong mutual working relationship and to explore opportunities for individuals to live in the community. This is in large part because the Alliance leadership has taken the time to build this relationship. One DSS director declined the interview, indicating she was too busy for an interview.

Based on these findings, documentation, and discussions with state staff and guardianship agencies, individuals with public or agency guardians were placed in the "needs more In-reach group."

The circumstances for placing other individuals on the "needs more In-reach" list varied widely as referenced above, including the need for additional assessments and/ or complex care reviews, health related issues including individuals recovering from surgery, unable to locate, impacted by

Helene, and more visits for individuals not seen often if at all or given the opportunity for community visits, individuals requesting more visits, and both the reviewer and In-reach worked needing more information.

Individuals who have chosen not to move and family guardians making the same choice were, on the whole, clearer on their reasons for agreeing that individuals could move than public guardians. Public guardians often did not give specific reasons or referenced tasks and skills individuals would have to have that they could not gain in an ACH or FCH. Of the 32 individuals that were identified as having family guardians out of the 151 individuals reviewed, 17 family guardians refused to consider whether an individual could entertain moving, four (4) guardians gave individuals choice, and two (2) did not have a qualifying diagnosis thus were not considered.

Figure 5: Individual Choices[5]

Individuals:	Alliance	Partners	Trillium	Vaya	Totals
Choosing to/Can Move to SH	13	18	14	2	47
Needs more In-reach	21	55	17	10	103
Choosing to Stay in an ACH/FCH	17	14	14	10	55

Assuming the validity of the sample and number of individuals living in ACHs and FCHs at the time of the review, the Reviewer projects that up to 470 individuals on In-reach status living in ACH/FCHs could move, 1030 individuals need more In-reach to determine interest and ability to move, and 550 individuals are likely to choose to remain, or their family guardian would be unwilling to consider such a move. When the number of individuals choosing to move is added to 314 individuals on ACH transition status on February 17, 2025, the number choosing to move is 784, not including individuals on the continued In-reach status.

Another finding from this review was the number of individuals living in ACHs who do not meet TCL eligibility requirements, the number who are living somewhere else, are deceased, or have been diagnosed with dementia. This was reflected in the high number of individuals not seen for a face-to-face interview, which was 138 or 48% of the sample. DHHS reported 2,696 individuals on In-reach status living in ACHs/FCHs on September 4, 2024, two weeks before the review started and 2,265 on April 22, 2025, a drop of 431 individuals.

This was in part expected since only 79% of individuals had been seen in 90 days according to the first quarter of FY 2025 data ending on September 30, 2024. DHHS reported in September 2024 that 87 individuals had not been seen in the last 365 days. This was reduced to eight (8) by the end of February 2025.

Below is a chart depicting the findings for individuals reviewed. Those not located and individuals either incarcerated or hospitalized and likely to return to the ACH are included in this chart. There

[5] Individual choices include choices made by guardians

were a few exceptions to these situations. Individuals not seen, even in another location per Medicaid claims and individuals likely to be incarcerated for an extended period of time because of the nature of their crime were placed in the cannot move group. Individuals refusing to speak to the reviewer were counted in the number of individuals who cannot or will not move. In-reach staff reported they had made multiple attempts to work with each of these individuals.

Figure 6: Individuals not Seen

	Alliance	Partners	Trillium	Vaya	Total
LME may request, has, or in process of requesting an individual be withdrawn	16	14	10	9	49
Living in the community, (incl a group home)	6	17	12	4	39
Unable to Locate (UTL) [6]	11	12	12	0	35
Moved to an SNF permanently, has dementia but still in an ACH (23)[6]	9	7	3	4	23
Does not have a qualifying diagnosis	1	2	5	1	9
Hospitalized, incarcerated, or impacted by Helene at the time of the review[7]	1	3	3	1	8
Deceased	0	2	3	1	6
Refused a visit when Reviewer arrived	0	2	3	0	5
Moved and switched services to another LME	1	1	0	0	2

Living Conditions and Locations: The Review Team had access to most ACHs during this review and an opportunity to interview individuals inside and outside the home. The ACHs continue to range from clean to homes that appeared poorly maintained, mostly due to the age of the building, to being loud and not inviting, with crowded and dimly lit hallways and rooms, and individuals with clothes that were dirty and did not fit them.

There were two individuals who the LMEs could verify were homeless at the time of the review. One service provider said that one man living in a tent in the woods was safer there than in

[6] UTL does not include 12 individuals served by Partners that were relocated following Helene and not reviewed.
[6] LMEs have either or are in the process of requesting withdraws for individuals who have permanently moved to an SNF or remaining in an ACH or FCH following their confirmed dementia diagnosis. LMEs were seeking confirmation on individuals during the time of this review. There may be some overlap between these numbers and the withdrawn numbers above. One individual was in an SNF temporarily and is moving to the community. [7] Individuals in this category remain on the continued In-reach list unless multiple types of attempts to locate the individual have failed

another location. The LMEs indicated they also could not locate 26 individuals in the sample although they were still searching for some individuals and able to locate a few.

