NC TRANSITIONS TO COMMUNITY LIVING

ANNUAL REPORT 2021–2022

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

—

NC General Statute 122C-§20.15

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

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I. OPENING REMARKS

Ten years ago, in response to a United States Supreme Court case, Olmstead v. L. C.[1], a settlement agreement was signed between the United States Department of Justice (DOJ) and the North Carolina Department of Health Human Services (NCDHHS). The agreement required the State to develop a framework for the delivery of community-based housing, and services, and supports for people living with "serious and persistent mental illness."[2] The purpose of this agreement was, and still is, to make sure that people living with either serious mental illness (SMI) or severe and persistent mental illness (SPMI) are able, if they so choose, to live in communities alongside other North Carolinians. The settlement agreement created Transitions to Community Living (TCL) and gave people with disabilities the opportunity to live and work in the community, in places the agreement called "the least restrictive settings of their choice."[3]

While, the State has not yet met the legal standard of "substantial compliance" with the settlement agreement, we have learned much along the way. North Carolina has assisted over 5,000 people with serious mental illness or severe and persistent mental illness to find community and a path to recovery through an approach called "permanent supportive housing" and through the broader, Transitions to Community Living framework. Here are some of our top takeaways:

- People living with SPMI can live successfully in the community in accessible housing with wrap around supports and services. Transitions to Community Living's *Olmstead*-driven outcomes in housing, work, education and the broader community offer a shared vision of the need each of us has for dignity and interdependence, whether we are participants in TCL, peers, providers, families, agency staff, policymakers or members of the general public.
- Services and supports must be recovery-oriented, person-centered, individualized and flexible to meet the unique needs of each person.
- Research has taught us that "while peer support and clinical practice typically perform fairly equally on traditional outcome measures like re-hospitalization and relapse, peer support scores are better in areas related to the recovery process."[4] "In particular, peer support tends to offer greater levels of self-efficacy, empowerment, and engagement."[5] We have seen, first hand and repeatedly, the importance and power of peer involvement in helping people to progress along the path to recovery.
- Employment is more than a paycheck. It is a means of empowerment and self-reliance, and it can pave the way to acceptance in the community.
- The opportunity to choose where you live and receive services must be honored.
- Transitions to Community Living is an *Olmstead*-based agreement. When the right to live life in the community is implemented successfully, outcomes that matter to people – from increases in one's quality of life to decreases in the use of emergency care and unnecessary incarceration and institutionalization – align and are achieved.

[1] In the U.S. Supreme Court case, *Olmstead v. L. C.,* 527 U.S. 581 (1999), the Court held that the unjustified segregation of people with disabilities in institutional settings was unlawful discrimination under the Americans with Disabilities Act (ADA). Individuals with disabilities, the Court said, have the right to live in the community rather than in institutions if "the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." The case was brought by the Atlanta Legal Aid Society, Inc.

[2] The TCL settlement agreement uses the term "serious mental illness" for both those with serious or severe and persistent mental illness.

[3] Today, the language would likely be the "most appropriate integrated setting of their choice."

[4] Retrieved on September 15, 2022 from https://onlinelibrary.wiley.com/doi/full/10.1002/wps.20530.

[5] Farkas M, Boevink W. Peer delivered services in mental health care in 2018: infancy or adolescence? *World Psychiatry*. 2018;17(2):222-2 https://onlinelibrary.wiley.com/doi/full/10.1002/wps.20530

- Robust tenancy support is critical to people maintaining their housing. Tenancy Support is embedded in the Assertive Community Treatment (ACT) and Community Support Team services. Tenancy Support is also a stand-alone, state-funded service.
- With a well-designed, standardized screening tool, people can be successfully screened for SPMI; be diverted from entry into segregated settings; and be linked to appropriate service providers for a prompt determination of eligibility for community-based services and supports.
- Being an integral part of a community – what we call community inclusion – is an outcome that matters deeply. The need to be accepted and valued is common to us all.
- TCL is the foundation for the State's work to extend the opportunity to live "an everyday life" in communities across North Carolina to all people with disabilities served in publicly funded programs. Transitions to Community Living has become more than an initiative.[6] It has become a key, "opening the door to community" to all North Carolinians with disabilities.

We are often asked if TCL will continue after the settlement agreement is reached. The answer is an unequivocal "yes." The work will live on through the State's Olmstead Plan; a new Medicaid 1115 waiver[7] that will roll out in early 2023, the *Olmstead* values and principles that have been infused in the Tailored Plan[8] contract amendments; and, as always, the advocacy of stakeholders who push for systems change, now and in the future.

In closing, Transitions to Community Living is no longer an initiative. TCL is just the way we do business for adults living with serious or severe and persistent mental illness.

Respectfully submitted,

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[6] Transitions to Community Living was initially called the "Transitions to Community Living Initiative."
[7] Federal Section 1115 law permits the secretary of the U.S. Department of Health and Human Services to approve experimental, pilot or demonstration projects that test and evaluate state-specific policy changes in Medicaid and CHIP programs to improve care, increase efficiency and reduce costs without increasing federal Medicaid expenditures. According to the Centers for Medicare and Medicaid Services (CMS), "Section 1115 demonstration projects present an opportunity for states to institute reforms that go beyond just routine medical care and focus on evidence-based interventions that drive better health outcomes and quality of life improvements." Under the waivers, states have considerable flexibility to: expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible; provide services not typically covered by Medicaid; and use innovative service delivery systems that improve care, increase efficiency and reduce costs." Retrieved from Medicaid_Waivers_State_31797.pdf (ncsl.org) on September 12, 2022.
[8] Tailored Plans are for NC Medicaid beneficiaries who need enhanced services for a mental health disorder, substance use disorder, intellectual/developmental disability (I/DD) or traumatic brain injury (TBI). Tailored Plans include coverage for physical health services, pharmacy services, care coordination and care management, behavioral health services, and added services, such as wellness programs. Retrieved from Tailored Plans – NC Medicaid Ombudsman on September 12, 2022.

II. ACKNOWLEDGEMENTS

The North Carolina Department of Health and Human Services offers sincere thanks to this year's contributors to the Transitions to Community Living Annual Report. Your efforts to assist the Department in meeting its obligations under the Americans with Disabilities Act are invaluable to North Carolinians seeking to live their best lives in communities.

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III. HOUSING

Summary

In reflecting on fiscal year (FY) 2021 – 2022, the NC Department of Health and Human Services (NCDHHS) Transitions to Community Living (TCL) Team faced overwhelming challenges with the COVID-19 pandemic and closure of the State's largest Local Management Entity/Managed Care Organization (LME/MCO), Cardinal Innovations. Regardless of these and other barriers, TCL has continued to serve individuals with serious mental illness (SMI) or severe and persistent mental illness (SPMI) across the state, providing them with safe and affordable permanent housing options; an innovative approach to the delivery of the best supportive housing model possible; and the necessary supports, services and resources needed to empower them to thrive in communities of their choice. While adjusting to so difficult a year has not been easy, our commitment to rebuild lives, offer hope and provide real housing solutions remains and is beginning to reach beyond TCL to other populations of people with disabilities.

The partnership among NCDHHS, LME/MCOs and the North Carolina Housing Finance Agency (NCHFA) has bolstered the transformation and expansion of housing policies, data compliance, incentive provisions and technical assistance/training efforts, improving access and stability in permanent housing. To that end, this report will capture the State's efforts toward meeting its community-based housing placement goals, outlined in the *Olmstead*-based settlement agreement with the U.S. Department of Justice (DOJ), and its efforts to create and maximize Permanent Supportive Housing (PSH)[9] for priority consumers identified by NCDHHS.

[9] Retrieved on September 13, 2022 from Permanent Supportive Housing Definition.

Accomplishments During State Fiscal Year 2021 – 2022

A few key accomplishments in this challenging year are particularly worthy of celebration. These include:

- Over 3,000 individuals have been stably housed during the ongoing pandemic and dissolution of Cardinal Innovations.
- TCL implemented the Transition Incentive Plan to accelerate transitions from Adult Care Homes (ACHs) to community-based supportive housing and to improve overall housing performance and associated outcomes.
- NCDHHS launched the Strategic Housing Plan.
- Discussion with the U.S. Department of Housing and Urban Development (HUD) Fair Housing Office on policies and practices set the stage to remove barriers to the development of 350 new Targeting Program[10] units.
- CLIVe[11] enhancements were undertaken to adapt to LME/MCO realignments and to maintain data integrity.
- Targeted skill building trainings improved access to and sustainability for individuals in community-based supportive housing.

Coordinated and Collaborative Approach to Permanent Supportive Housing

Title II of the Americans with Disabilities Act (ADA) of 1990 established a mandate for public entities to ensure that people with disabilities live in the most integrated settings possible ("integration mandate"). The U.S. Supreme Court's *Olmstead* decision affirmed this civil right. In its ruling, the Court strongly encouraged the development of "Olmstead plans" to establish actionable strategies that would support integration into the community and to serve as a potential defense for states facing allegations of violating the ADA's integration mandate.

The NCDHHS took heed and launched its Olmstead Plan under the leadership of the Office of the Senior Advisor for the ADA. The framework of this plan will address integrated housing, employment, transportation, community services and other important issues to serve people with disabilities in integrated settings. The Plan will provide a broad, strategic guide for diverse policy efforts and decision making but will not offer the detail necessary to create any community-based housing opportunities.

Although TCL has resulted in positive outcomes and improved delivery of services for many adults with disabilities, as a State, we recognize that we still have gaps in our housing system that impede community integration. Acknowledging the need to address these gaps, the NCDHHS engaged the services of the Technical Assistance Collaborative, Inc. (TAC) to work with the Department and its stakeholders to develop a Strategic Housing Plan.

THE DEPUTY SECRETARY FOR NC MEDICAID SET OUT THE STRATEGIC HOUSING PLAN'S CHARGE:

The plan will address the housing needs of individuals with disabilities, currently receiving or eligible for DHHS-funded services at the state and local levels, who are either homeless, currently residing in congregate settings or at risk of entry into these settings.

This Housing Plan will provide a strategic guide to focus policy efforts and resource decision-making in creating and maximizing community-based housing opportunities for identified populations over a five-year horizon.

The plan will build on existing Olmstead efforts within the NCDHHS (e.g., Transitions to Community Living (TCL) and Money Follows the Person [MFP]).

[10] The Targeting Program is a disability neutral housing program for low-income persons with disabilities who need supportive services to help them live independently in the community.

[11] CLIVe is the system of record for tenancies for all individuals participating in TCL.

Beginning in May – June of 2021, NCDHHS, with TAC's support, convened a group of diverse, key stakeholders and NCDHHS staff to begin developing the plan. Based on the charge from the NCDHHS Deputy Secretary for NC Medicaid, the Housing Leadership Committee devised a collective vision and mission, as well as driving principles for plan development:

- ✓ The Strategic Housing Plan will focus NCDHHS's policy effort and resource decision-making on creating and maximizing community-based housing opportunities.
- ✓ It will have a cross-disability focus, specifically, people with disabilities who are homeless, living in an institution or at risk of institutionalization.
- ✓ The Plan will focus on people with disabilities and those served by or eligible for NCDHHS services (e.g., seniors without disabilities, people experiencing homelessness who do not have disabilities).
- ✓ The Plan will cover a five-year implementation period (2023 – 2028).

Vision

Quality community-based housing, services and supports needed to thrive.

Mission

Develop a comprehensive five-year plan to eliminate barriers to housing and create quality, affordable, accessible and inclusive housing that supports the whole individual by improving services, funding, communication and statewide coordination for the population we serve.

In addition, TAC and NCDHHS engaged in over 100 interviews with advocates, service providers and people with lived experience[12] across the state. NCDHHS also developed and disseminated a survey to capture housing needs more fully.

Environmental Scan Findings

During 2021, prior to the kickoff of the strategic planning process, with TAC's support, NCDHHS conducted a statewide, environmental scan of the housing needs of NCDHHS service populations.
Major themes from interviews and surveys included:

- Not enough affordable housing to meet the need
- Need for increased "housing competency" and housing capacity
- Rising costs of housing and housing development
- Need for more local and state collaboration (inter- and intra- as well as public – private collaboration)
- Growing awareness of housing issues
- Need for more accessible housing
- Need for more resources – state, federal, local and private
- Need for more affordable housing development incentives
- Need for more landlord incentives, support, outreach and communication
- Need for increased and more flexible transportation options
- Lower screening barriers for credit, criminal, rental history and eviction
- Lack of support and tenancy services
- Lack of service provider coordination

[12] Lived experience refers to "representation and understanding of an individual's human experiences, choices, and options and how those factors influence one's perception of knowledge" based on one's own life. People with lived experience are individuals directly impacted by a social issue or combination of issues who share similar experiences or backgrounds and can bring the insights of their experience to inform and enhance systems, research, policies, practices, and programs that aim to address the issue(s). Retrieved from Engaging People with Lived Experience to Improve Federal Research, Policy, and Practice | ASPE (hhs.gov) on September 13, 2022.

- Need for more person-centered, trauma-informed care
- Staff burnout due to natural disasters/pandemic
- Need for improved, better coordinated and prioritized referral systems
- Need for more integrated, community-based housing options
- Housing discrimination
- Need for more focus on eviction prevention and diversion – resources, policy reform and leveraging among local programs

Collectively, the stakeholder interviews, survey responses and Housing Leadership Committee input determined the five (5) goals of the strategic housing plan focused on improving and expanding:

1) Housing Development
2) Non-Development Activities that Increase Affordable Housing Access
3) Housing Support Services
4) Coordination Among State Agencies Administering Housing Funding and Programs
5) Partnerships Across the State that will Increase Affordable Housing

From these goals, the team developed workgroups. Workgroup membership was diverse and included people with lived experience. Stakeholders from rural and metropolitan areas were represented, as well as those from state and local government. Workgroup members represented the following sectors:

- Affordable Housing Development
- Community Development
- Supportive Services
- Behavioral Health Services
- Housing Finance
- Health Care
- Supportive Housing Development
- Public Housing Authorities
- Local Government
- Non-profit service providers and developers

In addition to NCDHHS, key State and other agencies participated throughout development of the plan. These included:

- NC Council on Developmental Disabilities
- NC Department of Public Safety
- NC Department of Administration
- NC Department of Commerce
- Office of Resiliency and Recovery, NC Department of Public Safety
- NC Housing Finance Agency[13]

In early calendar year (CY) 2022, workgroups met at least once per month for six months to develop: 1) objectives; 2) strategies; and 3) action plans. After each step, the workgroup leads met with the Housing Leadership Committee and State staff to provide progress updates and to review the work to date. The workgroups used the data collected from interviews and the survey to inform their direction.

The NCDHHS Strategic Housing Plan Team is currently finalizing strategies with stakeholders and responsible parties and drafting the plan itself. NCDHHS expects to launch the NC Strategic Housing Plan in early 2023.

[13] NC Housing Finance Agency is a self-supporting agency rather than a state agency.

State and Local Efforts to Maximize Resource Utilization and Resource Development

TCL continues to display creativity and flexibility in giving people viable community options for transitioning to community living. Over the past 10 years, NCDHHS has seen the effectiveness of the Bridge Housing model[14] which gives people a safe place to live while looking for a home of their own in the community. Most notably, ninety percent (90%) of people who enter Bridge Housing go on successfully to Permanent Supportive Housing. Working collaboratively with Local Management Entities/Managed Care Organizations (LME/MCOs), TCL continued to cultivate its Bridge Housing program this fiscal year, using different models such as hotels, leased apartments and single room occupancy arrangements in socially diverse areas. Additionally, an expansion in funding allowed TCL to implement an Enhanced Bridge Housing model with two LME/MCOs: Alliance Health and Vaya Health. The enhanced, temporary housing models include service-enriched programs. These offer 24/7 security and onsite services, such as case management, mental health services, substance use disorder treatment, tenancy skill development and housing placement. These services go a long way toward helping residents stabilize their lives and move on to permanent housing. The preliminary results of these eight (8), newly developed programs, along with necessary supports and services, show improved tenancy skills and concomitant, successful transitions to community.

TCL offers several mechanisms to provide access to affordable apartments and rent assistance for individuals with income as low as Supplemental Security Income (SSI). TCL most commonly employs the Transitions to Community Living Voucher (TCLV). TCLV provides rental assistance to people with behavioral health disabilities to either be diverted from, or to transition out of, restrictive settings, allowing them to live in the community of their choice. The voucher operates as a partnership between NCDHHS and the State's LME/MCOs. The LME/MCOs' transition staff have made significant gains in developing relationships with private property owners. Their work has encouraged these owners to accept TCLV holders as tenants.

The TCL voucher not only provides rent assistance but can also help pay for security deposits and certain costs incurred by property owners. For several years, LME/MCOs have offered landlords Risk Mitigation Tools. These tools are an attractive mechanism for encouraging owner participation in TCL when repair expenses exceed the security deposit. However, post-pandemic, in several of the 20 priority counties[15], there has been significant rental market price inflation, as much as 19%, along with particularly low vacancy rates for one-bedroom units. As a result, the average monthly TCLV payment increased by 5.4% over the course of fiscal year (FY) 2021 - 2022. As of the end of FY 21 – 22, 2,186 households were utilizing TCLV with an average monthly subsidy of $668. There was only a 1% increase in the number of TCL participants utilizing TCLV over the year. This was in part due to efforts to increase utilization of HUD vouchers. In this environment, it has been imperative to strengthen efforts and incentives to landlords who are willing to work with TCL participants.

The Targeting Program is the second most utilized resource for TCL participants seeking safe and affordable supportive housing. The program is integral to achieving Olmstead-based TCL settlement goals for transitioning individuals to community-based living arrangements. Developed in 2002 through a partnership between the NC Department of Health and Human Services (NCDHHS) and the NC Housing Finance Agency (NCHFA), the Targeting Program increases access to affordable housing units for individuals

[14] Bridge Housing is an approach that allows the LME/MCOs to stabilize individuals who need immediate housing while they plan for living in the community. The Bridge Housing program is a transitional program for individuals diverted from Adult Care Homes (ACHs) and for individuals transitioning out of State Psychiatric Hospitals. The program offers settings located in areas with ready access to essential resources, such as bus lines, employment opportunities and places to shop for basic needs. Teams for these housing units help people successfully transition to permanent housing in their community of choice. See, e.g., https://pss.unc.edu/pssjobs/peer-support-specialistbridge-housing; retrieved on September 13, 2022.

[15] The term "priority counties" refers to the areas in which TCL participants tend to want to reside. These are: Alamance, Buncombe, Burke, Cabarrus, Caldwell, Craven, Cumberland, Durham, Forsyth, Gaston, Guilford, Henderson, Iredell, Johnston, Mecklenburg, New Hanover, Onslow, Orange, Pitt, Robeson, Rowan, Wake, Wayne and Wilson.

with disabilities. The program connects eligible participants to Low-Income Housing Tax Credit (LIHTC) properties to provide access to housing that is affordable, decent, permanent, integrated and accessible.

In 2004, NC became the first state in the nation to develop such a program by requiring developers seeking low-income housing tax credits to set aside 10% of units for people with disabilities. Operating initially through grant opportunities, the program received recurring funding from the NC General Assembly in 2006 to establish the Key Rental Assistance. This program increased utilization of the Targeting Program units by providing rental subsidies to people with disabilities who have an extremely low income and/or who are experiencing homelessness. Key Rental Assistance is only available in properties participating in the Targeting Program. In addition to rental subsidies, Key Rental Assistance pays for security deposits, hold fees and certain costs incurred by property owners. This mitigates against potential financial losses for owners and incentivizes their participation in the Targeting Program.

