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A. Introduction

Quality assurance and program improvement (QA/PI) is a key pillar established by the Transitions to Community Living (TCL) settlement agreement between the State of North Carolina and the United States which created TCL (Settlement Agreement). Led by the TCL Quality Leads, the TCL QA/PI system is designed to help ensure that TCL community-based placement and services are developed and implemented in accordance with the Settlement Agreement and that TCL participants receive services and supports that are recovery-oriented and that safeguard their health, safety, and welfare.

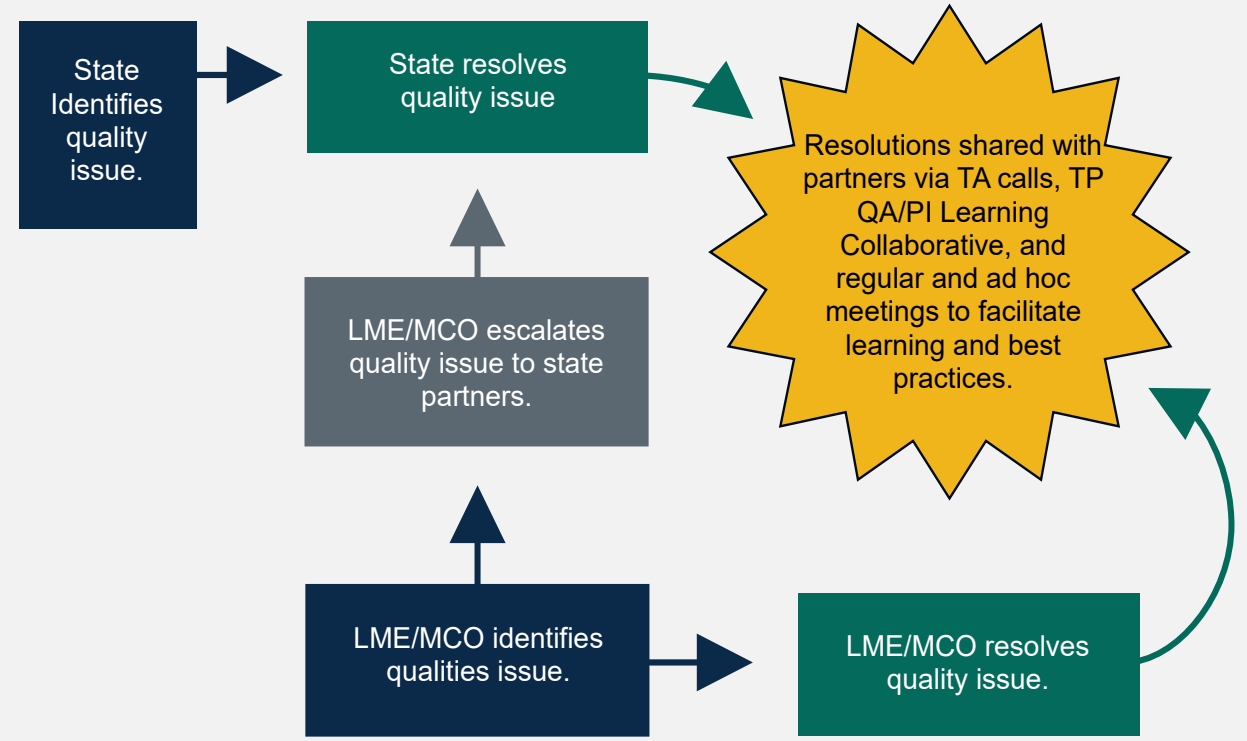
To meet those objectives, the TCL QA/PI system encompasses five complementary core processes that address the spectrum of quality issues: (1) the TCL Priority Measure Monitoring and QA/PI Cycle, (2) the Quality Assurance Committee, (3) the barriers identification and resolution process, (4) the Transition Oversight Committee for TCL, and (5) PIHP/TP contract monitoring. These core QA/PI system processes provide regular oversight and support to ongoing QA/PI action planning and implementation conducted across the North Carolina Department of Health and Human Services (NCDHHS or Department) divisions responsible for TCL operations. Through these core processes, the QA/PI system identifies and responds nimbly to urgent quality issues and methodically addresses complex, systemic quality issues (Table A.1).

Table A.1. TCL Core QA/PI Processes and Priorities

Core QA/PI Process	Concerned primarily with ...	
	Systemic or individual issues?	*Urgent/emergent or long-term issues?*
TCL Priority Measure Monitoring and QA/PI Cycle	Systemic	Long-term
Quality Assurance Committee, including the day-to-day activities of its members	Both	Both
Barriers identification and resolution process	Both	Urgent/emergent
Transition Oversight Committee for TCL	Systemic	Both
PIHP/TP contract monitoring	Systemic	Both

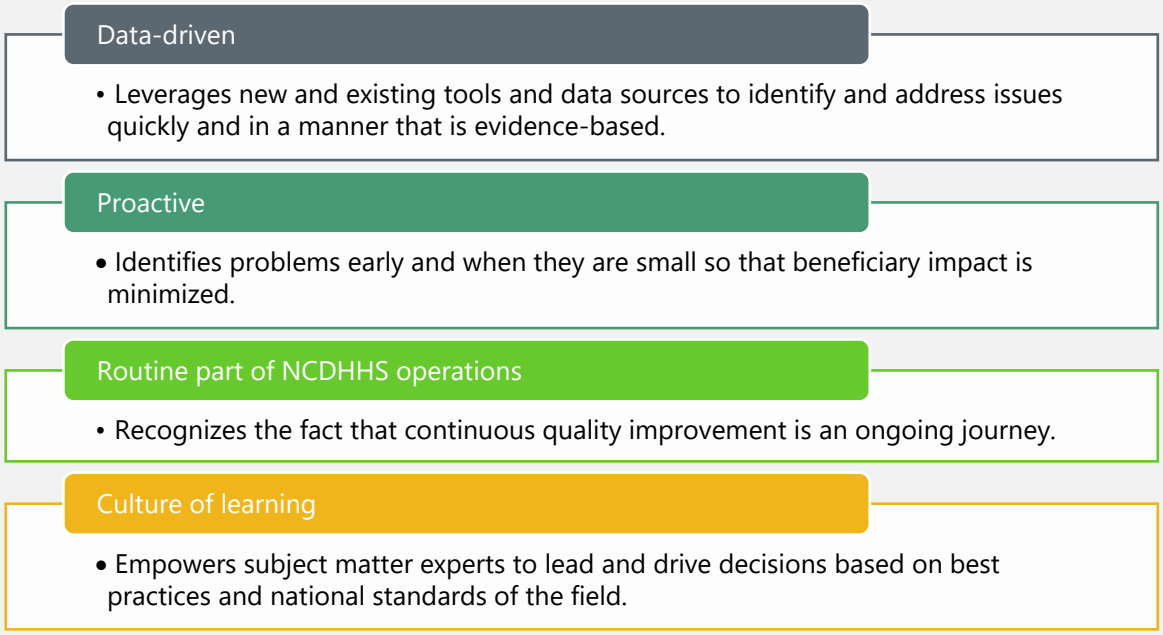
These processes are interlinked and responsible, both individually and collectively, for the feedback loops that promote a culture of learning and continuous quality improvement in TCL. These feedback loops are represented in Figure A.1 below.

