

**REPORT OF THE INDEPENDENT REVIEWER**

**In the Matter Of**

**UNITED STATES OF AMERICA v. THE STATE OF NORTH CAROLINA**

**Case 5:12-cv-00557-D**

**Submitted By: Martha B. Knisley, Independent Reviewer**

**October 26, 2019**

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## INTRODUCTORY COMMENTS

This is the sixth Annual Report<sup>1</sup> issued on the status of compliance with the provisions of the Settlement Agreement (SA) in United States v. North Carolina (Case 5:12-cv-000557-F) signed on August 23, 2012. The report documents and discusses North Carolina's (the State's) efforts to meet required obligations by June 30, 2019, and the State's overall progress in meeting all the Settlement Agreement obligations.

The State has agreed to develop and implement effective measures to prevent inappropriate institutionalization and to provide adequate and appropriate public services and supports. The State has agreed to use an individualized person-centered planning approach to provide services in the most integrated setting appropriate to the needs of the SA's "target population": individuals with Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI), who are in or at risk of entry to an Adult Care Home (ACH) or State Psychiatric Hospital (SPH). The State refers to the services, supports and resources referenced in this Settlement Agreement as the Transitions to Community Living Initiative (TCLI).

Six threshold compliance requirements in this Settlement Agreement cover: Supported Housing Slots, Community-Based Mental Health Services, Supported Employment, the Discharge and Transition Process, Pre-screening and Diversion, and Quality Assurance and Performance Improvement. The State is not yet on track to make all the improvements and changes necessary to comply with the Settlement Agreement.

As stated in the four previous Annual Reports, an effective community-based services and housing system, as contemplated in the Settlement Agreement, can only be developed if a robust set of structural pre-conditions are in place, improvements are being made continuously and leaders, stakeholders, and staff at all levels strongly support needed changes to reach compliance.

These changes are important for individuals eligible for services and resources identified in the Settlement Agreement, but also for the broader adult mental health system for individuals with serious mental illness. To separate the development of needed changes between those individuals who are currently receiving services and resources identified in the Settlement Agreement and those who have not been made eligible would be a mistake for two reasons. First, the populations are not entirely separate. Individuals become part of the Settlement Agreement's target population continuously. Second, developing and managing two separate

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<sup>1</sup> The Settlement Agreement requirements extend through June 30, 2021.

systems is costly, duplicative, and confusing to individuals, providers, and stakeholders. Sustainability is less likely; States cannot afford or adequately manage two systems.

The State is not making sufficient progress to meet Community-Based Mental Health Services requirements in the Settlement Agreement. Broadly stated, the State is required to develop and implement effective measures to prevent institutionalization and to provide adequate and appropriate public services and supports identified through person centered planning in the most integrated setting appropriate to the needs of individuals with SMI, who are in or at risk of entry into an adult care home.

In the first and third paragraphs of section **III(C)(1)(3) Community-Based Mental Health Services** in the Settlement Agreement states: “The State shall provide access to an array and intensity of services necessary to enable individuals with SMI in or at risk of entry into adult care homes to successfully transition to and live in community-based settings. The services shall be evidence-based, recovery focused and community-based, flexible and individualized to meet the needs of each individual. Services shall help individuals increase their ability to recognize and deal with situations that may otherwise result in crisis; and increase and strengthen individuals’ networks of community and natural supports, as well as their use of these supports for crisis prevention and intervention.” This report will detail the shortcomings of the services and supports provided to individuals with SMI in accordance with these Settlement Agreement obligations.

The State is not on track to meet the requirement to provide two thousand (2,000) housing slots to individuals exiting ACHs. This has to be done at the same time the State is required to provide housing slots for individuals who are or will be discharged from a SPH who are homeless or have unstable housing and individuals diverted from entry into ACHs who choose to live in Supported Housing. The State has made little progress providing timely access to supported housing for individuals being discharged from SPHs. In addition, the State is not making necessary progress to provide access to Supported Employment services for individuals who have been determined eligible for the TCLI program.

The State met the FY 2019 requirement for individuals living in Supported Housing with a housing slot. This is a major step forward and the first time the State has met its annual requirement for individuals living in Supported Housing.

The North Carolina’s Local Management Entities/Managed Care Organizations (LMEs/MCOs) who have obligations in this Settlement Agreement continue to provide critical In-reach services and manage Transition Processes necessary for eligible individuals to get needed

services and supports and secure permanent supported housing when exiting ACHs. The State is actively pursuing support from healthcare providers to provide care management and services for individuals who are transitioning to the community who have chronic medical conditions. The State is making good faith efforts to improve the areas where the State is not on track or where progress has been slow, but their efforts are not yet effective.

The State made progress developing their Quality Assurance and their Performance Improvement system. While challenging, the State and the LMEs/MCOs made progress meeting Pre-screening and Diversion requirements. The State overhauled their budget and allocation process. As a result, they have improved their accuracy in monitoring expenditures and improved the timeliness of their allocations.

Referrals to the TCLI program continue to rise dramatically. The number of individuals identified as meeting eligibility criteria for the Settlement Agreement will increase above twenty-five percent (25%) of all adults with serious mental illness getting public services in North Carolina in the past month. Policy change, funding and services improvements need to keep pace with demand in order for Settlement requirements to be met. This does not happen consistently. If implemented, systems improvements referenced in the Settlement Agreement will likely have positive benefits for individuals who have a serious mental illness regardless of whether they meet the target population criteria. This has two benefits. It helps the State shape the future with greater reliance on more cost effective community services and housing, and, more importantly, individuals in TCLI will get the benefits of an improved community-based system over the long term.

Staff of the NC Department of Health and Human Services (DHHS) has been helpful with requests for information and questions about compliance efforts. Kody Kinsley has provided leadership to improve DHHS's management, budgeting and oversight role and to draw attention to the need to strengthen the overall system's implementation of this Agreement. Sam Hedrick has continued to provide strong leadership in the role of Senior Advisor to the DHHS Secretary. Drew Kristel, AnneMarie Wiwatowski, Vicki Callair, and Jessa Johnson from DHHS and Paul Kimball and his team from the NC Housing Finance Agency, plus many others in both agencies, have been responsive to requests and have taken on new challenges to further the implementation of this Agreement.

The Local Management Entity/Managed Care Organization (LME/MCO) Chief Executive Officers (CEOs) and their staff have given their time, provided insight, answered endless questions, and responded to requests in a thorough and timely manner. The University of North Carolina (UNC) Institute of Best Practices and the i2i Center for Integrative Health, The

Disability Rights Network (DRNC), National Alliance for the Mentally Ill (NAMI) NC, Association of Retarded Citizens (ARC), NC Coalition to End Homelessness, NC Housing Coalition, and NC Justice Center have taken a special interest in this Settlement Agreement and how it can contribute to North Carolina making progress serving adults with serious mental illness.

## **METHODOLOGY**

The methodology for compiling this report is essentially the same as that used in the reports for the four previous years, FY 2015-18. Each year, special reviews and reports focused on key issues added to the Annual Report. Reviewer requested that the state provide data and documentation of its work for each compliance item. Reviewer assessed the Department's progress in meeting the provisions of the Settlement Agreement, in work sessions and Parties meetings, in discussions with providers and community stakeholders and through site visits to LME/MCOs, ACHs, supported apartments and individuals' residences, provider offices, and state psychiatric hospitals. Information contained in this report covers the SFY 2019 ending on June 30, 2019.

Elizabeth Jones, Damie Jackson-Diop, and Patti Holland again conducted individual services reviews and provided expert consultation. The Reviewer and her team met with LME/MCO executive and management staff in all seven catchment areas on multiple occasions. The Reviewer and staff conducted twenty (20) Assertive Community Treatment (ACT), Tenancy Support Management (TSM), Community Support Teams (CST), and Individual Placement and Support-Supported Employment (IPS-SE) roundtables with representatives of multiple providers in the seven catchment areas. The review team held meetings with local DSS staff and DVR staff, statewide and regional ACT and IPS-SE coalitions and other statewide groups. The Reviewer and staff met with key staff of the Broughton, Central Regional, and Cherry Hospitals during site visits to the hospitals.

The Reviewer held frequent meetings with DHHS staff, including monthly "work days" with TCLI leadership and representatives from a number of Divisions, including Mental Health, Developmental Disabilities and Substance Abuse, Vocational Rehabilitation, Medical Assistance, Aging and Adult Services, and State Operated Healthcare Facilities. The NC Housing Finance Agency (HFA) staff attended the workdays. Reviewer held separate meetings with the NC HFA, TCLI staff, and Regional Housing Coordinators as needed. Reviewer conducted two interviews with the DHHS supported housing consulting team from the Technical Assistance Collaborative (TAC). The Reviewer and expert team members participated in IPS, CST/TSM, supported housing, budget, pre-screening and ACT conference calls.

The Reviewer and her team held focus groups and/or staff interviews in seven catchment areas. The team conducted interviews with individuals in the target population, service providers, guardians, long-term care ombudsmen, and LME/MCO staff including In-reach staff and Transitional Coordinators, care coordinators, network staff, housing coordinators, and administrative and clinical staff. The review team held focus groups with LME, ACT, and IPS-SE provider staff in five catchment areas.

Senior LME/MCO staff were typically present in either exit or entrance meetings and in some interviews. Sam Hedrick, Stacy Smith, DMH Adult Services Team Lead and her staff, and Stacey Lee, DMH TCLI Diversion Lead were also present for a number of interviews and reviews, which was extremely beneficial. The Reviewer examined documents including TCLI Monthly and Annual Reports, Fidelity Review summaries and contract documents, LME/MCO allocation letters, DHHS Bulletins, manuals, and review documents covering the pertinent areas of compliance inquiries. Upon request, the DHHS TCLI staff provided additional data for review.

Individual recipient reviews (individual reviews) were conducted in seven LME/MCO catchment areas. Three review methods were used: (1) a review of individual recipient records including a review of Person Centered Plans and In Reach and Transition documents; (2) interviews with individual recipients using a short tool to summarize impressions and collect data consistently; and (3) interviews and meetings with LME/MCO staff, service providers, family members, and ACH and SPH staff. In a limited number of situations, the review team had to conduct a phone interview rather than an in-person interview.

The Reviewer used a proportional random sampling method to ensure the individual reviews reflected the target population accurately. There were names drawn randomly across each LME/MCO catchment area: Alliance Behavioral Health Care (Alliance), Eastpointe, Partners Behavioral Health Management (Partners), Sandhills Center for Mental Health & Developmental Disabilities (Sandhills), Cardinal Innovations Healthcare (Cardinal), and Vaya Health (Vaya). The sample was also stratified to assure at least one individual living in an ACH, one living in their own home (supported housing), one who had moved to their own home but then returned to an ACH, and one being served in a state psychiatric hospital, were selected in each catchment area. In FY 2019, the Reviewer over sampled individuals being pre-screened for admission to an adult care home because the State implemented a new Pre-screening and Diversion process.

In FY 2019, the review team conducted two reviews:

(1) IPS-SE Review: Patti Holland, the Reviewer's IPS-SE Expert, submitted a brief report to the Reviewer summarizing her findings and recommendations on IPS-SE. There is a reference to this report in the Supported Employment **(Section III. (3)(D))** below.

(2) Pre-screening and Diversion interviews with each LME/MCO. There is a summary of those reviews in Pre-screening and Diversion **(Section III. (3)(F))** below.

In FY 2018, the team conducted a TCLI Data Analysis, SPH Baseline Discharge Review, and a Housing Separations Review. This Report references improvements, changes, and challenges seen in FY 2019 that related back to findings in the FY 2018 reports.

### COMPLIANCE FINDINGS

This report assesses the State's compliance with each of the Settlement's substantive provisions as of June 30, 2019. The narrative portion of this report specifically addresses the provisions in the order listed in the Settlement Agreement: Supportive Housing Slots; Community Based Mental Health Services including Access, Person Centered Planning, ACT, Crisis, other services, and PIHP responsibilities; Supported Employment (SE); Discharge and Transition Process including In-Reach; Pre-Screening and Diversion; and Quality Assurance and Performance Improvement. Findings are related to the State's compliance with each major requirement. As with the 2018 Annual Report, this year's report embeds the compliance chart in each section rather than at the end of the report. This report includes a section for broad recommendations although recommendations are also included with each provision. All references to plans, data, meetings, and activities refer only to actions taken, plans, meetings, or data provided for the fiscal year ending June 30, 2019.

The Settlement Agreement acknowledges that sustainable systems change requires time, attention, and deliberative action. The parties recognize that implementing and sustaining the structure, systems, and services for individuals with serious mental illness will occur in important incremental phases as outlined in the Settlement. Special attention is made in this year's Report to the major issues that still require systems change for the State to come into compliance. The Report includes reference to items that require practice improvements, steps to fill housing slots, required services, and integration activities; actions to meet requirements; or, a combination of these. The Settlement's last substantive deadline occurs on July 1, 2021.

The State is required to take “effective measures” to prevent inappropriate institutionalization and to provide adequate and appropriate public services and supports identified through person centered planning in the most integrated setting appropriate to meet the needs of individuals with SMI, who are in or at risk of entry to an adult care home as referenced above.

The review team assessed the measures in multiple ways. In some instances, the State has met its annual obligations, but the measures must be effective to meet other related obligations. If services and supports are available but are not "adequate and appropriate" or measures are not effective, the State may not be in full compliance with the provision. If a requirement is trending in the wrong direction, it is noted. When there is progress toward meeting compliance for a specific requirement but that progress is not sufficient for a finding of compliance, this is noted.

Individual Reviews: Below is a general description of the sample and specific issues that have broader relevance. There is reference to information regarding findings from the individuals throughout the report, in the Sections relevant to the findings.

Number of Reviews: There have been four hundred and sixty-six (466) individual reviews conducted over the past four and a half years, as part of the Individual Review process. This included thirty-five (35) reviews in the last six months of FY 2015, one hundred and six (106) in FY 2016, and one hundred and twenty (120) in FY 2017. Forty (40) were conducted in FY 2018. In addition, in FY 2018, the review team conducted sixty-one (61) separation reviews and twenty-one (21) baseline reviews of individuals identified as eligible for TCLI hospitalized in SPHs. The review team conducted one hundred and five (105) reviews in FY 2019; forty-nine (49) of the 105 were individuals in the process of Pre-screening or Diversion.

There was limited information on fifteen (15) individuals reviewed in FY 2019. Ten (10) of those were individuals referred for pre-screening. There were two (2) names pulled of individuals who pre-screened and not found eligible. Staff made a referral to care coordination for other assistance. One individual going through Pre-screening was determined not eligible for services.

Of the five (5) other individuals, there was no information available for one name pulled for the sample. There was one individual in the sample, living in an ACH, diagnosed with Alzheimer’s disease in 2009 before entering the program. He is still in the state’s database.

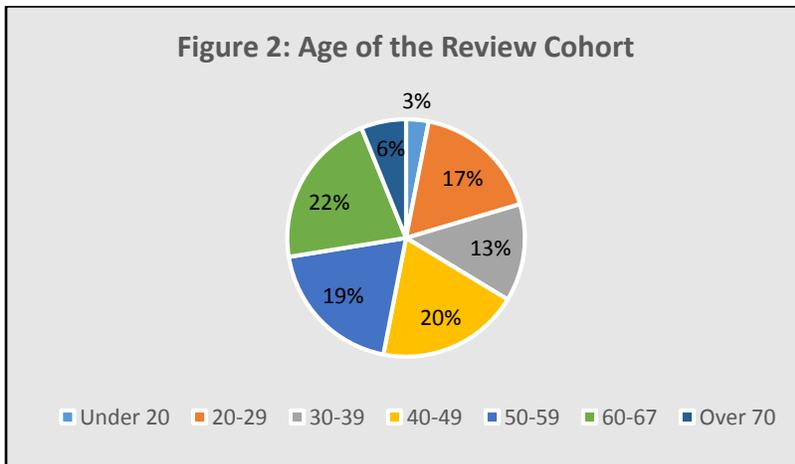
There were limitations with reviews for thirteen (13) individuals in FY 2019, either because the assigned LME/MCO was unable to locate the individual, or because the individual was in jail, hospitalized for medical reasons, or just referred through the new Pre-screening process and the

individual could not be located (8 individuals). One family guardian refused access but agreed to a phone call instead. One family guardian asked for an interview even though his daughter disappeared before her interview. One guardian was initially reluctant, and then agreed to an interview, but her provider did not inform the individual of the interview. For all the individuals not interviewed, the review team conducted record reviews and when possible third party reviews. As a result, information on some items below will not equal 105 and noted in the data. Twenty-eight (28) individuals or 30% of the sample had guardians.

**Figure 1: Demographic, Living Settings, Guardian, FY15-FY19 Sample**

Categories	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Average age <sup>2</sup>	54	49	55	60	47.2 <sup>3</sup>
Female	37%	43%	54%	52%	49%
Male	63%	57%	46%	47%	51%
Living in an SH with TCLI Housing Slot	37%	45 (43%)	33(28%)	18 (47%)	30(28%)
Living in an ACH	28%	29(28%)	35 (30%)	13 (34%)	16(15%)
Hospitalized in an SPH	11%	9 (9%)	16(14%)	2(1%)	10(10%)
Living in another location <sup>4</sup>	24%	29(27%)	33 (28%)	4 (10%)	49(47%)
Has a guardian	70%	37%	30%	15%	30% <sup>5</sup>

As referenced in **Figure 1**, in FY 2019, fifty-four (54) or 51% of 105 individuals in the sample were men and forty-nine (49) or 49% were women.



The average age of the individuals in the individual reviews was forty-seven (47). Services needs may be different for individuals in different age cohorts and this has significance for the State’s service array.

**Figure 2** depicts the age distribution of the priority populations.

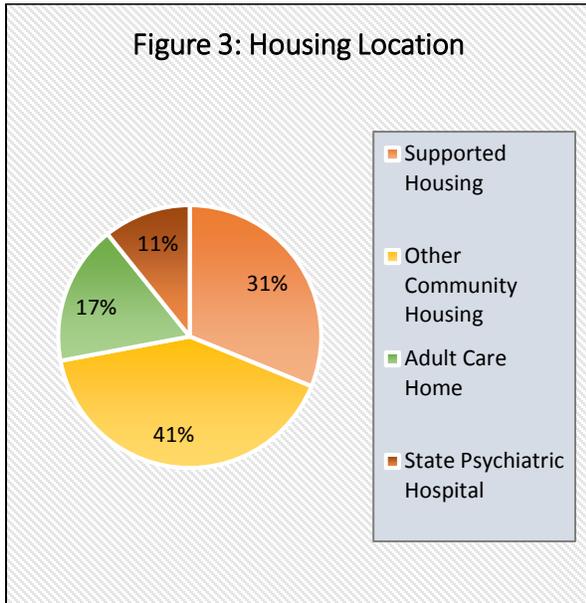
<sup>2</sup> The review team was unable to obtain the ages of six individuals being pre-screened or unknown to the LME-MCO.

<sup>3</sup> In FY 19, there were reviews conducted on 49 individuals being pre-screened before admission to an Adult Care Home (ACH) or in diversion status. This population is younger than individuals being discharged from ACHs. The pre-screening cohort average age was 44 and the average of individuals not going through pre-screening was 50.

<sup>4</sup> There was no information available on where twelve (12) individuals were living who were in the pre-screening process at the time of the review in FY 2019. Eleven (11) or 41% of individuals not in or having gone through the new pre-screening process of individuals living in the community were not living in Supported Housing.

<sup>5</sup> There was information regarding Guardianship on only ninety-seven (97) individuals.

Forty (40) individuals in the cohort were between the age of fifty-one (51) and seventy (70). Twenty-four (24) were between the ages of 41-50. Nineteen (19) were under the age of thirty-one (31), including three individuals who were nineteen (19) at the time they were referred through pre-screening. Ten (10) were between age 31-40 and five (5) were over age seventy (70), including two (2) over the age of eighty (80).



**Figure 3** displays where individuals were residing at the time of their review. The “other community setting” percentage is higher in part because this year’s reviews including individuals being pre-screened. The SPH percentage is lower to accommodate the need to do more pre-screening reviews. However, these percentages are likely going to be representative of where the priority populations are residing going forward. This also has implications for the State in planning its service array. It is likely there will be as many individuals living in other community settings as those living in supported housing.

Fourteen (14) individuals or 14% of the sample for whom information was available had a physical disability, chronic health condition, or were deaf and as a result needed accessibility features or equipment or needed a unit with easier physical access (location of the building or in the building). Two individuals used a wheelchair all or part of the time. One of the individuals who had had a stroke had only limited physical therapy while living in a skilled nursing facility and none after he moved back to an adult care home. He had bruises all over his body from falls. People continued to knock him over when he was using a walker, so he had started using a wheelchair. A third was concerned he could not continue to use steps or get around without help. A fourth used a walker. One individual was recovering from a stroke and two individuals were recovering from knee surgery. Their need was for equipment for the short term. Two individuals were recovering from open-heart surgery.

Other individuals had either physical pain, COPD or arthritis making walking difficult and expressed difficulty walking long distances. One woman lived at the end of a long hall and had already asked for an apartment closer to the door of the building. One woman who is deaf had equipment she needed installed before she moved. DHHS is making a concerted effort to increase the availability and installation of equipment for individuals who are deaf or hard of hearing.

Analysis indicates sixty-nine percent (69%) of the individuals seen, for whom the review team had information, had at least one chronic health condition. Twenty-five percent (25%) had more than one (1) and seven (7) had more than four (4) serious conditions. This continues to have implications for the State meeting services requirements. A number of individuals referred through the new pre-screening process had serious medical issues. There is discussion of this issue in the **Section III (V) Pre-screening and Diversion** of this Report.

Mental health service providers, including Peer Support staff and Tenancy Support staff, need to have basic knowledge of and assist, when appropriate, with daily self-care and or treatment needs such as taking insulin, checking blood pressure, exercising, adhering to a special diet, etc. Mental health treatment and medical personnel should work together on medication and other treatment decisions.

ACHs continue to range from being well maintained , to homes that are less well maintained, with the latter often noisy with many residents walking up and down the halls, sitting in wheelchairs or in TV rooms, or sitting outside near the front door.

A majority of the rental units where individuals were living appeared to be in relatively good condition, well maintained, relatively clean, and not overly cluttered. Other units were in dismal conditions and some appeared to be in high crime areas. Some communities have a scarcity of affordable, decent private rental units, which accounts for some of the problems with rental units. These tend to be in either rural areas or fast-growing urban centers such as Asheville and Raleigh. Four (4) individuals visited were living in trailers; two of these were pre-screening visits. There will be additional information regarding individuals' living setting in **Section III (E) Pre-Screening and Diversion**.

Units appeared better maintained in Low Income Housing Tax Credit<sup>6</sup> (LIHTC) properties than in private non-LIHTC units. Individuals turned down for LIHTC units sometimes often have to choose less well-maintained units; sometimes these are in less safe neighborhoods. This is generally because their background checks reveal credit problems or criminal records or because they cannot find housing that is more suitable. Five (5) individuals spoke about feeling isolated or worried about the neighborhood and others deflected the question. This raises a concern regarding the availability of safe, decent private housing. There was an eleven percent (11%) net decrease in the number of individuals living in LIHTC units in FY 2019<sup>7</sup>. There

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<sup>6</sup> Low Income Housing Tax Credit (LIHTC) units are units in multi-family rental units that have either been constructed or rehabilitated with multiple sources of financing including Low Income Housing Tax Credits. In North Carolina, a portion of these units are set aside (targeted) for individuals with disabilities.

<sup>7</sup> There were five hundred and sixty eight (568) LIHTC units occupied at the end of FY 2018 and only five hundred and forty-two (542) at the end of FY 2019.

were reports from LME/MCO staff that accessible units or units with accessible features were not easy to find.

In summary, age, chronic health conditions, housing generally and accessibility issues are factors in individual's well-being and integration into the community. There appears to be a growing difference in outcomes between individuals who get housing that works for them and assistance to make a successful transition to the community and those who do not get supported housing at all or who get access to supported housing but are isolated, have housing and health challenges.

## I. SUPPORTED HOUSING

Major Categories	Summary of Requirements	Progress Towards Compliance
<p><b>Section III. (B)(1)(6)(7)(e)(g)</b>  <b>Section III. (B)(1)</b> requires the State to develop and implement measures to provide eligible individuals with access to community-based supported housing. <b>Section III. (6)(7)(e)(g)</b> refers to the criteria for determining types of allowable housing the State may utilize for the purpose of meeting the Settlement Agreement requirements.</p>	<p>These sections set forth requirements for the target population’s access to community-based supported housing and set forth allowable use of housing slots by types of housing. The requirements refer to the State being able to use “ongoing” programs to fill slots provided those ongoing programs meet specific criteria. These criteria require supported housing be scattered sites, with one exception for specific criteria for disability neutral housing and priority for single-occupancy housing.</p>	<p>The State has been working toward meeting these requirements. Challenges remain with assuring access to supported housing. Serious problems have increased with access to Targeted Units<sup>8</sup> in the State’s Low Income Housing Tax Credit (LIHTC) Program, partly related to limited availability but also with the State’s process to access units. In some areas of the state, availability of adequate housing is limited. The State issued final guidance that meets the 250 housing slots in disability neutral multi-family housing requirement.</p>
<p><b>Section III. (B)(2)(4)(5)</b> These sections define categories of individuals eligible for housing slots, the priority ranking for each group, and the requirement for the number of housing slots by type of priority group. There is a requirement that housing slots be provided to 2,000 individuals from Categories 1-3 on July 1, 2021, and the remaining 1,000 from Categories 4 and 5.</p>	<p>The Settlement Agreement defines five priority categories for the receipt of housing slots. The first three priority categories, <b>Section III. (B)(2)(a-c)</b>, include individuals residing in adult care homes by the size and type of home. The fourth category is for individuals who are in or will be discharged from an SPH and the fifth category is for individuals diverted from adult care homes pursuant to the Pre-Screening and Diversion provisions.</p>	<p>The State reports annually on the numbers of individuals provided housing slots for each category. The major compliance requirement associated with these requirements is for 2,000 slots for individuals in Category 1-3. This is not required until July 1, 2021. There were 1,132 individuals in categories 1-3 and 982 individuals in Categories 4 and 5 on June 30, 2019.</p>

<sup>8</sup> “Targeted” units are units set aside in the federal Low Income Housing Tax Credit program for individuals with very low incomes who have a disability or are homeless. Set asides are typically 10 to 20% of the total units in a multi-family complex. Owners agree to set aside units for a specific time period, typically no less than thirty years. This is a longstanding policy of the North Carolina Housing Finance Agency in partnership with the DHHS.