Throughout state fiscal year (SFY) 2022, NCDHHS and the NCHFA continued efforts to review and revise policies, procedures and documentation requirements, with the goal of making Targeted Units more accessible to individuals in TCL. The policy prioritizing TCL participants was renewed. NCDHHS and the NCHFA continued to hold weekly operational and monthly strategic meetings to review efficiency and effectiveness of the program and to provide property profiles and pre-leasing notifications to the LME/MCOs and providers. In addition, the Targeting Program re-established meetings with LME/MCO staff to improve coordination and communication between agencies. As recommended in the 2021 Technical Assistance Collaborative (TAC) report, *An Assessment of the North Carolina Department of Health and Human Services' System of Services and Supports for Individuals with Disabilities*[16] (Recommendation 4), NCDHHS continued efforts to secure more funding for the Key Rental Assistance program. Although the Department did not obtain the full amount of funding it sought, the NC General Assembly did increase recurring funding for the Key Rental Program by $2M with the passage of SL 2021-180.

By the end of FY 21 – 22, there were 825 rental developments with executed Targeted Unit Agreements in 85 counties. This represented a total of 6,672 Targeted Units (AMS data[17]). Of the 3,033 TCL participants leasing housing at the end of FY 21 – 22, 26% of participants (783) were leasing Targeted Units. Seven hundred twenty-two (722) participants were using Key rental assistance (CLIVe data). Two hundred eighty (280) TCL participants moved into Targeted Units in FY 22 which showed an increase from 19% in FY 21 to 25% in FY 22, according to the Vacancy and Referral System[18].

Despite these achievements, challenges remain. Funding for the Key Program, although bolstered, is still an ongoing issue. In the wake of the COVID-19 pandemic, the challenges faced by program participants are becoming more evident. Evictions have increased from 2021 with the lifting of the moratorium on evictions. On the positive side, Key Program data suggests that the increase in evictions has been substantially less, by comparison, among TCL participants. NCHFA and NCDHHS will continue efforts to seek innovative ways to facilitate the housing of TCL participants and to improve outcomes for all Targeting and Key Program participants.

Much focus has gone into expanding access and utilization of Mainstream Housing Vouchers and the Section 8 Housing Choice Voucher Program[19] as other rental mechanisms to support individuals in TCL.

[16] An Assessment of the North Carolina Department of Health and Human Services' System of Services and Supports for Individuals with Disabilities (nc.gov); retrieved on September 13, 2022.
[17] Assessment Management System is a NCHFA online system used by owners and property management companies to enter property information.
[18] The Vacancy and Referral System is a NCHFA online system used by NCDHHS, or the Department's designee (e.g., LME/MCOs) and owners/property management companies to communicate vacancy and referral information. If a property has both Targeting and Integrated Supportive Housing Program units (defined at footnote 28), NCDHHS and the LME/MCO must designate one entity to use the system – either the NCDHHS Regional Housing Coordinator or the LME/MCO.
[19] The Section 8 Housing Choice Voucher Program is the federal government's major program for assisting very low-income families, the elderly and people with disabilities to afford decent, safe, and sanitary housing. It is for eligible families regardless of race, religion, or political affiliation in the private market. Program funds are awarded to the program by HUD through Annual Contributions Contracts and are used to subsidize the difference between the cost of rent and a maximum of 30% of the household's adjusted gross income.

Mainstream Housing Vouchers, administered by Public Housing Authorities are special purpose vouchers that are administered under the same guidelines as Housing Choice Vouchers, except that they serve households (Head of Households) that include a non-elderly (under 62 years of age) individual with a disability. This type of special purpose voucher is a more targeted resource for individuals served under TCL, because these vouchers assist individuals who are non-elderly and living with a disability or at risk of entering or residing in an Adult Care Home (ACH).

One thousand seven hundred and ninety seven (1,797) Mainstream Housing Vouchers were awarded to NC Public Housing Authorities under the CARES Act[20] and American Rescue Plan Act[21] to support communities' combatting the COVID-19 pandemic; North Carolina's Public Housing Authorities received an unprecedented number of vouchers disseminated from:

- 2017 – 2019 competitive process, yielding 1,215 Mainstream Housing Vouchers
- 2020 - 2021 non-competitive awards that added an additional 580[22] Mainstream Housing Vouchers.

In direct correlation to the NC Department of Health and Human Services' (NCDHHS) commitment to a global approach for facilitating collaborative support to LME/MCOs, there has been a substantial increase in the number of TCL households having access to Mainstream Housing Vouchers. As reported by LME/MCOs, by June 30th, 2022:

- 443 TCL Head of Households were supported to apply for Mainstream Housing Vouchers, with 119 approved and 60 obtaining housing.
- 749 TCL and non-TCL Heads of Household were supported to apply for Mainstream Housing Vouchers, with 262 approved, and 142 obtaining housing.

The State committed to multiple strategies to support the LME/MCOs to further increase access to and utilization of federal housing vouchers. As an example, an initial strategy developed a process and then captured the outcomes of Local Management Entity/Managed Care Organizations' (LME/MCOs) efforts to increase voucher access and utilization.

The State initiated contact with various stakeholders supporting this work including NC Housing Finance Agency; Technical Assistance Collaborative, Inc. (TAC); and NC Coalition to End Homelessness, NC Department of Administration Commission of Indian Affairs. This collaboration enhanced local support and facilitated non-traditional partnerships, such as outreach to the Executive Director of the NC Department of Administration's Commission of Indian Affairs Housing Authority to partner in expanding access to the federal vouchers (e.g., Housing Choice, Mainstream and Emergency Housing). These are administered by the Commission of Indian Affairs, through a now-established connection with the LME/MCOs.

> NC Commission of Indian Affairs Housing Authority gained remedial preference for its Mainstream Housing Voucher program, with guidance by the NC Department of Health and Human Services; TAC; and the North Carolina Housing Finance Agency.

Modification of the Commission of Indian Affairs' standard referral application packet was implemented. This allowed for a second contact name to be added and enhanced the ability of the LME/MCOs to provide support to and oversight of the application process.

[20] The Coronavirus Aid, Relief, and Economic Security Act, also known as the CARES Act, is an economic stimulus bill passed by the 116th U.S. Congress and signed into law on March 27, 2020, in response to the economic fallout of the COVID-19 pandemic.

[21] The American Rescue Plan Act of 2021, also called the COVID-19 Stimulus Package or American Rescue Plan, P.L. 117–2, is an economic stimulus bill passed by the 117th United States Congress and signed into law on March 11, 2021, to speed up the country's recovery from the economic and health effects of the COVID-19 pandemic and the ongoing recession.

[22] U.S. Department of Housing and Urban Development: Mainstream Voucher Awards by Public Housing Authorities and Funding Opportunity, updated December 23, 2020, at: https://www.hud.gov/sites/dfiles/PIH/documents/Mainstream_Allocations_by_PHA_and_Opportunity_12.23.2020.xlsx.

In March 2021, the Commission of Indian Affairs announced the availability of 39 Mainstream Housing Vouchers and began accepting referrals from five (5) of what were then six (6) LME/MCOs in the Commission's service area: Alliance Health (Cumberland, Durham and Wake); Cardinal Innovations Healthcare (Granville, Halifax, Orange, Person and Warren); Eastpointe (Robeson and Sampson); Sandhills Center (Hoke); and Trillium Health Resources (Columbus and New Hanover). As of June 6, 2022, the Commission reported that due to the excellent quality of program management, the Commission of Indian Affairs was able to exceed voucher allocation and issue 42 Mainstream Housing Vouchers.

The LME/MCOs developed internal processes to track and strengthen usage of federal housing vouchers by TCL members.

Most LME/MCOs designated a single point-of-contact and established processes for securing and exchanging information with Public Housing Authorities.

LME/MCOs established memorandums of understanding with their local Public Housing Authorities to facilitate sharing of information, role clarification and, with Alliance Health, securing Olmstead preferences[23].

Emergency Housing Vouchers

On May 10, 2021, through the American Rescue Plan, HUD released an Emergency Housing Voucher Operations Notice to further assist in the provision of housing for Heads of Households that had been disproportionately impacted by the COVID-19 pandemic.

Nationally, 70,000 Emergency Housing Vouchers were allocated to approximately 700 Public Housing Authorities. HUD required a memorandum of understanding to be developed, and referrals to be made via the Continuum of Care, Coordinated Entry System.[24] Communities were allotted the discretion to prioritize from four (4) eligible categories:

1) Individuals and families who are homeless.
2) Those at risk of homelessness.
3) Those fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking or human trafficking; or
4) Those who were recently homeless or who have a high risk of housing instability.[25]

NC was afforded an extraordinary opportunity when 23 Public Housing Authorities accepted their allocation for a total of 1,296 Emergency Housing Vouchers. Of this total, 414 were accepted by the NC Commission of Indian Affairs Housing Authority. According to HUD's Emergency Housing Voucher Dashboard, as of June 30, 2022:

- 1,296 total Emergency Housing Vouchers were awarded
- 965 Heads of Household were issued Emergency Housing Vouchers
- 274 or approximately 21%[26] Head of Households obtained housing

In FY 18 – 19, the NCDHHS partnered with the NCHFA to develop the Integrated Supportive Housing

[23] Olmstead preferences refers to the Public Housing Authority's adoption of a remedial preference for its Housing Choice voucher programs for persons with serious or severe and persistent mental illness, as defined by the State's Transition to Community Living/Olmstead Settlement Agreement and as approved by Housing and Urban Development (HUD).
[24] The NC Balance of State Continuum of Care has developed system standards to give specific guidelines for how best to operate regional coordinated entry systems to achieve the goal of ending homelessness. These guidelines create consistency across the State regions, putting participant needs first, and provide a baseline for holding all Continuum of Care coordinated entry systems to a specific standard of care. Retrieved on August 26 from nc-bos-coordinated-assessment-written-standards-updated-6-22-20.pdf (ncceh.org).
[25] PIH 2021-15: Emergency Housing Voucher Operating Requirements published May 5, 2021, at: https://www.hud.gov/sites/dfiles/PIH/documents/PIH2021-15.pdf; retrieved on September 13, 2022.
[26] HUD.gov: Emergency Housing Voucher Dashboard updated on July 30, 2022, at: https://www.hud.gov/program_offices/public_indian_housing/ehv/dashboard

Program[27] for the TCL settlement agreement population. These developments are affordable and part of the community, with a focus on access to community services, such as grocery stores and other amenities. This collaborative effort now funds 15 developments, garnering a total of 243 total Permanent Supportive Housing (PSH) units in six (6) LME/MCO catchment areas. There are 122 TCL participants housed in the Integrated Supportive Housing Program properties as of June 2022. Property management notified NCDHHS of 204 vacancies in FY 22. Sixty-three (63) referrals were forwarded to management for those vacancies resulting in 51 TCL participants moving into Permanent Supportive Housing units in the 15 Integrated Supportive Housing Program properties. In light of the current housing trends in the state, the approximately $3 million that remained in the PSH development contract between NCDHHS and NCHFA will go towards development of Integrated Supportive Housing Program units. The NCDHHS and NCHFA are currently reviewing needs in the state to prioritize project funds.

Although, the NCDHHS and NCHFA have strengthened their partnership over the years – increasing the availability and preservation of affordable housing through several mechanisms such as the Targeting Program/Key Rental Assistance, Integrated Supportive Housing Program and an Olmstead-related remedial preference by HUD – there are still inadequate resources to provide housing assistance to everyone who qualifies. Many renters with disabilities and very low incomes, such as TCL participants, remain severely cost-burdened, paying more than 50% of their income on rent and utilities. As a result, these households face housing instability, risk of eviction or homelessness. To address these concerns, the NCDHHS and NCHA requested a meeting with the Senior Advisor of Housing and Urban Development (HUD), Secretary's Office. In March 2022, HUD granted a meeting with the NCDHHS, NCHFA and key NC housing stakeholders. The discussion centered around four (4), broad topic areas:

1) NC housing infrastructure strengths and challenges
2) Strengthening cooperation and partnership among Public Housing Authorities, Health and Human Services and Housing Finance Agencies to streamline processes and better serve the disability communities
3) Barriers to tenant selection screening
4) Fair market rent payment standards

As a result of the discussion, the HUD Secretary's Office requested the following: a copy of NC's tenant selection policy for Low-Income Housing Tax Credits[28] (LIHTC); the report on the State's voucher utilization rate; localities in which the housing market affected the supply of units at Fair Market Rent levels; and a follow-up meeting. NCDHHS is in the process of scheduling a second meeting with HUD to solidify the partnership and so as to continue moving forward toward improving access to affordable housing.

Reinforcing Accountability

Discussions with LME/MCOs, providers and key housing stakeholders pointed to similar strengths and challenges regarding the service system's current capacity to successfully support community inclusion and housing tenancy for individuals in Permanent Supportive Housing (PSH). It became evident that provider capacity and accountability in delivering person-centered services is paramount to housing sustainability for the TCL population. To build accountability with regard to the housing requirements of the settlement agreement, the NCDHHS implemented a Transitions to Community Living Incentive Plan in February 2022.

Housing Incentive Plan

The Transition Incentive Plan rewards LME/MCOs for accomplishing performance goals in accordance with

[27] Integrated Supportive Housing Program (ISHP) is a program providing interest-free loans to community developments where up to 20% of the units are integrated and set aside for households participating in the TCL program.
[28] The Low Income Housing Tax Credit (LIHTC) is a federal housing program administered by NCHFA. The LIHTC provides a tax incentive to construct or rehabilitate affordable rental housing for low-income households.

defined outcomes that align with the TCL settlement agreement. The NCDHHS has offered financial incentives of approximately $10 million and liaison support to LME/MCOs to encourage investment in housing activities. The plan consists of initial requirements and performance measures/goals. It offers a financial payment to the LME/MCO for each component that meets compliance, specifically: 1) a one-time startup payment for meeting initial requirements; and 2) subsequent payments for meeting quarterly performance measures/goals.

Initial requirements for LME/MCOs participation in the Transition Incentive Plan include the following:

- Implementation of Complex Care[29]
- Creation and continuation of a local Barriers Committee that reports barriers monthly to the State Barriers Committee, along with identification of training needs consistent with state-issued protocols
- Submission of a plan for increasing federal voucher usage
- Submission of a plan for maintaining TCLD[30] and RSVP[31] data integrity
- Submission of a monthly plan detailing use of the Informed Decision-Making (IDM)[32] tool
- Submission of a plan for contracting with peers to serve as In-Reach[33] extenders or in other capacities to help people in Adult Care Homes transition into permanent housing.

The performance measures included in the Transition Incentive Plan are pre-determined measures designed to support substantial compliance for the housing pillar of the TCL settlement agreement. The NCDHHS is monitoring each LME/MCO's quarterly performance for the following measures over the next year to determine focus areas and the need for quality improvement plans:

- Housing Separation Rate - 3.30% or lower
- 50% of individuals who transition to supportive housing are from Adult Care Homes
- 33% of individuals who transition move into Targeted Units
- LME/MCO meets 100% of the expected number of transitions

As of the end of FY 22, all six (6) LME/MCOs were participating in the Transition Incentive Plan. In the first performance quarter, LME/MCOs made great strides as evidenced by their performance outcomes and implemented strategies:

- Two (2) LME/MCOs had 50% of individuals transition to Permanent Supportive Housing from Adult Care Homes
- Two (2) LME/MCOs met their expected number of transitions
- Four (4) LME/MCOs had 33% of individuals move in or re-house into a Targeted Unit

[29] Complex care seeks to improve health and well-being for people with complex health and social needs by coordinating and reshaping care delivery at the individual, community and system levels. It addresses root causes of poor health through interdisciplinary care teams and cross-sector partnerships that deliver person-centered care based around participants' own goals and priorities. These root causes extend beyond physical health and well-being to include social determinants of health including poverty, trauma, housing and/or food insecurity and lack of access to care. Retrieved on August 26, 2022 from What is Complex Care? – National Center (nationalcomplex.care).

[30] Transitions to Community Living Database (TCLD) is a system developed for the North Carolina Department of Health and Human Services to track and report activity related to the Transitions to Community Living. LME/MCOs involved in the initiative use the system to record contact and progress of individuals affected by the initiative. Retrieved on September 9, 2022 from TCLD User Guide (nc.gov).

[31] Referral Screening Verification Process (RSVP) initiates a screening for TCL. Retrieved from MyHousingSearch.com - Referral Screening Verification Process (RSVP) on August 26, 2022.

[32] The Informed Decision-Making tool is designed for In-Reach Peer-Specialists to guide conversations and document an informed decision-making process with individuals who are TCL eligible and have declined transitioning into the community; are undecided and want to remain in an Adult Care Home; or are reluctant to be discharged from a State Psychiatric Hospital. Retrieved on August 26, 2022 from download (ncdhhs.gov).

[33] In-Reach is an engagement, education and support effort designed to accurately and fully inform adults who have a serious mental illness or a severe and persistent mental illness about community-based mental health services and supportive housing options including, but not limited to, the availability of tenancy support services and rental assistance. Retrieved on September 14, 2022 from Transitions to Community Living | NCDHHS.

Training

The Transition Incentive Plan will continue until the State reaches the substantial compliance standard of the TCL settlement agreement.

The NCDHHS, the NCHFA and the NC Justice Center continued to work together in 2021 to offer fair housing trainings across the state. These included:

- Basic Fair Housing Trainings: 14 trainings in total (seven (7) for housing providers, seven (7) for service providers)
- Advanced Fair Housing Trainings: three (3) trainings in total (for service providers only)
- Basic Fair Housing trainings for providers of housing, 299 attendees
- Basic Fair Housing trainings for service providers, 121 attendees
- Advanced Fair Housing trainings for service providers, 143 attendees

Additionally, the NCDHHS and the NCHFA continued their Custom e-Learning Trainings designed for professionals/advocates with beginner to intermediate knowledge. These trainings are brief, interactive and scenario-based. In FY 2022, the agencies continued to work together by adding three (3) e-Learning courses to the existing Housing Skills Refresher series.

The series now includes the following courses:

- Assistance Animals in Housing
- Calculating Income Correctly for Program Purposes
- Community Engagement Communication Strategies (beginner) (new)
- Community Engagement Conversation Simulation (intermediate) (new)
- Eviction Due to Nonpayment
- Fair Housing Resources for Service Providers
- Informed Decision-Making Process and Tool (new)Reasonable Accommodation and Reasonable Modification (beginner)[34]
- Reasonable Accommodation and Reasonable Modification (intermediate)

Below is a quote from an LME/MCO employee after finishing a course:
"[The training] helped me understand that there are ways to help our members maintain housing…. I downloaded the reasonable accommodations form from the training… I thought [it]was super helpful, especially for me, being new to this field." --LME/MCO employee

The NCDHHS and the NCHFA are currently in the process of developing additional e-learning modules.

Robust Data and Evaluation

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

[34] Approximately 130 community partners have participated in the Informed Decision-Making Process and Tool course since January 2022.

allow for quality review of the TCLV program. These include rental costs incurred by each LME/MCO; tracking of late inspections; a record of reasons for "move outs;" and data regarding length of stay in housing.

In this fiscal year, timely entry of data and improvements to the quality of the data in CLIVe were put to the test with the transfer of Cardinal Innovations LME/MCO's TCL tenancies to the six (6) remaining LME/MCOs. The transfers were based on a schedule agreed upon between NCDHHS and each LME/MCO. All TCL tenant transitions took place from September 2021 through March 2022. To that end, NCDHHS and NCHFA staff met with each LME/MCO to review the work and timeline involved for moving TCL tenants to their new LME/MCO. The NCDHHS and NCHFA continue to work together with the LME/MCOs address any remaining discrepancies in CLIVe data due to the Cardinal Innovations operational wind down.