Figure A.1. TCL QA/PI Process Feedback Loops



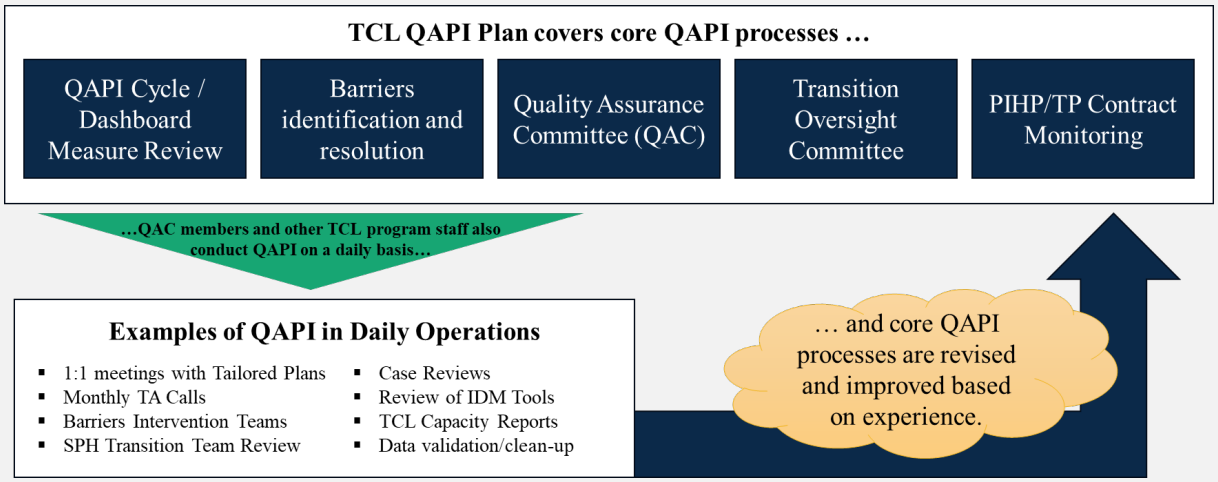
Ultimately, NCDHHS is committed to a QA/PI system that is data-driven, proactive, and a routine part of TCL operations. Following established QA/PI processes, NCDHHS will leverage new and existing tools and data sources to identify problems early and when they are smaller and develop data-informed improvement plans. QA/PI processes will empower subject matter experts to lead and drive QA/PI decision-making and will be embedded in routine operations (Figure A.2). It is worth noting that a well-functioning QA/PI system does not completely eliminate the possibility of problems arising in TCL operations. However, it supports early detection of potential problems and guides the steps to resolve them in a manner that reduces their impact. It also prevents similar problems from occurring in the future. The identification of such problems and development of responsive improvement plans is one sign that the QA/PI system is working effectively.

Figure A.2. Cornerstones of the TCL QA/PI System



This QA/PI Plan describes how the five core processes (Table A.1) operate and interact to promote efficiency and effectiveness of the TCL QA/PI System. As illustrated in Figure A.3 below, these core processes support a virtuous cycle of continuous improvement. Subject Matter Experts and other TCL staff interface with the five core processes. They use the methods and tools provided by the QA/PI pillar to support discrete quality assurance, monitoring, and performance improvement activities as part of the daily operations of their TCL elements. They frequently develop QA/PI and monitoring activities in response to specific identified issues or circumstances. Activities such as these are modified depending on their efficacy and may change frequently and thus are not captured in this plan.

Figure A.3. The QAPI Plan in Context



The QA/PI Plan serves as an internal document that describes generalizable frameworks, repeatable processes, and data sources that collectively NCDHHS staff may apply to any TCL component or requirement. In so doing, the plan aligns with the principles outlined in national QA/PI guidelines by The Centers for Medicare and Medicaid Services[1] in which QA/PI is understood as a system and a process. The result is a broadly applicable and flexible document that can be adapted to emerging TCL needs.

Reflecting the dynamism of the QA/PI system, the TCL QA/PI Plan serves as a blueprint and living document that the State can update as the TCL QA/PI System evolves to meet emerging needs or respond to changes in State infrastructure. At the start of each fiscal year, TCL Quality Leads will organize an annual review of the QA/PI Plan with TCL subject matter experts and leadership. This review will assess the extent to which the existing plan captured QA/PI system activities, artifacts, and outcomes in the previous year and whether updates are needed to reflect any QA/PI system structural changes or process modifications. The review will also encompass an evaluation of how well existing QA/PI system processes functioned to detect, address and resolve identified issues, and what, if any, process updates are needed. Proposed updates and revisions will be approved by TCL leadership before implementation.

In subsequent sections, the QA/PI Plan describes the following components of each core QA/PI System process:

1. **Background and Purpose** – the reason the process or entity exists and the goals it aims to accomplish.
2. **Participants and Roles** – who is involved and what each party is responsible for.

[1] See, for example: Guide for Developing a QAPI Plan. Centers for Medicare and Medicaid Services. Available at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPIPlan.pdf. Accessed June 2024.

3. **Core Activities** – the specific things that are done within or under the umbrella of the process or entity, including explanations of key artifacts and the timing of activities.
4. **Information Flow within the QA/PI System** – how the entity or process engages with other parts of the QA/PI system and LME/MCOs.[2] Discussions of information flow illustrate how lessons from quality improvement activities are disseminated throughout the TCL through planning meetings, direct technical assistance and generalized guidance.

[2] On July 1, 2024, all LME/MCOs transitioned to Tailored Plans, although they remain LME/MCOs for the population excluded from Managed Care. The QA/PI Plan consistently describes these organizations as LME/MCOs to acknowledge the foundations that were established before the transition.

B. TCL Priority Measure Monitoring and QA/PI Cycle

Background and Purpose

The QA/PI Cycle is a quarterly review of TCL descriptive and performance measures across TCL domains to inform ongoing quality improvement planning and implementation. The QA/PI Cycle is one of many processes that enables TCL quality improvement to be data-driven and proactive. These activities are essential to ensure effective continuous improvement across core TCL domains, including client outcomes, community-based mental health and employment services, pre-screening and diversion, housing, in-reach, and transition and discharge.

The QA/PI cycle analyzes measure data across quarters from the TCL Dashboard, which visualizes over 100 TCL measures statewide and by TCL Status or LME/MCO or a combination of both. Users can further stratify by additional sociodemographic or administrative characteristics, such as age group, race/ethnicity, geography, and population category. The TCL dashboard pulls measure data from a variety of sources, including administrative datasets (Transitions to Community Living Database [TCLD], Healthcare Enterprise Accounts Receivable Tracking System [HEARTS], Community Living Integration & Verification [CLIVe]), claims data (NC Tracks and Encounter Processing System [EPS]), and assessment data (North Carolina Treatment Outcomes and Program Performance System [NC-TOPPS]). At minimum, the dashboard refreshes measure data quarterly.

Through periodic analysis of selected measures across TCL domains, the QA/PI Cycle provides systematic, regular, and consistent insight into essential TCL processes and outcomes so that TCL staff can adjust, plan, and implement focused quality improvement activities into their existing quality improvement work. The TCL Quality Measure Report (QMR) documents this analysis and the subsequent quality improvement actions taken to address any identified issues. As the primary output of the QA/PI Cycle, the QMR provides transparency and accountability through dissemination to NCDHHS leadership and TCL subject matter experts.

Participants and Roles

The QA/PI cycle involves TCL Quality Leads and TCL Domain Subject Matter Experts (Domain SMEs), with support from other NCDHHS staff. Domain SMEs are staff across NCDHHS who lead TCL operations and quality improvement efforts in the various domains of TCL service delivery, including in-reach and diversion, discharge and transition, community mental health and employment services, and housing. The TCL Quality Leads and Mathematica provide support and oversight to Domain SMEs, who lead the analysis, interpretation, and design of quality improvement actions. Table B.1 lists current TCL Quality Leads and Domain SMEs. Other NCDHHS staff support issue analyses and quality improvement activities on an as-needed basis.

Table B.1. Current TCL Domain SMEs

Domain	Domain SME
TCL Quality Leads	Clinical Project Manager, TCL, Office of the Secretary

Domain	Domain SME
	Olmstead/TCL Quality and Data Lead, DMH/DD/SUS
Community-based services	IDD/TBI/Olmstead Section, TCL Team Lead, DMH/DD/SUS
Housing	Olmstead Housing Director, Office of the Secretary
In-reach	Community Transitions & Integration Team Lead, DMH/DD/SUS
Client outcomes	Olmstead/TCL Quality and Data Lead, DMH/DD/SUS
Diversion	Community Transitions & Integration Team Lead, DMH/DD/SUS
Discharge and Transition	Olmstead Discharge and Transition Manager, TCL, Office of the Secretary

Core Activities

The QA/PI Cycle involves four key steps that lead to the development and dissemination of the QMR (Figure B.1).

Figure B.1. QA/PI Cycle Process and Output

Step 1: Selecting priority measures

At the beginning of each state fiscal year, Domain SMEs select priority measures from the TCL dashboard for QA/PI Cycle analysis that are most important for success in LME/MCOs delivering high quality services for individuals with serious and persistent mental illness (SPMI). Each Domain SME selects the most important process measures ("what must occur for success") and/or outcome measures ("how success is defined"), if available, as priority measures.[3] Domain SMEs use a multi-faceted framework to identify whether a domain measure is a priority measure (Table B.2). Domain SMEs can adjust the list of priority measures during each quarterly QA/PI Cycle, as needed.