<p><b>Section III. (B)(3) The State will provide access to 3,000 housing slots</b> by the end of the Settlement period. The October 27, 2017 <b>Modification of Settlement Agreement</b> requires that by July 1, 2019, the State will be providing housing slots to at least two thousand one hundred and ten (2,110) individuals.</p>	<p>This requirement does not require a summary.</p>	<p>The State met the required annual target for this requirement in FY 2019. The State was providing housing to two thousand one hundred and ten (2,110) individuals on July 1, 2019. This was just over 100% of the FY 2019 annual requirement.</p>
<p><b>Section III. (B)(7)(a-d) and (f)</b> These sections and sub-sections describe criteria that housing slots must meet: integrated into the community, access to community amenities, and choice of daily activities.</p>	<p>This section includes a list of requirements that distinguish supported housing from other types of housing and residential services. Supported housing is permanent and individuals have Tenancy Rights. It includes tenancy support services. Individuals are afforded the opportunity to interact with individuals without disabilities. Individuals have access to community activities at the times, frequencies, and with persons of their choosing and have choice in their daily life activities.</p>	<p>The State has been diligent in ensuring individuals access is only to housing that is permanent and that individuals have choice of housing and Tenancy Rights. In some geographic areas of the state, individuals do not have the opportunity to access community amenities and typical daily activities because of either the location or lack of arrangements to assist the individual to get to amenities and/or activities. The review of tenancy support services is included as part of a Community Mental Health Services requirement in <b>Section III. (C)</b>.</p>
<p><b>Section III. (B)(8)(9)</b> These sections describe where the State cannot use slots and the process for giving individuals the choice of housing after informed of all the available options.</p>	<p><b>Section III. (8)</b> lists the types of housing where housing slots cannot be used. <b>Section III. (9)</b> describes the process the State must follow for individuals to choose other appropriate housing options.</p>	<p>The State has consistently met the <b>(B)(8)</b> housing exclusion requirement. There is still confusion regarding individuals' TCLI eligibility who do not take a housing slot at discharge from a SPH.</p>

**(A) Background**

The Community-Based Supported Housing Slots requirements in the Settlement Agreement require a comprehensive approach to assure the availability of, access to, and retention of affordable, safe, quality housing located in the communities and neighborhoods where individuals in the target population request to live. The approach to meeting supported housing requirements necessitates long term strategic planning to assure the State can meet and sustain compliance with this Settlement Agreement. It requires attention to individuals' access, including physical access, access to community activities and amenities, and tenancy rights when trying to lease a rental unit.

On October 27, 2017, **Section III. (B)(3)(f)** of the Settlement Agreement was modified to state that by July 1, 2019, the State will provide housing slots to at least two thousand one hundred and ten (2,110) individuals. The measure for this requirement is "occupied housing units." Findings, detailed below, demonstrate the State and LME/MCOs success in the short term in meeting this year's annual housing target. Findings suggest a number of challenges remain for the State to meet its housing obligations by July 1, 2021. These range from securing and financing enough safe, affordable, desirable housing units, the process of filling units, and reducing discrimination and separations from housing that make it more challenging for the State to meet its obligations.

Housing availability continues to be a major challenge. North Carolina has a shortage of 196,231 rental homes that are affordable and available to extremely low-income renters, whose income is at or below the poverty guideline or up to 30% of their Area Median Income (AMI)<sup>9</sup>. Even with a housing subsidy, which could cover up to 110% of Fair Market Rent (FMR), there is still a shortage of units for the low-income group. Individuals with disabilities make up 46% of all households at the extremely low- income level. With a rental subsidy, most individuals cannot find a suitable unit since not enough affordable units are available in North Carolina for individuals and families with low incomes.

Only forty-three (43) affordable and available rental homes exist for every one hundred (100) extremely low-income renter households (30% or below of the Area Median Income [AMI]) and sixty-seven (67) units for every one-hundred low income household units (50% of the AMI). Extremely low-income households face a shortage in every state and major metropolitan area. In the Charlotte (including Gastonia and Concord), Raleigh (including Johnston, Franklin Durham and Orange Counties, Asheville (including Henderson County), and Wilmington communities, and Brunswick, Camden, Currituck, Dare and Franklin counties, the average cost for a basic unit is above 100% of the monthly Supplemental Security income (SSI) income of \$771<sup>10</sup>.

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<sup>9</sup>*The Gap Report: A Shortage of Affordable Homes.* The National Low Income Housing Coalition (2019).

<sup>10</sup> *Out of Reach: A Shortage of Affordable Homes.* The National Low Income Housing Coalition (2019).

A recent Freddie Mac study shows that between 2010 and 2017, 86% of the nation's metro areas experienced a loss of affordable units. During that time, the Raleigh-Durham area lost over 40% of its affordable units, ranking second in the nation in the loss of affordable units. The Charlotte metro area was 7<sup>th</sup> in the number of lost affordable units<sup>11</sup>.

The situation became more complicated in recent years when, because of an earlier turn down in the economy, there were fewer federal LIHTCs allocated. In 2017, the NC HFA required twenty-seven hundred rental units (2,700) be "placed in service"<sup>12</sup> based on earlier awards. Four hundred and fifty-four (454) one-bedroom rental units and three hundred and thirty-one (331) targeted units were made available as part of that allocation. In FY 2018 the total number of units dropped to eight hundred and fourteen (814), with two hundred and one (201) one-bedroom units and eighty-four (84) targeted units that are "set aside" for individuals with disabilities in Low Income Housing Tax Credit properties. In FY 2019 availability rebounded to four thousand five hundred and thirty-one (4,531) units with one thousand one hundred and ninety-five (1,195) one-bedroom units and four hundred and sixteen (416) targeted units. By 2019, there were nearly thirty-five hundred (3,500) federal low-income housing tax credit units designated as targeted units and filled.

The swing from a high number to low number to high again is an important indicator for determining the availability of affordable rental units and units designated for individuals with disabilities. These numbers depict availability of new units, either new construction or rehabilitation and do not include availability of units on turnover.

DHHS continues to contract with the Technical Assistance Collaborative (TAC), to provide guidance on steps the State can take to meet the Settlement goals and to create a broader strategic housing plan. TAC assisted the DHHS to develop a "Pipeline Production Plan." In 2018, TAC recommended the State take advantage of multiple capital or rental financing and funding opportunities, including the HUD Mainstream program described below, making changes in the Qualified Allocation Plan (QAP) to provide more incentives in the LIHTC program for the target population.

TAC urged DHHS to work with the NC HFA on a plan for income averaging and to continue to utilize available funds for the Integrated Supported Housing Program (ISHP) and the Supported Housing Development Program (SHDP). TAC recommended that DHHS and the NC HFA continue to pursue resources for the private rental market and take advantage of opportunities to work with local Public Housing Authorities (PHAs) to create project-based vouchers. TAC also recommended reconsidering HOME Investment Partnerships Program funding and the National

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<sup>11</sup> *Diminishing Affordability-Inescapable*. Freddie Mac Multi Family Research Center (2019).

<sup>12</sup> Term used to signal that a unit has its certificate of occupancy and begins depreciation period for tax credits. It is a more reliable date to use for determining number of units that are going to be available rather than the date of the tax credit award. Housing Finance Agencies determine the date a unit must be 'placed in service.'

Housing Trust Fund as resources since both have received federal funding increases in the past two years.

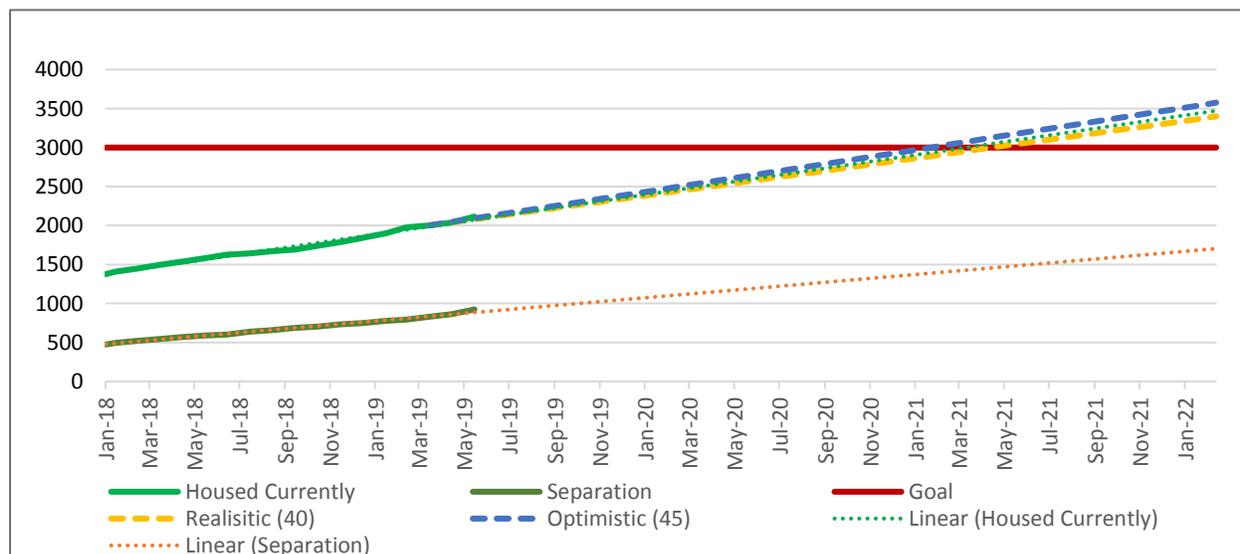
In 2018, TAC raised concerns about the State’s service strategies not being as robust and clear as needed for individuals to get and keep housing and cited breakdowns with handoffs between staff (Regional Housing Coordinators, TCLI staff, and service providers) and in treatment and care coordination both in the pre-tenancy and post-tenancy phases of housing. The State has recently taken steps to improve service strategies. The result of these recommendations is included in the findings section below.

**(B) Findings**

1. The state made significant progress providing housing slots for the target population in 2019 and is taking steps to increase housing slots for the next three years (**Figure 4**). The number of slots filled in FY 2019 increased from fifteen hundred and eighty (1,580) to two thousand one hundred and fourteen (2,114). This was a 27% increase or an average increase of thirty-five (35) slots filled per month. In the last quarter of FY 2019, the average number of slots filled was forty-four (44) per month. Based on an optimistic projection, the State will meet its housing slots filled requirement of three thousand (3,000) by April 1, 2021. Considering a range of variables, the State will be at or just short of meeting the Settlement Agreement requirement of 3,000 slots filled by July 1, 2021.

These variables include the continuing trend of a high separation from housing rate, the State not always being consistent in meeting their target from month to month, availability of affordable units in high demand areas and the flat trend with filling targeted units.

**Figure 4: TCLI Housing Slots Filled Projection**



The LME/MCOs continue to fill units mostly proportionate with their population numbers, Medicaid enrollment, and location of ACHs, their priority population for filling units (**Figure 5**). Eastpointe and Trillium both struggled after Hurricane Florence. Eastpointe, in particular, had a net loss in units filled for a four-month period but recovered in the last half of the fiscal year. The State uses a formula to set the LME/MCO annual “housing slots filled” performance target, that sets targets for smaller LME/MCOs higher than their population and Medicaid penetration and sets targets lower for larger LME/MCOs. This may affect the state meeting its housing slots filled requirement by July 1, 2021.

**Figure 5: FY 2019 Currently Housed by Type of Unit by LME/MCO**

LME/MCO	TCLI recipients	Targeted/ Key	Other	Private Units Filled	% Total Units Filled <sup>13</sup> by LME/MCO- FY 18	% Total Units Filled by LME/MCO-FY 19
Alliance	171	118	2	171	14%	14%
Cardinal	482	126	7	482	30%	29%
Eastpointe	138	32	4	138	9%	8%
Partners	192	61	11	192	13%	13%
Sandhills	182	44	7	182	10%	11%
Trillium	223	61	5	223	12%	13%
Vaya	136	99	13	136	12%	12%
<b>Total</b>	<b>2114</b>	<b>541</b>	<b>49</b>	<b>1524</b>	<b>100%</b>	<b>100%</b>

- The LME/MCOs continued to expand the use of private, non-targeted (low-income housing tax credit unit) units. The LME/MCOs have cultivated property owners and managers and used incentives for referrals. Vaya and Alliance have a greater percentage of LIHTC units filled in part because three properties with new ISHP “set aside” units took new referrals in FY 2019 (**Figure 6**). Partners housing staff has done an exceptional job cultivating both private owners and tax credit developers.

**Figure 6: FY 2018-2019 Currently Housed in a Private Rental unit by LME/MCO**

LME/MCO	TCLI recipients	Private Rental Units Occupied in FY 18	Private Rental Units Occupied (increase) in FY 19	% Change
Alliance	291	91	171 (80) 59% of total	53%
Cardinal	615	347	482 (135) 78% of total	28%
Eastpointe	174	99	138 (39) 79% of total	28%
Partners	264	129	192 (63) 73% of total	33%
Sandhills	233	108	182 (74) 78% of total	41%
Trillium	289	127	223 (96) 77% of total	43%
Vaya	248	77	136 (59) 55% of total	43%
<b>Total</b>	<b>2114</b>	<b>978</b>	<b>1534 (556) 72% of total</b>	<b>36%</b>

<sup>13</sup> Percentage of units filled statewide

In some areas of the State individuals appear to have limited choices for housing based on their immediate need for housing, the scarcity of available units, and the locations where they want to live. This is not just a rural issue. Options in some high valued communities and neighborhoods where having a voucher is not enough are limited; there simply are not enough rental units in the price range needed for individuals with low incomes. Staff responsible for getting access to housing have repeatedly voiced concerns about access to targeted units and their fear of running out of private rental options based on their knowledge of local rental markets.

3. The State is also still struggling to make targeted units available to individuals with disabilities (**Figure 7**). There was a five percent (5%) decrease in targeted units filled in FY 2019 from FY 2018. There was an overall drop of seventy percent (70%) in total number of units placed in service in the 2018 calendar year. There were additional units made available through ISHP and SHDP funding (see below) which should have mitigated this by keeping the number of units occupied at a higher percent.

**Figure 7: FY 2018-2019 Currently Housed in a Targeted/Key Unit by LME/MCO**

LME/MCO	TCLI recipients	Targeted/Key Units Occupied in FY 18	Targeted/Key Units Occupied in FY 19	% Change
Alliance	291	125	118(-7)	-9%
Cardinal	615	125	126(1)	.009%
Eastpointe	174	37	32(-5)	-14%
Partners	264	68	61(-7)	-9%
Sandhills	233	59	44(-14)	-26%
Trillium	289	54	61(+7)	13%
Vaya	248	100	99(-1)	.009%
<b>Total</b>	2114	568	541	-5%

4. There is a need for improvement in access to targeted units related to the process of referring TCLI members for targeted units. This is also true for ongoing relationships between property managers and providers and LME/MCOs. There have been issues with timely notification of TCLI staff and/or TCLI staff responding in a timely manner to targeted unit vacancies or new-targeted units coming online. DHHS has attempted to remedy this problem but the underlying problem still exists.

The DHHS Aging and Adult Services Division Regional Housing Coordinators manage this referral process, which adds an additional set of notifications and follow-up with new units coming online, with turnover, and where tenancy issues emerge. Adding steps and staff involved in these processes leads to increased chances of miscommunication and/or delays in notifications and responses. It also means the team working closely with individuals during pre-tenancy, move-in, and post tenancy is not the first person responsible for resolving any

issues that might arise. Not having responsibility means that staff members do not increase their skills and knowledge to resolve the problem and always rely on others to solve the issue. The problem is exacerbated with frequent inspections and more oversight by property managers in the LIHTC program than exists with private landlords and property owners.

The counter argument is that with fewer Regional Housing Coordinators quality control over the process is better and they know the process reasonably well. The Regional Housing Coordinators facilitate the notification, move-in, and tenancy management process for the other disability groups. This does not outweigh the benefit of getting providers and LME/MCO staff more engaged in making the process work. The LME/MCOs are the only organizations that have performance requirements for this function that comes with financial penalties. LME/MCOs control more of the process for filling privately owned units and they have demonstrated the ability to manage the front-end process. Providers are still not as skilled and knowledgeable about tenancy issues as needed and that is a problem with setting expectations and communication between the Regional Housing Coordinators, LME/MCOs, and service providers. If providers are told not to engage with landlords, it sends a message they do not need to learn and use negotiating skills.

The Targeted and Key program has grown from approximately two thousand (2,000) units filled with individuals with disabilities in 2015 to thirty-four hundred and four (3,404) in FY 2019. Both LME/MCO and Regional Coordinator staff have increased as well. This is positive but also it means there is a need for improved communication and clearer expectations. Tax credit developers have voiced their concern and focused it on TCLI. Individuals in TCLI only represent sixteen percent (16%) of the total of filled Targeted and Key units. There have been challenging episodes with individuals in the TCLI program. As TCLI recipients, much of the focus is on them and not on the program as a whole. This is a more perplexing situation given that individuals in TCLI tend to have longer-term services and more options.

6. Conversely, the number of individuals in Category 5 living in housing at the end of FY 2019 increased thirty-four percent (34%) compared to an average of a twenty percent (20%) average increase for each of the five (5) previous years. This indicates the State is at seventy-three percent (73%) of the fifteen hundred and fifty-six (1,556) individuals who should be living in supported housing from the priority populations Categories 1-3, individuals residing in adult care homes. This is the rate projected based on the current pace of filling slots from those three (3) categories **(Figure 8)**.
7. Eight hundred and sixty-eight (868) additional individuals need to be living in supported housing from these categories or a thirty-six (36) monthly net gain for the State to meet this requirement in 2021. The net gain over the past three months of FY 2019 was twenty (20) or an average of 6.6 per month but over six months it was twenty-nine (29) per month.

**Figure 8: Increase in Units Filled by Priority Population Categories**

	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya	Total
<b>Cat.1-3 FY 13-18<sup>14</sup></b>	74	233	93	138	115	105	143	901
<b>Cat. 1-3 FY 2019</b>	9	18	1	30	24	34	43	1132
<b>Cat. 4 FY 2013-18</b>	106	35	26	29	36	27	7	266
<b>Cat. 4 FY 2019</b>	28	23	22	6	8	9	5	366
<b>Cat. 5 FY 2013-18</b>	38	208	21	45	19	55	37	423
<b>Cat.5 FY 2019</b>	34	25	11	26	31	59	14	616

8. The State continues to develop, implement, and refine measures to improve access to supported housing for individuals in the target population. Nonetheless, measures for Category 4 (individuals discharging from State Psychiatric Hospitals) are still not effective. Five percent (5%) of SPH discharges moved directly into supported housing in FY 2019. The percent of individuals who moved into bridge housing while final housing arrangements were being made was less than one (-1%) with only four (4) individuals given this opportunity in FY 2019. If measures were effective, the direct move to supported housing percentage would be higher at discharge or after a very short stay in bridge housing. The evidence is clear. Readmission rates are lower if individuals move directly into supported housing with pre-tenancy, move-in, and immediate post tenancy support and immediate follow-up appointments, peer support, and a focus on helping the individual build their own support systems. Choice of housing and provider is essential to this process.

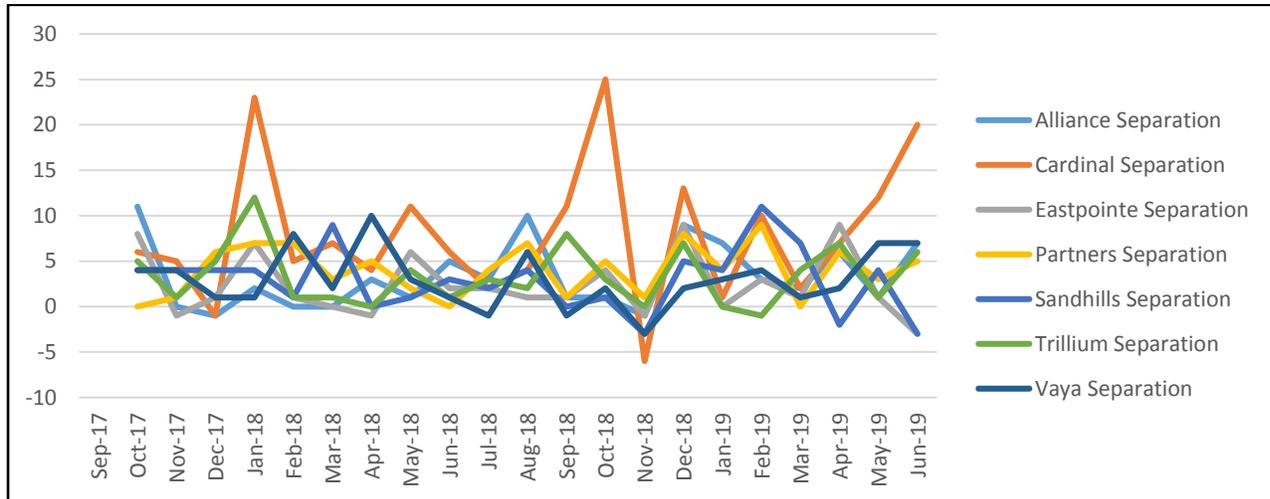
One issue influencing effectiveness is the need to refine further the point in time and criteria for TCLI referrals. This was a challenge during the shift in pre-screening processes in FY 2019.

9. Housing retention remains a challenge, affecting the State's ability to meet supported housing targets. Many factors influence retention, including those related to individuals aging, needing a higher level of care for their medical or psychiatric conditions, or dying because of an advanced illness and/or age. **Figure 9: Housing Separations by LME/MCO** illustrates there is no discernable pattern of separations across LME/MCOs during FY 2019. The separation rate at the end of the fiscal year was high, sixty-three (63) in June. There was an increase of one hundred and forty (140) individuals housed between May 31, 2019, and June 30, 2019, but the net gain for the month was only seventy-seven (77). Overall, the Alliance and Cardinal have fewer separations per capita. Other factors present a somewhat

<sup>14</sup> This is total filled from FY 2013 through FY 2018

different picture and will be discussed in the Community-Based Community Mental Services section of this Report.

**Figure 9: Housing Separations by LME/MCO**



10. Through a combined effort of DHHS, the NC HFA, LME/MCOs, committed developers, service providers, and legal advocates, the State made steady progress toward meeting its Supported Housing requirements in FY 2019. This progress included expanded utilization of bridge housing (Targeted Unit Transition Program, or TUTP) and utilization of available funds to fill funding gaps in capital projects to complete projects through the Integrated Supported Housing (ISHP) and the Supported Housing Development Programs (SHDP) for the target population. It also included establishing better mechanisms for rental subsidy management, improving processes for managing rental assistance, filling slots in both private market units and the LIHTC units, and creating a clearer, more advanced set of tenant selection policies.
11. A number of local and state level advocates and organizations are working toward expanding housing opportunities. The State, LME/MCOs, and advocates have the same overarching goal--increasing affordable housing and rental subsidies to individuals with very low incomes. Many of the groups have similar goals on fair housing. Opportunities are available for advocates and organizations to work collectively with local LME/MCO staff and State staff to further their goals and meet challenges associated with securing needed housing for individuals with disabilities and low-income households. There is even staff within state agencies working on these issues but not through collaboration or a well-coordinated effort. There should be an organized effort to work together to effectively seek and use valuable and often scarce resources and promote collective aims rather than all competing for the same limited resources.

12. The Targeted Unit Transition Program (TUTP), often referred to as a “bridge” program or “temporary housing,” expanded by seventy-five percent (75%) between FY 2017 and FY 2019 (**Figure 10**). The goal of the program is to assist an individual to have a stable place to live while establishing their eligibility and finding a permanent place to live. A place to live on an interim basis fills an immediate need for a safe, stable place to live. Individuals using the program are typically beginning the housing search process, gathering eligibility documents, and/or waiting on a unit to become available. Some individuals may have been trying to prevent a crisis or released from a hospital with no place to live and no time to make permanent living arrangements. An individual can remain in the program up to ninety- (90) days.

LME/MCOs continue to ask for more resources and more flexibility, including using funds for small residences or Single Room Occupancy options (SROs) more suited for this purpose than hotels and short-term master leasing for individuals who may have difficulty getting leases in their own name.

Three LME/MCOs, the Alliance, Cardinal, and Vaya, are the highest utilizers of the program. Trillium began TUTP in FY 2018 and Eastpointe and Sandhills began their program in FY 2019. The success rate as measured by an individual gaining access to permanent housing is 87%. LME/MCOs have used several different options including hotels, apartments leased to a provider, and a Single Room Occupancy (SRO) style apartment arrangement. Challenges will continue to affect finding safe, affordable bridge housing. The LME/MCOs have expressed concern about using hotels, motels or isolated apartments. Both Cardinal and the Alliance are utilizing small residences. The Alliance is leasing an SRO and Cardinal is renting a small home. Both programs have staff.

**Figure 10: The FY 2017- FY 2019**

LME/MCO	FY 17	FY 18	FY 19 <sup>15</sup>	Annual % change <sup>16</sup>	Moved to PSH <sup>17</sup>	% of Individuals who moved to PSH <sup>18</sup>
<b>Alliance</b>	5	36	44	14%	43	95%
<b>Cardinal</b>	22	41	54	24%	48	80%
<b>Eastpointe</b>	0	0	25	100%	17	68%
<b>Partners</b>	5	7	19	63%	15	100%
<b>Sandhills</b>	0	0	9	100%	7	0%
<b>Trillium</b>	0	10	33	70%	32	66%
<b>Vaya</b>	29	45	61	26%	53	21%
<b>Total</b>	61	139	248	56%	215	87%

<sup>15</sup> Accumulative over the life of the program

<sup>16</sup> % of those who moved during their stay of after they completed TUTP

<sup>17</sup> Individuals moved to supported housing at the end of the TUTP eligibility period.

<sup>18</sup> Percentage of individuals who moved into permanent supported housing over the life of the program.

13. The State has developed a policy and guidance for using two-hundred and fifty (250) housing slots in disability neutral developments that have up to sixteen (16) units. Individuals with a disability known to the State can occupy no more than 20% of the units in these developments.
14. The DHHS, HFA, and TAC encouraged and provided technical support to LME/MCOs to make applications for HUD Mainstream Vouchers as referenced above. Seven (7) PHAs submitted applications for over two hundred (200) vouchers in FY 2018. There were two hundred and thirty-five (235) vouchers funded. Several PHAs have struggled with getting these vouchers used in FY 2019. It is not clear that the PHAs understand the tenancy selection and waiting list requirements for these vouchers. There has not been any indication that the PHAs are allocating any of these vouchers as project-based vouchers. This could be attractive to developers so they could use these as dedicated sources to fill a gap in the financing of mixed used projects. This type of use helps the State meet its budgetary obligations for new rental subsidies and helps LME/MCOs build relationships with property owners.
15. HUD released a Notice of Fund Availability (NOFA) on July 2, 2019, for Mainstream Vouchers to assist non-elderly persons with disabilities. HUD expects to award one hundred and fifty million (\$150 million), which will house approximately 18,000 individuals or families. The funding in this NOFA is fifty million (\$50 million) above the FY 2018 NOFA. The DHHS had already put the LME/MCOs on notice that the State expects at least sixteen (16) Public Housing Authorities in large counties to apply. TAC and DHHS began assisting LME/MCOs immediately.