Based on the aforementioned work in CLIVe, it became apparent to the NCDHHS and NCHFA that clearer policies and procedures, focused on timely entry of data and improving the quality of the data, were needed.

In addition, the NCDHHS initiated an update of the TCL Housing Guidelines, in these respects:

- Waivers for rents that are over the Fair Market Rent rate will not be triggered unless the rent exceeds 120% of Fair Market Rent.
- A live-in aide that is a relative of a TCL tenant will be required to complete an attestation and verification form.
- LME/MCOs will be able to offer tenancy preservation funds to landlords during tenancy in addition to offering risk mitigation funds at tenancy termination.

Each of the Housing Guideline updates, above, will require that NCHFA information technology staff effect enhancements to the CLIVe system after there is a scope of work and the Housing Guidelines are finalized.

Best Practices in Housing

Many of the LME/MCOs have completed a root cause analysis regarding housing separations and have begun implementing a variety of best practices to address barriers to accessing and maintaining housing. These are improving TCL households' experiences during tenancy and reducing separations from housing.

Alliance Health

- Developed financial incentives to providers for adopting certain activities related to tenancy support and education. The incentives were offered for staff attending trainings; completion of the tenancy checklists, biennial recertifications, Special Assistance In-home[35] and separation documentation; passing inspections; transferring members onto federal vouchers; securing new Individual Placement and Support - Supported Employment[36] (IPS-SE) engagements; and reducing avoidable separations from housing.
- Developed a series of virtual provider trainings, spearheaded a partnership with Cumberland Metropolitan Housing Authority and conducted joint, federal voucher trainings for providers.[37]

[35] The Special Assistance In-Home Program (SA/IH) provides an alternative to placement in a Special Assistance facility by providing a cash supplement to individuals who desire and are able to live at home safely with additional supportive services. Retrieved on August 29, 2022 from Special Assistance in home program manual (ncdhhs.gov).

[36] The Individual Placement and Support (IPS) - Supported Employment (SE) Program helps people with severe mental illness find competitive, community employment and provides ongoing, individualized services with a focus on employment. Services include: Personalized counseling to understand how work may affect your benefits.

Ongoing treatment to help you manage medications, symptoms and other behavioral health needs.

Employment specialist and peer support to help you succeed on the job and advance professionally.

Retrieved from Individual Placement and Support | NCDHHS on August 29, 2022.

[37] Alliance Health: Better at Home – Supportive Housing Training Series on September 13, 2022 from : https://www.youtube.com/playlist?app=desktop&list=PL50Kl40ScrVhL4yyMK7kaJbVxTb26YanY

- Provided an extra $500 as incentive payments to landlords. These funds are not required to be utilized to offset rent, utilities or security deposits, and offered a $1,000 to 2,000 incentive payment to provider agencies that moved from using TCL funds to using a federal voucher subsidy.
- Dedicated units for TCL members in the Community Transition Recovery Program for use in the "enhanced Bridge Housing program," a program which offers the additional supports of a part time nurse and a clinician.
- Negotiated a contract for direct billing with Extended Stay America, throughout the LME/MCO's catchment area, for continued use of Bridge Housing.
- Utilized enhanced Bridge Housing for 48 TCL members and hotels for 92 TCL members.
- Launched a housing academy in partnership with the UNC Center for Excellence. This bi-weekly, 1.5 hour, academy for providers used both a didactic and case presentation. An average of 20 people per session attended.
- Offered 31 weekly or biweekly housing trainings called "Better at Home." "Better at Home" supports providers, staff and other stakeholders regarding tenancy and community living. An average of 30 people attended each session. It was especially helpful for providers to build competencies around housing.
- Offered three (3) opportunities for one-hour trainings in Mecklenburg and Orange counties in February to launch an 8-week "Better at Home" training for new providers, subsequent to the Cardinal Innovations wind-down and realignment. There were over 100 people in attendance.
- Contracted with Rapid Resources for Families to develop a Tenancy Database. The database allows Alliance and its providers to communicate and submit documentation such as Daily Living Activities-20[38], Monthly Checklists, Separations Forms and Provider Response Forms.
- The housing face sheet for people living in TCL supportive housing has important information for providers such as inspections dates, biennial and property manager information to ensure timely responsiveness.

Eastpointe

- Began planning phase of expansion of its community inclusion footprint with the Alliance of Disability Advocates of NC[39] to provide In-Reach services for members in Robeson, Wilson and Warren counties as part of the complex care management program.
- Planned an expansion of the Bridge Housing program to begin in FY 23 and to include a peer component and skill building requirement.
- Fostered relationships with the Rocky Mount Housing Authority, Wilson Housing Authority, Targeting Housing Team and the Lumbee Tribe of North Carolina Housing Department to assist with utilization of Emergency Housing Vouchers.
- Coordinated with the Targeting Program and the Rocky Mount Public Housing Authority to facilitate a transfer of several Key housing subsidies over to Mainstream Housing Vouchers.
- Diverted 100% of the "In or At Risk" population in FY 21 – 22. This means that for members who had a complete RSVP; were not currently in an Adult Care Home; and were deemed eligible for TCL, the diversion effort resulted in a member transitioning to the community with a housing slot.

[38] The DLA-20 Functional Assessment is a comprehensive functional assessment and outcome measurement tool for behavioral health providers. It provides a reliable and valid measure of their clients' level of functioning in daily living activities; enables clinicians to measure the everyday parts of life impacted by mental illness or disability; and supports the functional assessment data needs of service providers. See DLA20 — MTM Services; retrieved on September 21, 2022.

[39] Alliance of Disability Advocates (ADANC) is a federally recognized Center for Independent Living (CIL) established in 1999 (then Universal Disability Advocates). Funding for Centers was authorized by the Rehabilitation Act of 1973, as amended. Retrieved on August 29, 2022 from History | Alliance of Disability Advocates NC (adanc.org).

- Exceeded the LME/MCO's housing goals for FY 21 – 22. Had the highest Informed Decision-Making Tool completion and submission rate in the state.
- Received the highest marks during the fall 2021 State Psychiatric Hospital federal review, in collaboration with partners Cherry Hospital and Eastpointe's provider agencies.

Partners Health Management

- Developed a memorandum of understanding with Winston Salem Housing Authority.
- Served TCL members in two Bridge Housing programs.
- Implemented Value-Based contracting with Community Support Team[40] and Assertive Community Treatment (ACT)[41] Team Providers.
- Completed four (4) Community Support Team – Permanent Supportive Housing Trainings
- Incorporated five (5) new counties and 150+ members into housing programs after the Cardinal Innovations LME/MCO county realignment.
- Established internal process and tracking processes for referring all members transitioning to the community to the Targeting Program.
- Established an internal process for tracking referrals for Mainstream Housing Vouchers.
- Completed five (5) events to recruit and educate landlords about housing the TCL population and the role of Partners Health Management.
- Created a "Housing First" tutorial for the Partners Training Academy.
- Provided training for providers on the Partners Housing Assessment Tool.

Sandhills Center

- Developing a provider incentive that will reimburse IPS-SE providers for pre-transition IPS-SE presentations to TCL members at a rate of $100 per presentation.
- Developing provider incentive payments to reimburse Community Support Team and Transition Management Services[42] providers $200 for each viable IPS-SE referral of a TCL member.
- Contracted with the Alliance of Disability Advocates of NC's In Reach-Peer Extenders.
- Drafted a memorandum of understanding with the Greensboro Housing Authority to enhance working relationships.
- To increase use of federal resources, established a utilization goal of two members per month shifting from state-funded voucher programs to federally-funded voucher programs.
- TCL/housing staff agreed to meet monthly with the Targeting Program to discuss referrals, issues or concerns which improve use of state rental assistance and federal vouchers.

[40] Community Support Team (CST) services consist of community-based mental health and substance use disorder rehabilitation services and necessary supports provided through a team approach to assist adults in achieving rehabilitative and recovery goals. It is intended for individuals with mental illness, substance use disorders or both who have complex and extensive treatment needs. CST is designed to reduce psychiatric or substance use disorder symptoms; to promote symptom stability; restore the individual's community living and interpersonal skills; provide first responder intervention and deescalate the current crisis; and ensure a linkage to community services and resources. CST is available 24/7. Retrieved on August 29, 2022 from Adult Mental Health Services | NCDHHS.

[41] An Assertive Community Treatment (ACT) Team consists of a community-based group of medical, behavioral health and rehabilitation professionals who use a team approach to meet the needs of an individual with severe and persistent mental illness. An individual who is appropriate for ACT does not benefit from receiving services across multiple, disconnected providers and may become at greater risk of hospitalization, homelessness, substance use disorder, victimization and incarceration. An ACT Team provides person-centered services addressing the breadth of an individual's needs, helping him or her achieve their personal goals. Retrieved on August 29, 2022 from Assertive Community Treatment | NCDHHS.

[42] Transition Management Service (TMS) is a service provided to individuals participating in the Transitions to Community Living (TCL); it was formerly called Tenancy Support Team. TMS focuses on increasing the individual's ability to live as independently as possible, managing the illness, and reestablishing his or her community roles as these relate to the following life domains: emotional, social, safety, housing, medical and health, educational, vocational and legal. Retrieved on August 29, 2022, https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/adult-mental-health-services.

- Effectively tapped motels in designated counties for Bridge Housing for over 50 individuals.
- TCL and housing staff completed the training, Section 8 Made Simple for Practitioners: Understanding Your Public Housing Authorities' Housing Choice Voucher Program Trainings - Parts 1 - 4.
- Implemented Community Inclusion Supports with Alliance of Disability Advocates of North Carolina to improve housing retention numbers.

Trillium Health Resources

- Exceeded housing goals for this year. Seventy-four (74) people transitioned into housing; 17 were from Adult Care Homes (TCL Population Categories[43] 1 - 3); Fifty-one (51) members were re-housed.
- Developing Value-Based Purchasing to incentivize providers with the goal of reducing separations from housing with implementation assistance from the Practice Management and Data Science teams.
- Held meetings with Greenville Housing Authority once a month; memorandum of understanding discussion started in June.
- Met with Section 8 Director of East Carolina Human Services Agency, Inc. in June 2022, to coordinate transfers of Emergency Housing Vouchers to member's desired community of choice and developed a memorandum of understanding with their agency.
- Formed a working relationship with the Commission of Indian Affairs to increase available Emergency Housing Vouchers in their catchment areas.
- Developed a Smartsheet tool to assist in tracking housing applications and subsidy referrals. This data will be used to ensure all housing and subsidy/voucher options were explored with the member.
- TCL continued to make referrals to the Project Transition program in Wilmington, an enhanced Bridge Housing model, through the Wellness and Recovery Center. This program is available for all eligible Trillium members.
- Expanded Oxford House to add four (4) new houses per year. This program is available for all eligible Trillium members with a substance use disorder history.
- NCHFA - CLIVe refresher training was held on September 30, 2021, and October 20, 2021, to ensure processes are being completed correctly and data across platforms are accurate. Also discussed CLIVe transfer process for Bladen/Halifax members.
- Continued to offer monetary incentives to properties for new leases and to prevent rent increases after the first year.

Vaya Health

- Implemented an incentive for TCL participant referrals to IPS-SE after intake is complete.
- Implemented an incentive with ACT providers for the TCL participants that they support in attaining and maintaining employment.
- Implemented landlord incentives for continuing leases or for new landlords who provide units for participants who have been difficult to house.
- Established relationships with four (4) of the 16 local Public Housing Authorities; formalizing relationships by executing memorandums of understanding with at least ten (10) Authorities within the next year.

[43] Under TCL's settlement agreement with the Department of Justice, priority for the receipt of Housing Slots is given to the following individuals: 1. Individuals with serious mental illness (SMI) who reside in an adult care home determined by the State to be an Institution for Mental Disease; 2. Individuals with severe and persistent mental illness (SPMI) who are residing in Adult Care Homes licensed for at least 50 beds and in which 25% or more of the resident population has a mental illness; 3. Individuals with SPMI who are residing in adult care homes licensed for between 20 and 49 beds and in which 40% or more of the resident population has a mental illness; 4. Individuals with SPMI who are or will be discharged from a State psychiatric hospital and who are homeless or have unstable housing; and 5. Individuals diverted from entry into Adult Care Homes pursuant to the preadmission screening and diversion provisions of Section III(F) of this Agreement. These are known as the TCL population categories. Retrieved on August 29, 2022 from SETTLEMENT AGREEMENT (ncdhhs.gov).

- Developed a Public Housing Authority educational tool that equips internal and external stakeholders to navigate county rental assistance resources and provides training to stakeholders upon request.
- Strengthened the Public Housing Authority workflow and data tracking with internal TCL Team for TCL participants and strengthened the Complex Care Management Team for non-TCL members.
- In FY 22, expanded landlord network opportunities. Staff located 55 private-market vacancies which resulted in utilization of 30 units and assistance to 30 landlords; identified 70 new landlords; and worked to resolve 250 landlord/tenant matters.
- In FY 21 – 22, served 39 individuals in Bridge Housing utilizing hotels. Of those 39, 13 individuals moved into Permanent Supportive Housing; nine (9) of those individuals transitioned into a private Fair Market Rent unit; and four (4) individuals moved into a Targeted unit.
- Conducted four (4) Connecting Community Support Team and Permanent Supportive Housing trainings in FY 22 with four (4) staff dedicated to ensuring that Community Support Teams are equipped to work within the Permanent Supportive Housing framework.
- Facilitated quarterly Assertive Community Treatment/Community Support Team Learning Collaboratives, offering Vaya and Tenancy Support providers an opportunity to share best practices.

IV. TCL Community-Based Mental Health Services

Assertive Community Treatment

Due to the ongoing impact of COVID-19 on community-based providers, NCDHHS continued COVID-19 waivers and flexibilities until June 30, 2022. While these flexibilities resulted in an "extended pause" in the administration of the in-person Tool for Measurement of Assertive Community Team (TMACT)[44] fidelity evaluations, NC DHHS's Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) continued to provide training, technical assistance, oversight and support to ACT providers. In lieu of in-person fidelity reviews during FY 21, the State's contractor, UNC Institute for Best Practices, continued to conduct virtual ACT Evidence-Based Practice Reviews and Targeted Remote ACT Chart Reviews. Specific benefits of these reviews included a systematic review of practices and guidance in areas needing improvement. Staff from DMH/DD/SAS's Adult Mental Health Team facilitated quarterly monitoring of each LME/MCO to assess support ACT teams in their provision of evidence-based, recovery-focused services. Focus was on strengthening the provision of employment services, along crisis resources – much needed during the pandemic – and increasing community and natural supports as in-person services resumed.

The Adult Mental Health team, with the UNC Center for Excellence in Community Mental Health, resumed TMACT fidelity evaluations of ACT teams and separate fidelity evaluations of IPS-SE teams, using an improved process. The Adult Mental Health Team and the UNC Institute for Best Practices developed a streamlined, desk review, submission process that provide evaluators with team-specific data. This allowed for a more careful review of documentation and reduced the amount of time spent on-site. Evaluators will, as a result, be able to prepare more efficiently for onsite evaluations. These improvements and others, clarifying roles and responsibilities, were released as Joint Communication Bulletins #J431 and #J432.

Accomplishments During State Fiscal Year 2021 – 2022

- The UNC Institute for Best Practices completed a total of nine (9) ACT Evidence-Based Practice Reviews.

[44] The Tool for Measurement of ACT (TMACT) is a contemporary evaluation tool used to assess how well a program is implementing critical elements of Assertive Community Treatment (ACT). The TMACT is used to assess ACT program fidelity and guide higher quality ACT implementation efforts. Retrieved on August 29, 2022 from Tool for Measurement of ACT (TMACT) – UNC Center for Excellence in Community Mental Health.

- The UNC Institute for Best Practices completed a total of eight (8) Targeted Remote ACT Chart Reviews.
- Virtual NC ACT Coalition held meetings ten (10) times.
- One (1) in-person NC ACT Coalition meeting occurred (39 attendees).
- Five (5) ACT Team "Specialist Meetings" occurred (Co-Occurring Disorders specialists, Employment and Education specialists, Peer Support specialists, Nursing and Housing specialists).
- Sixty-four (64) of 83 of ACT Teams (77%) completed a quality improvement plan this year.
- Eastpointe and Vaya were provided with expansion money for individuals receiving ACT in rural counties.
- The UNC Institute for Best Practices provided over 50 Technical Assistance sessions on a variety of topics:
    - Psychiatric Advanced Directives
    - Nursing
    - Employment Services
    - Co-Occurring Disorders Treatment
    - Assertive Engagement
    - Tenancy Supports
    - Treatment Planning
    - Preparing for TMACT Evaluations
    - Building Natural Supports

Adult Mental Health Team quarterly monitoring of LME/MCOs resulted in an increased focus on employment and education for ACT recipients. Prior to this, very few LME/MCOs were actively tracking how many TCL ACT recipients were receiving employment/educational services from the ACT Team, nor were the LME/MCOs tracking how many individuals were competitively employed. We saw increased effort by all LME/MCOs to monitor/track these outcomes actively. Now that all LME/MCOs are monitoring these, there has been a significant increase in the number of TCL ACT recipients receiving employment/educational services. We also saw some increase in the number of TCL ACT recipients who are competitively employed. The LME/MCOs' development of new strategies to address these numbers is yet another positive outcome of quarterly monitoring. Monthly ACT collaborative meetings with providers addressed employment; the ACT Scope of Work, inclusive of specific, employment benchmarks; and the incentive payments and value-based contracting. The UNC Institute for Best Practices, with other subject matter experts, provided a variety of specialized training for ACT, Community Support Team and Transition Management Services providers.

DURING FY 2021, UNC PROVIDED:

- Introduction to Motivational Interviewing – four (4) times
- Mental Illness and Permanent Supportive Housing (PSH)
- Mental Illness and Individual Placement and Support (IPS-SE)
- Mental Illness and Co-Occurring Disorders
- Mental Illness and Peer Support Specialist
- Recovery-Oriented Cognitive Therapy – two (2) times
- Recovery-Oriented Cognitive Therapy Practice Circle – four (4) times
- Cultural Diversity – Blind Spots – two (2) times

DMH/DD/SAS now consistently tracks data from the Division of Vocational Rehabilitation Services (DVRS), UNC Institute for Best Practices and LME/MCOs on numbers served in ACT; trainings provided to ACT staff and specialist positions; and technical assistance, including expectations and recommendations to ACT teams and LME/MCOs regarding TCL settlement requirements. Most data is accrued on a quarterly basis with items of high importance, such as employment data, gathered monthly.

Community Support Team

While NCDHHS COVID-19 flexibilities resulted in a "extended pause" of the LME/MCOs' facilitation of routine, in-person monitoring of Community Support Team (CST) providers, DMH/DD/SAS saw improved efforts throughout 2021 with regard to training and technical assistance. Permanent Supportive Housing (PSH) training continued to be facilitated virtually and was made available to providers at least once every 90 days. *Tea with CST* continued to be offered virtually during FY 21. DMH/DD/SAS's Adult Mental Health Team provided quarterly monitoring of each LME/MCO to assess their monitoring of CST providers for adherence to the PSH model and CST participant outcomes.