[3] Not all domains have both process and outcome measures. For example, the services measures in the TCL Dashboard consist entirely of measures of service receipt, which are process measures. Conversely, the client outcomes measures in the Dashboard are entirely outcome measures.

Table B.2. Important Factors to Consider during Priority Measure Selection

Factor	Key questions
Importance to the lives of TCL participants	Is the concept being measured an outcome that is specifically aligned with TCL goals as described in the Settlement Agreement? If not, is the underlying measure concept causally connected to the achievement of TCL goals for person-centered planning and recovery?
Feasibility of improving	Is improvement of measure results within the sphere of influence of the State or LMEs/MCOs? What is the likely level of effort and timeframe associated with improving measure results?
Analyzability and interpretability	Does the measure have clear directionality such that higher or lower is always better? Is the measure's meaning clear in isolation or is it necessary to bring in other measure results to interpret it?
Of long-term interest	Is the underlying measure concept always relevant to achieving TCL outcomes? If a measure result is related to a specific event and not of long-term interest, what other QA/PI process could meet near-term needs for discussion?

Domain SMEs may consider additional measures in subsequent steps of the QA/PI cycle as analysis of selected priority measure data may lead to additional questions about trends or interpretation of related domain measures. Because the nature of circumstances that affect TCL service delivery and participant outcomes evolve over time, Domain SMEs meet with TCL Quality Leads at the beginning of each state fiscal year to ensure that the TCL dashboard measures selected as priority measures are responsive to any changing circumstances. Along with annual measure selection, Domain SMEs may identify new priority measures at any time since circumstances in the State can change more rapidly.

Step 2: Setting prioritization thresholds

Once priority measures are selected, Domain SMEs set prioritization thresholds. Prioritization thresholds are the quantitative level above or below which Domain SMEs can conclude that the measure result alone does not indicate a quality issue for DHHS focus, at that point in time. Whether a higher or lower priority measure value indicates a quality issue depends on the nature of the priority measure.

In this way, prioritization thresholds provide TCL staff and the Department with a method for focusing their efforts on the most important quality issues. Unlike national benchmarks, prioritization thresholds do not indicate a performance goal, but rather serve as a tool for NCDHHS to identify areas where the State could direct resources to support LME/MCOs whose progress is slower or stagnant compared to their peers. Prioritization thresholds are calibrated to the local context. They allow SMEs to interpret LME/MCO performance on priority measures against North Carolina's own progress towards national benchmarks. Domain SMEs also apply their judgment and experience to calibrate prioritization thresholds for a given priority measure (Table B.3). Like priority measures, these prioritization thresholds may change over time, from QA/PI cycle to QA/PI cycle.

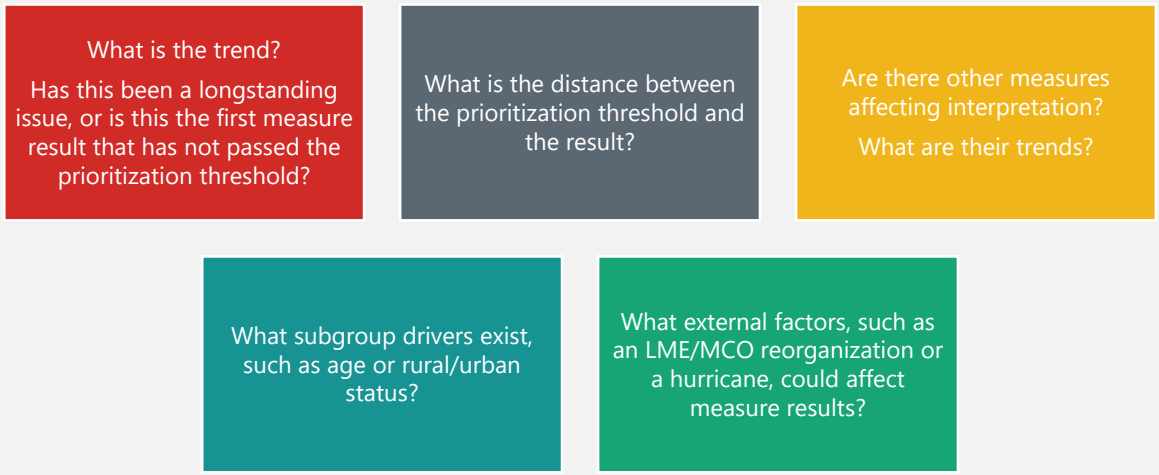
Table B.3. Important Factors to Consider when Setting Prioritization Thresholds

Factor	Factor Description
The logic of TCL	In some cases, the way that TCL is structured and operated heavily influences prioritization thresholds. For example, frequent, in-person in-reach is necessary within the logic of TCL for members to have full choice and autonomy, which mitigates in favor of a higher prioritization threshold for related In-reach measures.
Historical trends	Whether measure results are improving or declining over time may affect prioritization thresholds. For example, an improving historical trend suggests that a less restrictive prioritization threshold may be appropriate given that improvement is already occurring organically.
Natural breakpoints in the data	In some cases LME/MCO measure results cluster in ways that create natural breakpoints in the data. For example, two LMEs/MCOs might have inpatient admission results below 2% while the others are above 7%. It may be desirable to locate prioritization thresholds between natural breakpoints to facilitate direction of quality improvement resources toward lower performance.
The statewide average	TCL SMEs will consider the statewide average as a reference point.

Step 3: Conducting issue analysis

Using a multi-step process, Domain SMEs review measures that do not pass prioritization thresholds to understand the extent and nature of any flagged quality issues. The process includes analysis of associated measures, subgroup factors, and external factors (Figure B.2). Domain SMEs also apply their historical knowledge of the flagged issue and the State's existing efforts to address the issue. Based on this multistep analysis, Domain SMEs, with the guidance of TCL Quality Leads, determine whether or not a flagged quality issue requires quality improvement action. Failure to pass a prioritization threshold does not automatically lead to a recommendation for an improvement action. For example, if an LME/MCO does not pass a prioritization threshold for a priority measure, but the LME/MCO is aware of the issue and is taking active steps to improve, a Domain SME may decide not to intervene further and to continue monitoring.

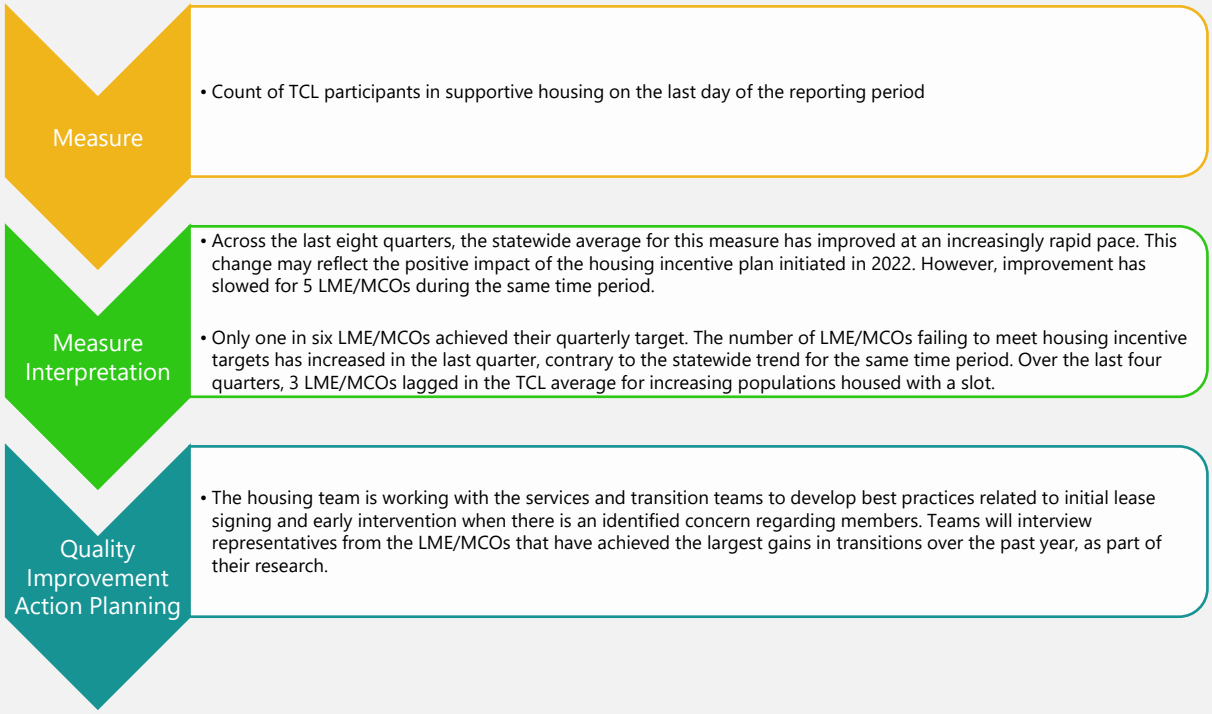
Figure B.2. Questions to Consider During Issue Analysis



Step 4: Conducting quality improvement

In response to observed quality issues determined to require action, Domain SMEs will develop a specific action plan to improve performance on the associated priority measure and related process and outcomes measures (see Figure B.3 for an example). Between QA/PI cycles, Domain SMEs and other NCDHHS staff implement the specific quality improvement actions with the support from TCL Quality Leads and the QAC. In partnership with the TCL Quality Leads, Domain SMEs will monitor the issue over time until the issue is resolved. Through future QA/PI cycles, SMEs and TCL Quality Leads can assess the impact of actions implemented and areas where additional action is required.