As reported in the FY 2018 Annual Report, the NC HFA and DHHS created the Integrated Supported Housing Program (ISHP), utilizing funds allocated for this purpose by the NC General Assembly. The source of funds is unspent DHHS TCLI funding that becomes available at the end of the fiscal year, each year. The LME/MCOs, DHHS, and the NC HFA worked with developers to get \$15.35 million allocated for 144 units that are being set aside for the target population for twenty years. A portion of funds also went into the bond financing of a project for seventeen (17) units. Two ISHP projects financed primarily with 4% bonds opened in FY 2019 with thirty-nine (39) units made available to individuals in the TCLI program. The remaining one hundred and twenty-two (122) units will be available in FY 2020 barring any unforeseen delays.

16. The NC HFA is continuing to work on two additional projects with ISHP and other NC HFA funding to add to this portfolio. At the end of FY 2019, through timely efforts on the part of DHHS and the NC HFA, there was an additional \$4.3 million added to the ISHP program with the goal to finance as many as seven (7) projects in FY 2020. This timely effort may make it possible for additional units to come online before July 2021, depending on a number of

financing and other variables. Not all the funds were made available “to pay for the transition of individuals with severe or severe and persistent mental illness from institutional settings to integrated, community based supportive housing and to increase the percentage of targeted housing units<sup>19</sup>” in FY 2019 as required in State statute at the end of FY 2019. The State diverted funds at a time when there was a shortfall in the Key program, not to increase the percentage of targeted units. The funds then covered Key expenses for TCLI members. The State, both DHHS and the NC HFA, took action to add funds from other sources to partially replenish funds for ISHP and SDHP projects.

17. In addition, the NC HFA awarded bonus points to applicants requesting funds through their Supportive Housing Development Program for projects funded from FY 2016 through FY 2019. There were sixty-eight (68) units set aside in seventeen (17) different projects. Seven (7) projects were rehabilitation projects and nine (9) projects were new construction. One project was a development brought out of foreclosure following the allocation of these funds. There were projects funded in ten (10) counties across five (5) catchment areas.
18. This process established a new method for distributing unspent funds for ISHP and for utilizing SHDP funds. The State provides incentives to six (6) “high value” counties. Individuals more often ask to live in these counties.
19. There were two hundred and forty-nine (249) TCLI applicants for targeted units<sup>20</sup> in FY 2019, down from four hundred and three (403) the previous year. Denials of lease applications for individuals in the TCLI population to targeted units continue because of their criminal record, credit problems, or other issues. There were twenty-nine (29) individuals denied a lease either because of their criminal background check, credit, or both, or for other issues for the first ten months, down from fifty-two (52) during the same period in FY 2018. Since there were a lower number of referrals in FY 2019, the percentage reduction was only 2% less than the previous year.
20. Twenty-nine (29) individuals found other housing and seventy-five (75) listed as “other,” meaning they stopped looking for housing or removed themselves from the list for other reasons. The number is approximately the same, but the percentage is higher from the year before. This may occur for a number of reasons. Individuals may become ambivalent about moving while they are waiting for a unit or because their health, legal or personal situation changed while they were searching for housing. Regardless of the reasons for not following through with trying to secure a lease, it requires further analysis.

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<sup>19</sup> NC General Statute 112E.-3.1.

<sup>20</sup> Including new SHDP, ISHP, and Bond financed units in 2019 through April 1, 2019.

21. One other significant difference in FY 2019 is that individuals looked at units in fewer properties. This is partly because there were more units in ISHP and SHDP projects and also the result of LME/MCOs discerning which property managers and locations are more favorable to individuals. In FY 2019, there were 2.25 applications made per individual; this year it was lower, 1.15 on average, which may mean there were only referrals to properties where individuals are more likely to be accepted.
22. There was no information available this year on the number of Reasonable Accommodation requests made, accepted, or denied.
23. There is no quantifiable evidence on the impact of the changes the NC HFA made on its Fair Housing and Tenant Selection Policy in FY 2018. There will be a review of this impact in FY 2020 after there is more time to determine if the change made a difference.
24. The NC HFA and the LME/MCOs are also continuing to provide Fair Housing training and support from the Justice Center and local legal services across the state. The NC HFA is also offering advanced fair housing training and is working closely with LME/MCOs on fair housing issues.
25. In FY 2018, the principal consultant from the Technical Assistance Collaborative (TAC) made a number of recommendations to the State for how they could increase the pipeline of housing for individuals in TCLI. The TAC services consultant also made recommendations if implemented could have a significant bearing on the State meeting its Supported Housing Requirements by July 1, 2021.

TAC recommended the following for increasing housing resources:

- (1) NC HFA adopt “income-averaging” in their LIHTC Qualified Allocation Plan for mixed used LIHTCs to create more deeply affordable units in LIHTC properties.
- (2) NC HFA modify its Administrative Plan for their National Housing Trust Fund (NHTF) allocation to create a priority for ISHP for individuals in the TCLI program.
- (3) NC HFA and DHHS request HUD approve a statewide remedial Olmstead preference for housing choice vouchers and other federal programs for individuals in the settlement population exiting institutions.
- (4) Encourage PBV commitments from PHAs in “high volume” counties to use the authority under the HOTMA<sup>21</sup> modernization legislation to make more set aside units available using project-based vouchers.

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<sup>21</sup> The statute allows PHAs to project-base an additional 10% of its authorized number of vouchers (above the 20% base limit) if these PBVs are tied to units that serve households who are homeless or include a veteran, provide supportive housing for persons who have a disability or who are elderly.

(5) DHHS and LME/MCOs urged PHAs to apply for HUD Mainstream Vouchers in the proposed FY 2019 round of funding.

(6) NC HFA use federal HOME and CDBG funding and state Housing Trust Fund for ISHP.

(7) NC HFA and DHHS expand project-based funding through the various means available to support the creation of more ISHP units.

(8) Continue to expand the ISHP program. TAC had earlier made recommendations to create the ISHP program.

The NC HFA and DHHS moved forward in part or fully on most of these items. The NC HFA adopted income-averaging going forward and included it in their 2019 Qualified Allocation Plan for LIHTCs. On April 24, 2019, the DHHS and NC HFA requested HUD approve a statewide remedial *Olmstead* preference for Housing Choice Vouchers and other federal programs; they are expanding ISHP and urging PHAs to apply for HUD Mainstream Voucher funding. They made a change in their NHTF Administrative Plan and have used some of their own state trust funds for a SHDP projects. They have not indicated they are using HOME or CDBG funding for ISHP.

26. At the end of FY 2019, DHHS completed, with TAC's assistance, a PSH Production Pipeline Plan. This plan provides a clearer and more detailed roadmap to expand and improve upon the State's PSH Production strategies across three fiscal years (FY 2019, FY 2020, and FY 2021). The Plan was in draft for a number of months and available to the LME/MCOs and the NC HFA for the purpose of communicating action steps and setting goals even while the Plan was under review. For example, the Plan names the sixteen (16) counties the DHHS asked LME/MCOs to focus on to generate their PHAs to apply for HUD Mainstream Vouchers.

The plan sets production and dedicated subsidy goals across multiple types of units and subsidies based in part on fund sources across all three years. The Plan did not include due dates where applicable and persons/entities responsible for each action item.

27. There continue to be serious issues with access to community amenities and daily community activities at the frequency and with persons of the individual's choice. While housing location is not the only factor causing this problem, it remains a contributing factor. One man was living in an adult care home in a town where he had many friends but there was only one unit offered to him. It was outside of town and not in walking distance so he could spend time with friends. Four (4) other individuals reported feeling isolated in their new living setting, which could result in their separating from housing. Housing locations, lack of transportation, and lack of support made available in the State's service array compound this problem. These are factors in the number returning to adult care homes. This is especially true for those

homes that provide transportation and outings to shopping, restaurants, and doctors' appointments.

28. The availability of and access to accessible units for individuals with physical disabilities and individuals who are deaf and hard of hearing remains a barrier for a small but significant number of individuals in the target population. There have been reports from LME/MCOs that if individuals cannot be guaranteed they will get an accessible unit or a unit with necessary equipment they will not move to the community. There were four (4) individuals living in a supported housing unit who needed either equipment or accessibility features; the same percentage seen in FY 2018. There were ten (10) individuals in the pre-screening cohort who had serious medical and mobility issues. It was not clear that all of the individuals were eligible for TCLI but without immediate access to accessible units, they would not have been able to live successfully in the community.

There was a positive change this year for individuals hospitalized in the Broughton Hospital Deaf Unit. The newly formed DHHS Barriers Committee took action to increase access to supported housing. Through their leadership the Broughton staff, LMEs, and service providers made changes to provide better access to supported housing, benefits, needed equipment and services for individuals who are deaf or hard of hearing being discharged from Broughton Hospital.

***(C) Recommendations***

1. Take all necessary steps to secure sufficient number of housing units in locations that individuals will choose. This includes dedicating all unspent funds to increasing the percentage of targeted units in supported housing for individuals with serious mental illness and serious and persistent mental illness.
2. Implement the Pipeline Production Plan. Add dates for completion and responsible parties for each action step.
3. Take steps to access HUD Mainstream Vouchers to the greatest extent possible, improving the PHA processes where necessary to use the vouchers when awarded.
4. Use available federal and state funds to maximize ISHP and SHDP and promote income averaging as now available in the LIHTC program to assure there will be enough units available for the State to meet its housing slots and permanent housing
5. DHHS, TAC, the NC HFA, housing stakeholders and organization, and the LME/MCOs work together to maximize resources, refine and implement the Production Pipeline goals to increase housing.

6. Establish “housing slots filled” targets for each LME/MCO for each of the next two FY years. Use equitable targets based on either population or Medicaid enrollment penetration.
7. Establish “housing slots filled” targets for Categories 1-3, 4, and 5.
8. Improve referral processes and communication by streamlining referral requirements where possible. Give service providers working most closely with individuals during the pre-tenancy, move-in, and post tenancy stages of housing, clear responsibilities for their required tasks. Give the working day-to-day responsibility with LIHTC property managers to the LME/MCOs. The LME/MCOs can then add responsibilities to providers based on their demonstrated competence with these tasks.
9. Enhance and re-define the role of the regional Housing Coordinators to focus more on tracking vacancies and dispute resolution where necessary.

One option used successfully in other states is a transition team approach with a Regional Manager serving as the team lead, adding vacancies with upcoming vacancy dates, and maintaining the pipeline, and the LME checking the database daily and managing the referral process with the provider and prospective tenant. There would be clear lines of responsibility between the LME and providers on pre-tenancy, move-in, and sustainability issues. The service provider becomes the primary contact with the property manager or landlord in most situations. The landlord notifies the provider and the tenant, and the tenant does the same if the concern is related to an issue with the property manager or landlord.

If either party, after trying to resolve the issue, feels it cannot be resolved, that party may request a more formal dispute resolution process with the Regional Coordinator and LME/MCO attempting to resolve the dispute. If unsuccessful, it would go to a NC HFA designee and DHHS Supportive Housing Policy Director for final resolution. The owner could then choose to move to terminate the lease.

10. Pursue requests for Reasonable Accommodation for all rental denials where the owner does not appear to be treating the applicant fairly and when applicant agrees to make request.
11. Increase involvement of local legal services and the Justice Center Legal Aid to assist individuals with requests for Reasonable Accommodation and leasing violation issues.
12. Ensure individuals have access to community amenities at the times, frequency, and with persons of their choosing and provide assistance with individuals’ choice of daily life activities.
13. Monitor and comply with individuals’ accessible unit and individual supports, including home health and personal care services requests. This may include modifications of policy to ensure individuals with physical disabilities can get access to individual supports.

14. Expand bridge housing and master leasing. This is possibly the most important step for meeting diversion demands and increasing SPH referrals in FY 2019.

## II. COMMUNITY BASED MENTAL HEALTH SERVICES

Major Categories	Summary of Requirements	Progress Towards Compliance
<p><b>Section III. (C)(1-2)</b> The State shall provide access to the array and intensity of services and support to enable individuals in or at risk of entry to adult care homes to successfully transition to and live in the community. Requirements apply to individuals with a housing slot and to those not receiving a housing slot. Services provided with state funds to non-Medicaid eligible individuals are subject to the availability of funds.</p>	<p>These two requirements specify that access to services and supports to each individual for which they are entitled is available, either services covered under the Medicaid State plan or a service in the State funded service array.</p>	<p>The State has not taken effective measures for individuals to access and receive the array and intensity of services necessary for individuals to live in the most integrated setting possible consistent with Settlement Agreement requirements. The State is expanding the array of services based on the assessed needs of the population. This expansion has not yet resulted in individuals getting the array of needed services by type of service, intensity, and location.</p>
<p><b>Section III. (C)(3)</b> The State is required to meet four core requirements for the provision and outcomes for community-based services and supports.</p>	<p>Services and supports are to be evidence-based, recovery-focused, and community-based. Services are to be flexible, individualized, focused on building community and natural supports and preventing crises.</p>	<p>The State has not yet taken steps to provide services at the level required for compliance for this requirement. There was evidence in individual reviews that major deficiencies in service provision exist in all four of the required characteristics listed here and in the Settlement Agreement.</p>
<p><b>Section III. (C)(4)(6)</b> requires the State to rely on a specific set of community-based mental health services and any other services included in the State’s service array as set</p>	<p>Five services are explicitly referenced in this section. These include ACT (summarized with other ACT Settlement requirements below), Community Support</p>	<p>The State has been in the process of updating CST, folding TSM into the service since FY 2016. The service is still out for public comment. There is also a challenge with implementing a stand-alone Peer Support Service that would be Medicaid eligible. This service has also been under development for some time and based on</p>

<p>forth in <b>Section III (C)(1)(2)</b> of the Agreement.</p>	<p>Teams (CST), Peer Support, and psychosocial rehabilitation services. The State has developed Tenancy Support<sup>22</sup> (referenced in <b>Section III. (B)(7)(b)</b>) in its service array and plans to make a major change in this service in October 2019.</p>	<p>reviews of the draft definition, it is possible there will be an underutilization or high staff turnover of this important service for the TCLI target population. LME/MCO staff has recognized the need for nursing consultation, personal care, and occupational care based on the healthcare needs of individuals moving to the community. The State is supporting this effort with state funds and Medicaid. IPS-SE is not available at the level needed and as requested.</p> <p>The State has taken steps to improve the services and support allocation process. This will likely have a positive effect on services provision over the next two years.</p>
<p><b>Section III. (3)(7)</b> The State is required to hold the LME/MCOs accountable for providing access to community-based mental health services and for monitoring services and service gaps through LME/MCOs.</p>	<p>These requirements identify the LME/MCO Medicaid managed care requirements generally. Where applicable they are required for individuals with SMI, who are in or at risk of entry to adult care homes to transition to supported housing and for long-term success in supported housing.</p>	<p>The State has not taken all the necessary steps for meeting this requirement. The State’s gaps analysis requirements have improved but the quality of the responses from LME/MCOs regarding their gaps varies. The State’s contract requirements do not yet line up with requirements in the Settlement Agreement and LME/MCOs do not always ensure that community mental health service providers are available. The State is giving it attention but there is not sufficient evidence has not met requirements for accessibility of services provided consistent with federal requirements in 42 C.F.R. § 438.10.</p>
<p><b>Section III.(C)(8)</b> specifies who is to receive information and training, requirements for language and accessibility to services, and types of services including Peer Support,</p>	<p>A number of requirements for LME/MCOs are included in this section. They range from providing materials and information to every beneficiary consistent</p>	<p>Information appears to be available to beneficiaries consistent with federal statutes but not always highlighted in a manner necessary for TCLI recipients to get the supports and services they need. The same applies to accessibility requirements. There were issues with accessibility for individuals reviewed in FY 2019. Accessibility has been a</p>

<sup>22</sup> DHHS refers to Tenancy Supports as Tenancy Services Management or “TSM.” It is a direct service funded with State funds.

<p>ACT, and Transition Year Stability Resources (TYSR) under the Medicaid State Plan in accordance with the original MCO implementation schedule.</p>	<p>with 42 C.F.R. § 438.10 and to local providers, hospitals, homeless shelters, police departments, and Department of Corrections facilities. It references the LME/MCO start-up schedule (no longer applicable) and accessibility requirements.</p>	<p>key focus of the Barriers Committee and their work has already enabled individuals to move into the community. This should improve based the Barriers Committee approach.</p>
<p><b>Section III. (C)(5)(9)</b> The State shall provide Assertive Community Treatment (ACT) by teams using a nationally recognized fidelity model. By July 1, 2019, the State will have increased the number of individuals served by ACT teams to 50 teams serving 5,000 individuals at any one time.</p>	<p>These provisions include requirements for the delivery of ACT, by number of teams meeting and number of individuals served. There is a requirement for the provision of ACT by teams that operate to fidelity and meet requirements of the State service definition. All the individuals receiving ACT services will receive services from employment specialists on their ACT teams. (The State selected the TMACT fidelity model.)</p>	<p>The State did not meet the requirement to serve 5,000 individuals on June 30, 2019. On June 30, 2019, only four thousand eight hundred and twenty-six (4,826) individuals were receiving ACT services on seventy-two (72) teams. The Settlement Agreement requires individuals receiving ACT services receive services from employment specialists. This may not be necessary but there should be a requirement for individuals in the TCLI population to get this choice and services as requested. The LME/MCOs monitor ACT performance but have not established requirements commensurate with the needs of the TCLI target population. Fidelity scores have identified the weaknesses in service delivery that are necessary for the State to meet the Settlement Agreement requirements. The UNC ACT TA Center provides technical assistance on these issues.</p>
<p><b>Section III. (C)(10)(a-c)</b> The State shall require that each LME/MCO develop a crisis service system, with a wide range of services and services provided in the least restrictive setting. The State will monitor</p>	<p>There shall be a range of crisis services interventions delivered in locations including at the individual’s residence whenever practicable, consistent with an already developed individual</p>	<p>The State and LME/MCOs are taking steps to meet this requirement and develop a more robust crisis system. There was no evidence that there is use of required crisis plans by staff and individuals to deal with situations that may otherwise result in crises. There is not sufficient evidence that crisis intervention and stabilization are available to prevent individuals from losing housing. The</p>

<p>crisis services and identify service gaps.</p>	<p>community-based crisis plan. Crisis services are required to be accessible and delivered in a timely manner.</p>	<p>data indicates individuals’ re-admission to hospitals or using emergency rooms is low after moving into supported housing. LME/MCOs identified TCLI crisis services gaps in their 2017 Gaps Analysis. There will be a review of their progress on using crisis plans and filling gaps in the FY 2020 review.</p>
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**(A) Background**

Access to the array and intensity of services and supports necessary to enable individuals to successfully transition to and live in community-based settings is a major requirement in this Settlement Agreement. The FY 2019 compliance review of Community-Based Mental Health Services and Supports reflected the challenges facing individuals to get and keep housing and to live successfully in the community. Meeting these requirements requires a very focused and tailored approach to developing and implementing effective services and supports measures.

Each year, the principal method used to measure the State’s compliance is a review<sup>23</sup> of randomly selected individuals and their records. This review includes interviewing the selected individuals, service providers, SPH staff, guardians, family members, and LME/MCO staff. In FY 2018, there were two additional methods used to supplement and verify the random review results. These methods included an analysis the target population (and sub-groups) characteristics and service use patterns during the different stages of treatment and living arrangements, pre-transition, during transition, and post transition<sup>24</sup>.

The 2018 analysis purposefully looked back at services provided during the first four years of the Settlement period. Conducting that analysis enabled the State to review data to make systemic changes, if needed, before the end of the Settlement period. FY 2019 review results were compared to previous years’ reviews and the 2018 analysis. There was virtually no difference in the results in previous years’ reviews and the data analysis findings.

The State also conducted a paid claims analysis for services provided in FY 2017 and FY 2018. For the items that were constructed similarly to the items in the earlier data analysis conducted by HSRI, the results were virtually the same especially in service penetration for individuals getting at least one unit of service during the prescribed time frames. There were also differences in the scope of the reviews. The HSRI data reviewed services delivered for individuals in six cohorts, individuals living in ACHs getting In-reach, individuals with transition in progress, individuals in

<sup>23</sup>This is a random selection of individuals in the TCLD database with stratification by treatment living setting. Special reports have targeted individuals on In-reach status, hospitalized at SPHs, and separated from housing.

<sup>24</sup> The Human Services Research Institute [HSRI] [Cambridge, MA.] conducted this review. They analyzed paid Medicaid and state funded services claims through December 2017 with the assistance of DHHS.

Pre-screening status, individuals living in the community but not in supported housing, and individuals who were deceased but only after referral to TCLI. HSRI reported on characteristics of the population, amount and patterns of use, service use for individuals exiting housing. HSRI also examined pre-transition and post transition differences in services delivered patterns by LME/MCO.

The 2018 Separations Review elicited information regarding services use, individual characteristics, housing location or other housing related issues, factors that have an effect on the transition process, and other factors that influence individuals' separation from housing. The FY 2019 random reviews revealed the same patterns and factors as influencing separations in previous years. Separations remained high. Age related issues, death, cognitive decline, and illnesses that require skilled nursing account for some separations. Fear of being alone, missing friends, and pressure from ACHs to return account for other separations.

Other review methods that have been and will continue to be used include a review of ACT fidelity outcomes by individual teams and by LME/MCO; a review of contracts, allocation letters, monthly reports, and dashboards; a review of service gaps, PCP, and service planning; and feedback from providers and stakeholders through interviews and focus groups.

The State's inability to meet Community-Based Mental Health Service requirements remains a major obstacle to the State's compliance with this Settlement Agreement. There is growing array of services but under-utilization, limited intensity and duration of the current array of services including the utilization of Peer Support, IPS-SE, and health related services and support. This varies by LME/MCO. The State's inability to meet requirements is also contributes to community and social isolation, lack of personal support, and lack of assistance from natural supports to prevent crises. Individuals institutionalized for a long period or intermittently have difficulty overcoming their negative symptoms and restoring their functioning lost through isolation, inactivity, and negative perceptions they and others have of them. Services and supports require a focus on recovery, restoration of skills necessary for successful community living, illness management, crises, and interventions to avoid crises.

The State has taken steps to expand their service array. The State has recognized the TCLI population's vulnerabilities, especially with chronic medical conditions, in integration into the community. There is a growing recognition of the degree to which functional limitations and the iatrogenic effects of long-term institutionalization, isolation, and unstable living settings are exacerbating individuals' return to community life. With changes in Pre-screening responsibilities shifting to LME/MCOs, these is also the opportunity to analyze the needs of individuals being considered "at risk" of ACH placement. The test with expanding the array is doing it in a manner that will produce the required change.

The State's plan to enhance TSM and combine it with CST has been in development since early calendar year 2016. It is still a work in progress although the State planned to implement the new service on October 1, 2019 or as soon after that date as possible. This means that the new service cannot be reviewed fully until near the end of FY 2020 but more likely in FY 2021. The requirements for Community-Based Mental Health Services are such that compliance will be difficult to achieve in a short period. There is a more complete description of the State's planning and implementation process in the findings sub-section below.

The State is also in the process of creating a Medicaid reimbursable stand-alone Peer Support service and updating the state definition of Peer Support. This is a stand-alone service, which, if funded and supported as needed, is essential for the State meeting its service array requirements. Peer Specialists must have a required level of experience and training to be certified. In-reach staff are Certified peer Specialists, per the Settlement Agreement. The State requires ACT and IPS-SE teams have a certified Peer Specialist but is not requiring a Certified Peer Specialist be included as a member of a CST team. Nor will Peer Support services be allowed to be provided if an individual is receiving a CST Team service. The State is reviewing this latter omission. Peer Support may be widely used in this state but unless attention is made to ensuring it is available to the TCLI target population, there is a possibility this new stand-alone service will be less available to the TCLI population than to other populations. This has already occurred with IPS-SE services (to be discussed further in the next section). Stand-alone Peer Support services are not the only proven method of Peer Support Services. There is robust evidence for other types of Peer Support services including but not limited to providing wellness and recovery services, peer respite, and programs, facilitating service delivery and transitions as navigators and trainers.

The State has continued to utilize the UNC ACT TA Center for ACT and IPS-SE fidelity reviews and technical assistance. The ACT and IPS teams also assist ACT and IPS Collaboratives and, based on recent discussions with Collaboratives, this appears to have a number of benefits and is a good use of TA Center and State staff time. This year's findings point to the need for a longer-term sustainable training and technical assistance strategy critical to the State meeting its services obligations. The State forwarded Fidelity Review descriptions and ratings to the LME/MCOs this year and provided context and recommendations for LME/MCOs to consider in establishing contractual obligations and technical assistance.

The State updates its DMA and DMH contracts with LME/MCOs every year. The contracts include requirements for TCLI and for services to individuals in the priority population. There is specific language for the LMEs to evaluate the quality of service delivery and compliance to service definitions but there is no reference to monitoring for compliance with TCLI requirements.

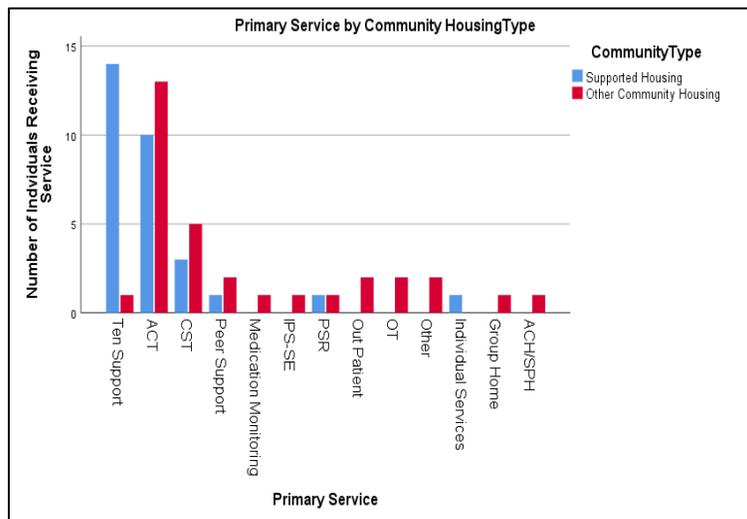
Numerous other issues remain with the contracts referred to the State but at the time this Report was completed there was no response to these questions.