DMH/DD/SAS determined that CST providers needed a training venue, as well as a place in which they could provide support to each other. *Tea with CST Meetups* originated through a NCDHHS contract with the UNC Institute for Best Practices. The meetups provided an opportunity for regular guidance, support, training and technical assistance for CST providers. UNC began facilitating meetups in May 2020 and continued facilitating meetings on a monthly basis throughout FY 2021. These 45-minute meetings were provided virtually. Participation varied, ranging from 12 to 51 people. Each meeting had an identified topic with time for discussion. This became an excellent avenue for the discussion of TCL-related topics such as assertive engagement; harm reduction; self-determination; employment; substance use disorder interventions; and supporting physical health. During one session, the Adult Mental Health Team facilitated a training on employment engagement. This training provided an overview of employment statistics for the serious mental illness/severe and persistent mental illness (SMI/SMPI) population. Trainers discussed benefits of having a job; provided strategies to engage individuals in conversations about employment; and discussed referrals to IPS-SE teams.

The Adult Mental Health Team's quarterly monitoring of LME/MCOs increased focus on assessing CST providers' implementation of the full array of PSH interventions and ensuring participant outcomes. While most of the LME/MCOs had paused in-person monitoring of CST providers due to the extension of COVID-19 flexibilities, we did see an increase in informal monitoring; the development of CST Provider Monthly/Quarterly Collaboratives in four (4) of the six (6) LME/MCOs; and opportunities for technical assistance. We also saw the development of tenancy-based trainings. Quarterly monitoring additionally included assessing whether individuals who required Peer Support Services were referred to a CST Team with a Peer Specialist on staff. After several quarters of monitoring, all LME/MCO staff reported that they had CST Teams with peers for any individuals needing a peer support specialist.

Individual Placement and Support – Supported Employment

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

After nine years, the State is proud of its many accomplishments regarding IPS-SE and its sustainability. Currently, North Carolina has thirty-two (32) IPS-SE providers with three (3) new providers awaiting approval. With technical and training support from the UNC Institute for Best Practices, providers have improved their fidelity to the model. The Institute has been instrumental in promulgating the service and reinforcing the principle that employment is a vital to recovery, resulting in many individuals finding and keeping employment. Despite the significant challenges of the pandemic, IPS-SE providers remained steady statewide with the TCL population achieving competitive integrated employment rates of 47% and 46%, respectively, during SFY 21 – 22.

In December 2019, the State implemented the sustainability plan for IPS-SE. The North Carolina

Collaborative for Ongoing Recovery through Employment (NC CORE) is an outcome-based, braided funded model in the Vaya Health catchment area. It has begun expanding IPS-SE during the past fiscal year.

Accomplishments During State Fiscal Year 2021 – 2022

- NC CORE has significantly reduced reliance on State funds by increasing utilization of DVRS funds in the Vaya catchment area. NC CORE has also increased DVRS shared cases (up 13% from the previous SFY); supported multiple payments for long-term supports and career advancements; and enhanced the ability to track specific outcomes through claims data.
- Alliance Health LME/MCO fully implemented NC CORE in December 2021 while Partners Health LME/MCO implements the model with a single provider. Trillium, Sandhills, and Eastpointe LME/MCOs are developing proposals with assistance from NCDHHS.
- Incentive payments to IPS-SE providers for successful enrollments and job placements of TCL individuals were developed by Vaya Health and Alliance Health, with Alliance Health adding an incentive for long-term job supports. All the LME/MCOs have developed or are developing an incentive for successful IPS-SE enrollments for TCL individuals who are receiving either Community Support Team or Transitional Management Services.
- The DVRS Program Specialist for Behavioral Health has provided technical assistance and support in various meetings for Vocational Rehabilitation counselors, IPS-SE providers, and/or LME/MCO staff. The establishment of IPS-SE liaisons in the local Vocational Rehabilitation offices and the extensive support from the DVRS has led to strengthened relationships between IPS-SE providers and local Vocational Rehabilitation offices and refinements to delivery of the service.
- All LME/MCOs have established provider collaboratives that include IPS-SE, ACT, CST and/or Transition Management Services to provide education and assistance toward improved IPS-SE enrollments.
- The Adult Mental Health Team at the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) provided the division-developed training – TCL Engagement in Employment – to LME/MCO TCL staff, the National Alliance on Mental Illness of NC, the Alliance of Disability Advocates of NC, and ACT, CST and Transition Management Service providers. A training for the Division of Aging and Adult Services will be provided in SFY 2022 – 2023.
- The DMH/DD/SAS partnered with the Alliance of Disability Advocates of NC to provide community inclusion supports and connect to IPS-SE providers for employment and education services.
- The Institute's SFY 22 – 23 contract will include supports for targeted IPS-SE and ACT coaching; data collection; behavioral health integration and referral; In-Reach shadowing, to model employment engagement; development of media content to support engagement efforts; and a dedicated CST/Transition Management Services trainer.
- The Adult Mental Health Team is developing an IPS-SE incentive plan for increased enrollment (to 5% for In-Reach and 20% for housed individuals) and attainment of competitive, integrated employment (45%) of In-Reach and housed individuals.
- The competitive, integrated employment rate for TCL and In-ACH or At Risk of transitioning to an ACH[45] individuals in the IPS-SE service during SFY 21 – 22 is 46%.
- While fidelity evaluations were paused during the pandemic, the Institute offered evidence-based, practice quality reviews to IPS-SE providers to support the provision of the service per fidelity. The Institute conducted 13 Evidence-Based Practice quality reviews during SFY 21 – 22. Debriefing sessions saw an increase in participation from LME/MCOs.

Despite the State's extensive efforts, the statewide TCL enrollment and competitive integrated employment rates for IPS-SE remain low. In SFY 2021 – 2022, the TCL enrollment rate was 14%, while the

[45] Often referred to as "In- or At Risk" individuals.

competitive integrated employment rate was 17%. In addition, the Independent Reviewer noted that TCL In-Reach and housed individuals were not being adequately engaged around employment and education; nor were a number of these individuals receiving job supports from the IPS-SE provider once enrolled and working.

The State is, however, confident that it will meet substantial compliance with the settlement agreement's supported employment requirements, as evidenced by its many accomplishments and its plans to improve TCL enrollment and IPS-SE provision. Additionally, the State's sustainability plan has demonstrated successful braiding of funding and cost savings of State funds, along with the ability to track the outcomes-based data that informs technical assistance needs for IPS-SE providers. The DVRS, the Division of Health Benefits and the DMH/DD/SAS all continue to advocate for additional LME/MCOs to adopt NC CORE. They have seen significant movement with LME/MCOs developing proposals and implementing the payment model. Increased transitions to NC CORE milestones and DVRS' extensive technical assistance has resulted in a significant increase in shared Vocational Rehabilitation cases across the state, further supporting the inclusion of NC CORE services in the IPS-SE model.

Expected outcomes established in the draft IPS-SE incentive plan and targeted technical assistance and training will significantly increase IPS-SE enrollments and the competitive integrated employment rate for TCL individuals. In addition, the LME/MCOs have increased their efforts to address barriers to TCL IPS-SE enrollments.

The draft IPS-SE Clinical Coverage Policy, part of the Medicaid 1915(i) option[46], includes changes that support improved fidelity to the model, including co-located behavioral health services within the agency and a benefits counselor on the IPS-SE Team. Policy changes will also result in the development of a stronger, person-centered employment plan. IPS-SE fidelity evaluations will resume in SFY 2022 – 2023, providing valuable information for providers to build on strengths and identify technical assistance needs.

IPS-SE will remain a critical component of the adult mental health service array, even after the State exits the TCL settlement agreement. It is part of the Tailored Plan service array and DMH/DD/SAS continues to explore ways to tie employment-specific outcomes to its contracts. Employment clearly promotes valued life outcomes for people with serious mental illness or severe and persistent mental illness. It is vital to the success of community transition for individuals in TCL.

[46] Section 1915(i) of the Social Security Act gives state Medicaid programs the flexibility to cover home and community-based services through a Medicaid state plan amendment without the need to seek a federal waiver.

V. TCL Community-Based Mental Health Service Patterns

Overview

This annual report section addresses the requirement in Section III.G.8.a. of the settlement agreement with U.S. DOJ for the State to "*publish, on the DHHS website, an annual report identifying the number of people served in each type of setting and service described in this Agreement*." Service summaries are based on NCTracks Medicaid and DMH/DD/SAS adjudicated behavioral health service claims for the TCL participant populations described in Table 1.[47]

TABLE 1: SFY 2021 TCL PARTICIPANT POPULATIONS BY STATUS AND SETTING

Participant Status and Service Setting	Description	Count
TCL Supportive Housing	Individuals in TCL supportive housing during the reporting period	3,411
Transition Planning[a]	Individuals with approved TCL supportive housing slots who had an initial transition attempt in progress	1,116
Rehousing Planning	Individuals separated from TCL supportive housing who had a subsequent transition attempt in progress	98
In Progress (In-Reach)	Individuals residing in an Adult Care Home or State Psychiatric Hospital	6,820
In Progress (Diversion)	Individuals who had an Adult Care Home Diversion attempt in progress	1,576
Housed in the Community without a TCL Housing Slot	Individuals residing in community-based settings other than TCL supportive housing	3,321
Unduplicated Total[b]	Total count of TCL participants, each counted once regardless of transitions across setting and status	13,649

a- Where the housing slot was assigned fewer than 90 days before the initial lease start date, the transition planning period for the purpose of services analysis is defined as the 90 days before the transition to supportive housing.

b- In service summaries that follow, sums of individual counts per setting will exceed the Table 1 unduplicated total. The degree of duplication will be greater for annual versus quarterly measurement periods.

Data tables in the remainder of this section show, by the TCL statuses and settings shown in Table 1, statewide annual and recent quarterly percentages of individuals who received services, and SFY 2021 numbers and percentages by LME/MCO of individuals who received services within the date range of Table 1 status periods. Table 2 shows the specific services included in each service category.

[47] NCTracks is the multi-payer Medicaid Management Information System for the NC Department of Health and Human Services. Service summaries are based on TCL Performance Data Dashboard measures, which incorporate TCL participant behavioral health service claims with elements from the TCL Database and other client-level data sources.

TABLE 2: SERVICE CATEGORIES

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

Data Interpretation of Service Summaries

Participant status and setting reported in the data tables that follow reflect documentation in the TCL Database (TCLD) and leasing information in the Community Living Integration Verification (CLIVe) system. Professional mental health service claims from the NCTracks data warehouse were processed through the TCL Performance Data Dashboard. The following notes related to these data sources are provided to assist with data interpretation.

- Service analysis is based on claims adjudicated through July 2022. Timely filing limits may affect data completeness, especially for services provided in more recent reporting periods.
- Due to lag time between service delivery and the availability of complete service claims information in the NCTracks data warehouse, 2021 is the most recent full state fiscal year for which service claims summaries are presented.

- TCL Performance Data Dashboard standardized service measure definitions differ from the method used to develop service summaries in previous annual reports. Service rates shown in this report are based on counts of all TCL participants per status documented in TCLD and CLIVe during the reporting period indicated. In previous services reporting, individuals who could not be matched to NCTracks eligibility data were excluded from service measures. Elimination of this exclusion results in larger percentage denominators and lower calculated percentages compared to service rates previously reported. This difference primarily affects reported service rates during periods when individuals were not in or not planning for transition to TCL supportive housing.
- To simplify year-to-year statewide comparisons, SFY 2017 through SFY 2021 annual service rates that were calculated using the same TCL Performance Data Dashboard specifications are presented.
- Statewide service rates for SFY 2021 and the first two quarters of SFY 2022 are presented to allow for comparison of quarterly service rates from the most recent full state fiscal year of claims data, SFY 2021, and the first two quarters of SFY 2022.
- TCL Performance Data Dashboard undergo continuous quality assurance review and are refreshed each quarter. Slight variation in reported client counts and service rates for the measurement periods reported may occur in future reporting for the same periods due to data quality improvements and re-adjudication of service claims.
- In cases of client LME/MCO transfers, where TCLD records were updated to reflect the receiving LME/MCO, client counts and services for transferring participants may be reported only under the receiving LME/MCO.
- Statewide client counts may include a small degree of duplication due to client LME/MCO transfers.
- Medicaid and State-funded IPS-SE services provided under the NC CORE value-based payment model in Alliance Health and Vaya Health catchment areas are submitted to NCTracks and reimbursed only when member service milestones are achieved. IPS-SE services paid by the Division of Vocational Rehabilitation Services are not submitted to NCTracks. As a result of these two factors, client service counts derived from paid NCTracks claims may underestimate numbers of individuals who received IPS-SE services during each measurement period, and the degree of underestimation will be greater for quarterly than for annual measurement periods.
- Service rates for individuals planning for rehousing after a housing separation are not available for SFY 2017.
- To aid in visual comparison between service rates across TCL settings and services, all service rate data presented in bar graphs and line charts use the same Y-axis scale and maximum percent (70%).

Summary of Service Trends

The following patterns are seen in the most recent analysis of service claims data:

- Members in TCL supportive housing received required tenancy support services, through Tenancy Management Supports (TMS), Community Support Team (CST), or Assertive Community Treatment Team (ACT) services.
- Crisis service use remained low across settings and declined over a five-year period for participants in TCL supportive housing.
- IPS-SE service rates trended upward over a five-year period for participants during transition planning and diversion attempts.
- Rates for comprehensive services such as ACT were higher for participants in TCL supportive housing and during transition planning and rehousing planning compared to other statuses and settings.
- Rates for comprehensive services such as ACT trended upward over a five-year period for participants with active diversion attempts.

- Rates for stand-alone services such as Peer Supports, Psychotherapy, and Evaluation and Management visits were higher for individuals in TCL supportive housing compared to participants in pre-transition settings and individuals housed in the community without TCL supportive housing.[48]
- Percentages of participants receiving services in congregate day programming through Psychosocial Rehabilitation Services decreased over a five-year period across TCL setting and status.

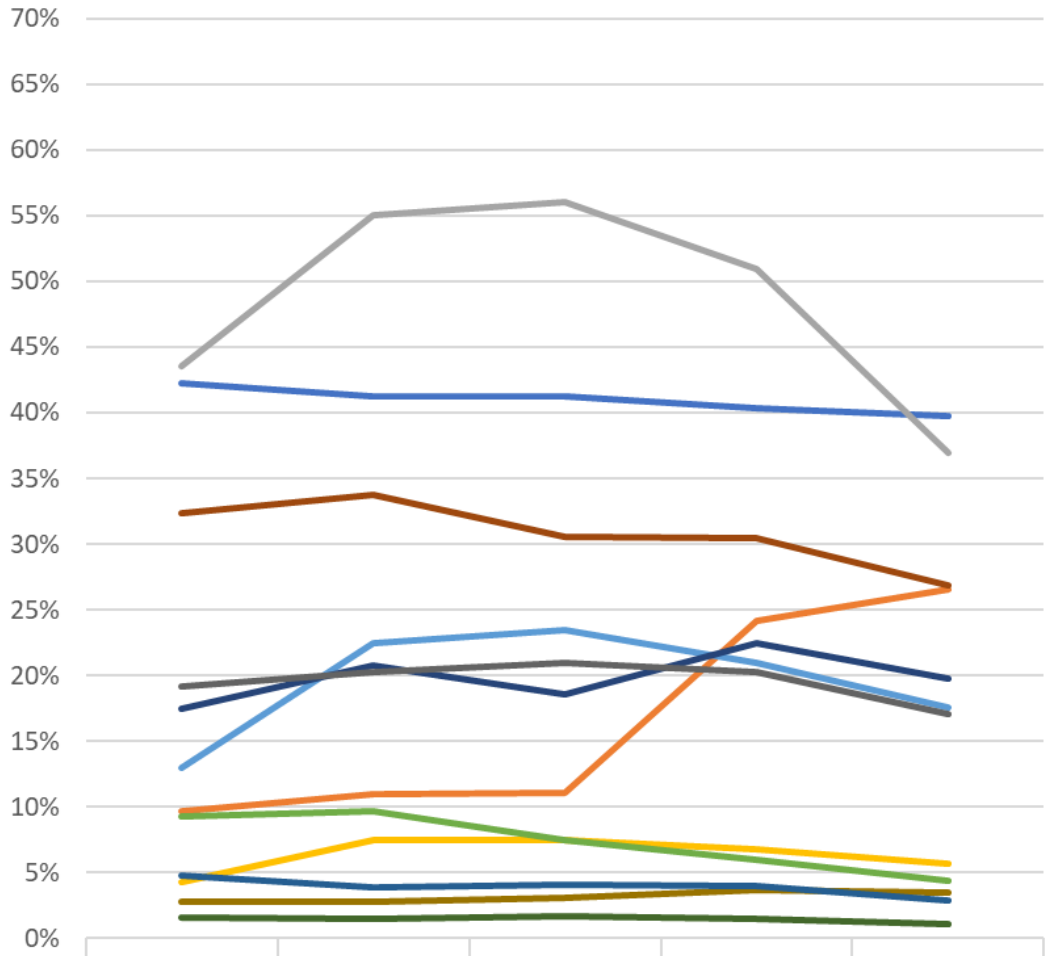
Service Summaries by TCL Status and Setting

The remainder of this section includes counts and percentages of TCL participants in each setting described in Table 1.

[48] Previous annual reports showed higher rates of stand-alone services for participants housed in the community without a TCL housing slot and for participants in some pre-transition settings. This was likely due to the exclusion from previous service rate measures of individuals who could not be matched to NCTracks eligibility data.