Figure B.3. Example Hypothetical Quality Improvement Action for an Identified Quality Issue



Key Artifact

Once Domain SMEs complete a QA/PI cycle, they update a controlling measures spreadsheet with the domain measures selected, prioritization thresholds set, measure results, and any quality improvement actions recommended and implemented. This spreadsheet provides a historical record of QA/PI cycles and a source of truth for Domain SMEs and TCL Quality Leads to reference for long-term monitoring of identified quality issues.

Output: QMR

At the end of the QA/PI Cycle, the QMR summarizes identified quality issues and quality improvement plans. Domain SMEs, TCL Quality Leads, NCDHHS leadership, and other NCDHHS staff can review detailed measure tables for each priority measure to pinpoint quality improvement actions planned or taken and related status updates, including timelines for implementation milestones. Measure tables also track quality improvement actions previously taken by NCDHHS, helping to inform future QA/PI planning by Domain SMEs. Tables are organized by domain and Domain SME, promoting transparency and accountability. Additionally, a summary table offers a quick comparison across LME/MCOs and statewide averages for each priority measure with an identified quality issue. This summary table can help NCDHHS staff identify if certain LME/MCOs are underperforming across multiple domains and thus may need more intensive NCDHHS support to address quality issues.

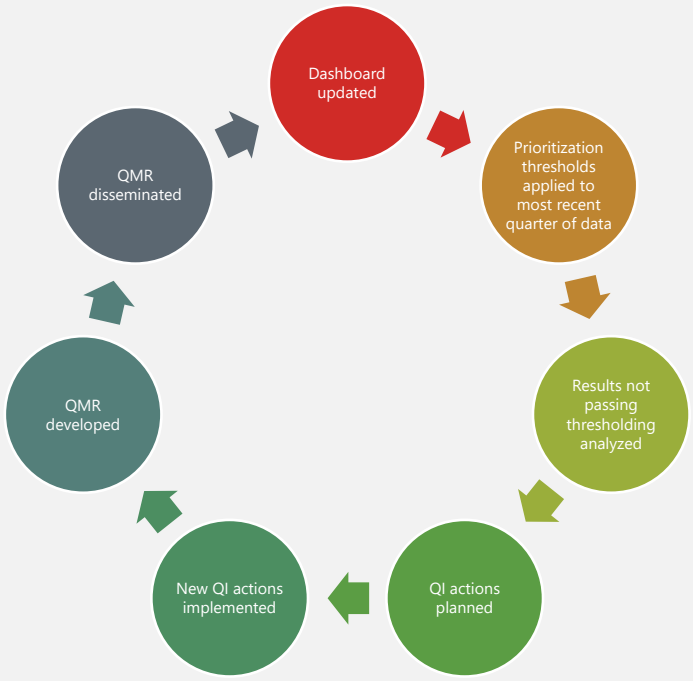
Key Artifact

Domain SMEs complete a standardized QMR template each QA/PI cycle to ensure that the process of analyzing, interpreting, and developing quality action plans is informative and consistent across domains and QA/PI cycles.

Timing of Activities

The TCL Dashboard is updated on a quarterly basis. Once the dashboard data is refreshed, the QA/PI cycle begins, followed by dissemination of the QMR (Figure B.4). While priority measures and prioritization thresholds are formally assessed on an annual basis, SMEs and TCL Quality Leads can update measures and thresholds at any time, during or between QA/PI cycles.

Figure B.4. QA/PI Cycle Workflow



Information Flow within the QA/PI System

Quarterly updates to the dashboard reflect regular collaboration between SMEs, other NCDHHS staff, and LME/MCOs to improve the quality of TCL. Consistent information sharing through the QA/PI cycle supports more accurate issue analysis and the development of more effective quality improvement actions. SMEs share insights from their analyses with LME/MCOs by sharing data, providing technical assistance, or issuing sub-regulatory guidance. Insights germane to only a single LME/MCO might be offered through a 1:1 meeting. Oftentimes, analyses may generate insights that apply to all LME/MCOs. In such cases, SMEs might share generalized lessons through monthly TA calls or TOC meetings.

Similarly, LME/MCOs also share information with NCDHHS that can inform advanced analysis of related priority measures or the addition of new priority measures during subsequent QA/PI Cycles. For example, if an LME/MCO identifies a quality improvement action it has already taken to address an emerging quality issue, a SME can track in subsequent QA/PI Cycles whether that action might have contributed to improvement in associated priority measures. If so, that SME can identify the action as a best practice to scale to other LME/MCOs.

Within NCDHHS, progress on quality issue analysis and quality improvement activities are disseminated to other parts of the QA/PI system via regular meetings and dedicated NCDHHS internal communications. During meetings and in communications with other TCL experts and personnel, SMEs can solicit additional feedback on how to address identified quality issues and any implementation challenges that may arise. Quality improvement actions may also involve deeper collaboration across NCDHHS divisions. For example, quality improvement actions may include activation of contract mechanisms, such as performance improvement plans and value-based contracting provisions, based on data and information generated through the QA/PI cycle.

C. Quality Assurance Committee (QAC)

Background and Purpose

The QAC supports TCL SMEs in performance monitoring, identification and communication of barriers and quality issues, and quality improvement planning. It does so by facilitating cross-division discussion and collaboration and conducting ongoing data review, analysis, and evaluation of progress toward TCL objectives. QAC input and feedback focuses on major TCL elements such as those highlighted in Figure C.1. That said, given its membership, structure, and broad mandate, the QAC may touch on any aspect of TCL. The QAC reinforces an ethos of person-centeredness and recovery-orientation and supports TCL recipients in transitioning to the community, living in their preferred residence, and strengthening community integration.

Figure C.1 Examples of TCL Elements Informed by QAC Feedback

Note: QAC feedback is not limited to the TCL elements listed. As the figure suggests, the QAC can provide feedback on quality improvement for the breadth of TCL elements.

Participants and Roles

The QAC is chaired by the TCL Quality Leads and comprises representatives from the DHHS Office of the Secretary – Olmstead/TCL section; Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS); Division of Health Benefits (DHB); Division of Employment and Independence for People with Disabilities (EIPD); and Division of State Operated Healthcare Facilities (DSOHF). QAC members from these divisions are engaged

daily in improving TCL quality across domains through ongoing monitoring and strategic engagement with LME/MCOs, state hospitals, service providers, and consumer groups.

Core activities

While the QAC meets quarterly, members collaborate daily to identify and resolve quality issues. Whether through collaboration on action items identified through QAC meetings or emergent/urgent issues that arise during daily TCL operations and monitoring, QAC members communicate the nature of quality issues and the status of subsequent quality improvement planning and implementation to TCL Quality Leads on an ongoing basis.

QAC Meetings

QAC meetings follow a standing agenda, providing time for structured data review as well as open discussion on TCL QA/PI (Figure C.2). This standing agenda reflects a core objective of the QAC, as cited in settlement agreement Section III.G.7, to aggregate and analyze data collected by the State, LME/MCOs, and the External Quality Review Organization to determine whether the State is progressing toward increased integration, stable integrated housing, and decreased hospitalization and institutionalization for TCL participants. QAC meetings are meant to be a space for NCDHHS staff working across all TCL domains to regularly convene and reflect on the data and progress toward TCL objectives and share learnings and ideas for new collaboration across divisions to improve TCL participant outcomes.