**(B) Findings**

1. The access to the array and intensity of services and supports requirement (**Section III.(C)(1)**), for both Medicaid and state funded services for individuals, in or at risk of entry into an ACH with a housing slot is not being met. The requirement in **Section III. (C)(2)** referencing services for individuals, in or at risk of entry to an adult care home who do not receive a housing slot is not being met. This is similar to the FY 2018 findings.

As noted in **Figure 11 below**, most individuals living in the community reviewed in FY 2019 were receiving either ACT or Tenancy Support as their primary service. If implemented as written in the State’s draft definition, individuals can get Community Support Team services before entering or after exiting supported housing. This could improve continuity of care and help sustain a trusting individual-provider relationship.

**Figure 11: Primary Community Service by Type of Service**



Individuals living in other housing settings in the community have not been getting TSM which is one reason other services are listed as the primary service.

The results of the individual reviews and roundtable discussions in FY 2019 are consistent with the findings in the 2018 TCLI Data Analysis and the State’s 2019 data analysis.

2. The State is making a concerted effort to expand the array of services with two initiatives. The first is a broad initiative to expand and improve access to health care management/personal care and the second is actually two (2) community inclusion initiatives. The State is arranging for Personal Care Services (PCS), home health, and support from health care providers to be more available and accessible as needed. LME/MCOs have done the same with hiring nurses whose role is to provide nursing assessments and consultation for individuals with chronic medical conditions.

The State established an initiative in FY 2019 to promote community Inclusion through start-

up and incentive grants to community organizations to set goals for community inclusion and to fund “start-up” activities. The i2i Center for Integrative Health<sup>25</sup> manages the “I’m In” initiative. The long-term goal of this initiative is to put into place more policies, programs, and practices that support individuals with mental illnesses so that they may participate more fully in the activities that define everyday community life. To get this initiative underway, i2i is funding four pilot projects across the state to extend the impact of the initiative and to learn what works well to promote and achieve community integration.

The State is bolstering this initiative with a grant to one LME/MCO, Eastpointe, who in turn is contracting with the Alliance for Disability Advocates<sup>26</sup> to advance individual community integration strategies. Their method tailors support to individuals referred by Eastpointe for assistance with their individual community inclusion goals. There was little evidence of the impact of these initiatives on individuals’ lives in the FY 2019 review. The most noticeable was the presence of nurses on Diversion and In-reach teams. It is more likely the impact will be discernable in the FY 2020 and 2021 reviews.

3. Otherwise, individuals are not getting services in the broader array as needed. An example of this limit is with referrals and support of employment specialists and IPS-SE services. Of the forty-six interviews<sup>27</sup> conducted with individuals in FY 2019, twenty-three (23) individuals expressed a significant or potential interest in employment. Of that number, four were working jobs off the books or in exchange for a living space, three were getting assistance from an ACT Employment Specialist, and one was getting IPS-SE services. The individual getting IPS-SE services was a person for whom IPS-SE was their only service. One other individual reported being referred months before the interview but had never been contacted by the IPS-SE team. There is a perception that individuals in the TCLI target population do not want to work. This is not reflected in the data and not consistent with the experience of the Reviewer’s experts. Nationally it is reported approximately sixty-six percent of individuals with SMI typically report wanting to return to or retain employment.<sup>28</sup>
4. The key is recognizing when an individual feels de-valued and unable to work again after a long period of being out of the work force. Individuals’ negative symptoms and cognitive

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<sup>25</sup> The i2i Center convenes health care leaders and promotes integrative care and collaborative efforts across the state.

<sup>26</sup> The Alliance of Disability Advocates North Carolina (ADANC) is a local and statewide Center for Independent Living funded under Title 7 as an organization run by a majority of individuals with disabilities to promote independence through advocacy, benefits and services.

<sup>27</sup> There were forty-six (46) interviews where reviewers were able to determine if an individual had an interest in work and if so, whether they were getting assistance from an ACT Employment Specialist or with a referral to IPS-SE.

<sup>28</sup> Drake, R. E., Bond, G. R., Goldman, H. H., Hogan, M. F., & Karakus, M. (2016). Individual placement and support services boost employment for people with serious mental illnesses, but funding is lacking. *Health Affairs*, 35(6), 1098–1105.

<sup>7</sup> Sherman, L.J., Lynch, S.E., Teich, J. and Hudock, W.J. *Availability of supported employment in specialty mental health treatment facilities and facility characteristics: 2014*. The CBHSQ Report: June 15, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD.

functioning are predictors of what approach to use to assist an individual to return to employment. Assuming this is correct (and it is consistent with this Reviewer's findings) attention to minimizing the impact of negative symptoms through support and cognitive remediation can help individuals complete tasks associated with their vocational preferences and build their confidence to return to work.

5. Other services often absent from the array are individualized supports, Integrated Dual Disorder Treatment (IDDT) and other substance abuse treatment groups and interventions, Peer Support, Self-Directed Care (SDC), Cognitive Based Therapy, other cognitive and trauma informed therapies, Occupational Therapy, and Occupational Therapy Assistants (to provide direct support). Information from interviews suggests staff would benefit from more guidance and training on how to use harm reduction as a tool. Harm reduction is not simply doing nothing, allowing individuals to continue to use drugs and alcohol or engage in risky behavior. Harm reduction includes practical strategies aimed at *reducing* negative consequences associated with alcohol and drug use and other risky behaviors.

The State is expanding two services in the fall of 2019: (1) Community Support Team (CST) which will become more robust by combining it with Tenancy Support Management services and (2) Peer Support. Community Support Team interventions and responsibilities include skills development, symptom management and recovery, crisis intervention, and coordinating and managing services. Adding skills development, illness management and recovery, crisis intervention and managing services by definition makes this service more robust and enables staff to intervene to help reduce separations from housing, individuals manage their own symptoms and their crises and further develop or restore their community and daily living skills. Tenancy management did not include these interventions thus staff were not permitted to provide interventions critical to recovery, self-sufficiency and community integration.

This new CST service includes a "pass through" to allow providers to begin services while staff completes an assessment necessary to authorize services, which makes it possible for assertive outreach and treatment to occur before and while a comprehensive assessment is completed. This is a service delivered primarily in community settings, including an individual's home, and includes reimbursement for collateral contacts. These attributes are important; they can help shift services toward assisting individuals toward their recovery and life goals. Tenancy Support Management (interventions related to tenancy support) have not historically been available to individuals who receive CST but return to their own home after being institutionalized without a housing subsidy or move in with family or others. Given the number of individuals who qualify for TCLI who don't have a housing slot, adding these functions actually expands the array of services.

6. The new Peer Support service definition adds Peer Support to the array of Medicaid reimbursable services; previously it was only funded as an optional service. This is a positive change but it does not, in and of itself, indicate the State is expanding access and availability of Peer Support for TCLI recipients nor does expand to the range of Peer Support programs and interventions demonstrated as effective recovery services.

The Reviewer's Data Analysis in FY 2018 revealed that twenty-four percent (24%) of individuals living in the community had gotten at least one unit of Peer Support but the Analysis the number of units per person was low. The State's FY 2017-2018 data of individuals living in supported housing indicated the same percentage. Of individuals in the individual review sample living in the community, twelve percent (12%) were getting Peer Support at the time of their review. This does not include the number of individuals getting ACT or TSM services who get support from the peer support staff on the ACT or TSM team.

7. Specific questions were asked of each individual during the review to determine the adequacy of the following:
  - (1) Intensity of services
  - (2) The effectiveness of the PCP
  - (3) The assistance provided to individuals to increase their ability to recognize and deal with situations that may otherwise result in crisis situations and to prevent crises
  - (4) Individualization and flexibility of services and support to increase and strengthen the individual's network of community and natural supports as well as to use those supports to prevent crises
  - (5) The degree to which care is evidence-based, recovery focused, and community-based.

The above list encompasses the **Section III(C)(3)** requirements. The State and the LME/MCOs also have obligations to provide services with the frequency and duration required for an individual to successfully transition to and successfully live in a community-based setting. To meet this obligation, the State needs to establish service definitions but also needs to monitor LME/MCO performance, the sufficiency of the LME/MCO provider network, and LME/MCO requirements for effective utilization management. The LME/MCO contracts with providers, establishes effective utilization management consistent with the needs of this target population, monitors service providers, and sets performance targets.

8. The State has selected the TMACT fidelity model for ACT and for complying with **Section III. (C)(5)**. The State is not meeting the 2019 annual requirement to serve five thousand (5,000) individuals at any one time although the State is meeting the requirement for fifty (50) teams providing ACT. **Section III. (C)(9)**, the State reported that on July 1, 2019, LME/MCOs were

contracting with seventy-three (73) teams providing services to four thousand eight hundred and twenty-six (4,826) individuals. This is a nine percent (9%) reduction from July 1, 2018.

9. Evidence is not sufficient to support that individuals who want to work are receiving services from employment specialists on ACT teams. Five (5) of the individuals interviewed who were receiving ACT services reported they were interested in employment but only two (2) were receiving services from the ACT employment specialist.
10. The most recent report submitted on ACT fidelity scores revealed that twenty-three (23) teams improved their fidelity score on their last review. Nineteen (19) teams' scores were lower than their last or their original score. Only two (2) teams moved into the "high" range of fidelity during FY 2019.
11. There were discussions with ACT teams during roundtables (held during LME/MCO reviews) and Collaborative meetings. Likewise, there were discussions with LME/MCOs regarding their ACT contracts. The ratios of the number of individuals in TCLI on each team varied widely from nearly half for one team to almost no one for other teams. The average for most teams was either slightly above or below 25% of their active members. The range of individuals on TCLI on ACT teams was between 10% and 32%, which has implications for how much attention a team can give to individuals in the TCLI population.
12. The ACT teams continued to raise concerns about challenges with individuals accessing and maintaining housing and about the delineation of roles and responsibilities between the providers and their LME/MCO. On a positive note, the State and the LME/MCOs voiced the need to include ACT staff in tenancy support training and to provide information to ACT teams on a regular basis regarding their obligations for individuals in need of, moving into, and/or living in supportive housing.

The questions posed by the ACT teams reflect general interest and the need for regular contact with the LME/MCO on housing related issues. It was also clear that the challenges related to communication between the LME/MCOs and the Regional Housing Coordinators are posing a challenge for ACT teams. As stated in last year's Annual Report, regardless of where these breakdowns occur and by whom, it is essential to resolve these issues since ACT is the primary service for nearly 50% of individuals in TCLI.

Specific findings for individuals receiving ACT:

- (1) Twenty-three (23) individuals in the FY 2019 individual reviews were receiving ACT. Only twenty (20) were actively receiving services at the time of the review. Of the 20, five (5) were getting the intensity of services commensurate with their need. One issue influencing this finding is that there is often no requirement for the number of contacts made per month for each individual served. There is reference in the State's ACT service

definition<sup>29</sup> for the team (ACT) to “see beneficiaries, on average, 1.5 times per week and for at least 60 minutes per week”. The State only requires one fifteen-minute encounter for the provider to get their per diem payment. Based on individual reviews this often means the minimum face-to-face contact<sup>30</sup> becomes the maximum. This practice, absent payment for performance, rewards high caseloads and less time devoted to each individual.

- (2) Of the 23 individuals receiving ACT, ten (10) were getting services that were recovery oriented, six (6) were getting services that were personalized, and five (5) were getting choice and needed services.
- (3) The TMACT has discrete categories. Through a review of the ACT TMACT scores, teams are generally getting high scores or moderately high scores on items related to the team structure, role of staff, assignment of responsibilities, and meeting other team requirements. These items have higher weight on the overall scores in other categories and sub-categories critical to the recovery individuals in the TCLI population. Averages are lower across most teams in the six sub-categories critical to serving the Settlement Agreement target population. The areas where scores are generally averaging between 3.0 and 2.7 across the teams are:
  - Strengths inform treatment plan
  - Full responsibility for psychiatric rehabilitation
  - Intensity of contact
  - Frequency of contact
  - Frequency of contact with natural supports
  - Supported employment and education
- (4) These are important for serving individuals with SMI in this Settlement Agreement’s priority population. For example, if individuals moving out of ACHs have few friends or family, they would benefit from more frequent contact and assistance with making new friends or re-connecting to their social supports. If individuals have lost or did not have skills in instrumental activities of daily or community living, taking on full responsibility for psychiatric rehabilitation is critical.
- (5) Two (2) individuals, randomly selected, typify the consequences of lower performance of a team that is not as engaged and focused on recovery and individualizing support and

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<sup>29</sup> NC Division of Medical Assistance Clinical Coverage Policy No: 8A-1. Effective date November 1, 2015.

<sup>30</sup> Up to 25% of contacts can be collateral contacts (individuals who provide support or resources to or on behalf of the individual).

one (1) typifies high performance:

*Individual 1:* XX had been living in his apartment for one year. The staff cited “harm reduction” as the reason his apartment was messy and smelled of smoke. Based on discussion with the team they said they were using “harm reduction” allowing him to set his own course with his recovery without using any techniques used in effective “harm reduction” strategies. His PCP was out of date. His staff cited his visiting his daughter as his primary social outlet but there is no reference to his having a daughter or visiting her as a goal on his PCP or assisting him to do that. He cited not having a car as his biggest concern and having a car was important so he could see his daughter. While there, the LME/MCO staff accompanying the Reviewer, not the provider, began developing a plan to get the car fixed. This was promising but there was no explanation on why the ACT team had not done this earlier.

*Individual 2:* XX has been living in what appears to be a poorly maintained ACH for two years, getting services from an ACT team that entire time. His guardian was present for the interview. She recently fired her ACT team that, in her words, had failed to provide adequate services and supports. XX is an active drug user. From direct observation, it is easy to purchase drugs at that home. XX wants to move to the community but the guardian reports that over the past year there has been virtually no help for him to work on his goals and get support through some type of organized program away from the home, what she had hoped would happen. His PCP identifies he will be seen four (4) times a month. The Crisis Plan in the PCP included the instructions meant to be example for how to write a crisis plan on the form itself. The plan simply restated the instructions.

*Individual 3:* XX has been living in an apartment in a well-maintained apartment complex. He is very engaged with his ACT team. He meets with an ACT team member three times a week and attends an Integrated Dual Disorder Treatment Group (IDDT) group. He is working “off the books” but expressed interest in taking classes either through adult education or at a community college. He attends other groups and the “Y.” His guardian joined the meeting and reported requesting and getting a transfer to this ACT team because of dissatisfaction with a previous team not providing the kind of help he needed. XX has been stable and sober for a year and a half after assigned to this team. Previously he lived, for an extended time, in adult care homes. This example illustrates the positive difference an ACT team can have versus a team simply going through the motions of delivering services.

- (6) Of the twenty three individuals reviewed who were receiving ACT, eight (8) had adequately written and updated PCPs (person centered plans) that were being followed with attention to the individual’s choices and needs. There was not enough information

available for five individuals reviewed to determine the adequacy of the plan. Plans and planning processes tended to be formulaic. Teams were not giving individuals the opportunity to move to the community even though their PCPs referenced this goal repeatedly as if this was going to occur without their taking action to assist an individual to move. This is mis-leading and is a serious practice and contract issue. One LME/MCO contracting an ACT team providing services to one of the individuals referenced above took no action after advised of this misrepresentation and poor practice.

13. Sixteen (16) individuals in the individual review were receiving Tenancy Support Management (TSM) as their primary service. All but one individual was residing in supported housing. Eight (8) individuals were receiving Community Support Team (CST) as their primary service and three of those individuals were living in supported housing. Each of the three (3) individuals was also receiving TSM. The remaining sixteen (16) individuals were receiving IPS, medication management, Psychosocial Rehabilitation (PSR), Peer Support, IPS-SE, outpatient (OP), occupational therapy, other services, or a combination of these services. Only two (2) of the individuals getting services other than TSM or CST as their primary service were living in supported housing.

Eleven (11) of the fifteen (15) individuals with one of these other services as their primary service were either in the Pre-screening or in the Diversion category. At the time of the review, staff had referred all but one of the individuals to TCLI to get a housing slot, not for ACH admission.

14. Seven (7) individuals or 44% of individuals receiving TSM were getting services at the level of intensity needed. Two (2) individuals getting PSR, one (1) getting CST, and one (1) getting Peer Support as their primary service were getting the intensity of services needed. Overall, this is a higher percentage receiving the intensity of services needed than those receiving ACT. There is a difference in the level of need and eligibility requirements between those getting ACT and those individuals getting TSM. ACT recipients have a higher level of need based on their history and severity of their illness. TSM teams have lower caseloads and focus of tenancy support needs but also there was a much better matching of services needed and services provided at the level of intensity needed.

15. On the remaining indicators, there was variation with individuals getting TSM. Fifty-six percent (56%) were getting choice of services, only twenty-five percent (25%) of their services were personalized services but forty-three percent (43%) of services and supports were assisting an individual with their recovery. Individuals getting other services as their primary service scored on or close to fifty percent (50%) on these indicators. Again, this is indicative of providers demonstrating their desire to assist individuals they are serving to get housing slots. While this is not definitive, these are likely providers with a strong commitment to

helping individuals with their recovery, choice and successful tenancy.

16. Of the eight (8) individuals served by the providers listed above who expressed an interest in employment, there was only one (1) with a previous referral to IPS-SE.
17. Two other long-standing problems that, based on FY 2019 review and earlier reviews, are indicators the State is not yet taking effective measures to prevent institutionalization and to provide adequate and appropriate public services and supports identified through person-centered planning and transition planning. There have been references to these issues in previous reports. Neither has been resolved and both have an impact on overall performance across a number of requirements.

The first is the imbalance in time spent and responsibilities of service providers assisting individuals prior to, during, and following transition compared to the responsibilities of In-reach staff and Transition Coordinators employed by the LME/MCOs. This imbalance is the result of the initial decision that LME/MCOs would hire staff for In-reach and to manage transitions processes. This was done without consideration of the unintended consequence of needing more LME/MCO staff as numbers increase over time. The cost of these staff is assumed by the State and the LME/MCOs with no possibility for reimbursement beyond what the LME/MCOs can cover as part of their administrative rate. The LME/MCOs administrative rate is capped so it is not an unlimited source of funds. Thus several LME/MCOs are constantly needing to add staff or fall behind in initiating or completing timely transitions because their caseload increases. This decision was exacerbated when responsibilities were not initially made clear, required and/or assigned to service providers, only to LME/MCO staff. TCLI staff often asked service providers to assist but have had to step in to deal with issues providers did not feel they were responsible to manage. This problem is made more complicated by the fact that Medicaid will only reimburse for services provided for 30 days prior to SPH discharge and by the fact some service providers are not trained, experienced or willing to carry out needed tasks.

The second is the number of individuals separating from housing, especially those separating within six months of moving. Both of these challenges have one common community services element: the time and focus of service provider interventions prior to, during, and after someone moves into supported housing. Other facets to each problem exist, but this common element impacts the effectiveness of community based mental health services.

18. The LME/MCOs' In-reach staff and Transition Coordinators have very specific transition responsibilities. Both have finite resources, timeframes they must meet, and a myriad of demands on their time as more individuals are diverting from ACHs and more individuals are moving into supported housing. The primary service provider has service responsibilities for almost the entirety of this time and is in a better position to provide crisis prevention, which

is important at the point when an individual moves. The primary service provider has the responsibility for assisting the individual with their person-centered plan, the longer-term responsibility for services and support, and the need to engage with the individual as fully as possible.

The difference noted with this year's reviews and previous years is that most LME/MCO TCLI staff are trying to give providers more responsibility. The LME/MCO TCLI staff are not getting the level of support they need from LME/MCO contracts and network staff. It is also important for the State to support this shift in how they support and, where necessary, use the methods they have to hold LME/MCOs accountable for this shift.

19. Separations remain high. Eight hundred and seventy (870) individuals moved into supported housing this past year. There was only a net gain of five hundred and thirty-four (534) more individuals living in supported housing at the end of the year. Of the number of individuals separating, twenty-five percent (25%) returned to ACHs, twenty-two percent (22%) died after moving, seven percent (7%) moved to other mental health group homes, residential facilities or treatment settings, and twelve percent (32%) moved to independent settings, with friends or with family. The remaining thirty-six percent (14%) left housing for other reasons including going to hospice, skilled nursing, jail or prison, hospitals or unknown locations. Most deaths were of natural causes. Moving in with friends and family can sometimes be exploitive, but it can be a positive move.

Individual review records indicate that thirty percent (30%) of those listed as moving to an independent setting are individuals who left housing to avoid eviction, without notice, or to move to another community and often their whereabouts are unknown. If there were a reduction in the number of individuals returning to ACHs or leaving without notice, separations would be in the acceptable range for individuals in the same age range who have serious disabilities. The challenges are the same as reported in earlier years. These include isolation, lack of support, assistance with potential tenancy violations, and more attention to ensuring the location is desirable and close to amenities, friends and family. These point to the need to provide more effective pre-tenancy, move-in, and post tenancy services.

20. The primary requirement in **Section III (C)(7)** is for the State to implement pre-paid capitation plans and contract with LME/MCOs to operate the plan. The State is required to monitor services and service gaps and ensure that the number and quality of community mental health service providers is sufficient to allow for successful transition and diversion of individuals from ACHs. The State is required to do this in a manner that enables individuals to have success in supported housing and long-term stability in the community.

The State has made improvements in the DMA contract with LME/MCOs related to the TCLI Settlement. There were improvements in the FY 2019 contract for SPH discharge planning.

There were comments submitted to the State in April 2019 to consider for the FY 2020 contract. These are still under review as the State goes through its contracting process. The issues included adding Pre-screening and Diversion requirements and ensuring In-reach responsibilities reflect the requirements in the Settlement Agreement. There were questions about items that needed additional clarity and several questions about items where the LME/MCOs needed guidance to fulfill their responsibilities.

The State improved their 2018 Network Adequacy and Accessibility Analysis Requirements (gaps analysis) guidance to LME/MCOs for TCLI as a Special Population. The LME/MCOs submit their responses by July 1<sup>st</sup> of the year following the analysis. This review is referring to the FY 2018 plans. The plans were similar in some respects although while some LME/MCOs include references to their gaps, barriers, and improvement strategies, others simply describe their program with limited information on gaps, barriers, and improvement strategies. Given the challenges facing the State to meet Settlement Agreement requirements, there is a need to place greater emphasis on LME/MCOs submitting plans that refer to filling gaps and reducing barriers, including improving access, availability, and quality of services.

21. **Section III. (C)(8)** is primarily a description of LME/MCO responsibilities to beneficiaries under 42 C.F.R. § 438.10 as well as to hospitals, providers, police departments, homeless shelters, and department of corrections facilities. It also references requirements the LME/MCOs assumed when becoming MCOs. It includes the LME/MCO responsibilities for meeting federal accessibility requirements. These are standard requirements, yet there was an instance with one review where a qualified interpreter was not provided. Wait lists exist for services in certain geographic areas. The State has taken action to improve access for individuals who are deaf and hard of hearing.
22. DHHS has greatly improved the TCLI allocation process. The process is now timelier with opportunities for the State and LME/MCOs to shift resources to LME/MCOs who have increased placements beyond expectations, need start-up funds for additional required services, and in some situations helped LME/MCOs take advantage of opportunities to fill gaps, start new initiatives, and improve services and supports. The demands for shifting categorical non-recurring funds always outweigh what is possible to do on an annual basis. The Special Advisor's staff manages this process with the DHHS budget and Division staff. The obligations in the Settlement Agreement will require even greater flexibility and support over the next two years. The DHHS is now poised to do that.
23. **Section III (C)(10)(a-c)** includes requirements for an LME/MCO to develop a crisis service system, for the state to monitor gaps in crisis systems, and for crisis services to be provided in the least restrictive setting consistent with their individualized crisis plan. Crisis systems

are in place and monitored through the “gaps analysis.”

24. DHHS has done considerable work, as have the LME/MCOs, to develop local crisis systems, both mobile and facility based. This past year, the crisis review was conducted in two ways. First, as part of the Individual and Separation Reviews, information was gleaned from reports of crisis incidents and crisis services use. Second, the TCLI Data Analysis included four specific questions regarding crisis services use.
25. As reported in previous Annual Reports, when individuals experience crises before the move into the community and following their move (including when they are moving into supported housing), the In-reach staff and Transition Coordinators manage the crisis, including attempting crisis prevention, intervention, and stabilization. ACT teams provide crisis support, and even though TMS service description did not include crisis intervention, TMS providers delivered crisis services out of necessity. The new CST definition includes crisis intervention. The inclusion of crisis prevention and interventions strategies in the requirements for the aforementioned providers enables the State to assist individuals in the least restrictive setting.

The TCLI Data Analysis and the State’s review of crisis services delivered to individuals living in supported housing in FY 2017 and FY 2018 indicates crisis services utilization is low. The State’s FY 2018 analysis indicates six percent (6%) of individuals who moved into supported housing used mobile crisis and only two percent (2%) used facility-based crisis services. The data does not show the number of crisis episodes per individual per year. The HSRI data on costs indicate the costs are low and the use of these services is less frequent after an individual moves into supported housing. This data reflects that either the need for crisis services was low, that TSM and ACT providers are responding to an individual’s crisis without needing crisis service provider’s help, or that individuals are not getting crisis support when needed.

26. Sufficient information is not available yet to determine if crises resulting in loss of housing or someone abandoning their housing occurred after an effective crisis prevention, stabilization, or other intervention occurred.
27. Crisis plans are not used to help individuals increase their ability to recognize and deal with situations that may otherwise result in crises although some individuals report they know their crisis triggers and try to prevent an escalation of situations that result in crisis.