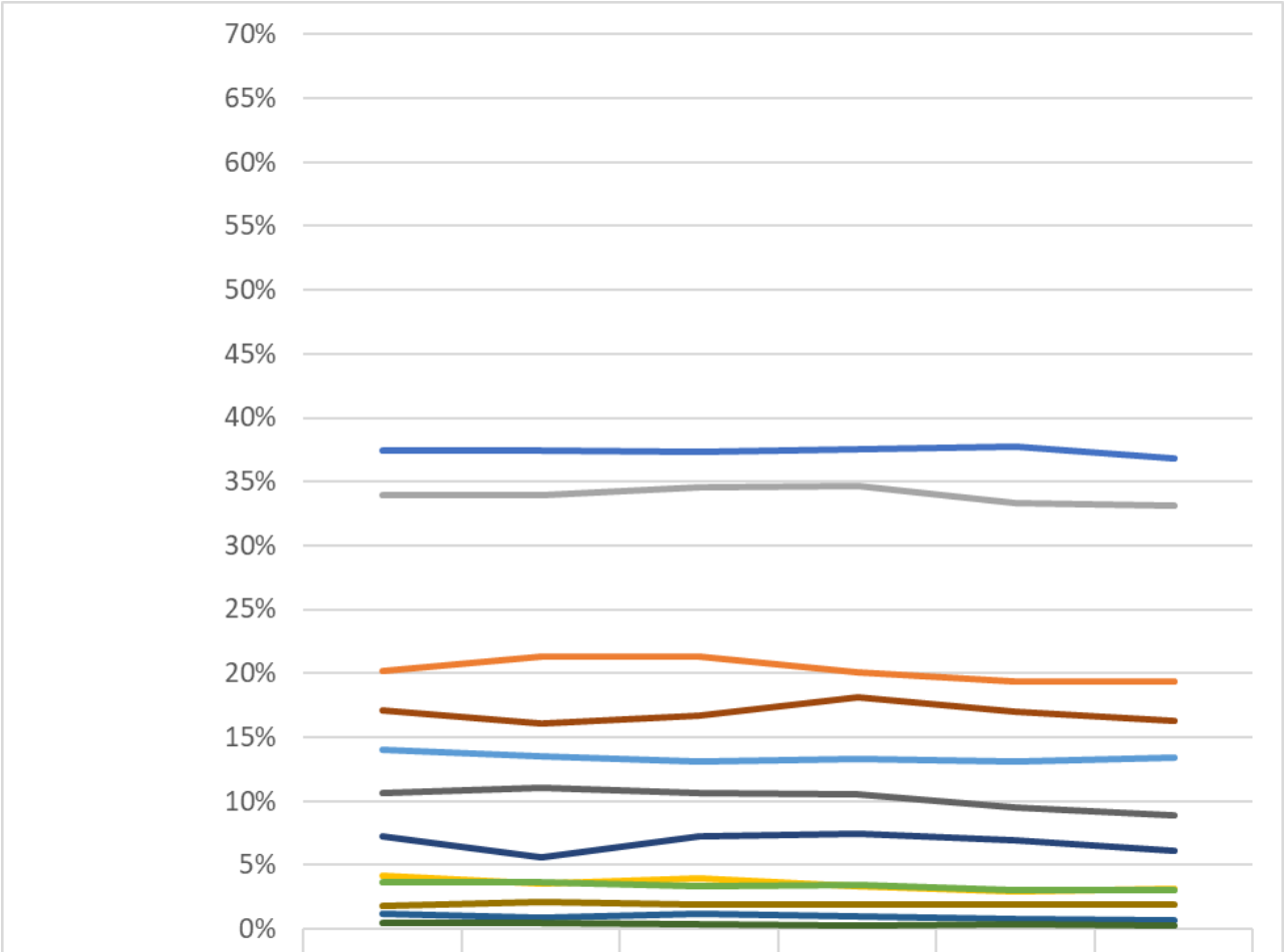
Participants in TCL Supportive Housing

ANNUAL SERVICE RATES IN TCL SUPPORTIVE HOUSING, SFY 2017 TO SFY 2021



	2017	2018	2019	2020	2021
ACT	42%	41%	41%	40%	40%
CST	10%	11%	11%	24%	27%
TMS	44%	55%	56%	51%	37%
IPS	4%	8%	8%	7%	6%
PSS	13%	23%	24%	21%	18%
PSR	9%	10%	8%	6%	4%
PsyDx/Testing	18%	21%	19%	23%	20%
E&M	32%	34%	31%	31%	27%
Psychotherapy	19%	20%	21%	20%	17%
SUD	3%	3%	3%	4%	4%
MCM	5%	4%	4%	4%	3%
FBC	2%	2%	2%	2%	1%

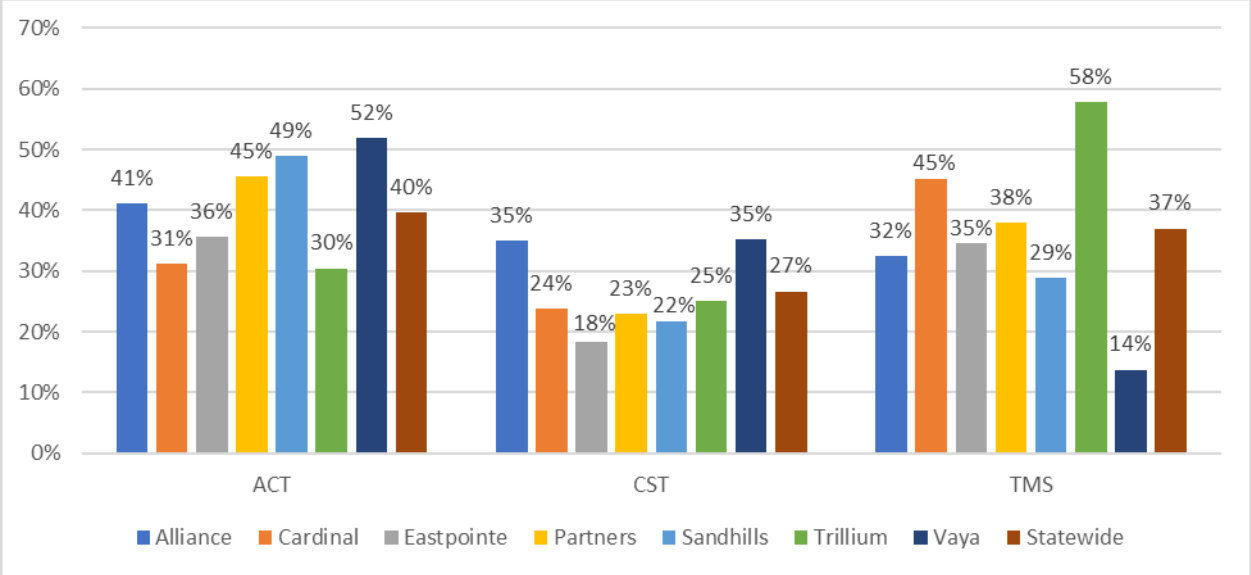
QUARTERLY SERVICE RATES IN TCL SUPPORTIVE HOUSING, SFY 2021 QUARTER 1 TO SFY 2022 QUARTER 2

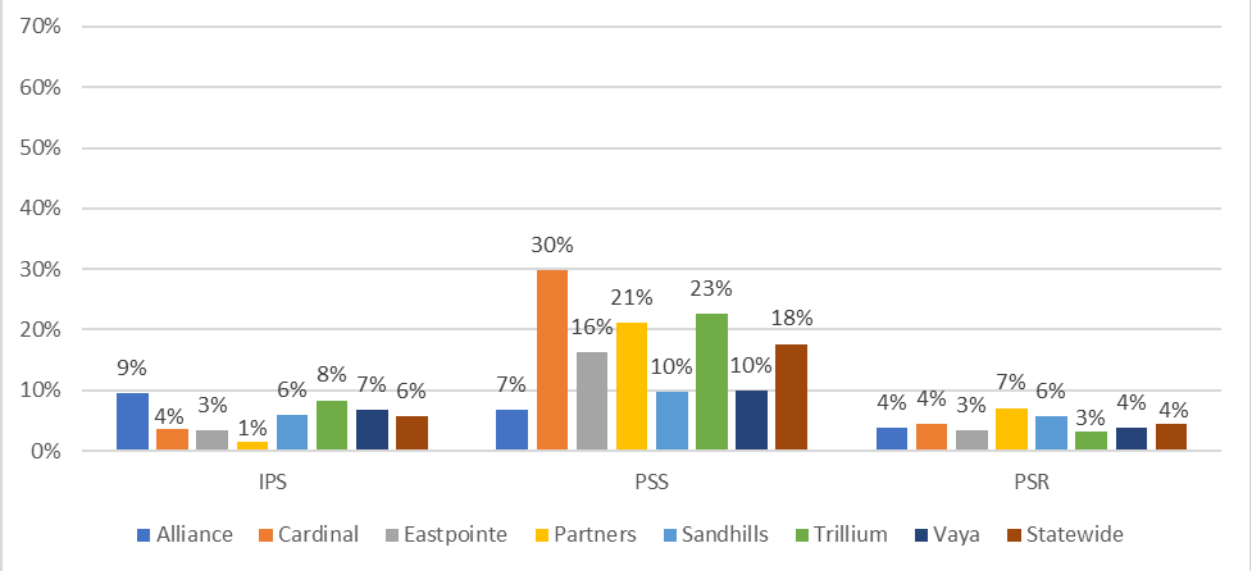


	21Q1	21Q2	21Q3	21Q4	22Q1	22Q2
ACT	37%	37%	37%	38%	38%	37%
CST	20%	21%	21%	20%	19%	19%
TMS	34%	34%	35%	35%	33%	33%
IPS	4%	4%	4%	3%	3%	3%
PSS	14%	14%	13%	13%	13%	13%
PSR	4%	4%	3%	4%	3%	3%
PsyDx/Testing	7%	6%	7%	8%	7%	6%
E&M	17%	16%	17%	18%	17%	16%
Psychotherapy	11%	11%	11%	11%	10%	9%
SUD	2%	2%	2%	2%	2%	2%
MCM	1%	1%	1%	1%	1%	1%
FBC	1%	1%	0.4%	0.3%	0.4%	0.3%

PARTICIPANT SERVICE COUNTS AND RATES, MEMBERS IN SUPPORTIVE HOUSING, SFY 2021

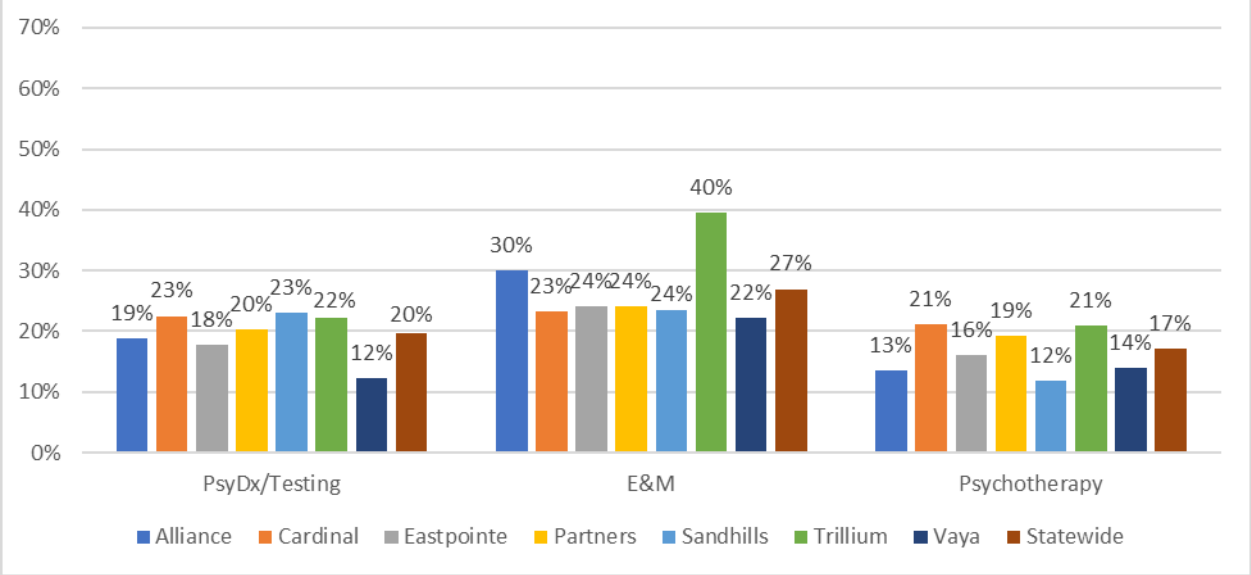
	Total N	ACT	CST	TMS	IPS	PSS	PSR
Alliance	580	238	203	188	55	39	22
Cardinal	760	237	181	343	28	226	34
Eastpointe	300	107	55	104	10	49	10
Partners	411	187	94	156	6	87	29
Sandhills	370	181	80	107	22	36	21
Trillium	516	157	129	298	43	117	16
Vaya	474	246	167	65	32	47	18
Statewide	3,411	1,353	909	1,261	196	601	150

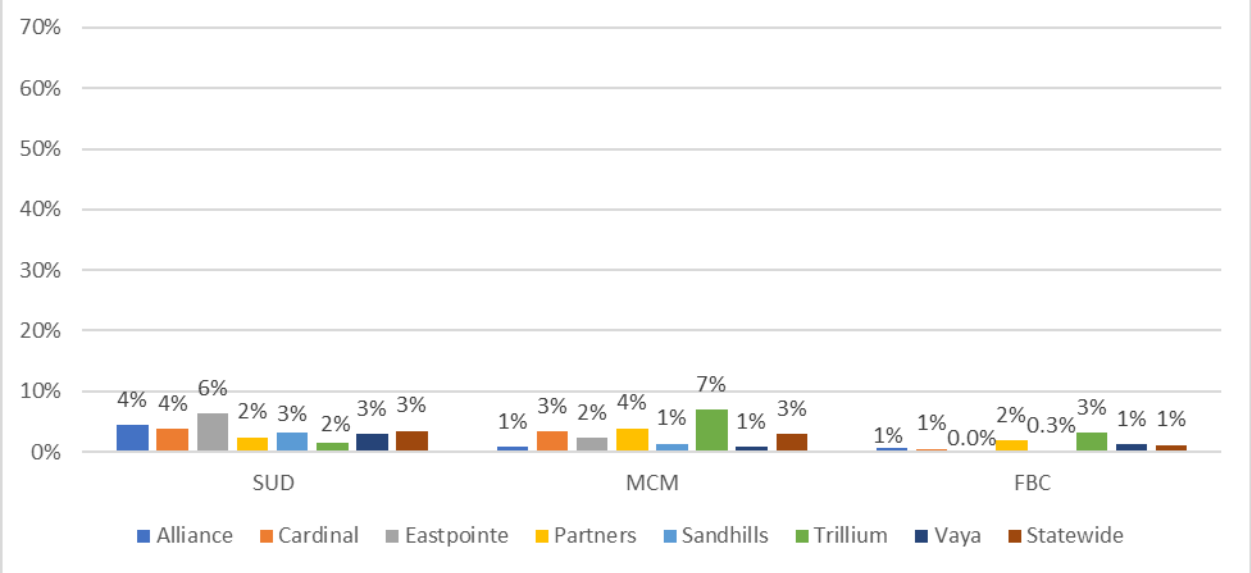




PARTICIPANT SERVICE COUNTS AND RATES, MEMBERS IN SUPPORTIVE HOUSING, SFY 2021 (CONT.)

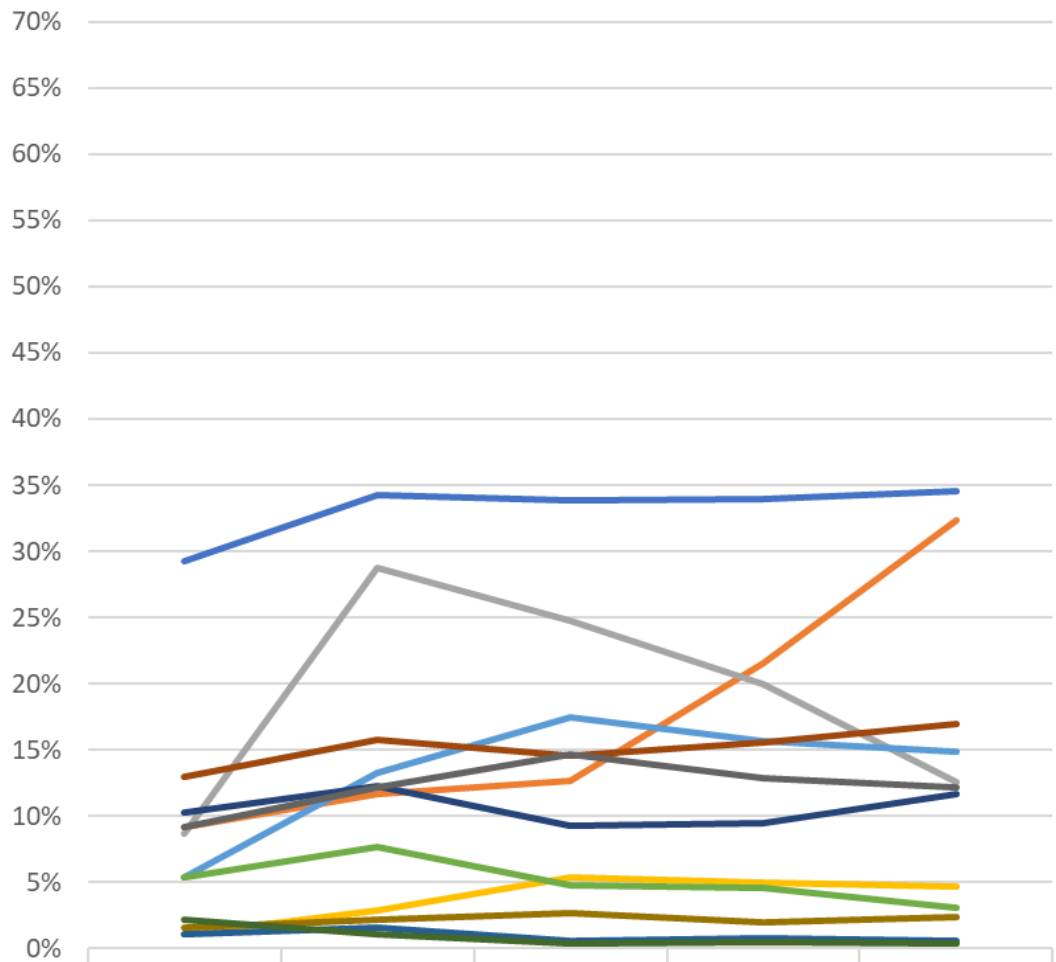
	Total N	PsyDx/ Testing	E&M	Psycho-therapy	SUD	MCM	FBC
Alliance	580	109	174	78	26	5	4
Cardinal	760	171	177	160	29	25	4
Eastpointe	300	53	72	48	19	7	0
Partners	411	83	99	79	10	16	8
Sandhills	370	85	87	44	12	5	1
Trillium	516	115	204	108	8	36	16
Vaya	474	58	105	66	14	4	6
Statewide	3,411	674	918	583	118	98	39





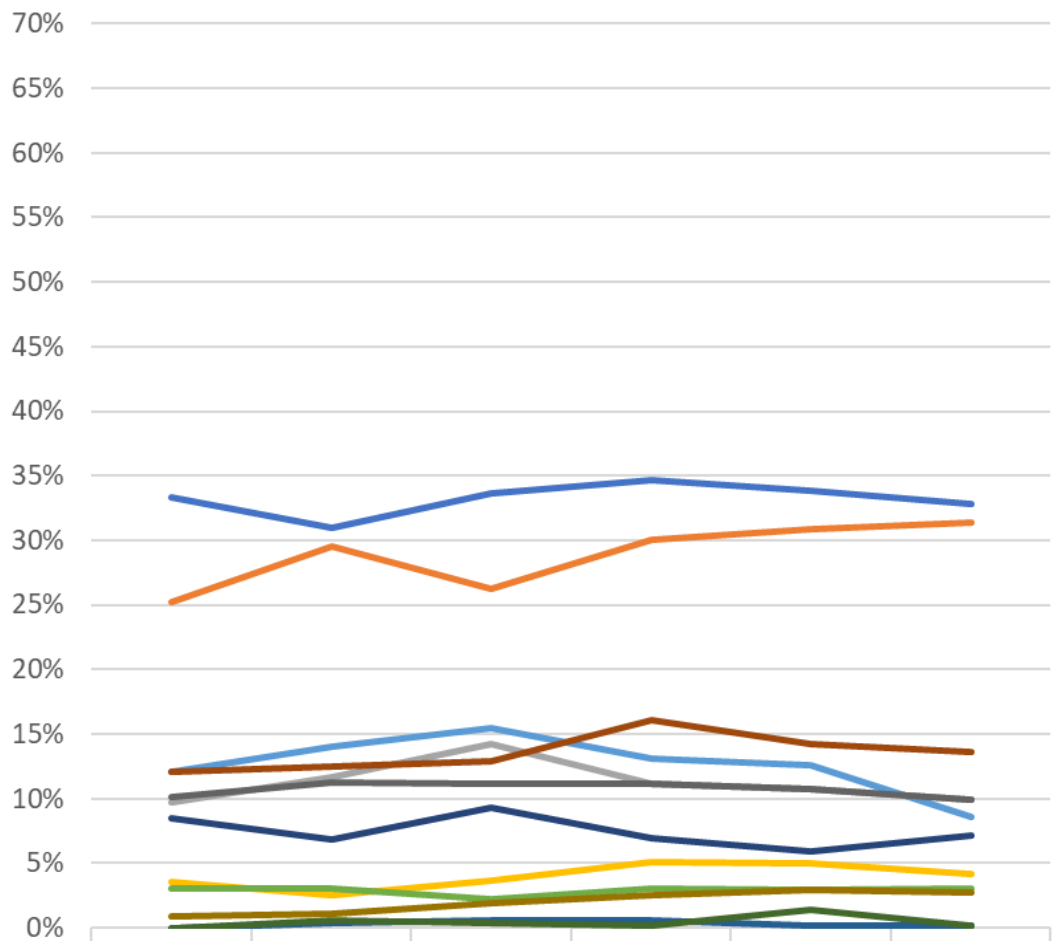
Participants in Transition Planning

ANNUAL SERVICE RATES FOR PARTICIPANTS IN TRANSITION PLANNING, SFY 2017 TO SFY 2021



	2017	2018	2019	2020	2021
ACT	29%	34%	34%	34%	35%
CST	9%	12%	13%	22%	32%
TMS	9%	29%	25%	20%	13%
IPS	1%	3%	5%	5%	5%
PSS	5%	13%	18%	16%	15%
PSR	5%	8%	5%	5%	3%
PsyDx/Testing	10%	12%	9%	10%	12%
E&M	13%	16%	15%	16%	17%
Psychotherapy	9%	12%	15%	13%	12%
SUD	2%	2%	3%	2%	2%
MCM	1%	2%	1%	1%	1%
FBC	2%	1%	0%	1%	0%