Figure C.2. Standing QAC Meeting Agenda

Standing Agenda Item #1: QA/PI Cycle Update

TCL Quality Leads provide an update on current QA/PI cycle progress and review the timeline until QMR dissemination.

Standing Agenda Item #2: Data Presentations

The TCL data presentation is the most important QAC standing agenda item and will consume a significant portion of each meeting, with two to four Domain SMEs presenting their analysis of the most recently available data for TCL elements in their respective domains (Table C.1). Presentations include discussion of quality issues identified statewide and/or by LME/MCOs over time and subsequent quality actions taken or considered by NCDHHS and LME/MCO staff.

Table C.1. Sample QAC Data Presentation Topics

Topic
Institutional admissions and length of stay, ER visits, crisis service utilization
Housing numbers, stability, and separation patterns, including maintenance of chosen living arrangement; ACH admissions and readmissions after housing separations; housing incentive plan measures; enhanced and bridge usage
High-level State barriers summary
ACH in-reach, diversion, and transition planning; Informed decision-making
Employment and IPS-SE service patterns, employment incentive plan data, IPS-SE milestones and provider-reported outcomes
Community Mental Health services monitoring
SPH in-reach, and discharge and transition planning
External Quality Review (EQR) results of TCL functions
Adverse incidents
Quality of Life survey results, TCL dashboard community integration measures
Person centered planning
Tailored Plan contract quality measures for TCL population

The structure of data presentations aims to foster discussion and collaboration among NCDHHS staff across divisions. Data presentations follow a three-part structure that maps to the data-driven analysis and quality improvement action planning that SMEs utilize to address identified quality issues (Figure C.3). Additionally, each presentation allocates time for the QAC to ask questions and provide input on data interpretation and quality improvement action planning.

Figure C.3. Data Presentation Format and Discussion Framework

Standing Agenda Item #3: Settlement Compliance and Implementation Plan Progress

TCL domain leads provide updates on Settlement compliance and implementation plan progress and challenges or barriers encountered, including asking QAC support in interpreting domain data that informs QA/PI planning and implementation, when needed. Leads have the opportunity to ask for support or present opportunities for collaboration following the meeting.

Standing Agenda Item #4: Open Forum

The meeting concludes with time for any QAC members to ask questions or raise issues that may benefit from committee feedback. This discussion may lead to post-meeting action items for additional analysis by Domain SMEs and TCL Quality Leads or follow-up meetings between a subset of the QAC for additional collaboration on cross-cutting TCL quality issues. During this time, Domain SMEs also have the opportunity to ask the larger QAC for any input on QA/PI cycle measure interpretation and/or quality improvement action planning, if needed. Lastly, the open forum can serve as an ad hoc space to discuss QA/PI actions addressing time-sensitive quality issues, implementation of proposed quality improvement actions, or other cross-division touchpoints that require prompt attention.

Key Artifacts

QAC meeting agendas

Agendas are created by the TCL Quality Leads. Through ongoing meetings and touchpoints with SMEs and other QAC members, TCL Quality Leads contribute ad hoc items to the agenda, as needed.

Data presentation slide decks

Presenting SMEs create data presentation slide decks with talking points and with support from TCL Quality Leads and contractors. After each QAC meeting, data presentation slides are available in a secure SharePoint folder ("data repository") that all QAC members can access for reference and continued learning.

Meeting notes

Contractors prepare the meeting notes, which start with a table of any action items discussed during the QAC meetings. Action items may be logistical, such as sending the link to the data presentation repository. They may also be substantive, such as completing a secondary analysis to support measure interpretation and/or quality improvement planning.

Timing of Activities

In preparation for quarterly QAC meetings, all QAC members consider questions or concerns arising from daily quality improvement efforts that would benefit from the attention of a large, cross-division body. These may include larger programmatic or systemic concerns that may not be easily addressed through an individual division's regulatory guidance or technical assistance. TCL Quality Leads meet with SMEs at least four weeks before QAC meetings to provide support for preparation of data presentations. They are also available to help plan quality improvement actions following QAC meetings.

Information Flow within the QA/PI system

The QAC produces two types of quality information. The first is the information generated through day-to-day activities of its members, as described above. This information may cover any aspect of TCL operations and performance and may be specific to a single

member, cover all TCL members, or anything in between. Individual QAC members and their teams route this information to other NCDHHS staff and LME/MCOs through established channels, including but not limited to monthly TA calls, regular and ad hoc one-on-one meetings with LME/MCOs, focused email communication, and DHHS staff meetings. The monthly LME/MCO TA calls play an especially important role as the primary mechanism for sharing lessons learned and best practices.

The second is the information produced within and for the regular QAC meetings, themselves. This information is generally aggregated and systemic. Work is assigned during QAC meetings and individual members complete those assignments with their teams between QAC meetings, routing information to LME/MCOs on an as-needed basis, following the mechanisms described above. In some cases, QAC meetings will generate findings that need to be communicated and addressed with LME/MCOs on a short-term basis. In these cases, the TCL Quality Leads will track and follow up to ensure that the information loop is closed.

QAC meetings are also opportunities for core TCL NCDHHS staff to learn from each other about successful initiatives and means of addressing quality issues. As appropriate, NCDHHS staff take these learnings back to their teams for application to day-to-day operations or route them to LME/MCOs who may not be in the loop.

D. Barriers Identification and Resolution Process

Background and Purpose

Per the Settlement Agreement (SA), a barrier is something, "…preventing individuals from transitioning to an integrated setting… and does not include the individual's disability or the severity of the disability." DHHS interprets that to include any obstacle to transitioning or maintain community integration, including housing and employment. A barrier to TCL transition and/or community living can take many forms. Although not limited to the following list, barriers may arise from:

1) TCL procedures that may need updating.
2) Available funding and legislative dynamics.
3) Tailored Plan staff, providers, hospitals, and others not following standard TCL practice.

The barriers identification and resolution process provides a mechanism for all TCL partners and participants to improve TCL through broad-based, "no wrong door" reporting of such obstacles. Once identified, tracking and resolution processes refer to the structured mechanisms by which State Psychiatric Hospitals (SPHs), LME/MCOs, and the State take specific action to remediate barriers identified and increase the community integration of individuals participating in TCL.

Participants and Roles

Participants in the barriers identification and resolution process include all TCL partners, such as TCL participants, their guardians and families, advocates, service providers, LME/MCOs, and all State staff. The entities in Table D.2 below are essential to developing and maintaining a transparent and accountable process.

Table D.2. Barriers Committee Participants and Roles

Participants	Roles
State Barriers Lead	A representative from the Olmstead/TCL office who oversees and coordinates the barriers identification and resolution process. The State Barriers Lead develops protocols and related training for barriers committee operations and ensures committee members receive necessary training. The Barriers Lead may also own the resolution of specific barriers.
Barriers Intervention Teams	Intervention teams are ad hoc groups of State staff and other partners created for the specific purpose of resolving a barrier. An individual on each intervention team will be designated as the owner of the assigned barrier. Intervention teams comprise whoever is necessary to resolve the barrier; team members are not limited to participants of existing barriers committees.
State Psychiatric Hospital (SPH) Barriers and Solutions Committees	These are SPH-specific teams whose membership include Social Work Directors, SPH Managers, and representatives from (1) the Division of State Operated Health Facilities (DSOHF), (2) LME/MCOs in each SPH's catchment area, (3) the Olmstead/TCL Office. These committees address SPH-specific barriers and improve coordination between SPHs, LME/MCOs, and NCDHHS on transition and discharge workflows.
State Barriers Committee (SBC)	The State Barriers Committee is led by the State Barriers Lead. The TCL Director maintains oversight of SBC activities. Its membership is formalized, with divisional representation and