**(C) Recommendations**

*Fourteen recommendations are referenced below. Because the pace and level of change has not been sufficient to meet the community mental health services Settlement Agreement requirements, it is important the State take a focused cohesive approach to meeting these*

*recommendations. The State has a limited amount of time to take multiple steps, requiring changes in interconnected and multiple types of contracts, policies, practices and reviews. Establishing sequential action steps, priorities and feedback loops are important as is communicating proposed changes in clear concrete terms. On numerous occasions assumptions have been made that each entity knows what they need to do to implement proposed changes and often input isn't sought until after the fact, if at all. This leads to miscalculations, lost time and redundancies. It's a matter of ensuring the communication gets made to the right audience at the right time.*

*Rather than treating these as stand-alone recommendations, the State is advised to consider using a project management approach to meet these requirements, taking timely, informed action steps, with constant feedback loops and rapid assistance and monitoring. Meeting these requirements requires understanding that taking each step may have unintended consequences on meeting other requirements. For example meeting Discharge and Transition Processes and Pre-screening and Diversion requirements will create more demand for housing slots for individuals in Categories 4 and 5 of the target population at the same time the State is struggling to meet the requirement to fill Slots for individuals in Categories 1-3.*

1. Ensure the expanding array of services are available to the priority populations in a manner that matches needs of the target population with the new CST service and a greater emphasis on use of health care management arrangements, individual supports, and Peer Support, both the proposed stand-alone service and other peer support initiatives that are not typically made available to individuals in the TCLI program. The highest priority for this array is for the effective implementation of Community Support, expansion of Peer Support, focused on individuals in the current and future TCLI target population and support from health providers who are knowledgeable on wellness and recovery and on managing and preventing deterioration of chronic health conditions.
2. Expand evidenced based services and supports focused on recovery and building community and natural supports to enable peer led and/or directed services to be available to anyone in the target population. Peer Services include employment supports, IPS-SE, and/or assistance to create a business or services development opportunity, outreach and peer navigator services, social clubs and drop-in centers, wellness and recovery education, mentoring/coaching, and/or partnerships with health centers and individual, community, and crisis or respite support.
3. Implement the State and Medicaid reimbursed stand-alone Peer Support service with a focus on ensuring Peer Support services are provided for the TCLI target population. This could be done by providing technical assistance from peer leaders who have overcome challenges and expanded services in North Carolina or other states working directly with LME/MCOs and

stakeholders.

4. Ensure primary service providers are assigned and actively providing services for individuals at the earliest point possible but no later than when the individual begins transition planning (while hospitalized, before exiting ACHs, or when an individual is determined eligible through the Pre-screening process).
5. Identify the responsibilities for all pre-tenancy, move-in, and post tenancy tasks that primary service providers are required to meet as a condition of their contract with each LME-MCO. This is ultimately a State requirement. Establish performance indicators for all primary service providers that meet Settlement Agreement “effective measures” requirements statewide. Shift responsibility to LME/MCO and service provider staff to have the direct responsibility for assisting individuals to meet tenancy requirements including working with landlords and property managers. Be specific on who is responsible for resolving issues during the shift of transition responsibilities between the LME/MCO and service provider.
6. Implement CST using effective contracting requirements that include required competencies for all staff, for the primary provider, tenancy support for providing recovery-oriented services with crisis support and with the frequency, intensity, and duration needed for an individual to live successfully in the community.
7. Require LME/MCOs to arrange for CST and TSM teams to complete transition to becoming teams that meet the new CST requirements. For every individual who qualifies for the new CST service, this should be the first choice of a service recommended to each individual getting TSM currently. Establish effective clinical guidelines for practice and utilization management for this service. Such practices are based on a clear understanding of negative, mood and cognitive symptoms that often result in individuals being considered as no longer needing services based on their initial modest goals or their being identified as “non responsive”, refusing services, which is often temporary or being ‘treatment resistant”.
8. Improve the person-centered planning process in four ways. First, establish criteria for the team/individual responsible for the person-centered plan when multiple agencies are providing services, and between the LME/MCO Transition Coordinator and single or multiple providers. Provide staff training on person-centered planning including how to develop an effective person-centered plan that meets the Settlement Agreement Community-Based Mental Health Services and Discharge and Transition Process requirements. Second, establish a process for facilitating person-centered planning that includes a formal designation of a facilitator and staff responsibilities for each participant. For individuals on In-reach status, in transition status (moving from an adult care home, being discharged from an SPH, or being diverted), or in post transition status, the facilitator will typically be an LME/MCO Transition Coordinator. At a designated point, the responsibility shifts to a lead agency provider, but the

facilitator role does not change. An LME/MCO may choose to retain this role.

Third, ensure staff have competencies in person-centered planning, including ensuring the individual's goals and choices drive the plan. Introduce self-direction principles and options as appropriate. Fourth, establish a review process for monitoring plans to ensure they are individualized and meet requirements for intensity and duration, and include supports based on need choice and goals, wellness and health care, personal care, employment, and daily living, and community supports. Ensure all the participating agencies are participating as referenced in the plan. This also includes monitoring those agencies for meeting IPS-SE Fidelity requirements (Org. 1-2, 6 and 8).

9. Improve capacity and performance of service providers to reduce crises that lead to housing separations either through provision of crisis respite, bridge housing, crisis stabilization or in-home crisis respite, establishing collaboration between TSM and mobile crisis teams, or expanding ACT crisis stabilization capacity.
10. Continue the annual services data analysis. Include data on the characteristics of each of the Settlement Agreement priority population categories. Develop a separate analysis of individuals determined eligible for TCLI through Pre-screening. Measure and analyze services provided to individuals living in community locations other than supported housing and individuals getting In-reach and Transitional Services. Include longitudinal data to analyze services use per person to identify intensity and duration by priority population groups. This includes measuring intensity of ACT services.
11. Ensure other responsibilities referenced in the Settlement Agreement are included in LME/MCO and service provider requirements, are monitored, and are enforced. These include providing services that: (1) are evidence-based and recovery focused; (2) are flexible and individualized; (3) help individuals to increase their ability to recognize and deal with situations that may otherwise result in crises. This includes the State providing guidance on measures that are effective and that meet the Settlement Agreement requirements.
12. Provide services to individuals who continue to qualify for TCLI who are no longer using a housing slot or who, after being pre-screened, may use one in the future. Where necessary, remove barriers including building or unit access. Continue to make seek housing near amenities, transportation, friends and family when individuals indicate this is their choice and in the individual's desired location.
13. ACT teams meet accepted levels of performance on their TMACT in each of the six requirements listed on page 41 of this report. DHHS and LME/MCOs provide guidance to ACT providers on overall performance of ACT providing services for individuals in the TCLI target population. Consider creating or designating specialty ACT teams as recommended in the FY

2018 Annual Report.

14. Analyze workforce capacity and rates to determine what impact the availability of both professional and paraprofessional staff, staff turnover, potential for a career path, and rates have on the State's ability to meet the requirements in **Section III. (C)**.

### III. SUPPORTED EMPLOYMENT

Major Categories	Summary of Requirements	Progress Towards Compliance
<p><b>Section III. (D)(1)</b> states the State will develop and implement measures to provide Supported Employment Services to individuals with SMI, who are in or at risk of entry to an adult care home, that meets their individualized needs. The Settlement Agreement defines the aim of the services.</p>	<p>The Settlement Agreement spells out a description of Supported Employment that provides clarity of the requirements and adequate measures for meeting this provision.</p>	<p>The State is continuing to make progress but is not yet meeting this requirement. The State is falling short of taking effective steps to plan for the services, build adequate capacity, establish an incentivize performance to achieve better outcomes, fill the pipeline, and establish a business model for providers to improve performance, delivery, and sustainability of services for the target population.</p>
<p><b>Section III. (D)(2)</b> establishes the requirement for Supported Employment to be provided with fidelity to an evidenced based supported employment model for supporting people in their pursuit and maintenance of integrated, paid, competitive work opportunities.</p>	<p>The State selected the IPS-SE Fidelity Scale as the evidence-based model to assess Supported Employment services.</p>	<p>The State is meeting this requirement. The State and its technical assistance provider regularly assess providers using the IPS-SE Fidelity Scale. This model makes clear the staffing requirements and interventions required for a State service definition and for funding this service. This helps shape the compliance review for <b>Section III. (D)(1)</b>.</p>
<p><b>Section III. (D)(3)</b> defines the number of individuals who will be provided Supported Employment Services by the each fiscal year through July 1, 021<sup>31</sup>. The total by July 1, 2019 is 1,885.</p>	<p>Each year the State is required to increase the number of individuals “in or at risk” of admission to an Adult Care Home getting Supported Employment.</p>	<p>The State met the requirement for the total number of individuals provided Supported Employment by SE teams meeting fidelity to the IPS-SE model by July 1, 2019 by providing IPS-SE to 2222 individuals in or at risk of admissions to an Adult Care Home.</p>

#### **(A) Background**

The Settlement Agreement requires effective measures be developed and implemented to provide adequate and appropriate public services and supports identified through person

<sup>31</sup> The Plaintiffs filed a motion on January 17, 2017 that, among other requests, the Court ruled the Settlement Agreement requires the target population for this measure be individuals with SMI who “are in or at risk of” admission to an Adult Care Home. The Court granted the Plaintiff’s motion on this measure. The Parties entered an agreement to extend the time period to meet this requirement to July 1, 2021 to comply with this order.

centered planning in the most integrated setting appropriate to meet the needs of individuals with SMI, who are in or at risk of entry into an adult care home. The Community Services section of the Settlement Agreement further states that individuals' services be evidenced based, be individualized, and that individuals have access to services they are entitled to receive. The Settlement Agreement does not differentiate among individuals in the priority population regarding who gets access to a service and who does not.

There is a requirement in the Settlement Agreement that the State select an evidenced based Supported Employment model. The State selected the Individualized Placement and Support model as their evidenced based supported employment model. This was a good decision on the part of the State. This model is without comparison in its positive outcomes for adults with serious mental illness.

As many as 66% of individuals with serious mental illness want to work, which is consistent with findings in TCLI recipient random interviews<sup>32</sup>. At least twenty-three (23) randomly controlled studies demonstrate the efficacy of IPS-SE over other supported employment models<sup>33</sup>. Based on this Reviewer's experience, information reference in the literature cited above is correct. It takes significant attention from state and local leadership, coupled with a strong financing plan, to overcome the challenges of assisting individuals with serious mental illness who are included in the TCLI target population with returning to or seeking out work the first time.

For purposes of this review, and consistent with Settlement Agreement requirements, effective measures for Supported Employment include the following:

- 1) The service is available and accessible to any individual in the priority target population.
- 2) The service best matches the individual's needs and carried out in a manner to enable an individual to achieve their personal outcomes including integrated, paid competitive employment.
- 3) The service includes specialized job training, transportation, job coaching, assistive technology assistance, individually tailored supervision, and on-going support.

Six methods used to review IPS-SE in FY 2019 included:

- 1) Analyzing information solicited from individuals during individual reviews regarding their participation in IPS-SE, their desire to participate in this service, their current or past employment, and/or their desire to go to work. Where applicable and possible, there were

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<sup>32</sup> Burns EJ, Kerns SE, Pullmann MD, Hensley SW, Lutterman T, Hoagwood KE. *Research, data and evidenced based treatment in state behavioral health systems, 2001-2012. Psychiatirc Serv. 2016; 67 (5): 496-503.*

<sup>33</sup> Drake RE, Bond, GR, Goldman, HH, Hogan MF, Karakus, M. *Individual Placement and Support Services Boost Employment for People with Serious Mental Illnesses, But Funding is Lacking, Health Affairs. 2016:35(6): Abstract*

interviews with staff for individuals not offered IPS-SE who said they wanted to work, to determine the reason for not recommending IPS-SE.

- 2) Reviewing the State's analysis of data on service use for individuals living in Supported Housing.
- 3) Interviewing stakeholders (providers, the UNC TA team, and LME/MCO staff) involved in training, fidelity reviews, managing contracts, and developing IPS-SE as a unique service.
- 4) Conducting regular meetings, interviews, and reviews of written materials and data from TCLI and DMH staff.
- 5) Reviewing IPS-SE verifications and IPS-SE provider fidelity scores.
- 6) Meetings and follow-up discussions with Vaya, DMH, the Senior Advisor, and DHHS DVR staff regarding a pilot of a new business model for IPS (Vaya Pilot).

To assist with the IPS-SE review, Patti Holland, the Reviewer's Psychiatric Rehabilitation Expert, participated in Supported Employment roundtables with LME/MCO, and participated in two meetings regarding the Vaya Pilot. She continued to review Supported Employment progress from previous review periods.

As reported previously, IPS-SE is a relatively new service in North Carolina, initiated in late 2013. Implementing IPS-SE statewide is a challenge. It requires generating interest among the provider community to deliver the service. This includes getting support (and referrals) for the service from inpatient, outpatient and rehabilitation service providers, guardians, family members, and others. It also requires developing the workforce, assuring teams are available in all areas of the state, and integrating mental health and supported employment through joint treatment meetings and planning and outreach to individuals to consider employment. Developing effective measures for delivering the service is complex. IPS-SE teams must meet fidelity requirements to assure good outcomes and navigate between two systems (MH and VR) that have different payment models. The State and LME/MCOs must make sure service requirements, reimbursement, and financing drive rather than hinder performance. As with ACT, it is not possible to measure performance and meet Settlement requirements with fidelity alone.

The DMA's contracts with MCOs requires them to contract only with providers that meet fidelity. The FY 2019 contract also required MCOs to:

- (1) Provide reasonable training and technical assistance;
- (2) Link a specific number of individuals to IPS-SE as determined by the Settlement and communicated by DHHS to the MCO;
- (3) Establish and measure provider performance;
- (4) Monitor IPS-SE providers to evaluate the quality of service delivery and compliance to the waiver service description in the FY 2019 contract; and

(5) Contract with a sufficient number of providers for IPS-SE services for “enrollees” with SMI/SPMI, including those in the TCL Special Healthcare Population, in accordance with waiver service descriptions.

There was not a corresponding section in the DMH contract with LME/MCOs, although there is reference and some corresponding language.

IPS-SE fidelity measures provide an excellent framework for essential service delivery obligations. State-LME/MCO contract language is critical to articulate requirements in the Settlement Agreement and hold LME/MCOs accountable. Information gleaned from LME/MCO discussions, IPS-SE provider forums, as well as annual, monthly and fidelity review data suggests fidelity reviews and contract language are necessary but not sufficient to assure that the State meets the Settlement Agreement requirements for “developing and implementing effective measures”. Meeting fidelity and adding contract language does not substitute for robust planning, implementing an effective financing model, and setting performance targets and measuring performance. The State continues to need to implement a comprehensive plan with adequate funding for appropriate and sustainable Supported Employment services.

Since 2015, the Independent Reviewer’s Annual Reports have included four broad recommendations. These tie progress and consistency of efforts across years. The State’s Corrective Action Plan for Supported Employment submitted in June 2016 had goals and action steps consistent with previous Annual Report recommendations. There has been some movement to implement these recommendations but there is an even more urgent need now, with less than two years remaining in the Settlement Agreement, to implement these recommendations. Below are four updated recommendations with a brief FY 2019 update:

1. Clarify State (DMH, DVR and DMA), LME/MCO, and service provider roles, responsibilities, and expectations, and tie them to LME/MCO and provider expectations in contracts; establish performance measures between the DMA/DMH with LME/MCOs, between the LME/MCOs and service providers and with the DVR system; conduct quality monitoring and strengthen collaborative engagement and training. Even with clarification, additional guidance is still needed on performance measures and expectations, increased collaboration and contracts between local DVR offices and IPS service providers, and clearer expectations for serving individuals in TCL, not just individuals “in or at risk” of entry into an ACH.

2. The second recommendation was to develop and implement a sustainable IPS business model(s). A more viable, sustainable business model is possible using lessons learned from a Vaya Pilot discussed in more detail below. Two pre-requisites exist with this opportunity. One, due to the nature of the pilot, it will take time to determine the pilot’s viability and then roll it out across the state when it demonstrates it can help the State to meet the Supported Employment obligations in the Settlement Agreement. Vaya is strongly committed to the pilot;

this same commitment is necessary statewide. Second, it will need to be determined if the pilot results in more access to the service and integrated competitive employment for individuals in TCLI.

3. The third recommendation was to develop and implement an Action Plan to fill the IPS pipeline. Data shows there is consistent movement to fill the pipeline but not necessarily with individuals getting services and support in TCLI (i.e., individuals in the SA's target population). The State has repeatedly urged providers and LME/MCOs to take steps to include TCLI recipients. None have been effective to date. The Vaya Pilot adds incentives for serving individuals in the TCLI program. Monitoring the success with that incentive is important but it may not be sufficient to fill the gap. Additional actions such as a higher payment level, additional payments for engagement and follow-along and/or monitoring individual requests and provider engagement, are likely necessary.

4. The fourth recommendation was to develop and implement a targeted plan to build IPS-SE capacity in the most needed areas. The efforts to target growth where needed has only been partially successful. A summary of IPS-SE services availability by LME/MCO by county is located in the findings sub-section below.

In 2018, DMHDDSA and DVR staff began examining joint payment methods. This was to take advantage of multiple payment sources to expand resources and build collaboration between their two delivery systems. They chose to test out a "milestone" model for this purpose. The premise of this model is to pay providers for meeting specific milestones as an individual moves through steps to employment and to sustaining their employment with support from an IPS-SE team and DVR counselors. These steps include, but are not limited to, paying for developing a career profile, job search, employment, and ongoing support. DVR already pays providers for reaching milestones. The proposed DMHDDSA-DVR model shifts more services and supports to milestone payments.

Staff at Vaya Health had voiced interest for some time in improving the IPS-SE business model, which is an important way to build capacity, better finance and improve outcomes than using the standard fee-for-service model for mental health services and a separate incompatible "milestone" payment model for VR services. DMH and DVR invited Vaya Health to pilot their approach. Vaya quickly countered with a proposal and after continued discussions, they reached an agreement on a hybrid approach, building on the strengths of both proposals while adhering to state and federal requirements. The agreement came at the end of FY 2019 and they are still working on details but plan to implement this "pilot" in the fall of 2019. This leaves the State with less than eighteen (18) months to implement this model statewide assuming the pilot progresses as planned, there is strong state leadership, it's financially viable, and it proves effective for serving individuals in the TCLI program.

Last year the annual review included service provider roundtables and/or LME/MCO staff discussion regarding progress and challenges with IPS-SE. This year's roundtable discussion focused on provider capacity, number of TCLI recipients served, and provider and DVR challenges. This year the Cardinal roundtable participants also included local DVR staff. There is a description of those discussions in the findings sub-section below.

As referenced in each section of this Annual Report, the LME/MCOs submit information regarding their provider network (services) in a report to the DMHDDSAS (DMH) and DMA entitled "Network Adequacy and Accessibility Analysis." The 2018 Network Adequacy and Accessibility Analysis submissions included information related to Transition to Community Living Initiative (TCLI) and more specifically Supported Employment. The State asked each LME/MCO to describe the network adequacy of IPS-Supported Employment services, including number, locations, and capacity of fidelity teams; the LME-MCO's total service capacity requirements (including but not limited to the TCLI population); and service gaps and needs. A report on the LME/MCO responses is included in the findings sub-section below.

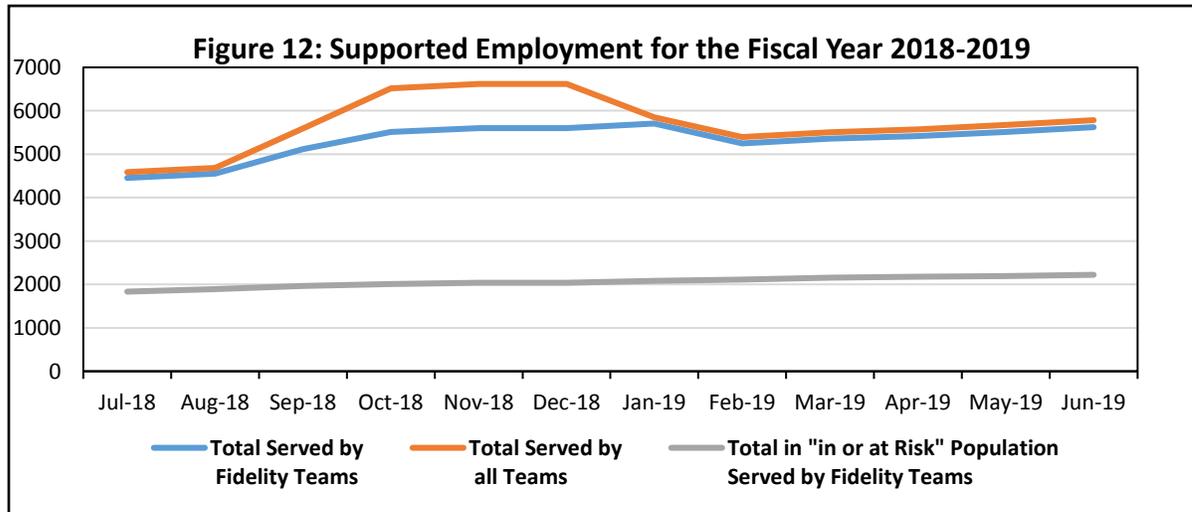
As part of this year's review, there was an analysis of fidelity sub-scores in two catchment areas to see if patterns of performance appeared that were indicative of the challenges that were evident in the field. There is a description of these in the findings sub-section below.

On January 9, 2017, the US Department of Justice moved to enforce the Settlement Agreement and, in that motion, contended the State could only count individuals in the target population in meeting their employment services obligation. The State had previously contended it was required to provide the service, not to only count the service provided to "individuals in or at risk" of ACH placement. The Court concluded the requirement for employment services was that the service target population would be individuals "in or at risk" of placement in an adult care home as stated in **Section III. (D)(1)** of the Agreement. At the Court's behest, the Parties modified the Settlement Agreement on October 27, 2017, to change the annual requirements and final requirement that the State will provide Supported Employment Services to a total of 2,500 individuals on July 1, 2021 (**Modification of Settlement Agreement [Case 5:12-cv-00557-D]**). The modification clarifies requirements for this and future reviews.

### **(B) Findings**

1. As described in findings below the State is not meeting **Section III. (D)(1)** but is meeting **Section III.(D)(2) and Section III. (D)(3)** requirement for the number of individuals provided Supported Employment by Supported Employment teams meeting fidelity to the IPS-SE model by July 1, 2019. There were two thousand two hundred and twenty-two (2,222) individuals served in FY 2019 and three hundred and thirty-seven (337) above the requirement for individuals served by July 1, 2019.

2. The number of individuals “in or at risk” of adult care home placement getting IPS-SE services increased by four hundred and seventeen (417) or 29% in FY 2019, this was lower than the six hundred and six (606) added in FY 2018 (**Figure: 12**). This is likely attributable to the State’s efforts, in response to the Reviewer’s recommendations, to define more accurate criteria for identifying individuals who are in the target population by virtue of being “at risk of” ACH admission. It is also possible the number of referrals the teams are receiving of individuals who are “not” at risk of ACH placement or in TCLI is increasing. Reports from IPS staff, verified by the Reviewer’s data, indicate it is more difficult to serve individuals in the SA’s target population than other individuals who are eligible for IPS-SE, because they have greater challenges returning to the workforce. The current payment models reinforce serving individuals who can be engaged and return to the workforce more easily. As a result, it is more cost effective for providers to serve individuals who are not in the target population.



3. The percentage of TCLI recipients referred and getting at least one unit of an IPS-SE service continues to range between seven and twelve percent (7-12%) of the individuals identified as in TCLI. The extent of sustained IPS-SE services and employment is yet unknown beyond information in the HSRI study, referenced in last year’s Annual Report, and information gathered during individual interviews. The HSRI information showed a rapid decline in service participation after individuals moved into the community from ACHs with a 60% attrition in one year. The number served actually went down, not up, after individuals moved into the community. This data suggests that individuals are referred to ACT but either because individuals choose to discontinue the service or ACT staff have difficulty serving individuals in the community they discontinue the service. Given the eligibility requirements for this service, this rapid decline should be reviewed.
4. The IPS-SE teams are serving a very low percentage of individuals in the TCLI program. Information from a review of IPS-SE verification worksheets and responses to questions

during the individual reviews this year revealed this problem. Individuals who are in the TCLI target population are less likely to get IPS services than individuals considered “at risk of” adult care home placement and the larger group of individuals served by IPS teams that meet fidelity. Of fifty-four (54) individual reviews, four (4) individuals were getting IPS/SE or vocational employment services from their ACT team. This represents approximately four percent (4%) of the total number of individuals in TCLI getting services. The percentage is closer to eight percent (8%) of those who indicated interest in employment.

5. The State has not yet made access to this effective service a reality for individuals in the SA’s target population (TCLI members). The number of individuals getting access to this effective service in the “in or at risk” group since the beginning of the Settlement period is 2,222. The State reports<sup>34</sup> the number of individuals in TCLI who got at least one (1) unit of IPS-SE services, not including B-3 services, as one hundred and seventeen (117) in FY 2017 and one hundred and sixty-eight (168) in FY 2018.
6. DMH also collects data on the census of individuals served by IPS-SE teams who are in “in or at risk” of admission to an adult care home and individuals in TCLI. DMH does not break this data out by individuals “in” (transitioning from adult care homes or exiting adult care homes” from individuals considered “at risk of” adult care home placement. The DMH report includes the number and percentage of individuals who had integrated competitive employment at any time during the quarter and the number of individuals in some type of educational program (secondary or post-secondary). During the third quarter (3<sup>rd</sup> quarter) of FY 2019, there were four hundred and sixty one (461) individuals either “in or at risk” or in TCLI, on the census of an IPS-SE provider. This represents twenty-one percent (21%) of the total census of the IPS-SE teams. This is consistent with the State’s reporting of the number of individuals getting this service. The FY 2019 3<sup>rd</sup> quarter census indicates 21% of individuals who are in this target group were on the provider census in that quarter.

The State also reports that of the total “in or at risk” or in TCLI group, there were one hundred and seventy five (175) or 38% of the total number of individuals enrolled who were employed in integrated competitive employment and twenty-eight or six percent (6%) who were in school. The employment percentage is down slightly from the previous quarter (46%) but the number of individuals on the census is up as is the total number of individuals employed. This percentage is encouraging but the State does not break down the number “in or at risk” from the number of individuals in TCLI so the total number of TCLI recipients on the census or being employed or in school is not counted.

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<sup>34</sup> DHHS TCLI Annual Report: *TCLI Service Patterns and Service-Related Personal Outcomes, Calendar Years 2017 and 2018 Report*. There is always a lag in reported claims based on the adjudication and reporting processes which means that FY 2019 data is not yet available.