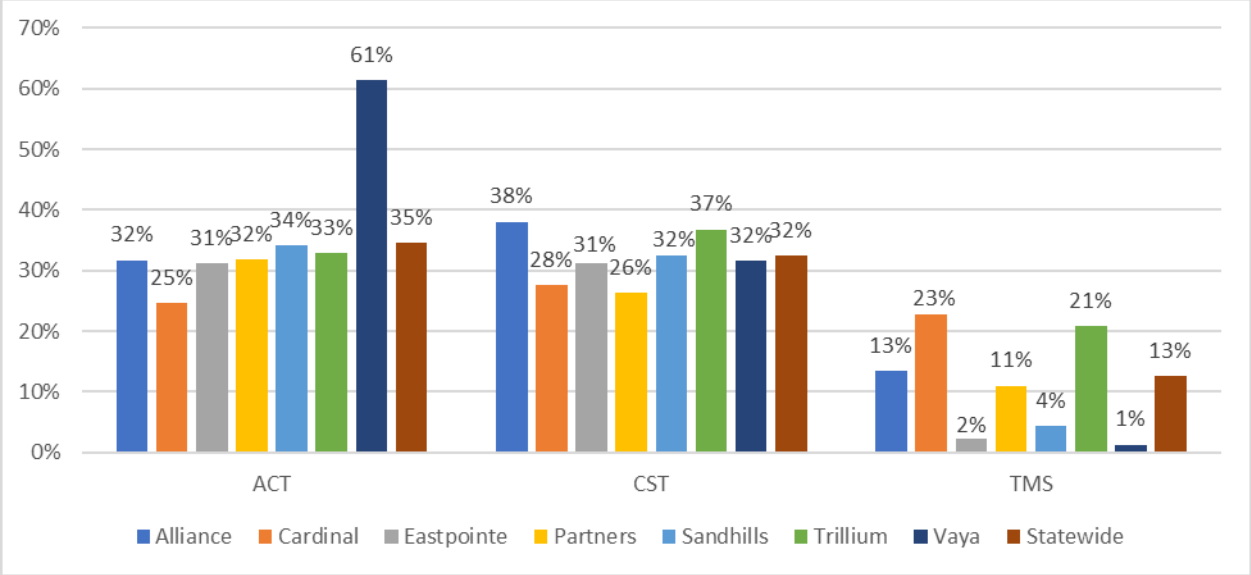
QUARTERLY SERVICE RATES FOR PARTICIPANTS IN TRANSITION PLANNING, SFY 2021 QUARTER 1 TO SFY 2022 QUARTER 2

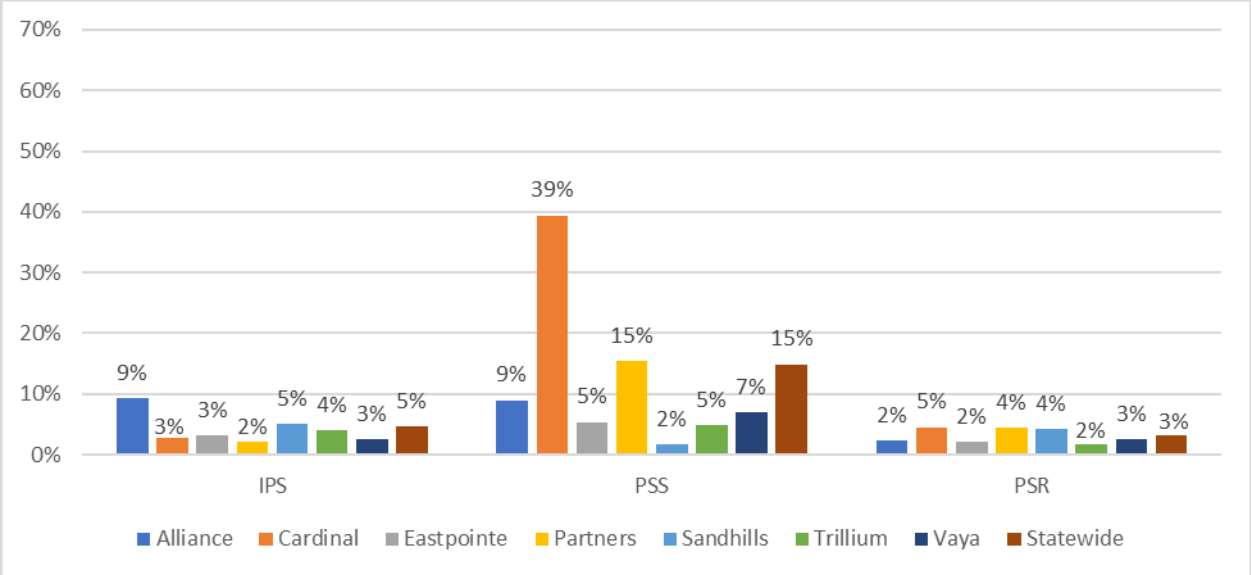


	21Q1	21Q2	21Q3	21Q4	22Q1	22Q2
ACT	33%	31%	34%	35%	34%	33%
CST	25%	30%	26%	30%	31%	31%
TMS	10%	12%	14%	11%	11%	10%
IPS	4%	3%	4%	5%	5%	4%
PSS	12%	14%	16%	13%	13%	9%
PSR	3%	3%	2%	3%	3%	3%
PsyDx/Testing	9%	7%	9%	7%	6%	7%
E&M	12%	13%	13%	16%	14%	14%
Psychotherapy	10%	11%	11%	11%	11%	10%
SUD	1%	1%	2%	3%	3%	3%
MCM	0%	0%	1%	1%	0%	0%
FBC	0%	1%	0.4%	0.2%	1.4%	0.2%

PARTICIPANT SERVICE COUNTS AND RATES, MEMBERS IN TRANSITION PLANNING, SFY 2021

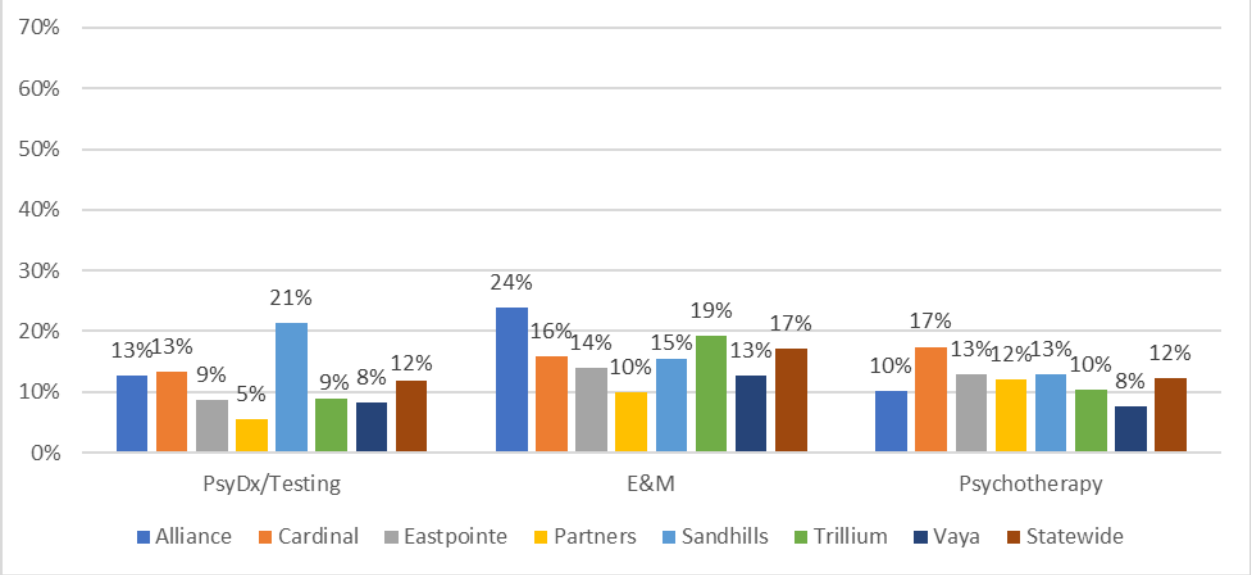
	Total N	ACT	CST	TMS	IPS	PSS	PSR
Alliance	268	85	102	36	25	24	6
Cardinal	264	65	73	60	7	104	12
Eastpointe	93	29	29	2	3	5	2
Partners	91	29	24	10	2	14	4
Sandhills	117	40	38	5	6	2	5
Trillium	125	41	46	26	5	6	2
Vaya	158	97	50	2	4	11	4
Statewide	1,116	386	362	141	52	166	35

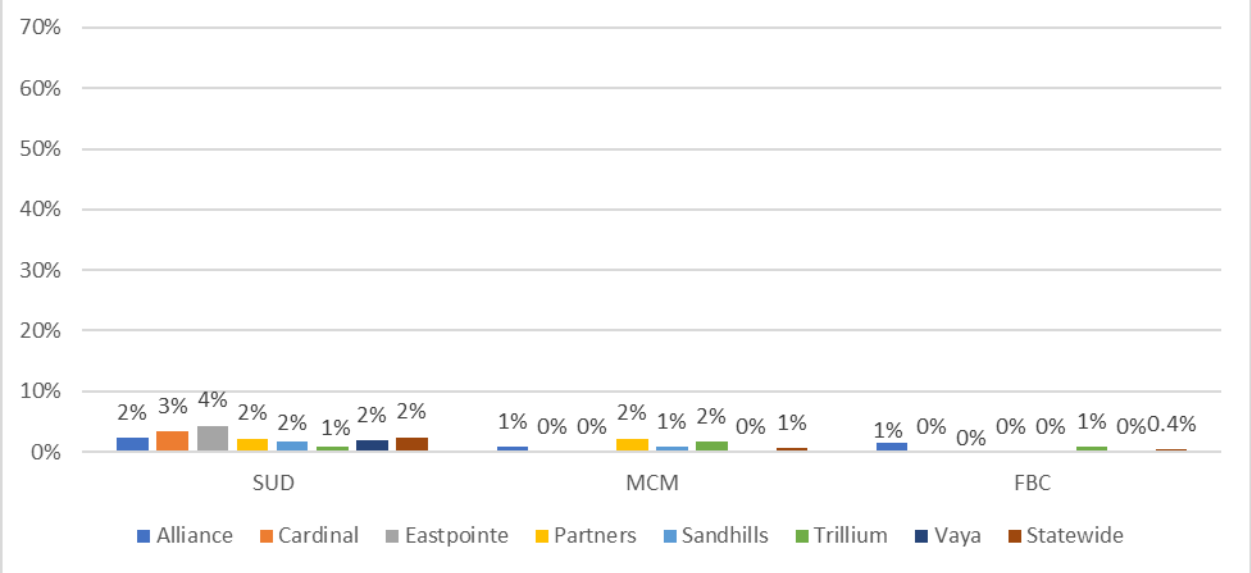




PARTICIPANT SERVICE COUNTS AND RATES, MEMBERS IN TRANSITION PLANNING, SFY 2021 (CONT.)

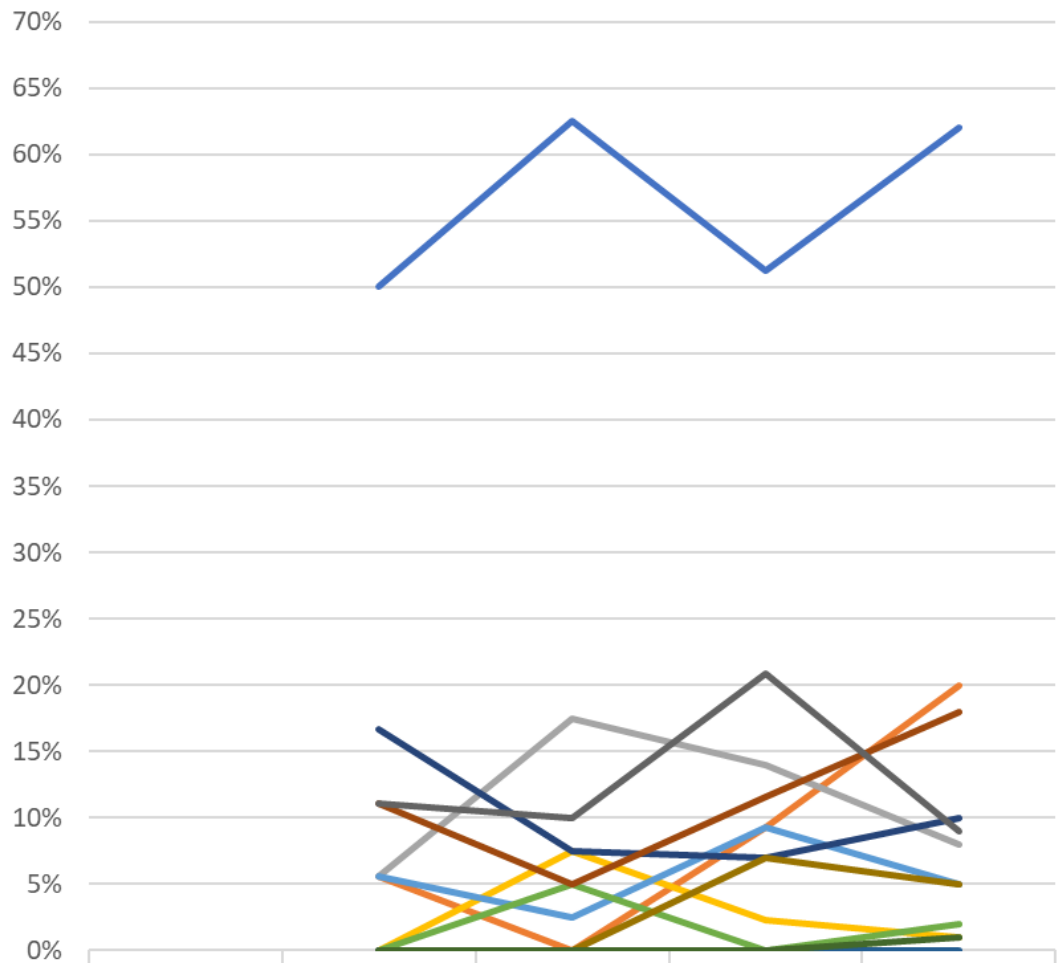
	Total N	PsyDx/ Testing	E&M	Psycho-therapy	SUD	MCM	FBC
Alliance	268	34	64	27	6	2	4
Cardinal	264	35	42	46	9	0	0
Eastpointe	93	8	13	12	4	0	0
Partners	91	5	9	11	2	2	0
Sandhills	117	25	18	15	2	1	0
Trillium	125	11	24	13	1	2	1
Vaya	158	13	20	12	3	0	0
Statewide	1,116	131	190	136	27	7	5





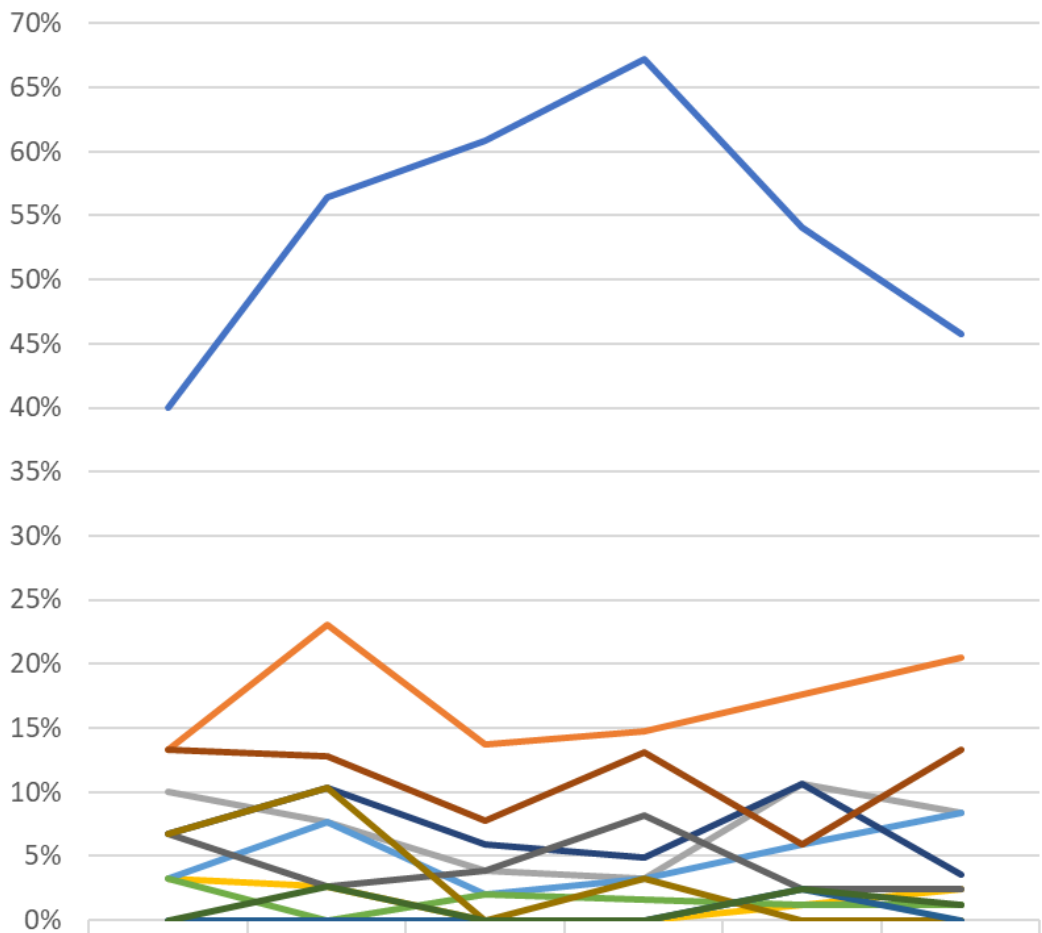
Participants in Rehousing Planning

ANNUAL SERVICE RATES FOR PARTICIPANTS IN REHOUSING PLANNING, SFY 2017 TO SFY 2021



	2017	2018	2019	2020	2021
ACT		50%	63%	51%	62%
CST		6%	0%	9%	20%
TMS		6%	18%	14%	8%
IPS		0%	8%	2%	1%
PSS		6%	3%	9%	5%
PSR		0%	5%	0%	2%
PsyDx/Testing		17%	8%	7%	10%
E&M		11%	5%	12%	18%
Psychotherapy		11%	10%	21%	9%
SUD		0%	0%	7%	5%
MCM		0%	0%	0%	0%
FBC		0%	0%	0%	1%