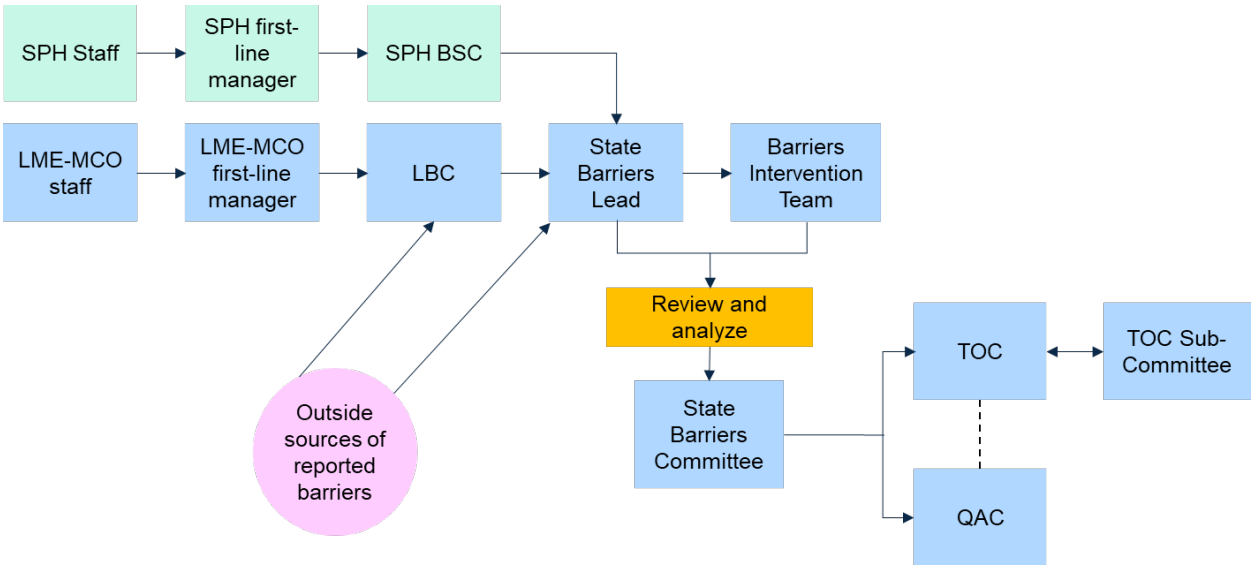
	regular participation. Membership entities include NCDHHS, the Area Agency on Aging ombudsmen, National Alliance for Mental Illness (NAMI), and LME/MCOs. The SBC provides guidance to the individual or team assigned to address a barrier and assesses whether it needs to be further escalated to the Transition Oversight Committee or Quality Assurance Committee. In consultation with State Barriers Lead, the SBC establishes the guidelines for general barriers workflows. LME/MCO representatives participate on an ad hoc basis, depending on the barrier being addressed. However, SBC guidance that applies to all LME/MCOs is disseminated through monthly TA calls or other mechanisms.
Local Barriers Committees (LBCs)	Local Barriers Committees (LBCs) are administered by the LME/MCOs and may have a variable makeup of staff. LBCs conform to requirements disseminated by the SBC to track, review, and resolve any barriers experienced by TCL members. They identify the entities and strategies to address barriers. They report barriers, by status, to the SBC, and identify training needs consistent with state-issued protocols and the LME/MCO's specific challenges. LBCs escalate barriers that they cannot resolve on their own to the SBC.
Transition Oversight Committee (TOC)	Receives barriers escalated from the State Barriers Lead or State Barriers Committee and provides guidance to address the barrier. The TOC is primarily engaged for systemic barriers. The TOC can call for the creation of a subcommittee to address a specific issue and is updated on settlement agreement substantial compliance progress by the State Barriers Lead or designee.
Quality Assurance Committee	Receives periodic updates on Barriers via data presentations. Can serve as an ad hoc forum for discussing quality improvement activities meant to address barriers.

Core Activities

Barriers Reporting

The Barriers reporting process is intended to be accessible to all TCL participants and partners. Barriers may be reported by any person with an interest in TCL via email, to the TCL Inboxes (Olmstead.Barriers@ncdhhs.nc.gov or community@ncdhhs.nc.gov), or by personal report to NCDHHS staff. Individual members and their family members or guardians can also report barriers by contacting the Customer Service and Community Rights Team of the Department of Mental Health, Developmental Disabilities, and Substance Use Services (DMHDDSUS), contact the NCDHHS Office of the Secretary, or contacting their state representative. These channels all route reported barriers to the NCDHHS State Barriers Lead. Separately, LME/MCOs and State Psychiatric Hospitals have their own defined processes for escalating barriers to local committees charged with addressing local barriers and further escalating them as needed. Figure D.1 outlines the potential pathways for escalating barriers. At each stage of the process, if the relevant committee or team cannot resolve the barrier, it is escalated to the next stage in the escalation path.

Figure D.1. Barriers Reporting Escalation Path



At each stage in the process, when deciding whether to escalate a barrier, individuals consider what options are available to them based on their role. If a frontline staff member and their first-line manager have exhausted their resources and options to address an individual barrier or something related to their organization, they escalate to their LBC or SPH BSC. If the LBC or SPH BSC has similarly exhausted their resources to address the barrier, they escalate the issue to the State Barriers Lead. Regardless of classification, if something presents an immediate risk to a person's ability to live in or transition to the community, that issue is escalated to the State Barriers Lead.

Barriers Tracking

The State Barriers lead receives barriers reports and logs. For each barrier reported, the State Barriers Lead determines whether the escalation meets the definition of a barrier. If there is an existing process to address the issue, it is not a barrier, and the Lead will refer the issue to the correct point of contact for resolution. Similarly, if the issue is based on an individual's diagnosis or symptoms, it does not constitute a barrier.

If the reported issue falls under the jurisdiction of an SPH or LBC, the State Barriers Lead will route the issue to the point of contact for the appropriate body (LBC for LME/MCOs, and SPH BSC for SPHs) for tracking and resolution. If the resolution requires action by a NCDHHS division, the Barriers lead will assign it to a NCDHHS Subject Matter Expert to resolve.

All reports and reporters are responded to, even if the report is determined not to be a barrier. All barriers are assigned a "follow-up by" date by which the Barriers Lead expects to receive an update from the assigned owner. The Barriers Lead follows up with the assigned owner on the follow-up by date if they have not received an update.

Barriers are closed for tracking purposes only when one of the following occurs:

1. The barrier no longer exists. Note, this is not a sufficient condition for resolution when the barrier is systemic and further action, such as a policy change, might resolve the systemic barrier.
2. A process has been revised or a new process has been created that addresses the barrier and similar situations that may arise in the future.
3. The barrier has been handed off to another entity with its own tracking and resolution processes, such as the Transition Oversight Committee.

LBCs follow the norms and processes established by the SBC for tracking barriers. Following these norms, LBCs track barriers under their jurisdiction and report to the State on pending and resolved barriers monthly They also share minutes from LBC meetings.

With the July 2024 implementation of ServiceNow as a common platform for NCDHHS and LME/MCO staff to coordinate barriers-related activities. this application functions as the TCL Barriers Log and consolidates barriers-related communications into a single location. This includes barriers reported and resolved at the LME/MCO level. It also facilitates assignments and helps systematically document actions taken to resolve barriers.

Barrier Resolution

Barriers escalated to the State level are resolved via the following pathways:

1. The State Barriers lead assigns the barrier to a Subject Matter Expert (SME). The SME takes ownership of the barrier and pursues final resolution, consulting with any State staff or external partners, as necessary.
2. An intervention team is created and the assigned owner on the intervention team pursues final resolution, consulting with any State staff or external partners, as necessary.
3. The barrier is put forth to the SBC for consideration, brainstorming, and planning, after which it is assigned to a subject matter expert to implement the plan.
4. The SPH Barriers and Solution Committees resolve SPH-specific barriers in regular and ad hoc meetings.
5. LBCs resolve barriers according to their own internal processes. LBCs have flexibility in their resolution process so long as they conform to State requirements.

For Barriers addressed at the State level, the State Barriers Lead will provide a verbal or written (email) communication to the barrier reporter, which can include TCL participants, their families, and caregivers, on how NCDHHS has resolved the barrier. This communication will occur within 14 business days of the barrier resolution date. The State Barriers Lead will also disseminate barrier resolutions to all LBCs so that they can implement effective strategies to address similar barriers that occur via the monthly TA call or a written communication such as email, updated policies and procedures or other method, as appropriate.

Key Artifacts

Barriers Log

NCDHHS is implementing ServiceNow as a standard barriers tracking tool. This platform will serve as the primary repository of all barriers that have been reported to NCDHHS, either directly or via one of the SPH or LME/MCO committees.

Standardized Meeting Materials and Minutes

All committees follow standing agendas. The State Barriers Lead or a designee takes minutes using a standard template and documents actions needed to advance solutions to reported barriers or improve processes. Actions coming out of each meeting are brought back to subsequent meetings to maintain momentum on resolving institutional and systemic barriers.

Training Materials

The State Barriers Lead has developed and will maintain barriers training materials. The training covers definitions and standard processes. Barriers trainings are a contract requirement for LME/MCOs. With the launch of ServiceNow, Barriers points of contact at each LME/MCO will receive supplemental training on how to use ServiceNow to report and track barriers through resolution.