7. In a review of verifications conducted from December through May during the annual review process<sup>35</sup>, 23% or fifteen (15) of the one hundred and nine (109) correctly completed verification forms were for individuals living in adult care homes or already identified as being in TCLI. Eighty-seven percent (87%) of the individuals living in adult care homes or in TCLI getting services from providers in two LME/MCO catchment areas, Trillium and Vaya. The percentage for the other five LME/MCOs was 13%. Based on individual reviews, there is a difference between the number of individuals referred and individuals getting services. The reasons given for this difference vary and include the individual speaking once with the provider but either not getting a call back, the individual being ambivalent about following through and/or the staff of the organization responsible for completing the PCP not including employment as a goal and therefore not listing IPS-SE as a service. It is the LME/MCO's responsibility to monitor this service and to ensure if individuals express an interest in IPS-SE and/or employment to assure the service is made available.
8. During the random reviews, there were questions posed to individuals on their work status, on their interest in going to work, and on whether they were getting assistance from their ACT team or IPS-SE. Of the fifty-seven (57) individuals interviewed regarding employment, thirty-two (32) or fifty-six percent (56%) expressed interest, four (4) were working off the books, and twenty-one (21) showed no interest, although eight (8) of the 21 were either in PSR and wanted to stay with that service or were volunteering and wanted to continue doing that as their primary community activity. Two (2) were getting vocational support from their ACT teams and one individual who was seen right after she was pre-screened for TCLI was already getting IPS-SE services. Two (2) who indicated interest said they had said yes to IPS/SE. One had received one call, but no follow-up, and the other individual had not received any follow-up calls or visits.
9. The State reported thirty-six (36) teams were meeting fidelity on June 30, 2019 (**Figure 13**). The State reported there were thirty-one (31) teams meeting fidelity on June 30, 2018. There were two (2) new teams meeting fidelity in FY 2019 and two new (2) teams were going through their first fidelity review process at the end of the fiscal year. Two (2) providers dropped the service in FY 2019. The total number of teams formed after IPS-SE began in FY 14 was thirty-nine (39). This fluctuation is not dramatic but more an indication of a system still going through a start-up and stabilization period.

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<sup>35</sup> Reviews began in December, so the numbers of verifications were lower for the LME/MCOs reviewed between December and February and slightly higher for the LMEs reviewed in the last three months. However, this sample represents 60% of individuals verified as being in the TCLI population or "in or at risk."

**Figure 13: Number of “In or at Risk” Individuals Served/IPS-SE Teams by LME/MCO in FY 18-19**

	# of IPS-SE Teams Meeting Fidelity <sup>36</sup>	# of individuals "in or at risk" enrolled <sup>37</sup>	# of individuals "in or at risk" enrolled <sup>38</sup>	% change between FY 18 and FY 19
Alliance	7//6	339	392	14%
Cardinal	8//6	568	680	17%
Eastpointe	5//4	84	107	13%
Partners	2//2	42	93	55%
Sandhills	4//3	104	151	31%
Trillium	6//7	361	448	20%
Vaya	4//3	307	351	13%
Totals	36//31	1805	2222	29%

10. The DMH continues to provide additional resources to improve and expand IPS-SE. In FY 2019, the DMH added a provision allowing teams to hire administrative support and they increased allocations for the expressed purpose of enabling LME/MCOs to increase rates. Not all the LME/MCOs believed they could utilize the funds for the expressed purpose since adding administrative staff and increasing rates for their providers would be challenging. Making the situation more difficult was the amount of the allocation and the time of the year they received the allocation with no guarantee at that time there would be an annualization of funds. As with previous years, increasing funds has limited impact without also tackling the larger issue of creating a viable business model.
11. Choice of providers continues to be a challenge in rural areas. Seventy-four (74) counties have at least one (1) team providing services in their county<sup>39</sup>. In one (1) rural area, one (1) provider is providing services in eleven (11) counties where there is no other provider. Six (6) providers cover at least five (5) counties and six (6) providers covering three counties. In a limited number of situations, two (2) providers may be serving individuals in two (2) or more of these counties. Establishing a viable team that can cover the geography, make employer visits, develop career profiles, and provide job coaching and follow up support is challenging. The services payment model rewards higher volume. This is less likely to occur in rural areas.

<sup>36</sup> Comparison of numbers of teams meeting fidelity in FY 2019 compared to FY 2018.

<sup>37</sup> Enrolled on June 30, 2019.

<sup>38</sup> same

<sup>39</sup> The state reports the number of counties served by an IPS-SE team. The LME/MCOs also report the counties covered by each team during site visits and in their Gaps Analysis. Discrepancies exist across these reports. This report uses the State’s numbers submitted at the end of FY 2019.

12. Challenges persist in urban areas as well. In the state's largest counties, there should be a choice of at least two (2) providers to meet the demand and provide choice as required in the Settlement Agreement. Four (4) out of the ten (10) largest counties in North Carolina only have one provider that meets fidelity requirements whose office is located in the county. There is not a provider serving one of those counties. One provider serves individuals in three (3) counties but that provider's office is located in one county. Staff travels to the other counties.

13. It appears the business approach proposed as a pilot project in the Vaya area may have promise. The proposal requires the DVR system to respond quickly with approving referrals, plans, and payments. It necessitates less duplication in paperwork between the two systems, VR and MH, and cost finding to assure the proposed model is financially viable. It will need to modify the bifurcated and linear payment structures, milestone in VR, and fee-for-service payments, and create starting points for individuals to entry into VR and IPS-SE services.

The pilot project provides for co-location of dedicated DVR counselors with IPS-SE service providers for one half day a week. It adds milestones for individuals in the TCLI program, provides for rapid enrollment in VR, and adds requirements and a better structure for staff collaboration to the benefit of individuals getting services and employment. The pilot project has the potential to improve cash flow and resources for providers. Many questions remain unanswered. Four that stand out after a review of the preliminary proposal are:

- (1) Will the proposal improve the likelihood that providers and the DVR will accept all referrals? Specifically, will individuals in TCLI be referred and get services and supports they need, be offered a desirable job of their choice, be employed, and retain employment over time?
- (2) Will it cover costs to serve individuals with challenging issues who have been out of the work force for a long time, which includes individuals in TCLI, especially in the requirements for "time unlimited follow along supports," "individualized follow-along supports," and "assertive engagement"?
- (3) Will one half day of dedicated VR staff time and co-location with IPS-SE service providers be enough time to assure timely follow through? Will processes be less duplicative?
- (4) How does this proposal assure referrals? This is a concern when many clinicians, other staff, guardians, and family members continue to believe and voice that some individuals cannot or should not work. This is a point made to individuals both subtly and sometimes in a more overt manner.

The FY 2020 review will include an assessment of these issues and a review of outcomes and other issues if they emerge.

14. According to IPS standards, individuals employed must have face-to-face contact with their Employment Specialist (on the IPS team) at least monthly for a year or more, on average, after working steadily and as desired. IPS Employment Specialists also contact individuals within three days after learning of a job loss. Given this requirement, the length of time in the IPS-SE would likely be twelve to twenty-four months for individuals securing competitive employment. Vaya staff referenced this as a challenge with the current funding model. There was not enough information available from individual reviews to verify this problem. This is likely because no one in the individual review cohort had secured employment through IPS-SE.
15. The State has taken steps to narrow the categories of individuals “at risk of” of ACH placement to assure the categories represent individuals mostly likely to be actually at risk of ACH admission. They made two adjustments to the definition of “at risk of” ACH admission in FY 2019, the first in November and the second in May 2019. These adjustments were made to ensure that individuals being identified as “in risk of” are actually at risk of adult care home placement. The definition was overly broad and individuals were included who were likely not at risk for adult care home placement. For example, a number of individuals were listed at risk of ACH placement because they could not pay rent even if they had income to pay rent or young adults were “couch surfing” between jobs. This problem, coupled with the previously adopted payment model, led to the unintended effect of limiting access to individuals in the TCLI target population to the IPS-SE service. The definitional changes to what it means to be “at risk of” ACH admission were important, and, along with a change in the financing model, will help assure individuals in TCLI get access to IPS-SE services. This change does not rectify the over inflation of the number of individuals “in or at risk” of adult care home placement getting IPS-SE that has occurred over the past six years.
16. As referenced in each section of this Annual Report, the LME/MCOs submit information regarding their provider network (services) in a report to the DMHDDSAS and DMA entitled “Network Adequacy and Accessibility Analysis.” The 2018 Network Adequacy and Accessibility Analysis submissions included information related to Transition to Community Living Initiative (TCLI) and more specifically Supported Employment. The State asked each LME/MCO to describe network adequacy of IPS-Supported Employment services, including number, locations, and capacity of fidelity teams; the LME-MCO’s total service capacity requirements (including but not limited to the TCLI population); and service gaps and needs. All the LME/MCOs reported on the number, location, capacity, and teams meeting fidelity. The responses to IPS-SE service gaps and needs varied widely but were consistent with issues raised in roundtables. Two LME/MCOs indicated that family and guardians are discouraging individuals who say they may want to return to work. One LME/MCO referenced overcoming

stigma as a challenge. Two LME/MCOs referenced the type and level of funding and three LME/MCOs indicated provider engagement and willingness to serve individuals in TCLI as a challenge. Two LME/MCOs referenced provider staff turnover as an issue and five LME/MCOs reported needing additional teams in specific locations as the program grows. One LME/MCO indicated they did not have any barriers to individuals accessing this service.

Adding this section to the network analysis is positive. It shows the State's interest in identifying gaps in the IPS-SE service network. LME/MCOs identified some key issues but there was less recognition of the problem with low numbers of individuals in the TCLI population getting access to this service than expected, given the small number of individuals in TCLI getting IPS-SE services.

17. The DMH has promoted the development of a provider based IPS Collaborative for sharing ideas and information across the IPS provider community. This a good example of the value of peer-to-peer learning.
18. Overall, twenty-four (24) teams or 68% of the IPS-SE teams in North Carolina meeting fidelity are scoring in the "fair" range of fidelity in their last review<sup>40</sup>. Eight (8) or 23% are scoring in the "good" range and one (1) team is scoring in the exemplary range. Of the twenty-seven teams (27) reported to have been reviewed for fidelity in 2018 and 2019, twenty-seven (24) scored at the same level as their previous review. Five (5) of those teams scored lower within that range than an earlier review. Twelve teams (12) scoring in the fair range had higher scores in their previous review even though they did not move into a higher range. Three (3) teams scored at the "fair" level on their first review and one (1) team scored in the good range on their first review. Two (2) teams moved into the fair range after not meeting fidelity initially. One (1) team that had scored in the good range consistently dropped to the fair range. One provider shut down their team and one lost staff and closed.
19. There were reports that turnover in staffing was creating challenges with teams improving their fidelity scores and providing services in a timely manner. However, a survey of LME/MCOs in June 2019 revealed there were only seven (7) vacancies across all the teams at that time.
20. The DHHS publishes a monthly IPS-SE dashboard measure of the number of individuals "in or at risk" getting IPS from a team meeting fidelity for each LME/MCO. Five (5) of the seven (7) LME/MCOs met their dashboard requirement in FY 2019 and the overall number was above the statewide requirement. This signifies to LME/MCOs and other decision makers that the

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<sup>40</sup> Reviewers conduct IPS-SE reviews for IPS-SE fidelity at least every two years or more often depending on requests and circumstances. The review totals in this Report include teams last reviewed in either FY 2018 or 2019. There were some reviews that took place in FY 2019 not scored at the time of this report so until their final score is posted their previous score is used for this calculation.

State is meeting performance requirements for this service, masking the challenge of ensuring individuals in the TCLI population get access to the service. It also masks the leveling off IPS-SE team performance as indicated with Fidelity scores referenced above.

21. Local DVR offices do not have performance targets for the TCLI program but have obligations in this Agreement. The DHHS DVR staff have continuously advocated for local DVR offices to enter into contracts with IPS-SE providers. DVR reports eighteen (18) IPS-SE-DVR contracts are in place or approximately fifty percent (50%). This continues to be a struggle, but DVR continues its commitment to increase this percentage.
22. The DMHDDSAS FY 2019 “draft” contract states the MCO “shall have the authority to issue corrective action plans and sanctions against Providers who fail to meet the IPS-SE service definition, up to and including termination of the Provider’s contract to participate in the MCO Network, as applicable.” Comments on this draft were submitted to the State along with a request that the State provide additional guidance to the LME/MCOs regarding meeting the Settlement requirements for this service, establishing and measuring provider performance, and evaluating the quality of service delivery. This remains an outstanding question.
23. No corresponding section in the DMH contract exists although references to IPS-SE exist. There is a section in the DMH contract entitled “Development of Employment Opportunities for Supported Employment Opportunities,” but that section does not refer to IPS-SE.
24. The State is making a good faith effort to narrow the “in or at risk” population to define who is truly at risk and receiving IPS-SE services. The State is making an effort to increase benefits counselors for the same reason. Both of these actions should spur activity that would result in an increase in the number of individuals in the TCLI cohort receiving this service, but to date this has made little difference in numbers served.

**(C) Recommendations**

1. Implement the four recommendations made in FY 2016-18 in FY 2020. Take steps to address them fully. This will increase the likelihood the State can meet the requirement for taking effective measures to implement IPS-SE. There was progress in meeting three of the four recommendations this year.
2. The DMH and LME/MCOs take steps to ensure individuals in the TCLI target population have the choice and opportunity for competitive employment in an integrated setting. There needs to be a wider range of job choices to accommodate the needs of individuals who want to work but are worried about their stamina, their ability to ever work again, losing their benefits, or the potential stress of working given their chronic health conditions.
3. Implement an effective business model statewide.

4. Build stronger support, send a clear message that this service is valuable, and that funding will continue following the Settlement Agreement. This in turn will spur needed capacity, will stimulate better performance, and will enable the State to achieve compliance with IPS-SE as a needed service and as a stand-alone requirement.

#### IV. DISCHARGE AND TRANSITION PROCESS

Major Categories	Summary of Requirements	Progress Towards Compliance
<p><b>Section III. (E)(1)</b> Individuals are fully informed of the option of transitioning to supported housing.</p>	<p>This provision applies to individuals being pre-screened, during ACH In-reach and SPH discharge planning. It requires Individuals be informed of the benefits of supported housing as well as the array of services and supports available to them, including a rental subsidy and other assistance.</p>	<p>The procedures for ensuring individuals will be accurately and fully informed of community options in accordance with this requirement, are now in place. There are still delays and there are still some individuals not informed of community-based options before moving to an ACH following pre-screening and individuals not given this option prior to SPH discharge.</p>
<p><b>Section III. (E)(2) In-reach</b> is provided to individuals in adult care homes and State psychiatric hospitals on a regular basis but not less than quarterly.</p>	<p>In-reach includes providing information about the benefits of supported housing and services/ supports by staff knowledgeable about community services and supports, facilitating community visits and offering opportunities to meet with individuals with disabilities, living and working in integrated settings, and with families/ friends/ community providers.</p>	<p>The State has not met all of the provisions of this requirement. In-reach staff still needs to become aware of all the needed community supports and services.</p> <p>Opportunities are not always taken to make community visits as required.</p>
<p><b>Section III. (E)(3-8)(12)[a-c][d][i.-iv.] and (13)(a-c) Discharge Planning/ Discharge Plan, In-Reach, and Implementation of the Discharge and Transition Process</b></p>	<p>This provision requires the State to develop detailed requirements for a starting point, development, arrangements for, participants in, and components of the discharge plan. These requirements specify the starting point, timeframes, action steps and responsibilities to complete the transition process in a manner that the individual is more likely to live successfully in the community.</p>	<p>These requirements present a number of challenges and require multiple action steps. The State’s performance in assisting individuals to move to supported housing from adult care homes is improving. There were improvements in SPH discharge planning in FY 2019 related to eligibility and benefits acquisition. There will be further review of this process fully in FY 2020 to determine if implementation was successful in meeting Settlement Agreement requirements.</p>

<p><b>Section III. (E)(9-11) Transition Team:</b> The DHHS is required to create a state transition team and local teams.</p>	<p>DHHS is required to create transition teams at the State and local level. The State team is required to assist local transition teams to address and overcome discharge and transition barriers. The requirement for the teams' composition, training, and problem identification are spelled out in these provisions.</p>	<p>The State established a state level Oversight Team; there will be a review of this measure in FY 2020 to determine if the team is meeting the Settlement requirement and contributing to the State meeting its requirements overall.</p>
<p><b>Section III. (E)(13)(d)(i.-iv.)</b> Review requirements for an adult care home that receives a notice it is an Institution for Mental Disease (IMD).</p>	<p>These provisions spell out the required notification of a finding that an adult care home is an IMD and the discharge and transition process for individuals exiting IMDs.</p>	<p>There was no review of this provision in FY 2019 because there were no IMDs identified in FY 2019.</p>
<p><b>Section III. (E)(14)</b> The State and/or LME/MCOs will monitor adult care homes for compliance with Residents' Bill of Rights requirements.</p>	<p>The Residents' Bill of Rights is referenced in Chapter 131D of the NC General Statutes and 42 C.F.R. §4318.100 and spells out specific rights in detail. The State statute details monitoring requirements and requires that an individual is free to exercise his or her rights and that the exercise of rights does not adversely affect the way the LME/MCOs, provider, or State agencies treat the individual.</p>	<p>The State continues to fall short of meeting this requirement. LME/MCOs now report potential violations as required. There is typically not an interview with the LME/MCO after they make a complaint of residents' rights violations, the individual the complaint was made against has been reported to be sitting in on the interview of the complainant, and sometimes the complainant is not notified of the State's decision. The DHHS needs to interview the LME/MCO complainant and respond to these complaints with the LME/MCO complainant.</p>

**(A) Background**

Discharge and Transition Process requirements include: thirteen (13) major categories and sixteen (16) sub-categories, excluding the IMD notification requirements. These requirements are explicit and detailed. They provide clear direction for the State to develop and implement effective measures to come into compliance with these provisions. The Settlement Agreement includes core functions that are the same across ACH, SPH, and Diversion transitions as well as

functions that may only apply to one of these institutional transitions and diversion. The State has taken steps and made changes, especially those necessary to meet requirements for adult care home In-reach and Transition. The State took steps to attempt to do the same with adding contractual requirements to SPH-LME/MCO discharge planning and establishing a diversion transition process. The State has not implemented the Discharge and Transition process requirements for SPH discharges to “unstable housing.” These requirements are more complex and require the full participation of the SPH and LME/MCOs to make necessary policy and practice changes. The State is making progress, since the November 1, 2018 change in in the implementation of the new Pre-screening and Diversion process but the State has not fully implemented the Diversion requirements.

Managing the processes and carrying out the tasks simultaneously complicated and more time-consuming are more difficult than previously required. The responsibility for these functions falls almost entirely to In-reach and Transition staff.

A myriad of challenges to the SPH Discharge and Transition Processes remain. To meet requirements, though, requires more than writing those requirements into contracts. The State has initiated a Barriers Committee that focuses largely on transition issues. The committee is already having an impact, as described in more detail in findings below. In-reach staff from across the state created their own In-reach Collaborative. DMH has assigned staff to examine the In-reach process for improvements and to provide technical assistance. Quarterly meetings are held with hospital and LME/MCO clinical leadership specifically aimed at resolving issues with complex cases. LMEs have hired nurses to assist with assessments and care management. The Special Advisor and her staff have made significant contributions to breaking down eligibility barriers and engaging multiple DHHS Divisions to assist with making resources available.

Regardless of this support, the challenges facing In-reach and Transitions staff remain difficult to overcome and complicated to fix. There is much more that the State and LME/MCOs could do to overcome these challenges and meet the requirements of the Settlement Agreement, not just in Discharge and the Transition Process but in other requirements as well.

The success of the In-reach and Transition Process and implementation is central to the State’s ability to meet other requirements, filling housing slots and increasing supported employment for individuals in TCLI, when appropriate, and for individuals to have the opportunity to choose integrated housing and community support over institutionalized or congregate care and even longer term housing tenure. Conversely, transition staff cannot be solely responsible for all the LME/MCO actions necessary for successful transitions. As described in the Community Mental Health Services section of this report, utilization management, provider contract management, and provider services are critical to transitions.

The SPHs manage discharge, including completing discharge documents and discharge steps, counter to the requirements to do this as part of a transition team with the LME/MCOs. Likewise, LME/MCO and community provider staff participation in discharge planning cannot solely be the responsibility of the LME/MCO's In-reach staff and Transition Coordinators because the SPHs sometimes take steps without the LME/MCO staff or providers knowledge, thus it is not joint effort. Community service provider engagement in discharge planning is critical. Meeting community integration requirements is more than just moving to a new community location.

In addition to managing transitions from ACHs and SPHs in a timely and effective manner, LME/MCOs are required to meet transition processes requirements for individuals being diverted from ACH placement. The availability of housing and the timely response from local DSS offices on eligibility issues are also essential to transitions as is the availability of peer support, personal care services (PCS), and individual supports.

The LME/MCOs are required to recruit, hire, train, and sustain a new workforce of In-reach and Transition staff, which is often more difficult because of staff turnover and a lack of professional regard for peer In-reach staff despite the evidence of this new group's performance, insight, and creativity. In-reach staff face a number of obstacles including resistance from guardians and adult care home staff as well as a lack of information about community resources to assist with their providing information to individuals to help guide them with their choice to move to an integrated setting. This has only marginally improved over the course of this agreement.

As referenced in the Supported Housing Section of this report, challenges remain with availability and accessibility for transitions to supported housing. Delays in identifying housing can often mean individuals become ambivalent about moving. Likewise, SPH staff, adult care home operators, and guardians may have differences of opinions with Transition Coordinators and individuals themselves on where and when individuals should move. Differences frequently lead to delays and to more placements in restrictive environments than are appropriate.

The State's effort to break down barriers to discharge and transition has been the major achievement this year. Nonetheless, the State still needs to make more changes in processes and take additional action steps to meet the Discharge and Transition Process provisions in the Settlement. As referenced in the Community-Based Mental Health Services section, a stronger community-based services system is vital to successful discharge and transition. The same is true for SPH staff, guardians, and DSS offices, all of whom play a role in assisting individuals to plan and move to the most integrated setting that is appropriate to their need and of their choice.

**(B) Findings**

1. The DMH, DMA, and SPHs often work in parallel not collaboratively to broaden their understanding of the tasks and challenges with discharge planning and transition processes.

These groups often work separately and without a single point of accountability. Over time, it has become clear that when these divisions work collaboratively there is discernable progress in meeting system requirements. An example is the work underway by the TCLI staff, DSOHF, and DMA to update Medicaid eligibility on behalf of individuals transitioning to the community. Staff are also working collaboratively to improve timeliness and to get Medicaid county-of-origin issues resolved. Yet instances exist when transitions cannot occur because public guardians refuse to consider community-based service and living options without the benefit of discussion on the appropriateness of community living over institutional care where individuals have limited or no ability to make progress to live successfully in the community.

**(1) In-reach**

1. The State made progress in FY 2019 on reaching compliance with In-reach requirements for individuals in the target population residing in adult care homes. There is progress primarily related to the growing expertise of a number of In-reach supervisors and their staff, likely the result of key staff being in their roles for the past three to five years and the fact that In-reach staff are Peer Specialists with a basic understanding of the challenges inherent to moving back to the community.
2. There is evidence in materials made available for individual reviews that scheduled visits are weeks and months apart. This makes it much more difficult for staff to establish relationships and help individuals through the decision-making process.
3. There is clear evidence that TCLI In-reach staff give the option of transitioning to supported housing.
4. In-reach workers are still not as knowledgeable as necessary about community services and supports. This is not always a problem of their making but rather because the LME/MCO does not always provide or make arrangements for In-reach staff to get the information they need to become knowledgeable or because In-reach staff do not seek out the information. This is also the result of significant In-reach staff turnover in some areas due to the availability of qualified staff, low wages, lack of recognition of their role, and demands of the job.
5. In-reach staff are not routinely facilitating community visits for individuals to meet with other individuals with disabilities who are living, working, and receiving services in integrated settings, with their families, and with community providers. Part of the issue is the location of some adult care homes or the location of the SPH. Individuals are often living in ACHs or hospitalized at a SPH that is not close to the community where individuals will be moving, so a trip into the community is not always practical. In-reach staff need to make arrangements ahead of time for such visits and/or ask local peer support groups to make arrangements near

where the individual is moving or conversely make arrangements near the ACH or SPH. For example, if an individual from Charlotte is hospitalized at Broughton Hospital in Morganton, In-reach staff could make arrangements for visits with peers living or working in Morganton rather than driving to Charlotte.

6. There have not been arrangements for individuals to visit supported housing settings although some LME/MCO staff ensure individuals are able to see model or empty apartments. This is primarily a State responsibility.
7. The LME/MCOs organized a peer-to-peer In-reach Learning Collaborative with an initial meeting in FY 2018. They continued the collaborative in FY 2019. They held a statewide conference in April 2019. This continues to be a valuable professional development opportunity for In-reach staff.

**(2) Discharge Planning/Discharge Plan/Implementation of In-reach, Discharge and the Transition Process**

1. There was an increase in the number of individuals exiting ACHs and moving into supported housing (**Figure 14**) in FY 2019. The percentage was different across LME/MCOs but is relatively consistent with the percentage of ACHs in each of the catchment areas. Interestingly, the Alliance had the lowest percentage of individuals transitioned from ACHs but the highest percentage of individuals discharged from SPHs moving into supported housing. Conversely, Partners and Vaya both have a large number of ACHs and they have a higher percentage of individuals moving into supported housing than the percentage of the state’s population in their catchment areas.

**Figure 14: Individuals in Category 1-3 Who Moved into Supported Housing**

	Alliance	Cardinal	East-pointe	Partners	Sandhills	Trillium	Vaya	Total
<b>FY 2013-17</b>	61	243	85	131	121	129	139	905
<b>FY 2018</b>	32	83	50	56	44	40	69	374
<b>FY 2019</b>	38	162	33	60	37	55	65	450
<b>Total</b>	131 (8%)	488 (27%)	168 (10%)	247 (14%)	202 (12%)	224 (13%)	269 (16%)	1729
<b>Separations</b>	46 (34%)	157 (32%)	74 (44%)	89 (36%)	63 (31%)	85 (38%)	83 (31%)	597

2. Separations are higher for individuals moving into supported housing from ACHs, Category 1-3, than from those in Category 4 and 5. Shortcomings in the discharge and transition planning process are a contributing factor to separations, especially separations that occur within the first six months after an individual moves. For example, if services arrangements are not made before an individual moves, the individual may choose to move back to an ACH. One transition arrangement

that appears to have been resolved in the past year is making sure Personal Care Services are available for individuals when they move without delay. Two hundred and thirty-three individuals (233) have moved back to ACHs from supported housing since the beginning of the Agreement. If this did not occur, there would be a higher percentage of individuals living in supported housing since the inception of the program. All other factors being equal, limiting or eliminating this move could increase the percentage of individuals retaining their housing to seventy-seven percent (77%).