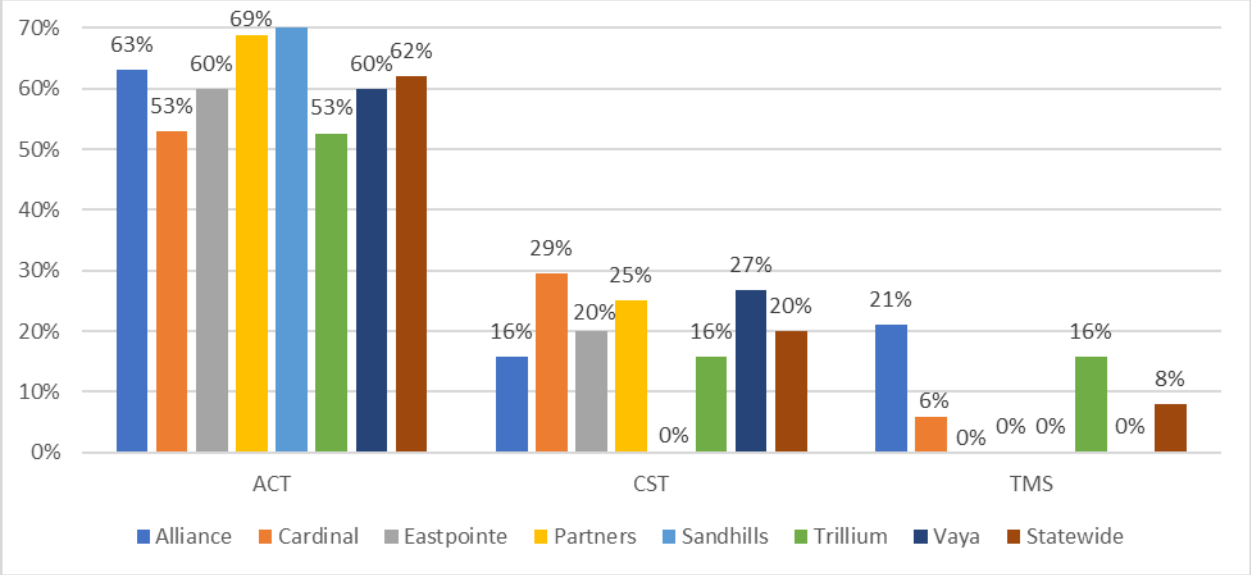
QUARTERLY SERVICE RATES FOR PARTICIPANTS IN REHOUSING PLANNING, SFY 2021 QUARTER 1 TO SFY 2022 QUARTER 2

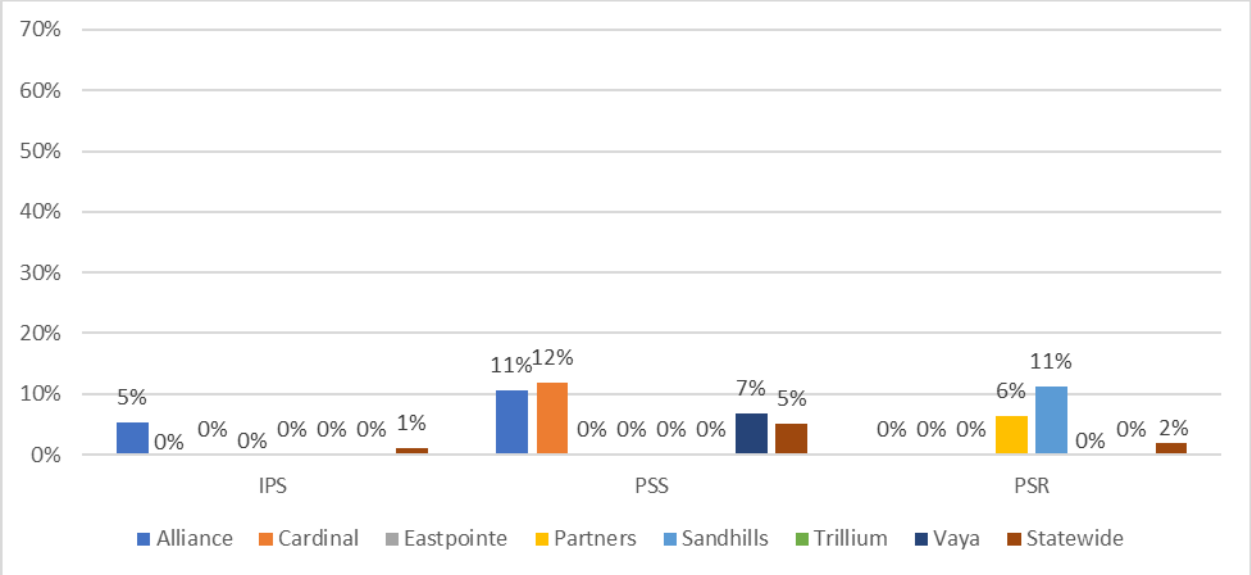


	21Q1	21Q2	21Q3	21Q4	22Q1	22Q2
ACT	40%	56%	61%	67%	54%	46%
CST	13%	23%	14%	15%	18%	21%
TMS	10%	8%	4%	3%	11%	8%
IPS	3%	3%	0%	0%	1%	2%
PSS	3%	8%	2%	3%	6%	8%
PSR	3%	0%	2%	2%	1%	1%
PsyDx/Testing	7%	10%	6%	5%	11%	4%
E&M	13%	13%	8%	13%	6%	13%
Psychotherapy	7%	3%	4%	8%	2%	2%
SUD	7%	10%	0%	3%	0%	0%
MCM	0%	0%	0%	0%	2%	0%
FBC	0%	3%	0.0%	0.0%	2.4%	1.2%

PARTICIPANT SERVICE COUNTS AND RATES, MEMBERS IN REHOUSING PLANNING, SFY 2021

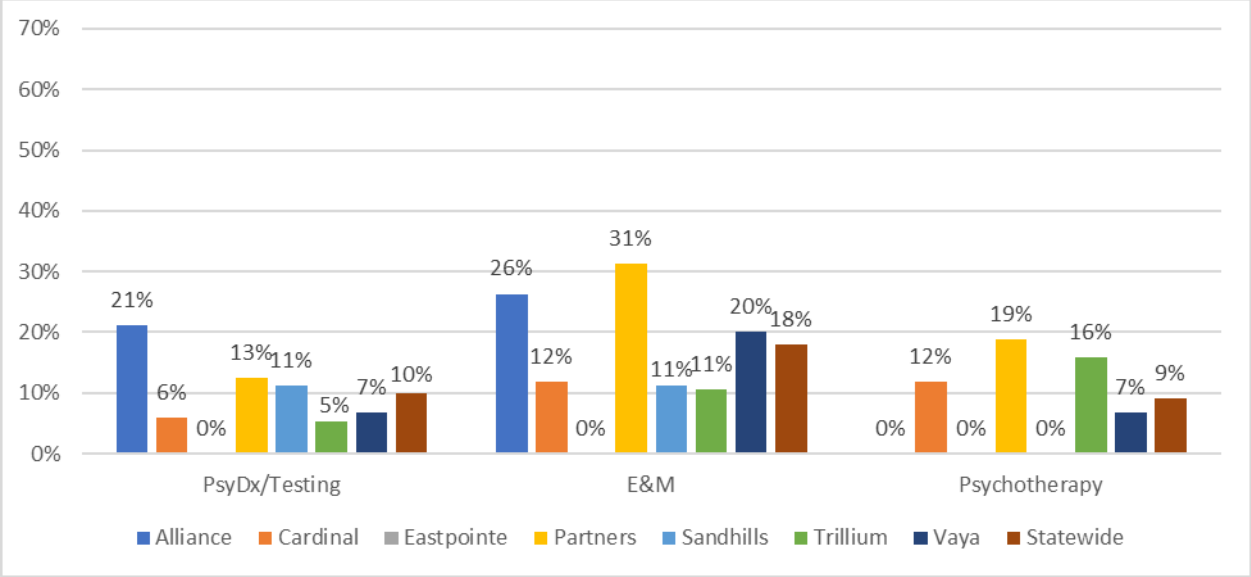
	Total N	ACT	CST	TMS	IPS	PSS	PSR
Alliance	19	12	3	4	1	2	0
Cardinal	17	9	5	1	0	2	0
Eastpointe	5	3	1	0	0	0	0
Partners	16	11	4	0	0	0	1
Sandhills	9	8	0	0	0	0	1
Trillium	19	10	3	3	0	0	0
Vaya	15	9	4	0	0	1	0
Statewide	100	62	20	8	1	5	2

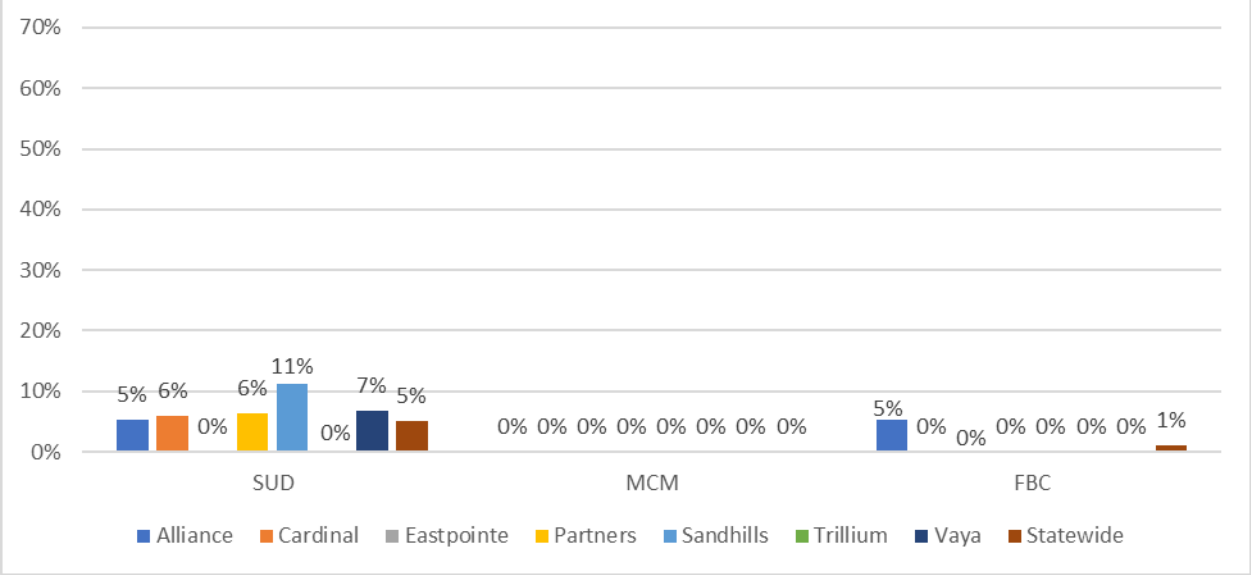




PARTICIPANT SERVICE COUNTS AND RATES, MEMBERS IN REHOUSING PLANNING, SFY 2021 (CONT.)

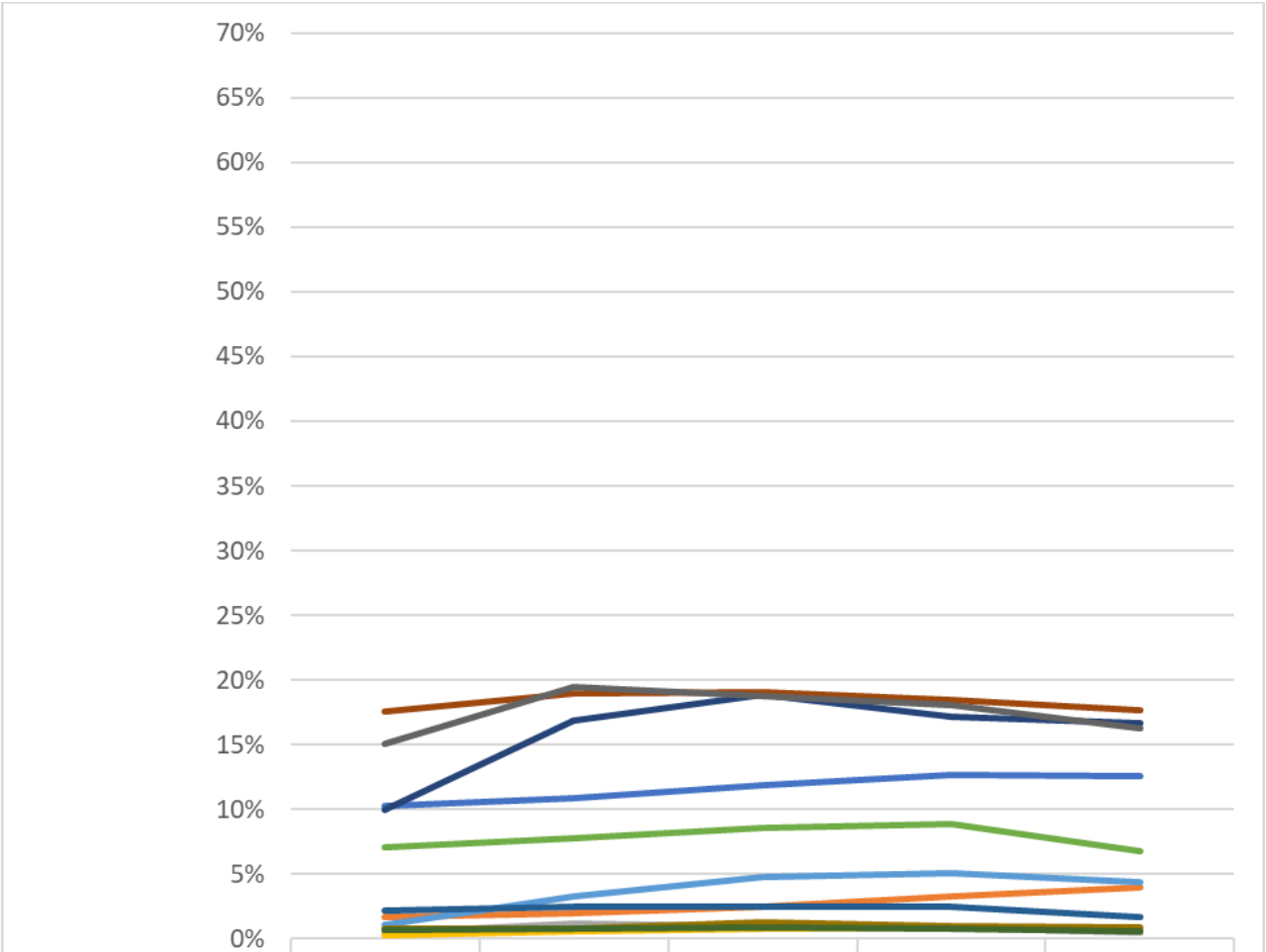
	Total N	PsyDx/ Testing	E&M	Psycho-therapy	SUD	MCM	FBC
Alliance	19	4	5	0	1	0	1
Cardinal	17	1	2	2	1	0	0
Eastpointe	5	0	0	0	0	0	0
Partners	16	2	5	3	1	0	0
Sandhills	9	1	1	0	1	0	0
Trillium	19	1	2	3	0	0	0
Vaya	15	1	3	1	1	0	0
Statewide	100	10	18	9	5	0	1





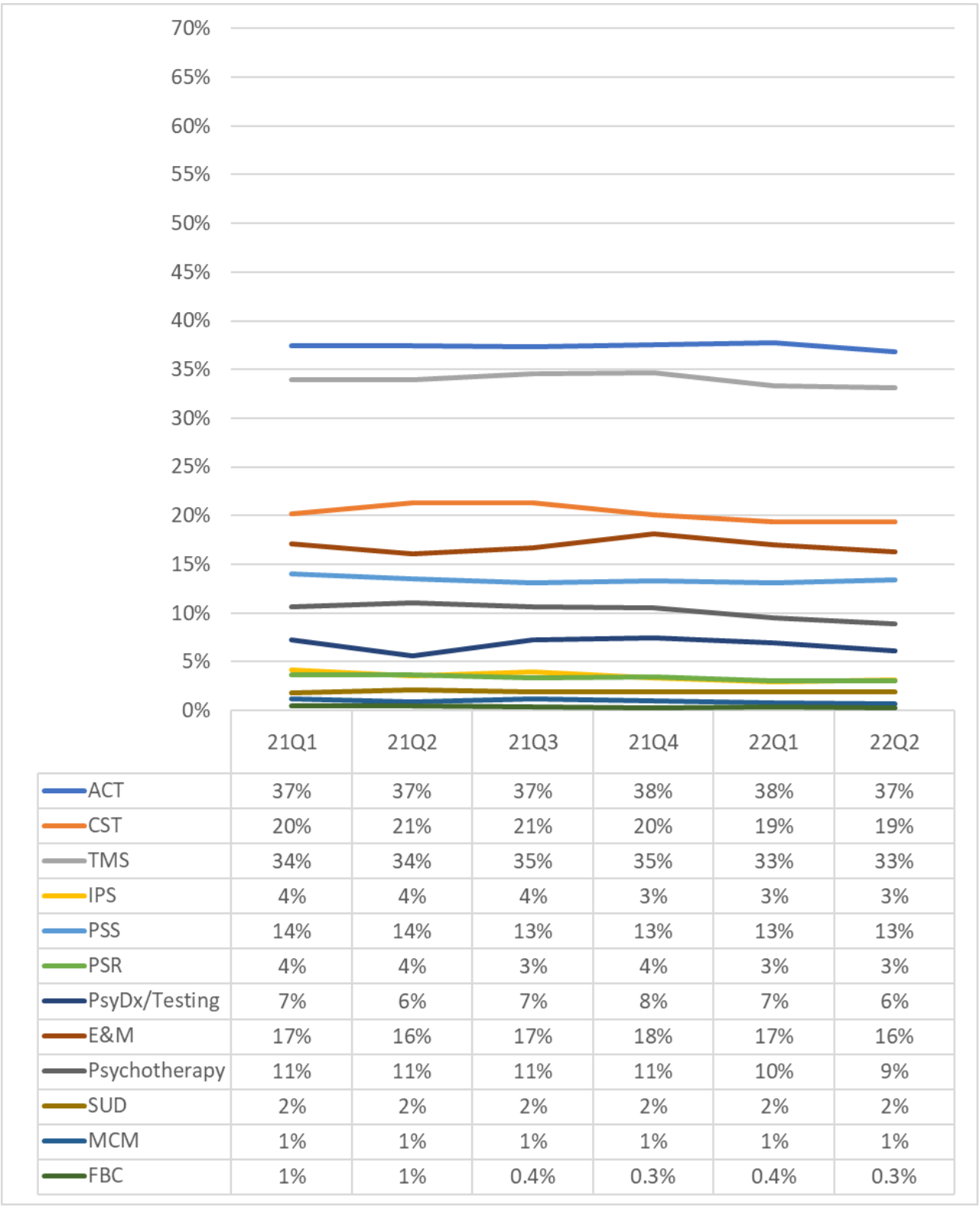
Participants in In-Reach

ANNUAL SERVICE RATES FOR PARTICIPANTS IN IN-REACH, SFY 2017 TO SFY 2021



	2017	2018	2019	2020	2021
ACT	10%	11%	12%	13%	13%
CST	2%	2%	3%	3%	4%
TMS	1%	1%	1%	1%	1%
IPS	0.3%	1%	1%	1%	1%
PSS	1%	3%	5%	5%	4%
PSR	7%	8%	9%	9%	7%
PsyDx/Testing	10%	17%	19%	17%	17%
E&M	18%	19%	19%	19%	18%
Psychotherapy	15%	20%	19%	18%	16%
SUD	1%	1%	1%	1%	1%
MCM	2%	3%	3%	3%	2%
FBC	1%	1%	1%	1%	1%