Timing of Activities

Barriers are logged within one day or receipt. When assigned, each Barrier is assigned a priority level based on the scale and severity of the potential impact it may have on TCL participant lives and community integration opportunities. Each of these dimensions follows the definitions established by NCDHHS' Medicaid Help Desk. The priority level informs how quickly the assignee must provide the State Barriers Lead an update on progress. Table D.3 summarizes the timing for updates and schedule for automatic reminders from Service Now.

Table D.3. Response Time by Assigned Priority Level

Priority	Response Time	Reminder Schedule
Low	7 workdays	• Immediately upon assignment • 24 hours before deadline for update • Subsequent indications of urgency for reminders sent through messages • Assignees receive a notification every 24 hours if there is no update to the case prior to the indicated response time
Med	5 workdays	• Same as above
High	3 workdays	• Same as above
Urgent	1 workday	• Immediately upon assignment. Wording will indicate assignee has 1 workday to provide update. • Assignees receive a notification every 24 hours if there is no update to the case prior to the indicated response time

Each Barriers Committee meets on a regular cadence to analyze barriers data, discuss barriers, and brainstorm resolutions (See Table D.4 below). Intervention teams that are formed to resolve a barrier meet more frequently, as needed, to advance solutions.

Table D.4. Barriers Committee Meeting Cadence

Committee	Meeting Frequency
State Barriers Committee	Monthly
State Psychiatric Hospital Barriers and Solution Committees	Every other month
Local Barriers Committees	At least monthly

Information Flow within the QA/PI System

As noted above in Figure D.1, barriers can be reported into the barriers tracking and resolution process from any source. Once within the process, all barriers are logged into ServiceNow, which serves as the primary platform for communication and coordination across key participants of the reporting and resolution process.

External information flow is central to the barrier resolution process, so that lessons and improvement are disseminated through TCL. Decisions and guidance from committee meetings is reported back to requestors through the State Barriers Lead. In addition, and especially when resolutions can benefit multiple entities, the State Barriers Lead and relevant SMEs can present them at monthly TA calls with LME/MCOs, or through Cabinet Calls with LME/MCO leadership. Finally, information regarding resolutions are communicated out to TCL participants and partners through methods including sub-regulatory guidance, contract modifications and direct technical assistance. Timing of these communications is commensurate with urgency of resolution.

E. Transition Oversight Committee for TCL

Background and Purpose

The Transition Oversight Committee (TOC) is a committee convened pursuant to settlement agreement Section III.G.2. to monitor monthly progress of implementation of the agreement. Examples of TOC progress monitoring areas include housing measures, discharge-related measures such as housing vacancies, discharge planning and transition processes, referral processes and subsequent admissions, and transition times to community-based settings.

Participants and Roles

The TOC is chaired by the Deputy Secretary of the Health Equity Portfolio and comprised of staff from multiple divisions across the Department who engage in the work of TCL. Participants include representatives from Division of Health Benefits (NC Medicaid); Division of Mental Health, Developmental Disabilities, and Substance Use Services; Division of Social Services, Division of State Operated Healthcare Facilities, including the State Hospital Team Lead and State Hospital Chief Executive Officers; Money Follows the Person Program; Office of the General Counsel; NCDHHS TCL Domain SMEs; and LME/MCOs (soon to be the Tailored Plans).

Core Activities

The TOC monitors monthly progress of implementation of the TCL Settlement Agreement as well as the progress of the Department's implementation strategies, including assessing any associated risks. The TOC meets monthly and follows a standing agenda that includes key TCL status updates, transition barriers and progress, LME/MCO data and progress updates, and transition related risks.

The ongoing work of the TOC is focused on the identification of action items and mitigation of issues, including resolution of systemic transition barriers which are unable to be resolved through the State Barriers Committee. These issues may require changes in policies and practices throughout the State, such as developing and improving housing opportunities, increasing staffing levels and workforce expansion, and providing support for informed decision-making.

TOC progress monitoring employs a combination of State and LME/MCO data and reporting. NCDHHS representatives review transition-related risks and ongoing activities undertaken to address them. They also present data stratified by LME/MCO related to crucial TCL areas, such as housing separations and transition barriers, and solicit LME/MCO interpretations of the data, recommendations for response, and updates on strategies for addressing identified issues.

The TOC also addresses the impact of state budget on the work and implementation of TCL and collaborates with NCDHHS budget officials to address challenges or needs for re-alignment of allocations to accomplish settlement agreement goals.

Information flow within the QA/PI System

As stipulated in Section III.G.2 of the settlement agreement, LME/MCOs must report on discharge-related measures at TOC meetings. To facilitate these reports, NCDHHS Domain leads summarize TCL compliance and implementation plan progress according to data LME/MCOs already submit to the State and prompt LME/MCO representatives to give more detailed qualitative updates on TCL activities driving changes in measures.

Risks to TCL compliance and the implementation plan are reported to the TOC via TCL leadership and staff, as well as NCDHHS' General Counsel. Barriers not addressable by any other committee are also escalated to the TOC.

Following deliberation at the TOC, any risks requiring further action are reviewed and addressed by the Deputy Secretary. High risks are further escalated to the Secretary and the Secretary's team. To address barriers, the TOC can form ad hoc, cross-division intervention teams. These teams work through necessary changes to policies or business practices and disseminate guidance via the State Barriers lead back to LME/MCOs, providers, and other TCL participants.

F. PIHP/TP Contract Monitoring

Background and Purpose

Intradepartmental, cross-divisional monitoring is conducted to evaluate Prepaid Inpatient Health Plan (PIHP)/Tailored Plan (TP) compliance with obligations related to the accessibility, adequacy, and quality of services and supports and other contracted TCL functions and enable the Department and LME/MCOs to address any identified performance issues and non-compliance. Specific activities and outcomes monitored relate to Medicaid PIHP/TP contract provisions covering requirements of the Settlement Agreement as reflected in TCL services and supports, operations, quality assurance and performance improvement, and data and reporting, including those related to the contract monitoring areas shown in Table F.1. Monitoring areas are subject to change as PIHP/TP contracts are renewed and amended.

Table F.1. PIHP/TP Contract Monitoring Subject Areas

Contract Scope	Examples of Contract Monitoring Areas
Services and Supports	Network adequacy and service gaps Service access and quality Person-centered planning Crisis planning Provider training and capacity Member surveys and assessments
Operations	Supportive housing slot provision and requirements Development of housing opportunities In-reach, discharge, and transition planning Pre-admission screening and diversion Informed decision-making Physical health and functional assessments Tailored care management Barriers committee operations Staffing levels and training
Quality Assurance and Performance Improvement	QA/PI planning, activities, and reporting Performance Improvement Projects (PIP) Member outcomes monitoring Adverse incident reporting
Data and Reporting	Community integration services and supports database entries Supportive housing rental subsidy and lease database entries TCL data integrity Timeliness and accuracy of required reporting

Contract monitoring for TCL is carried out through regular and systematic review and evaluation of PIHP/TP and NCDHHS data, documents, and reports. Primary data sources include External Quality Review (EQR) reports, contract quality and performance measures, member services data, provider review reports, network access and adequacy data, PIHP QAPI plans and

reports, Performance Improvement Projects (PIPs), database submissions, and other required reporting. Information from additional sources may be reviewed on an ad hoc basis.

Participants and Roles

NCDHHS participants in PIHP/TP contract monitoring for TCL include representatives from the Office of the Secretary Olmstead/TCL Office; Division of Health Benefits (DHB); and Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS). The Department's contracted External Quality Review Organization (EQRO) and LME/MCOs also perform crucial contract monitoring functions. The Office of General Counsel also may be consulted regarding potential or identified performance and compliance issues. Table F.2 identifies participating individuals, teams, and business units and describes their roles.