There were at least two individuals in the review sample living in unlicensed group homes or boarding homes. Residents of unlicensed group homes typically pay between $600 or $800 a month in rent and have to buy some or all of their meals.

Recommendations

1. The DHHS Olmstead Team: continue its focus on data collection, quality assurance to measure the agreed upon settlement requirements and purposeful performance improvement strategies the state LMEs can adopt as strategies to meet outcomes. The state Olmstead team's bi-monthly reports reveal these efforts and demonstrate that they are reporting data in a timely manner with the key issues staff must address. Their reports trend changes over time with attention to frequency of visits, removing barriers for individuals not diverted from ACHs and FCHs, identifying overlapping responsibilities, improving the individual decision-making process, strategies for engagement, utilization of peers, and facilitating transition responsibilities.

2. The LMEs should ensure each individual on In-reach who is either indicating their choice to move or requesting/needing more in-reach has a plan for their needs and support as they move. This extends not just to the group sampled in this review but to all the remaining individuals on In-reach status. It is especially important because of individuals' physical limitations, medical conditions, and medication needs. Ideally, this plan can have a focus on wellness and recovery strategies, health outcomes and stability. This can flow from conducting assessments where needed, Complex Care evaluations, and other information, including ensuring individuals are part of this process and helping identify their needs. It should not be an immediate demand but rather integrated into their existing processes. LMEs are uniquely prepared to develop these processes themselves although this will take time and sufficient resources.

   While planning for individuals who can and want to move quickly is important, it is equally important to plan ahead for individuals who will need accommodations, including a fully accessible unit, identification, and other help to get a lease. Individuals often look to their families for help and assurance that they agree with the plan.

3. Promote and build working relationships between public and agency guardians who provide guardianship for a significant number of individuals living in ACH/FCHs with LMEs. LMEs are uniquely suited for building relationships with these organizations as demonstrated by the recent outreach of the Alliance and Vaya Health. The State's Olmstead Team and DSS play an instrumental role promoting these relationships.

4. Ensure all the requirements of **Section III (D)(2)** are met with a special emphasis on "providing information about the benefits of supported housing; facilitating visits in such settings; and offering opportunities to meet with other individuals with disabilities who are living, working and receiving services in integrated settings, with their families and with community providers." Three important considerations with this recommendation:
    a) Take concurrent steps with service providers to ensure that when describing benefits that service providers become a part of those discussions and follow through on making those benefits available. Recent reviews of services indicated that most providers are not yet fully invested in ensuring those benefits will be made available.

    b) Each LME will need the flexibility to develop these arrangements based on their unique geography and staffing resources and can identify what steps they can take to achieve this step. Some tasks, including facilitating and supporting visits, can be done by In-reach staff. It is also important to provide resources, like ambassadors and community inclusion specialists, to help individuals make visits to community. Settings and meet with individuals who have moved successfully.

    c) In addition to facilitating community visits, Ambassadors, peer support specialists and community inclusion staff can lead day-to-day support to help individuals take small, simple steps towards wellness and recovery as part of this effort. This can be especially effective helping individuals build an exercise routine, learn to walk again, begin to explore cooking again, identify where they want to live, join a support group, etc. While this work is highly individualized, it is also a way to build a supportive community.

Summary

This sampling review provided valuable information for forecasting the work ahead to enable the State to meet its obligations for assisting individuals living in an ACH or a FCH, who qualify for TCL, to gain access to community-based supported housing as required in **Section III (B)(2)(a)(b) and(c) and (B)(5)**. (B)(5) requires 2,000 slots be provided to individuals in the (B)(2)(a)(b) and (c) categories.

Individual situations, sometimes an individual's fear, influence of others, or inability to comprehend that they could live outside of the home, will always dictate an individual choosing to move. However, the Settlement Agreement provides requirements that, if met, can help an individual make this choice. For example, the **Section III (B)(7)** requirements identify steps, supports, and conditions that, if met, enable individuals to move and live in the community as do many other services and transition requirements. Beyond these, through reviews and experience, we have learned that when supports are not available or individuals are less likely to move. Some individuals who attempted to move to supported housing have reported insufficient support for community living, similar to those who moved

but subsequently returned to ACHS. These factors discourage individuals from moving. Public guardians and families hear and see the same outcomes and public guardians are often closed to the idea that someone can live in the community, especially when it is described as "independent living."

A significant number of ACH and FCH staff and owners also discourage moving and sometimes impede it completely on a regular basis. In-reach staff, other LME staff, providers, and the State staff must constantly dispel myths and improve practices to achieve the required outcomes of this Agreement.

Established local and state barriers committees provide the platform for raising and resolving obstacles and advancing new supports. The LME/MCOs have established critical complex care teams to identify individuals' challenges with their health and medical conditions, their physical disabilities, and daily living and environmental challenges. When identified, it is possible for individuals to overcome their physical, emotional, and social challenges, which can help an individual live as self-sufficiently as possible. This is enhanced further when combined with peer support, community inclusion support, and other opportunities for community support.

While this review provided more information about individuals living in ACHs and FCHs, it also illustrated challenges the State has meeting the requirements referenced in this report.