3. The State is required to have two thousand (2,000) individuals from Categories 1-3 living in supported housing by July 1, 2021. To meet this obligation would require an increase of eight hundred and eighty-six (886) individuals, or a net increase of 37 per month over current numbers. The State has to meet this requirement at the same time it meets its supported housing obligation for individuals who would otherwise move to unstable housing at the time of an SPH discharge or pre-screening for TCLI eligibility (Categories 4-5).
4. Record reviews revealed SPH discharge plans and the LME/MCO and service provider Person Centered Plans continue to be separately developed. Hospital staff make plans without the input or participation of community staff. This happens either because TCLI and provider staff don't make themselves available or hospital staff plan without their involvement. This often leads to duplicative planning with the hospital team making one set of discharge plans and the In-reach and Transition staff either following along even when they may not agree or not being in the loop about the discharge date in time to make a referral to supported housing so the individual could move to supported housing or even to bridge housing when they are discharged. Individuals moving to supported housing when discharged from a SPH meets the core aim of the Settlement Agreement for individuals to have the opportunity to live in the most integrated setting possible. TCLI data shows individuals moving to supported housing at discharge tend to have fewer crises post discharge and low re-admission rates.
5. There was evidence the LME/MCOs are not fully included in SPHs' decisions regarding continuity of care arrangements and arrangements for housing. This creates post-discharge challenges and reduces the potential for individuals having the opportunity to move to the most appropriate, most integrated setting possible.
6. Guardians still do not always meet with SPH and LME/MCO staff jointly as a matter of policy and practice to consider community-based alternatives to adult care home placement on discharge from a SPH. There were reports this is happening more frequently.
7. In the FY 2017 Annual Report, there were references to the State needing to make housing more easily and quickly accessible and available, streamlining the transition processes, and providing better access to specialty health care, home health and personal care, wellness coaching, and wrap around services. LME/MCOs are taking more steps to assess individual's

chronic health care needs and to arrange health care for individuals to move to the community who have significant medical problems. However, as referenced in the Services section of this report, the State is not arranging for the delivery of services with the intensity and at the level required by this Agreement.

8. **Figure 15** illustrates that in FY 2019, five percent (5%) of individuals discharged from SPHs moved directly into supported housing. Eight percent (8%) discharged from SPHs moved into adult care homes and family care homes. There were one hundred and fifteen (115) discharges or eight percent (8%) of individuals discharged to hotels, boarding homes, and shelters. These types of housing fall into the unstable housing category.
9. The remaining seventy-nine percent (79%) of discharges moved to private homes/apartments (47%), correctional facilities (14%), group homes (7%), skilled nursing facilities, hospital and treatment facilities (4%), and seven percent (7%) in at least eight other placement categories including IDD group homes and facilities.

**Figure 15: SPH FY 2019 Discharges**

<b>Supported Housing (at discharge)</b>	<b>75</b>
<b>Adult and Family Care Homes</b>	121
<b>Boarding Homes, Shelters. Hotels</b>	115
<b>All SPH Discharges</b>	1452

10. The number of individuals who moved into supported housing at or after discharge (**Figure 16**) varies by hospital and LME/MCO<sup>41</sup>. The State made progress in FY 2019 over the previous four years but did not increase the number of individuals discharged to supported housing even after changing contract terms in early FY 2019. This is likely the result of SPHs and LME/MCOs not implementing changes referenced in the new contracts. The problem needs further analysis to determine if more individuals could be discharged to supported housing rather than to congregate settings, to other institutions or to unstable housing.

**Figure 16: Individuals in Category 4 Who Moved into Supported Housing**

	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya	Total
<b>FY 2013-17</b>	57	26	24	35	23	23	9	339
<b>FY 2018</b>	71	18	12	4	24	13	0	142
<b>FY 2019</b>	55	33	26	7	13	16	5	157
<b>Total</b>	183	77	62	46	60	52	16	496

<sup>41</sup> These are individuals who moved into supportive housing who are or “have been” discharged from SPHs, not the number currently living in supported housing and not only those directly discharged to supported housing.

11. **Figure 17** depicts the number and percentage of individuals in the Settlement Agreement’s target population listed in Category 4<sup>42</sup> as living in supported housing by each LME/MCO. An individual qualifies for Category 4 if they get a housing slot any time after discharge. Discrepancies were found in clusters and disparities were found in percentages.

**Figure 17: FY 2019 Individuals in Category 4 Living in Supported Housing**

	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya	Total
<b>FY 19</b>	28	23	22	6	8	9	5	100
<b>Total<sup>43</sup></b>	134 (37%)	58 (16%)	48 (13%)	35 (9%)	44 (12%)	36 (10%)	11 (3%)	366

12. There were two hundred and ninety-nine (299) individuals hospitalized in an SPH placed on the In-reach list in FY 2019 (**Figure 18**), a reduction from three hundred and eighty-two (382) the previous year.

**Figure 18: Individuals who started In-reach while hospitalized in a State Psychiatric Hospital**

	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya	Total
<b>FY 2019</b>	81	84	26	30	24	30	24	299

13. The FY 2018 Annual Report also referenced a need to expand “bridge housing<sup>44</sup>.” There is reference to expanding the use of this program in the Supported housing section of this Report. Bridge housing is an important resource for individuals when discharged from hospitals without firm housing arrangements in place.

14. In FY 2018 there were findings related to lack of supported housing options provided to individuals placed in the Broughton State Psychiatric Hospital unit for individuals who are deaf and hard of hearing. Following a roundtable with staff assigned to this unit and with staff with oversight of services provided for individuals who are deaf or hard of hearing, State and Broughton staff along with LME and provider staff took action to make supported housing available. State staff has been active in reducing barriers and increasing Broughton staff awareness, a major activity with the Barriers Committee.

15. There was a recommendation in the FY 2017 and FY 2018 Annual Reports to identify “high-users” whose lives are often characterized by repeated institutionalization, high emergency room use, and being discharged from hospitals into unstable housing. Service use data and

<sup>42</sup> Individuals with SPMI, who are or will be discharged from a State psychiatric hospital and who are homeless or have unstable housing.

<sup>43</sup> Over seven years

<sup>44</sup> Also referred to as the Targeted Unit Transition Program (TUTP).

interviews in FY 2019 continue to reflect this problem and a lack of transition options that may mitigate these issues.

16. A review of staffing of the LME/MCO In-reach, Transition Coordinators, and other staff dedicated to TCLI effective June 1, 2019 (**Figure 19**) revealed the following:

- (1) Two hundred and sixty-six- and one-half FTEs (266.5) are reported by LME/MCOs as dedicated to the TCLI program across the seven (7) LME/MCOs, an increase of 5.5 staff over FY 2018. Eighteen (18) housing specialists are assigned to work with individuals in the TCLI program and other housing programs. Each LME/MCO assigns staff and allocates resources for staff somewhat differently.
- (2) Seventy and one-half FTEs (70.5) are assigned to In-reach, an increase of four (4) over FY 2018, which averages out to a 1 to 90 ratio excluding twelve (12) In-reach Supervisors, a ratio increase of seventeen (17) staff per individual and twelve (12) In-reach supervisors over FY 2018.
- (3) Seventy-nine (79) Transition Coordinators and nineteen (19) Transition supervisors, forty-five (45) Care Coordinators, and forty (40) administrative staff are dedicated to TCLI. LME/MCOs report that five (5) Care Coordinators and three (3) Administrative staff were added this year.

**Figure 19: In-reach Staff to Individuals in In-Reach Category**

	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya	Average
<b>FY 19</b>	1 to 117	1 to 148	1 to 76	1 to 87	1 to 62	1 to 65	1 to 71	1 to 90

**(3) Transition Teams**

At the end of FY 2018, the DHHS initiated the requirement to create transition teams at the State and local level. The State team is required to assist local transition teams’ in addressing and overcoming discharge and transition barriers. Requirements include State and local level team composition, training, and problem identification/ resolution.

**(4) The State’s monitors the Adult Care Home Residents’ Bill of Rights**

LME/MCOs indicate they report a potential violation of an individual’s rights when they feel an individual’s rights are being violated in accordance with Chapter 131D of the North Carolina General Statutes and 42 C.F.R. § 438.100. During LME/MCO site visits, staff report they file complaints as required. LME/MCO staff are concerned about potential violations regardless of whether or not these impede an individual making a choice to move to the community. Staff making complaints reported they did not get an interview. Without additional information regarding response to these complaints, it is not possible to rate the

State as meeting this requirement. The State indicates the complainant should get a response.

**(C) Recommendations**

1. Take action to meet all the SPH discharge and transition planning requirements as set forth in the Settlement Agreement.
2. Continue to refine the diversion community planning process to develop and implement a community integration plan in a timely manner as required in **III. (F) (2)**.
3. Take actions to help increase the likelihood individuals identified as “high-users” because their lives are often characterized by repeated institutionalization, high emergency room use, and being discharged from hospitals into unstable housing can successfully transition to and sustain housing. This is particularly important for individuals being discharged from SPHs, individuals being diverted from ACHs or individuals who have left supported housing but have voiced interest in returning to supported housing. Actions include but are not limited to reducing provider stigma towards serving them, taking additional steps to build trust and a productive relationships with service teams, providing peer support and assuring collaboration across providers.
4. Consistent with Section III.F(2) of the SA, ensure that the State’s processes for diversion planning for individuals at risk of ACH admission meet the Discharge and Transition planning requirements as stated in the Settlement Agreement:
  - (1) Fully inform individuals of the option of transitioning to supported housing
  - (2) Provide In-reach (or outreach, for the diversion population)
  - (3) Develop an effective discharge plan (or community integration plan, for the diversion population)
  - (4) Establish a transition team whose members have the requisite skills, knowledge and expertise for this task
  - (5) Identify strengths, needs, preferences, capabilities, and interests, and devise ways to meet them in integrated community settings
  - (6) Develop the individual plan as required in Section III. (E)(7-8)
  - (7) Ensure local transition teams get assistance to overcome barriers that prevent individuals from transitioning to an integrated setting.
5. Examine the need and make necessary adjustments to expand the number of peer support staff, including through contracts, to accommodate the increased demand for their services

created by changes to the State's process for diversion while still meeting SPH discharge and transition process requirements.

6. Ensure that the entities involved, including SPH and State-level staff (DMH and DSHOF), LME/MCO staff and public and agency Guardians make continuity of care arrangements for those individuals exiting ACHs and SPHs to intermediate settings on a temporary basis, who have indicated interest in moving into a more integrated setting when possible. These settings include group homes, Oxford Houses, I/DD Group Homes, halfway houses, and other treatment settings.
7. Ensure that the entities involved, including SPH, State-level (DMH, DSHOF and DAS), LME/MCO staff meet the "local transition team" Settlement Agreement requirements, identifying who is a member, who has responsibility for each of the participant requirements, how they function, when they meet, how they identify and address barriers that prevent individuals from transitioning to an integrated setting, and how their performance is monitored.
8. Establish criteria, policy, and funding for service providers to participate fully in discharge planning.
9. For individuals diverted from an ACH, transitioning from an institutional or congregate setting or needing respite to remain in their home, evaluate the need for bridge or respite housing for each individual. Provide bridge housing for any individual with an identified need that would enable them to continue to live in an integrated setting.
10. Re-evaluate transition tools and housing and services plan requirements for potential redundancies and determine when transition steps can be reduced or carried out concurrently rather than consecutively.
11. Ensure LME/MCO staff who make complaints regarding the Residents' Bill of Rights get a response to their complaint regardless of the outcome of the investigation into the complaint.

**V. PRE-ADMISSION SCREENING AND DIVERSION**

Major Categories	Summary of Requirements	Progress Towards Compliance
<p><b>Section III. (F)(1): Eligibility Determination:</b> When an individual is considered for adult home placement, the State shall arrange for a determination, by an independent screener, if the individual has a SMI (Serious Mental Illness). The State shall connect any individual with SMI to the appropriate LME/MCO for a prompt determination of eligibility for mental health services.</p>	<p>The state arranges for an independent screen to determine whether the individual has SMI. The State is required to develop and implement processes, tools and training for LMEs/MCOs to make a prompt determination of eligibility</p>	<p>The State made progress towards meeting this requirement in FY 2019. The State began a new process for determining eligibility for admission to an Adult Care Home (ACH) on November 1, 2018 replacing the Preadmission Screening and Resident Review (PASRR) process. This arrangement has enabled LME/MCOs to determine eligibility for ACH placement or to assist an individual to make a choice of other living and services options. The State adjusted the process throughout FY 2019. These changes and these improvements will enable a full compliance review in FY 2020.</p>
<p><b>Section III (F)(2) and Section III (F)(3):</b> Once an individual is determined to be eligible for mental health services the State (LME/MCO) will work with the individual to develop and implement a community integration plan consistent with Discharge and Transition process provisions in Section III(E). After being fully informed of available alternatives to entry to an ACH, individuals may choose to transition to an ACH. The State will document objections to placement in integrated settings and shall offer In-reach, person centered planning and other services in accordance with this Agreement.</p>	<p>Once eligibility is determined, the LME/MCO is required to work with the individual to develop and implement a community integration plan consistent with the Settlement Agreement Discharge and Transition Process. The individual is to be provided the opportunity to participate as fully as possible in this process.</p>	<p>The State made some progress in meeting these requirements. In the last two months of the fiscal year, the State clarified eligibility and community integration planning to enable LME/MCOs and their providers to assist an individual to develop and implement a community transition plan consistent with Section III (E). The DHHS issued a Community Integration Planning Guide in May 2019. The DHHS issued an LME-MCO Joint Communication Bulletin (# J327) on June 14, 2019, to clarify further eligibility requirements, providing a worksheet for guidance on LME-MCO Diversion responsibilities for Community Integration Planning. These changes will enable a full compliance review in FY 2020.</p>

**(A) Background**

The Settlement Agreement requires the State to pre-screen for eligibility for an Adult Care Home (ACH) placement. The individual, if eligible, may choose a community living alternative to an ACH, as appropriate. It is the State's responsibility to assist an individual to develop and implement a community integration plan for diversion from an ACH. The State must follow the requirements of the Discharge and Transition Process identified in **Section III. (E)** for making community living arrangements.

The 2017 and 2018 Annual Reports referenced that diversion was not possible for most individuals based on the timing of referrals after a third-party contractor screened individuals. Individuals had little or no choice of living options other than moving to an adult care home. There were findings and recommendations in the 2018 report regarding concerns with planning for this new process.

The State made significant progress towards meeting its obligations in **Section III.(F)(1-3) Pre-Admission Screening and Diversion** over the course of FY 2019. The State implemented a new Pre-screening and Diversion system on November 1, 2018. The State named the new Pre-screening process, RSVP. The preparation for this change was challenging. The State automated the process, thus requiring its software vendor to develop an intricate decision process. The State faced a hard deadline to switch to the new system on November 1, 2018. The independent contractor's contract ended effective that date with no extension possible, leaving the State with little or no time to test the system. As a result, the State implementation team worked continuously throughout the remainder of the fiscal year making adjustments, making system upgrades, and clarifying policy.

The DHHS assigned the newly developed pre-screening responsibilities to the LME/MCOs. This was logical since the LME/MCOs have the responsibility for the Discharge and Transition Process.

The DHHS made one other significant change. Under the PASRR system, there were a limited number of individuals and organizations permitted to make referrals. The DHHS decided to open up the referral process, allowing current service providers, LME/MCO staff, homeless service providers, other agencies community hospital staff, family members, and guardians to make referrals. Individuals could self-refer as well.

There was too little clarity on who was eligible for placement at the outset of the program. A number of agencies and individuals saw this new process as an opportunity to assist individuals to get housing even though they were not "at risk" for placement in an adult care home. Many individuals were clear about not wanting to go to an adult care home. The LME/MCOs quickly became overwhelmed with referrals. In two months, the number of

referrals exceeded the total number of referrals made through the PASRR process for each of the previous three years. The State clarified this requirement in June 2019.

The LME/MCOs faced a new challenge to assist individuals who chose community options as an alternative to admission to an adult care home. The type of rapid response needed to divert individuals who chose to live in the community required extensive preparation to develop an operation that requires timely action and execution on the part of the LME/MCOs. Many individuals do not have a safe place or any place to live at the time of the referral. Community hospitals typically do not make referrals until a few days before or even the day before discharge. With individuals living in precarious circumstances or facing discharge with no or limited living options, diversion needs to occur quickly. Otherwise, individuals move to ACHs or continue to live in unhealthy and/or unsafe environments. Based on a significant review sample over the past five years, moving to an ACH may also result in a downward spiral of an individual's decision making and other life skills, health and personal well-being.

The State did not make sufficient information available or discuss diversion in-depth to help prepare or provide information to the LME/MCOs on the diversion requirements in this Settlement Agreement. The State assumed In-reach staff, already carrying significant caseloads, could be responsible for diversion. Similarities exist in transition planning from institutions but enough differences existed to have warranted more guidance and preparation. Because of this non-action and with the flood of new referrals, the diversion process was challenging.

Fortunately, the LME/MCOs worked out the process after the fact and the State provided guidance continuously that was helpful to implementation. The State made other helpful changes, clarifying information and responding daily to inquiries about the process. The most significant changes came in May and June 2019 when the State issued an LME-MCO Joint Communication Bulletin (#J327) to clarify Diversion and Community Integration Planning and a Community Integration Planning Guide. The State also issued a Pre-Admission Screening and Diversion Worksheet on June 14, 2019. These are valuable resources for staff in the field.

There was reference in each of the previous Annual Reports to the State listing anyone who had received a PASRR and not been admitted to an ACH as "diverted." This included individuals who chose other housing or individuals admitted to a hospital, a drug/alcohol treatment center, skilled nursing facility, arrested and in jail, died before they could move or moved without any forwarding address. With the new system, the State will be in a better position to identify individuals getting diversion assistance, including assistance with access to supported housing and other community service needs.

This year, the Reviewer's team attempted to conduct forty-nine (49) pre-screening reviews. Inherent challenges often precluded scheduling an interview with new referents. Information was sufficient for a review for forty-five (45) and the 49 individuals. There were thirty-four (34) face-to-face interviews, eight (8) interviews with referring family members or staff from referring organizations or guardians and three (3) LME/MCO Pre-screening staff interviews when the individual or referent was not available. LME/MCOs report a significant number of referents refuse the Pre-screening interview, cannot be located easily, or have difficulty to responding to questions. There were also interviews with Pre-screening and Care Coordination staff in each catchment area to review the process.

The review team conducted reviews over seven months, from December 2018 through June 2019, and observed a number of problems. The team was also able to identify improvements to the process over time. Once LME/MCOs gauged their time, focused their resources, and got staff hired and trained, they were able to conduct pre-screening in a timelier manner and were better able to explain choice and program specifics. However, this took time and there were a number of changes not made until near the end of the fiscal year. This will require another review in FY 2020 to determine if these changes had the planned impact and outcomes to enable the State to meet the Pre-screening and Diversion requirements.

**(B) Findings**

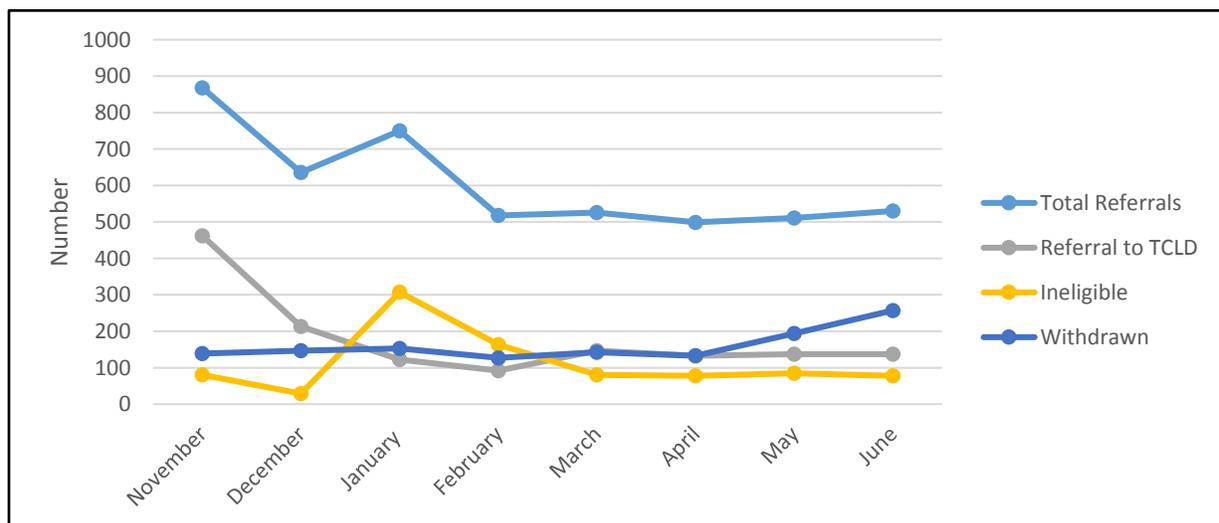
1. The State planned for and made substantial changes in the Pre-screening and Diversion process in FY 2019.
2. The State shifted responsibilities for this complicated process to the LME/MCOs on November 1, 2018. The State made plans for this change with the LME/MCOs, holding information sessions with LME/MCO staff and with potential referents to adult care homes. The State held information sessions with referents, including community hospitals, adult care homes, guardians, local Department of Social Services (DSS) staff, SPH staff, and others who were mostly likely to make referrals.
3. The State established a standing weekly progress/problem solving call for LME/MCOs and DHHS to discuss these issues four weeks before and after their "go live" date and every month thereafter for at least six months, possibly longer as needed.
4. The State allocated \$417,653 to each LME/MCO<sup>45</sup> for pre-screening staff and \$56,400 for one-time expenses in FY 2019. There was not a consideration of expected volume by LME/MCO with the distribution of these funds.

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<sup>45</sup> Trillium was allocated an additional \$404,812 for a Diversion Pilot.

5. The State’s initial planning and information dissemination focus was on the requirements for Pre-screening, not Diversion. This focus shifted in the last few months of the fiscal year. There was an increase in allocations for bridge housing, but the allocations do not appear to have yet yielded a marked increase in diversion options. Three LME/MCOs are attempting to enhance these options through provider contracts.
6. There was a flaw in the referral process initially. SPH staff was required to submit RSVPs to refer individuals to TCLI in addition to those they were specially referring to ACHs. This resulted in a higher number of referrals counted as eligible in Category 5 and overinflated the Diversion referral numbers. It also created more work for the LMEs and confusion on roles. These should have been Category 4 referrals based on individuals potentially leaving the SPH to unstable housing. The State is now reporting Pre-screening referrals on just individuals who qualify for TCLI as Category 5.
7. As shown in **Figure 20**, there were four thousand eight hundred and thirty-eight (4,838) individuals referred to LME/MCOs for an adult care home placement between November 1, 2018, and June 30, 2019. According to DHHS, after November 1, 2018, there were 1443 individuals or twenty-nine percent (29%) of all referrals found eligible and added to the Transitions to Community Living Data (TCLD) base<sup>46</sup>. There were nine hundred (900) individuals considered ineligible of those referred through RSVP after November 1, 2018. However, twelve hundred and ninety-two (1292) individuals withdrew or were withdrawn sometime during the process.

**Figure 20: Pre-screening Referrals and Dispositions**



<sup>46</sup> The State maintains a database with individuals eligible for services and housing as required in the Settlement Agreement. Their name and information is added at the point eligibility is established. At that point they either remain or move into a community setting from a hospital or enter adult care home.

11. The number of referrals trended lower after the initial rush of referrals resulting from the opening of the referral process to anyone who wanted to make a referral.
12. There were four hundred and forty-five (445) individuals in the Pre-screening pending category at the end of FY 2019. There were pre-screening dispositions made for Sixty-eight percent (68%) of individuals within thirty days. Two LME/MCOs accounted for fifty-nine percent (59%) of the total individuals pending, Cardinal and Sandhills. Cardinal's workload is much higher and Sandhills has had difficulty with staffing. None of the other LME/MCOs had more than five percent (5%) of their referrals pending after thirty days. Reviews may be in the pending because individuals LME/MCO staff can't find individuals after they were referred, LME/MCOs are awaiting documentation or individuals are unavailable for assessments for other reasons.
13. Referrals to adult care homes have historically been high as they are viewed as the only choice or first choice for living arrangements for adults with a serious mental illness. Opening up opportunities for community-based options is at the core of this Agreement. After the new Pre-screening and Diversion requirements are in place for one year there will be sufficient data to determine if fewer individuals are entering ACHs and more individuals diverted to TCLI.
14. Based on the individual reviews, a significant number of individuals who were administratively withdrawn have a SMI or SPMI and are qualified for services. This points to adults with SMI or SPMI needing services. There were fifty-one (51) individuals referred to the LME/MCO Care Coordination staff in FY 2019.
15. Many individuals referred through the pre-screening process after November 1, 2018, were living in precarious, unsafe, and exploited living settings. Thirty (30) individuals were living in doubled-up situations with friends or family in motel/hotel rooms, boarding homes, shelters, or unsafe living settings. Individuals discharged from community hospitals often had nowhere to live and had poor follow-up or no follow-up plan. As evidenced by the high number of individuals who withdrew or who were found ineligible, individuals and persons who referred them were not looking for adult care home placement but rather supported housing---or any housing.
16. Even with the shift to focus on diversion, it is not yet clear that transition planning is being conducted in full accordance with the applicable Discharge Transition Process requirements in **Section III(E)(13)**.
17. Of the forty-nine (49) individuals reviewed, there is sufficient information to list the common issues known at the time of the review for forty-five (45) or 92% of those reviewed during their Pre-screening or Diversion process. This list of issues may be

incomplete. Often it takes time to collect and collaborate all of the information related to common issues.

18. At least three individuals were referred to care coordination as TCLI staff quickly identified their need for assistance during our reviews even though they were not “at risk” for ACH placement.
19. Commonalities and differences between precipitating events, adequacy of services provided to individuals occur before and after their referral, and challenges with the review process. Four issues surfaced most frequently. For the forty-five (45) individuals for which information was available, the specifics of challenges and major findings are:
  - (1) Housing instability: sixty-seven percent (67%) of the referrals were living in unstable housing, were evicted or at risk of eviction, and/or were homeless at the time of their referral. While it was not entirely clear at the time of the review, it appeared that many of these referrals were for individuals not eligible for this program. They were in desperate need of housing. Many had serious mental illness but indicated they would not go to an ACH, so were not considered “at risk” of ACH placement.
  - (2) Exploitation and/or abuse: For twenty percent (20%) of the individuals referred there was clear evidence of exploitation and emotional or physical abuse by caregivers, including by family members and by two providers prior to and/or at the time of the referral.
  - (3) Serious medical conditions: For twenty percent (20%) of the individuals, this was a factor in their referral. One individual discharged by a medical center to a homeless shelter after triple by-pass surgery had no money or place to store meds. An injury occurred to one individual in route to a rehabilitation facility after emergency open-heart surgery. Five weeks later, he was discharged from the nursing facility with no place to live. In general, referrals of the individuals discharged from community hospital had inadequate follow-up care plans.
  - (4) Inadequate services prior to or at the time of the referral: There were provider related issues with eighteen percent (18%) of the individuals referred. These were issues generally related to providers wanting to refer individuals to adult care homes when there were indications the providers did not provide intensive, frequent, and appropriate services in order that an individual could maintain their residence. Other providers were doing everything possible to help an individual move into a more decent, affordable safe place to live.