Table F.2. PIHP/TP Contract Monitoring Participants, Roles, and Primary Data Sources

Participants	Roles	Primary Data Sources
DHHS Office of the Secretary and TCL QA Lead	Provide support for monitoring and evaluation of all major aspects of TCL contract compliance.	All primary NCDHHS data sources listed in this table
DHB Quality Management and Program Evaluation	Review and evaluate PIHP/TP QAPI plans, workplans, and reports; PIPs; contract quality and performance measures, and EQR findings	PIHP/TP QAPI submissions, PIPs and progress updates, contract performance measures, EQR reports
DMHDDSUS IDD/TBI/Olmstead Section TCL Team	Monitor and evaluate community mental health and employment service delivery and quality	Community mental health and employment services data, reports from reviews of service providers
DHB Behavioral Health	Monitor and evaluate community mental health and employment service delivery and quality	Community mental health and employment services data, reports from reviews of service providers
DHB Care Management	Monitor delivery and quality of care management services	PIHP/TP care management policies and procedures, PIHP/TP care manager training and technical assistance materials, EQR reports
DHB Network	Monitor access and adequacy of TCL services	Network adequacy reports, EQR reports
DHHS TCL Domain Leads	Identify potential contract compliance issues through regular communications and monitoring of PIHP performance and member outcomes measures and data	TCL Database entries, TCL rental subsidy database entries, other required PIHP submissions and reports
EQRO	Conduct EQRs	LME/MCO TCL policies and procedures, communications, service utilization management data, performance measures, member charts, and documentation of PIPs and other quality assurance activities, compliance monitoring of TCL Care Coordination and providers, staff qualifications

LME/MCO Representatives	Implement and report on QAPI processes and activities to ensure compliance with Medicaid PIHP/TP contract requirements related to core TCL components	LME/MCO TCL QAPI system services, operations, and member outcomes data
DHHS General Counsel	Provide guidance regarding potential compliance issues and options to address identified issues	Varied sources depending on issues identified

Core Activities

TCL contract monitoring carried out by DHHS personnel chiefly involves review and evaluation of relevant data sources against contract requirements in order to assess compliance. Table F.2 identifies some of the primary data sources that participants review and evaluate in their roles.

Contingent on compliance findings, an array of related actions that extend beyond review and evaluation activities may be taken by contract monitoring participants. Actions such as these may be carried out to support and ensure compliance and to address identified performance issues and instances of non-compliance:

- Development and delivery of guidance and technical assistance on contractual requirements
- Identification of risks related to apparent performance deficits or instances of non-compliance
- Presentation of data and compliance monitoring findings to DHHS leadership, decision-makers, TCL subject matter experts and committees, and other internal and external stakeholders, as appropriate
- Development and communication of recommendations to address non-compliance and performance issues
- Engagement of appropriate stakeholders to implement strategies to remediate non-compliance and performance issues

Contract monitoring activities thereby contribute to the development, implementation, and ongoing evaluation of corrective actions and responses when compliance and performance deficits are identified.

EQR and QA/PI

While not strictly a TCL QA/PI process, EQR plays a substantial role in PHIP/TP contract monitoring. The EQR process by its very nature encompasses extensive review of data and documentation to assess PIHP compliance with service delivery requirements mandated by their contracts with NC Medicaid as well as with state and federal regulations, and to verify the

delivery and determine the quality of contracted health care services. The reviews incorporate a variety of methods including desk review of required documentation and communications, onsite visits, compliance and program integrity reviews, and validation of PIPs, performance measures, and other data.

EQR also entails focused review of PIHP/TP functions specific to TCL, and EQR reports are an inherently important resource for TCL contract monitoring. Examples of TCL aspects covered include and are not limited to TCL policies and procedures, quality assurance and PIPs, service utilization management, PIHP compliance monitoring of TCL Care Coordination, member chart reviews, staff qualifications, and completion of required activities such as Quality of Life surveys.

Key Artifacts

Key artifacts of contract monitoring activities include written DHHS feedback provided in response to data reviews and PIHP/TP submissions and reports; internal DHHS communications; meeting agendas, presentation materials, and notes; technical assistance materials and communications; and DHHS communications and regulatory guidance issued to PIHPs.

Timing of Activities

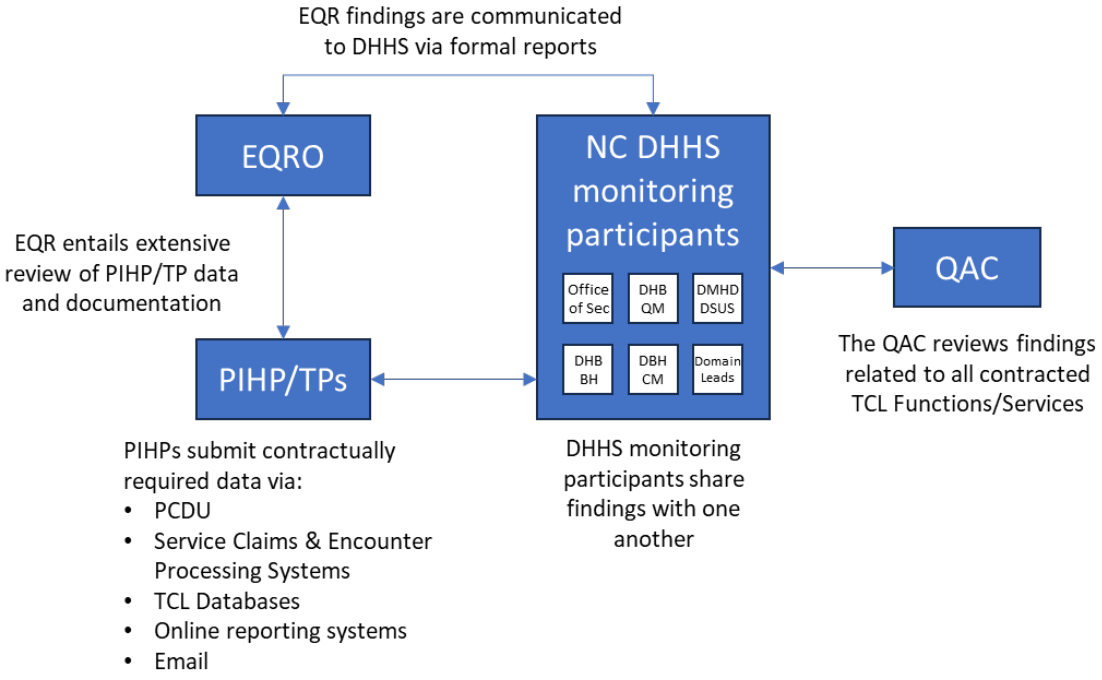
The timing of contract monitoring and data review activities largely reflects the cadence of contractually mandated data submission and reporting requirements. Data and reports that are typically submitted and reviewed on an annual basis include QAPI Plans and Workplans, PIPs, Quality and Performance Measures, Network Adequacy reports, EQR reports, and policy and procedure documents. PIHP/TP TCL QAPI activity reports are submitted and reviewed quarterly. Community-based mental health and employment services data summaries are produced for quarterly and annual reporting periods.

Other review activities are conducted on an ongoing basis or as data are available. Database entries and DHHS staff monitoring of data integrity are ongoing. Data and reports from activities such as provider reviews are evaluated as available. Data and information submitted outside the regular reporting cadence is reviewed on a timeframe appropriate to the urgency of associated compliance or performance issues or risks. The timing of activities responsive to contract monitoring review findings varies with the nature and seriousness of the issues identified.

Information Flow within the QA/PI System

The flow of contract monitoring information within the TCL QA/PI system includes bidirectional exchange of data and information between PIHPs and DHHS entities, as well as between and among entities within DHHS, including its contracted EQRO.

Figure F.1. PIHP/TP Contract Monitoring Information Flow



As illustrated in figure F.1, PIHPs submit and transmit contractually required data and reports through various means, including via the NC Medicaid electronic Contract Data Utility (PCDU) system, service claims and encounter processing systems, dedicated TCL databases and online reporting systems, and electronic mail.

EQR findings from review of PIHP data and documentation such as that listed in Table F.2 are communicated to DHHS via formal reports that are reviewed by monitoring participants. PIHP submissions and departmental data are distributed to, or retrieved by, contract monitoring participants for review and evaluation. Monitoring participants communicate review findings within DHHS using methods that vary with the nature of the information.

As illustrated in Table C.1, data and review findings related to all major contracted TCL functions and services, PIHP contract quality and performance measures, and EQR findings are shared with the NCDHHS TCL Quality Assurance Committee for collective analysis and evaluation.

When compliance issues and performance deficits are identified, information may be further communicated within DHHS by monitoring participants and QAC to the appropriate DHB or DMHDDSUS business unit or team, TCL Transition Oversight Committee, or the Office of the Secretary Olmstead Director and other DHHS leadership.

Communication back to the PIHP may include compliance findings as well as explicit steps or corrective actions that must be taken to remediate the identified issues.