(5) Lack of benefits or resources to maintain housing: eleven percent (11%) of individuals referred were having difficulty getting benefits they qualified for in order to remain in the community, in their own home.

(6) Family disruptions, deaths and/or illnesses of family caregivers were factors in referrals; one family member was hoping that her mother could get PCS and remain in her home.

**(C) Recommendations**

1. Meet the requirement that the development of the community integration plan be consistent with the relevant Discharge and Transition process in in **Section III. (E)(2)** Crosswalk the two sections of the Settlement Agreement to properly align and assign responsibilities and allocate resources.
2. Meet the requirement to “assist an individual to develop and implement a community integration plan.” The State provided guidance to better define diversion late in this reporting period. As a result, it will then be possible to assess implementation of this requirement in FY2020.
3. Maximize participation of providers, including peer support specialists, in the traditional In-reach role to strengthen relationships with provider staff and broaden system capacity. For Pre-screening and Diversion, this role is more “outreach” than in-reach. Working with individuals in the community who are living in unstable living arrangements and in need of immediate assistance is different than working with individual moving into supported housing. It is important to allocate staff to meet these new responsibilities, understand these differences and assure staff is knowledgeable and skilled in “outreach” roles.
4. Clarify the role of care coordination and assure care coordination staff promptly assume responsibility for service delivery for individuals not eligible for TCLI but eligible for other behavioral health, IDD, or care management for their medical condition(s).
5. Explore potential for reducing duplicate and redundant planning processes, especially with transition and person-centered plans, to focus on community integration and supporting individual choice.
6. Utilize the “Re-Thinking Guardianship” workgroup and local LME/MCO partnerships to reinforce diversion options as a choice to adult care home placement.
7. Establish a process to “flag” potential community hospital discharges early in an individual’s hospital stay, as required in the Settlement Agreement, and establish a

priority for community hospital pre-screening requests. Establish a requirement in hospital-LME/MCO contracts for this purpose. Provide education and consultation to community hospitals for this purpose.

8. Immediate response is important. Temporary or bridge housing arrangements, immediate referral to services, and making arrangements for permanent housing quickly are key to successful diversion. Otherwise, individuals move to adult care homes when they could be successful living in a more integrated living setting.
9. Establish a respite resource for individuals at risk of adult care home placement. Crisis respite is a temporary living option at discharge from a general hospital psychiatric unit or medical unit for individuals who have a need for short-term peer or medical respite as a stepdown service in lieu of adult care home placement. The State has funded two peer run crisis respite pilots and should consider expansion of these pilots. Medical and/or psychiatric or peer run crisis respite programs have proven very successful in other states for individuals to avoid state psychiatric hospital admissions or adult care home placement or to be in a safe place for a short period so they can retain their housing.

## VI. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Major Categories	Summary of Requirements	Progress Towards Compliance
<p><b>Section III. (G)(1)(3)(4) The State will develop and implement a Quality Assurance and Performance Improvement (QA/PI) monitoring system to ensure community based placements and services are made in accordance with this Agreement. As part of the quality assurance system, the State shall complete an annual PHIP and/or LME EQR process by which an EQR Organization will review policies and processes for the State’s mental health service system.</b></p>	<p>The State is required to develop a QA/PI system. The system’s goal is to ensure that all the State’s services are of good quality and sufficient to help individuals to achieve increased independence, gain greater integration into the community, obtain and maintain stable housing, avoid harms, and decrease the incidence of hospital contacts and institutionalization. The State is required to collect, aggregate, and analyze data on seven items and seven sub-items in III (G)(3) (g) related to in-reach, person-centered discharge, and community placement, including identifying barriers to placement. The State is required to review this information on a semi-annual basis to develop and implement measures to overcome barriers. The EQR, established for a more broadly defined purpose, includes a review of internal TCLI policies and procedures in the EQR.</p>	<p>The State has made fair progress towards developing a QA/PI monitoring system. The State has developed a database, TCLD, to collect and report data, a dashboard for monitoring monthly progress on placement efforts and Quality of Life reviews. The State has not reported on their semi-annual review of measures and their steps to overcome identified problems and barriers. The State’s Barriers Committee is successful in identifying barriers and taking steps to overcome these. The committee is viewing these on an individual basis or on items they track, not based on results and outcomes of standard reports from their QA/PI system. The State collects and analyzes the data but has not provided documentation for use in their QA/PI system that is not fully functional yet. In FY 2019, the State developed a Quality Assurance Plan template, with required structure, including State level committees and teams. The progress to date on having a plan as a cornerstone of a QA/PI system is minimal and does not meet Settlement Agreement requirements. The State analyzed Medicaid and State claims for FY 2017 and 2018 but only for individuals living in supported housing. The State is meeting the EQR requirement in the Agreement.</p>

<p><b>Section III.(G)(2) A Transition Oversight Committee will be created at DHHS to monitor monthly progress of implementation of this Agreement.</b></p>	<p>The Transition Oversight Committee chair is the DHHS designee (Deputy Secretary). Membership includes three Divisions, the State Hospital CEOs, the State Hospital Team Lead, the Money Follows the Person Program, and LME/MCOs. The Committee is required to report on implementation progress.</p>	<p>The Transition Oversight Committee met four times in FY 2019. The Committee is charged with reviewing progress and challenges that remain on critical issues. The meeting minutes reflect that required members of the committee often send representatives. It is not yet clear the degree to which the challenges are reviewed.</p>
<p><b>Section III.(G)(5) The State will implement three quality of life surveys to be completed by individuals with SMI who are transitioning out of an adult care home or a state psychiatric hospital.</b></p>	<p>The State is required to implement three quality of life surveys at specific intervals: (1) prior to an individual transitioning out of a facility; (2) eleven months after transitioning; and (3) twenty-four months after transition. The survey is voluntary.</p>	<p>The State is making substantial progress meeting this requirement. LME/MCOs either exceeded, met, or were within an acceptable level of the requirements set by the State for submission.</p>
<p><b>Section III. (G)(6) The State shall complete an annual LME/MCO External Quality Review (EQR) process</b></p>	<p>The State is required to meet specific EQR requirements in ten areas. An external EQR organization completes this review annually.</p>	<p>The State meets this requirement. The EQR organization has taken steps to include a review of TCLI policies, to conduct interviews with staff and review records.</p>
<p><b>Section III. (G)(7)(8) Each year the State will aggregate and analyze the data collected by the State, LME/MCOs, and the EQR Organization on the outcomes of this Agreement.</b></p>	<p>The State is required to aggregate and analyze data collected by the State, LME/MCOs, and the EQR organization on the outcomes of this Agreement. If this data shows that the intended outcomes of increased integration, stable integrated housing, and decreased institutionalization/hospitalization are not</p>	<p>The State is not meeting these requirements. The State collects, aggregates, and analyzes data but not on all the outcomes listed in this section of the agreement. The State aggregates and tracks data on the number of individuals accessing integrated supported housing by the housing priority categories in the Agreement but does not measure stability in other integrated housing other than Supported Housing. The State publishes an Annual Report but does not provide the number of people</p>

	<p>occurring, the State is required to evaluate why they are not being meeting their goals.</p>	<p>served in each type of setting and service described in this Agreement nor does the State provide sufficient information to reflect the quality of services and supports as required in the Settlement Agreement.</p>
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**(A) Background**

QA/PI requirements include the tasks, action steps, and processes essential to ensure the development of community-based placements in accordance with this Agreement. This provision includes goals for individuals to achieve greater independence, live a life more integrated in their community, obtain and maintain stable housing, avoid harm, and decrease institutional use. The State is required to measure and monitor the State’s performance and individual’s outcomes on meeting these goals. As such, the State needs to generate required reports on a timely basis. The State publishes a monthly dashboard approximately seventy days after the end of the month. The Dashboard is an important decision-making tool and appears to influence State and LME/MCO actions.

To be in full compliance with **Section III.G(1)**, which is the overarching obligation to create a QA/PI system, the State must identify accountability requirements and hold itself (DHHS Divisions, the SPHs, and the NC HFA) and the LMEs/MCOs accountable for all the specific requirements in the Settlement Agreement. The Agreement contemplates that QA/PI is a system not just a disparate set of ad hoc charts and reports but a system with a coherent set of action steps and more importantly a well-developed decision loop to reduce barriers and improve performance. The Special Advisor has started this process in FY 2019.

This section has eight (8) requirements. One of these has five (5) sub-requirements; one has eight (8) sub-requirements. Requirements in the first category are interrelated as described below.

Quality assurance and performance improvement are both a transformational (changes associated with changing a system) and a transactional (organizational performance toward meeting compliance or a goal) review and decision-making process. The focus of Quality Assurance is on compliance and performance Improvement. It is a proactive process focused on continuous improvement. A challenge for the State in meeting Settlement requirements is that these processes are the responsibility of six separate DHHS divisions, the HFA, LME/MCOs and service providers. As reported in the FY Annual Report, staff may see these interactions, transitions, and decisions as being separate and in some instances, divisions do not establish requirements within their purview assuming it is another division’s or department’s responsibility. The Special Advisor to the Secretary for the ADA has placed importance on cross division collaboration on performance improvement. In some instances, this has been successful. The next two years will be an even greater test as the IPS-SE business model work goes forward

and as LME/MCOs attempt to start the CST contracting process and meet other performance requirements where they need support from multiple DHHS Divisions.

The steps the DHHS has agreed to take related to Quality Assurance and Performance improvement include phase in of protocols, data collection, database enhancements, and use of data for on-going monitoring and evaluation of fifteen categories of data, all related to one or more compliance requirements. The QA/PI requirements relate to the State's capacity to aggregate, analyze, and use data collected by the State, LMEs/MCOs, and the EQR organization on the outcomes of this Agreement. The QA/PI system cannot be reviewed fully until the proposed QA/PI Plan is implemented.

The timing of the required release of this Annual Report and the State's release of its Annual Report does not coincide to enable this review to include a review of the State's most recent Annual Report. However, there is a review of the State's FY 2018 Annual Report below.

**(B) Findings**

1. The State continues to make improvement with the development of the required QA/PI monitoring system in accordance with the required system **(G)(1)**. The State is not yet identifying all the steps necessary to meet the requirements in **(G3), (G4), and (G7)**. Findings (4-6) below will identify areas where the State must make improvements to meet Settlement requirements.
2. The State has taken the steps necessary to meet the Transition Oversight Committee requirements. The committee met four times in FY 2019. The Settlement Agreement lists the required members. According to meeting minutes, representatives of the required members attend regularly. Most required members do not attend. The Committee has identified what they refer to as "Big Rocks that need to be lifted" prior to the end of the Settlement Agreement. They identify issues in each of the six major Settlement Agreement areas. The issues are consistent with the issues in the Reviewer's findings.
3. With less than two years remaining in the current Settlement Agreement period, the development and implementation of major initiatives in Community-Based Mental Health Services, Supported Employment, Discharge and Transition Process, and Quality Assurance and Performance Improvement are still incomplete. Improvements are necessary in filling housing slots for individuals for individuals in all the priority populations but particularly Categories 1-3. There appear to be plans in place for most of the required items, but they lack specificity, target dates for completion, and some do not cover the scope of the improvements needed. For some of these, information is available to apply a Performance Improvement process and/or Corrective Action Plan. For all of the items there is a need for timelier monitoring and the Transition Oversight Committee's attention.

4. The State took its first step toward developing a QA/PI Plan in FY 2019. The plan is still in draft. It includes an outline of activities in four major areas: (1) a Quality Assurance structure with four State and LME/MCO level committees as well as an External Quality Review Organization review; (2) the QA system activities by Settlement Agreement requirements; (3) action steps that would assist the State to come into compliance with QA/PI requirements; and (4) a brief nine-point Action Item Plan.
5. The draft plan references all the requirements in the Settlement Agreement in sections entitled Quality Assurance System Activities and Quality Assurance. It references some activities but does not identify who is responsible for each item, does not include tasks to complete each item, with data sources, applicable dates for completion, and methods for dissemination and feedback. It does not identify Performance Improvement activities by name and some of the Quality Assurance activities could fall into the purview of Performance Improvement.
6. The State produced a report entitled TCLI Service Patterns and Service-Related Personal Outcomes for Calendar Years 2017 and 2018 in June 2019. There is always a lag time between the provision of services and reporting data to assure the report includes all claims. The report includes NCTracks and DMHDDSAS paid claims data for individuals living in supported housing, excluding individuals living in other community settings, ACHs, or SPHs. It reports key personal outcomes for an important segment of the Settlement Agreement's priority populations but may be skewing outcomes because it does not include claims for individuals living in all the environments where individuals in the priority populations live. This also means it cannot measure community tenure.
7. The report includes information on time spent in congregate day programming, SPH and community hospital admissions and re-admissions, and emergency department visits and re-visits. It reports on numbers of individuals getting at least one facility and mobile crisis visit. It does not report adult care home admissions or re-admissions.
8. It is not entirely clear from interviews conducted in FY 2019 that the State's housing data system informs discharge planning. This appears to be in part a process and communication problem, not solely a systems problem.
9. DMH reports separately on IPS-SE outcomes quarterly, specifically the current census of individuals in TCLI or "in or at risk of" admission to ACHs. It does not break the two groups apart. It also includes the number of competitively individuals, in the "in or at risk" category" employed during the quarter and the number of individuals attending some type of secondary, college or other educational program. Collect data on individuals already identified as TCLI recipients not just in the "in or at risk" category.

10. There has been no report of FY 2018 personal outcomes for the number of people engaged in community life. To determine the number of individuals engaged in community life, the State has to propose a definition and method for measuring it. The State produces data to measure tenure in supported housing but not “maintenance of a chosen community arrangement” as required in the Settlement Agreement.
11. The State has effectively met the requirement for Quality of Life (QOL) Surveys. There has not been any reference made by either LME/MCOs or the State on the usefulness of this data for performance improvement. Individuals interviewed speak about their quality of life in the past tense or with some resignation that it cannot change. Many individuals are now accepting the fact they are defined by their patient status, which raises the fundamental question of what can be done to help individuals regain hope and how surveys or interviews can help in that process.
12. The State is required to develop and utilize a template for published annual progress reports. There has not been any template provided for review for this purpose.
13. Annual audits of LMEs/MCOs by the Carolinas Center for Medical Excellence (CCME) consistent with C.F.R. 438.58 are required. The EQR has become a relevant review process for TCLI. It includes reviews of policies and procedures, individual records, job descriptions, access issues, and transition processes. LME/MCO staff have the opportunity to identify key TCLI initiatives. There was a review of the Alliance Health audit in FY 2019. CCME staff provided useful and appropriate feedback on TCLI items. The CCME staff review these findings with LME/MCO and DHHS staff. The State could benefit from increasing CMME’s role in quality review. The State is meeting this requirement.
14. The State reported they are analyzing housing separations to determine what trends exist and what can the State do to reduce separations. There is no reference to this issue in the State’s draft Quality Assurance Plan, including either a process to review trends or a Performance Improvement initiative. This is not a requirement per se but flagged as an important issue for review.
15. The State continues to define and publish a monthly dashboard for monitoring selected metrics to measure compliance with the SA and to inform decision-making. The State should continue to refine and change items on the dashboard to assure the items are the most current and salient to SA compliance and sustainability. The Settlement Agreement references the need for “daily decision-support.” A “daily” decision dashboard is more relevant to how LME/MCOs measure their tasks, including each of the LME/MCO track housing slots filled and other items routinely. Unfortunately, the State has asked to delay the publishing of their monthly report for an additional 30 days, making it less relevant as a

dashboard tool. The State should refine its processes to make this report available as quickly as possible so it can truly be a decision tool.

16. The reliability of IPS-SE population eligibility data continued to be a challenge for the State in FY 2019. However, after two good faith efforts, the State appears to be more accurately reporting the “at risk” population. The State began using a similar tool to define “at risk” for Pre-screening. There was some confusion regarding the discharge of identifying individuals who were likely going to “unstable” housing from SPHs. The State worked out this problem in FY 2019.
17. The State is required to develop and implement a centralized housing data system to inform discharge planning. The State has been upgrading this database for payment flow, referral workflow, and streamlining functions overall. However, establishing a system fully to inform diversion and ACH/SPH discharge planning requires daily input and updating (real time) availability of housing.
18. Securing verification that an individual is not eligible (or no longer eligible) for TCLI has been a long-standing problem but there has been improvement both in timeliness and response to improve this process. Nonetheless, five percent (5%) of the individuals pulled for this year’s individual reviews (excluding names for a Pre-screening review) either had never been seen by the LME/MCO, were and had been ineligible for TCLI for a number of years, or had moved and should have been removed from the LME/MCO list pulled for the review.
19. The DHHS introduced a “Super Measure” for LMEs/MCOs to fill a specified number of housing slots in FY 2018 and again in the FY 2019 fiscal year, adding this measure to the LME/MCO contract. There was a financial penalty attached to this measure beginning in January 2018 for LMEs/MCOs who did not meet their “filling slots” requirement. This super measure appears to have helped draw attention to the need to fill housing slots. However, it is important the housing slots measure better reflect the percentage of Medicaid recipients or population of the relevant catchment area. The State is undercounting the targets for the larger LME/MCOs and over counting the numbers required for LME/MCOs with fewer Medicaid recipients and/or a smaller population base. LME/MCOs are penalized for not meeting these targets even though they do not fully control the availability and access to needed housing. This does not mean that setting targets with consequences is a bad idea, but it is important to have targets and consequences for all relevant parties.
20. The State published its FY 2017 Annual Report to the Joint Legislative Oversight Committee on Health and Human Services on October 11, 2018. The review of the Annual Report is always one year behind. If the State maintains this schedule for the Report required in the Settlement Agreement, the Reviewer cannot complete the FY 2021 Annual Report until November 2021. The FY 2017 Annual Report was comprehensive with sections devoted to

each of the major sections in the Settlement Agreement. It describes the number of people served in each type of setting and service described in the Settlement Agreement. It uses data collected through LME/MCO monthly reporting, the SPH tracking system, and service claims paid for services rendered in FY 17 for individuals residing in Supported Housing.

21. The State only reports on the quality of services, based on Fidelity Reviews, for ACT and IPS-SE. It does not point out scores for the items in each of these that are most pertinent to quality of the service interventions key to the recovery and community inclusion for individuals in the priority populations. The report points to the improvements in scores. It does not point out challenges with 80% of the IPS-SE teams only scoring a fair or below on IPS-SE fidelity. It does not report on all the required outcomes. This Report is an improvement over the report produced for the Legislative Oversight Committee for FY 2016 but falls short of meeting the Settlement Agreement requirements.

**(C) Recommendations**

1. Ensure the Transition Oversight Committee monitors monthly progress on the implementation of the Agreement. If the committee gets a report or the Special Advisor identifies barriers, incomplete action items, or a negative trend, ensure the responsible party takes steps to meet the requirement by July 1, 2021. If necessary, a short-term corrective plan should be developed and implemented to correct problems. Update any items requiring a corrective plan at each meeting until successfully resolved or completed.
2. Assign roles and responsibilities with clear accountability measures to all relevant entities, as referenced above. Examine accountability measures to avoid unintended consequences and to assure performance is required. Match reporting requirements with data collection points.
3. Determine the areas where the State could be, but is not, delegating responsibilities to the LMEs/MCOs to meet the Settlement Agreement requirements. Request the LMEs/MCOs establish policies and add contracting requirements with providers as necessary and required in EQR. As referenced in the Community Based Services section of this Report, identify IPS-SE and ACT roles, responsibilities, and performance expectations. Complete this analysis and establish guidance for performance expectations before completing FY 2019 DMH and DMA contract modifications.
4. Continue to make use of and refine the TCLI Dashboard. Evaluate each requirement on a regular basis for its relevance to critical compliance issues. Ensure there is a fair measure applied to each LME/MCO.
5. Develop an institutional tracking system as part of an overhaul to SPH discharge planning as referenced in the **Discharge and Transition Process** section of this report. Identify quality

assurance and performance measures utilizing the tracking system and other indicators for this process.

6. Develop a housing data system that matches housing availability in real time for all potential diversions, ACH transitions, and SPH discharges.
7. Systematically collect and transmit data to decision makers and end users.
8. Develop performance requirements for each local DSS and LME/MCO for measuring timeliness and follow-through with notifications and transitions (CLA, County of Origin) and with DVR and LMEs/MCOs for the number and effectiveness of contract agreements.
9. If the State proposes a housing slot filled as a “Super Measure” again in FY 2020, other entities with housing availability and accessibility responsibilities should be required to meet performance requirements they may be responsible for to fill housing slots.

## **SUMMARY OF FINDINGS AND RECOMMENDATIONS**

The State has made a number of necessary structural changes and is actively pursuing those not yet made. However, this year's review revealed little progress in the quality and effectiveness of services and supports for individuals in or at risk of institutionalization.

The Settlement Agreement requires the State to take effective measures to prevent inappropriate institutionalization and to provide adequate and appropriate public services and supports in the most integrated setting possible. This requires the State to make significant structural change, including regulatory, policy, financing and resource allocation changes. It requires the State to use these changes to establish and monitor performance and provide technical assistance and support to improve the practice necessary for services and supports to be accessible and available. Without the structural change, practice change at the scale required in this agreement is not likely.

The State made substantial progress meeting Supported Housing and Pre-screening and Diversion requirements. There was uneven progress towards meeting Quality Assurance and Performance Improvement requirements and limited or no progress meeting specific Discharge and Transition Processes and Community-Based Mental Health Services requirements.

Consistent support is needed across the leadership of a number of DHHS Divisions, the HFA, and the LME/MCOs. This is difficult to achieve when meeting these requirements requires significant changes in policy and operations and because of the multiple demands on staff at the same time. Nonetheless, the attention from leadership is essential for the State to meet its obligations in this Settlement Agreement. The Deputy Secretary for DMHDDSAS and the Senior Advisor for the ADA, along with key staff in critical positions, have created more stability in operations and budgeting and enabled the State to take critical steps towards compliance.

There have been major improvements in access to supported housing with an increased number of individuals getting housing slots, through funding awarded for project-based set aside units through ISHP and SHDP and through an award of federal Mainstream rental vouchers. The State met its annual housing slot requirement for the first time since FY 2014, with 2,014 slots filled by June 30, 2019. The DHHS, LME/MCOs, and the HFA are committed to increasing capital and operating funds and subsidies from federal and local resources to expand the availability of affordable housing resources. This improvement is largely due to an increase in filling privately owned units rather than in LIHTC financed units.

Improvements are still needed in Discharge and Transition Processes. There were changes made to contracts between the State and LME/MCOs to improve the SPH discharge planning process. Implementation has been very slow. The new Diversion process presents challenges to meeting discharge and transition process requirements. The Senior Advisor began convening key

committees, required in the Settlement, related to Transition Processes and other requirements and charged with performance improvement near the end of FY 2018. Her staff are also tracking expenditures and progress on Settlement Agreement requirements. Their efforts and efforts of other divisions are encouraging. They are committed to breaking down systemic barriers and elevating practice, especially for individuals who have special needs and/or are at high risk.

The State has not met its obligations for Quality Assurance and Performance Improvement (QA/PI). A QA/PI Plan necessary to demonstrate this system is in place is still under development and State has yet to demonstrate that all the necessary performance improvement actions being taken to meet its obligations in this Settlement Agreement are in place.

DHHS changed the Pre-screening and Diversion process on November 1, 2018. Making this change presented enormous challenges.. Through the State and LME/MCO's commitment to continuous improvement, processes have improved over time. The number of individuals with their reviews pending remains high. The State clarified several policies towards the end of the fiscal year.

The State continues to increase the number of individuals "in or at risk" of adult care home placement getting IPS-SE. Nonetheless two problems persist. The number of individuals in the TCLI target population getting this important service remains low and IPS-SE teams struggle to improve their performance. There is a connection between these two findings. The current IPS-SE business model and reimbursement do not adequately support this service for the TCLI target population. The State is now taking steps to improve the business model, but this will take time. This year's individual reviews demonstrated that many more individuals in the TCLI population want the opportunity to go to work or back to work. There is reliable data to support this finding. There is a lingering belief that individuals in this target population cannot work even when the evidence shows many individuals want to work and can work.

The biggest challenge remaining is improving the focus, flexibility, and quality of services and supports. This requires making the array of needed services and supports available with the frequency and intensity necessary for successful transition to community living. This also requires assuring the duration of services and supports matches an individual's request and recovery needs. It requires that staff help individuals to increase their ability to recognize and deal with situations that may otherwise result in crisis and to strengthen and expand individuals' networks of community and natural supports. The TCLI Data analysis conducted in FY 2018 with the assistance of the Human Services Research Institute provided information about the cost, numbers served, types, and duration of services rendered pre and post transition. The State's data analysis first reported in FY 2019 but covering FY 2017 and 2018 reinforced these findings.

There were few changes in the service use and outcomes in the FY 2019 individual reviews from previous years. Housing separations remain high. Chronic health conditions are contributing to a

lack of long-term stability in the community as is the constant pressure placed on individuals to return to adult care homes. The TCLI target population is not a single homogenous group where one size of services fits all. Improving services requires a better understanding of needs, more intensive and frequent services, individualized person centered supports and services, flexibility, use of effective resources, a focus on recovery, use of natural supports, and use of data for decision-making. The implementation of a new CST service and both CST and ACT providers improving their performance providing tenancy supports are key tests in FY 2020. A smooth transition along with improved performance will be key to the State meeting its services requirements.

The State, LME/MCO leadership, their network staff, and service providers must take the steps to meet services requirements. This Settlement Agreement is important beyond the State meeting its requirements. It is also the LME/MCOs' future. It is a reflection of what is required for Tailored Plan administrators.

The message at the conclusion of the past two reports lingers today. In many respects, the TCLI target population remains invisible. The daily needs, hopes, and fears of individuals placed in an adult care home or a state psychiatric hospital fade from our view. With the changes in the screening system, the needs of individuals pre-screened for adult care home placement have come into focus. TCLI staff in each of the LME/MCOs, including their In-reach staff and Transition Coordinators, see this every day and are stepping up to assist individuals to secure stable permanent housing and supports. They will need LME/MCO leadership to support them to be successful meeting this requirement.

As stated last year, many obstacles persist. There is still a need for all the organizations and stakeholders in the State's "system of care" to support and provide help for individuals to reach their recovery goals. So many individuals in this Settlement Agreement's target population have voiced their feelings of being isolated, lonely, and unsure if they have the strengths to live successfully in the community. Life is not just a service, although services and supports are essential. It is also community, faith, friends, acquaintances and family, a safe and decent home, a job, and/or activities that an individual finds rewarding and fulfilling.