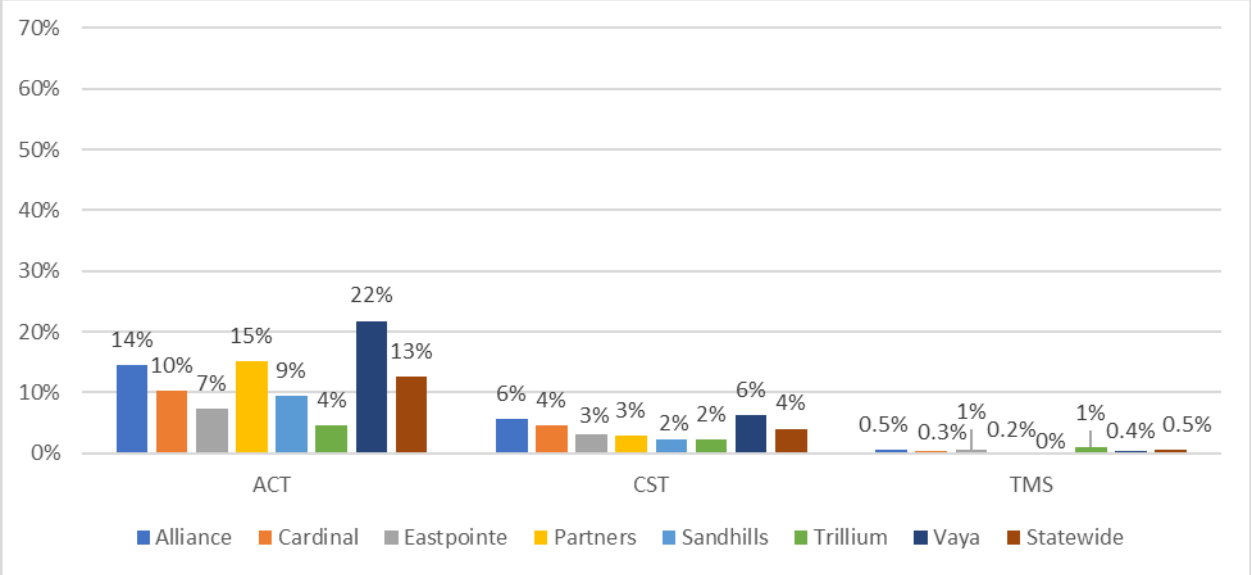
QUARTERLY SERVICE RATES FOR PARTICIPANTS IN IN-REACH, SFY 2021 QUARTER 1 TO SFY 2022 QUARTER 2

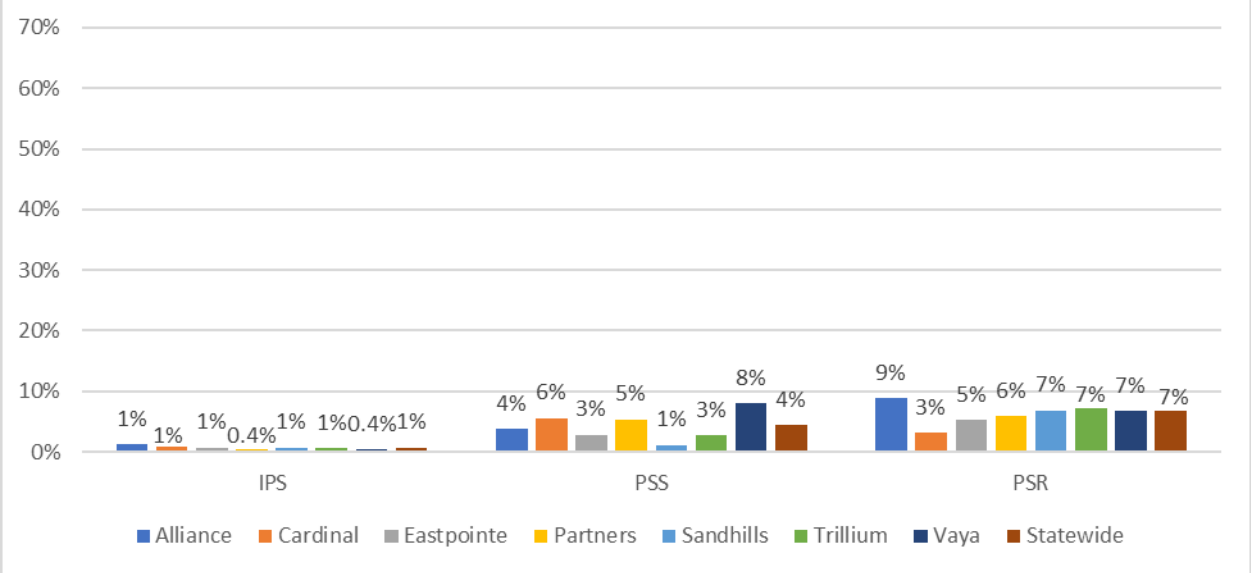


	21Q1	21Q2	21Q3	21Q4	22Q1	22Q2
ACT	37%	37%	37%	38%	38%	37%
CST	20%	21%	21%	20%	19%	19%
TMS	34%	34%	35%	35%	33%	33%
IPS	4%	4%	4%	3%	3%	3%
PSS	14%	14%	13%	13%	13%	13%
PSR	4%	4%	3%	4%	3%	3%
PsyDx/Testing	7%	6%	7%	8%	7%	6%
E&M	17%	16%	17%	18%	17%	16%
Psychotherapy	11%	11%	11%	11%	10%	9%
SUD	2%	2%	2%	2%	2%	2%
MCM	1%	1%	1%	1%	1%	1%
FBC	1%	1%	0.4%	0.3%	0.4%	0.3%

PARTICIPANT SERVICE COUNTS AND RATES, MEMBERS IN IN-REACH, SFY 2021

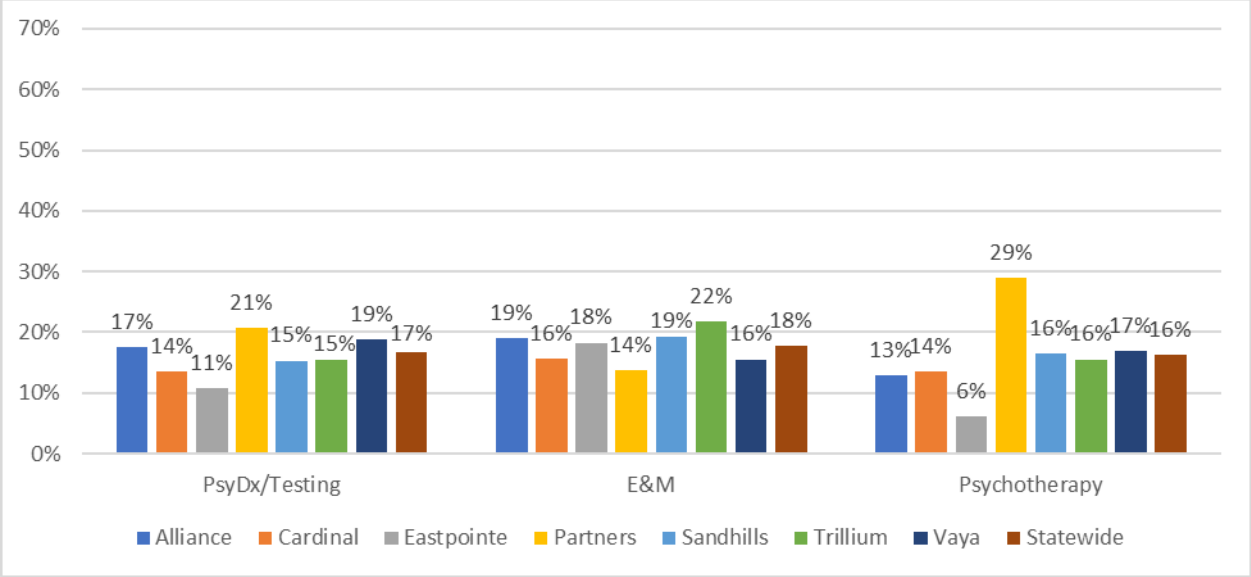
	Total N	ACT	CST	TMS	IPS	PSS	PSR
Alliance	1626	235	91	8	20	62	145
Cardinal	627	64	28	2	5	35	20
Eastpointe	564	41	17	3	4	16	30
Partners	1046	158	29	2	4	56	62
Sandhills	700	66	15	0	5	8	48
Trillium	1122	50	24	12	7	30	80
Vaya	1135	247	70	4	4	91	76
Statewide	6820	861	274	31	49	298	461

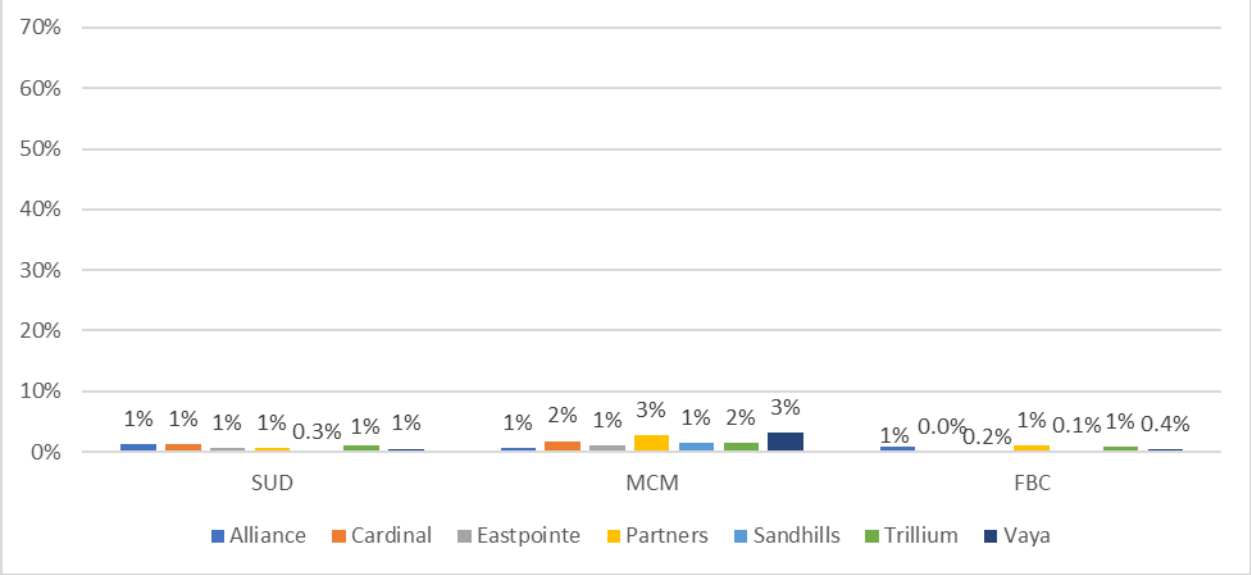




PARTICIPANT SERVICE COUNTS AND RATES, MEMBERS IN IN-REACH, SFY 2021 (CONT.)

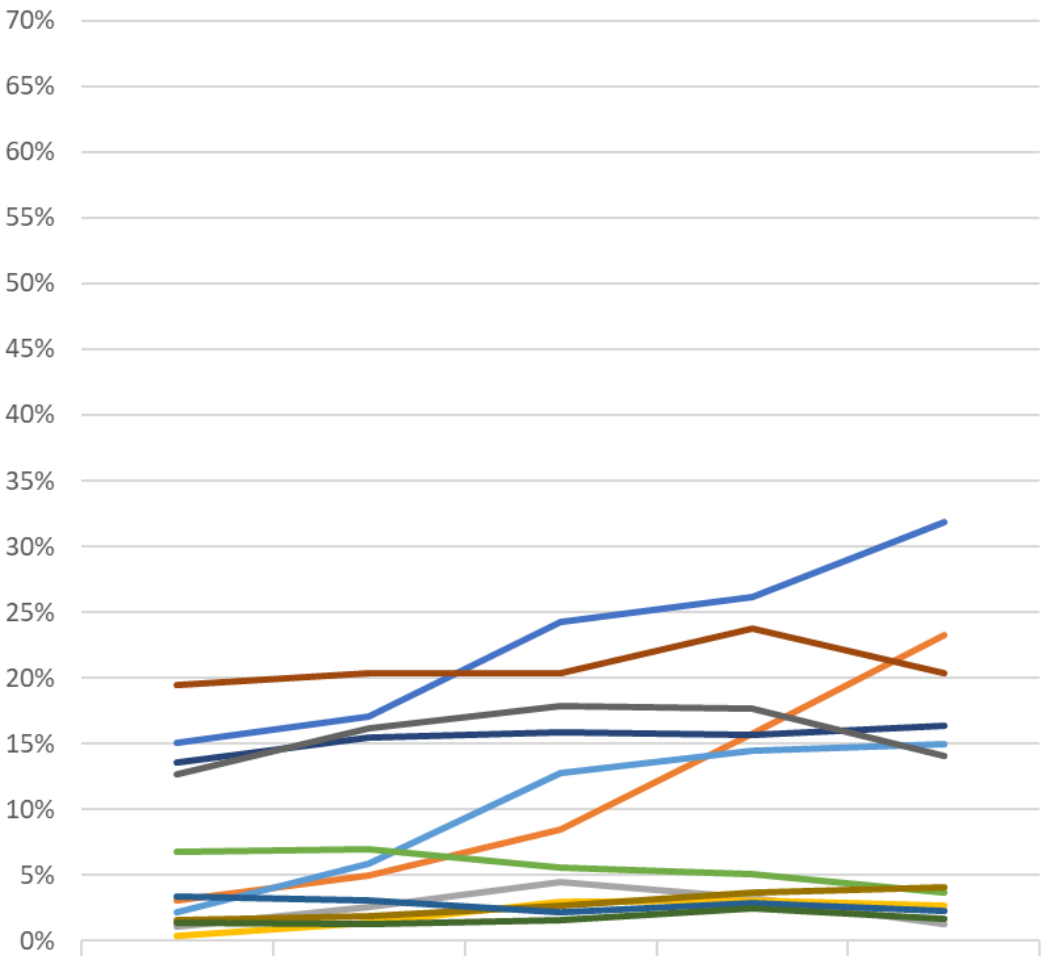
	Total N	PsyDx/ Testing	E&M	Psycho-therapy	SUD	MCM	FBC
Alliance	1626	284	309	209	21	9	13
Cardinal	627	85	98	85	8	11	0
Eastpointe	564	61	103	34	3	6	1
Partners	1046	216	144	302	6	28	11
Sandhills	700	107	134	115	2	10	1
Trillium	1122	173	245	174	12	17	9
Vaya	1135	213	176	192	6	36	5
Statewide	6820	1139	1209	1111	58	117	40





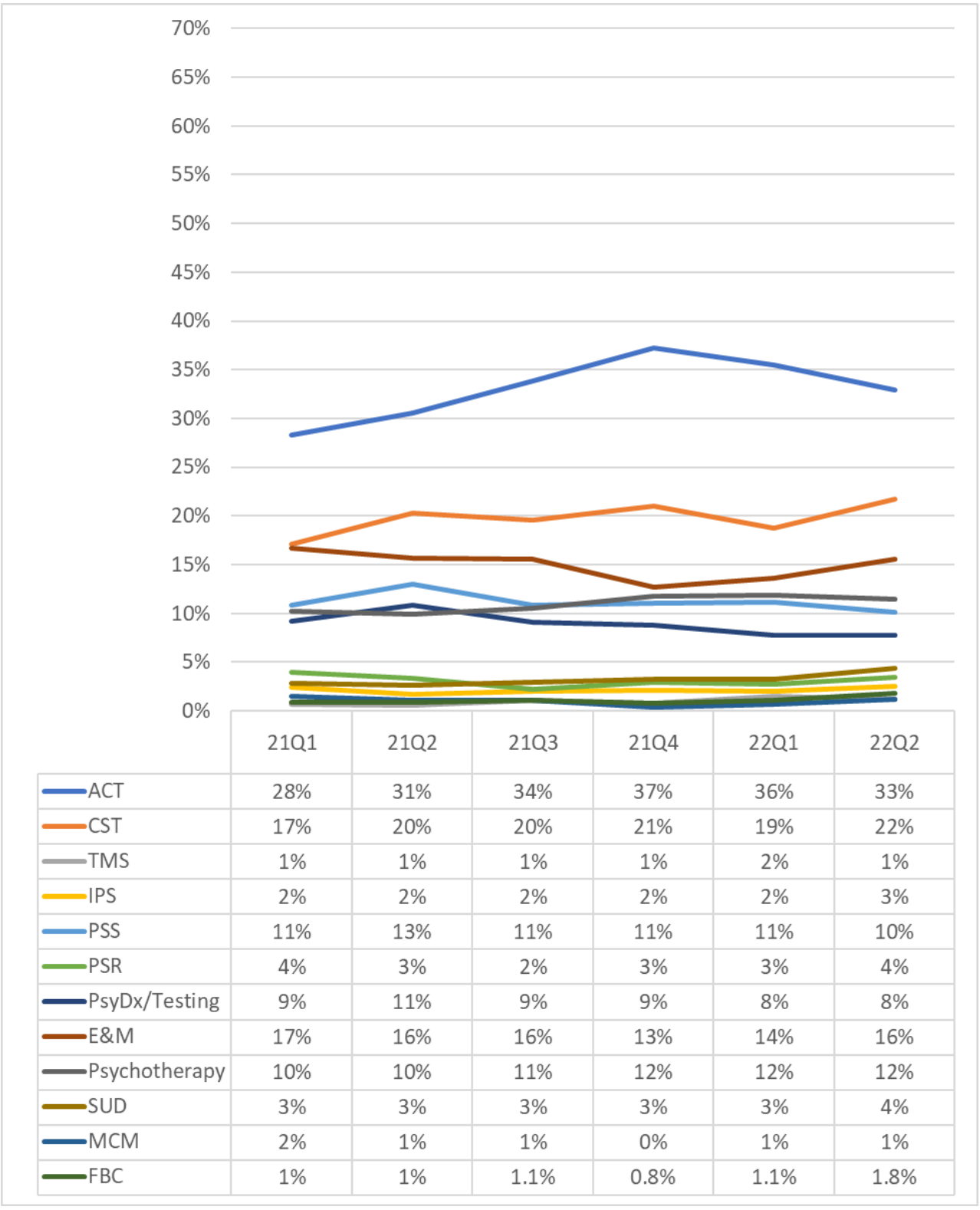
Participants in Diversion Status

ANNUAL SERVICE RATES FOR PARTICIPANTS IN DIVERSION, SFY 2017 TO SFY 2021



	2017	2018	2019	2020	2021
ACT	15%	17%	24%	26%	32%
CST	3%	5%	9%	16%	23%
TMS	1%	3%	5%	3%	1%
IPS	0%	1%	3%	3%	3%
PSS	2%	6%	13%	15%	15%
PSR	7%	7%	6%	5%	4%
PsyDx/Testing	14%	16%	16%	16%	16%
E&M	20%	20%	20%	24%	20%
Psychotherapy	13%	16%	18%	18%	14%
SUD	2%	2%	3%	4%	4%
MCM	3%	3%	2%	3%	2%
FBC	1%	1%	2%	3%	2%

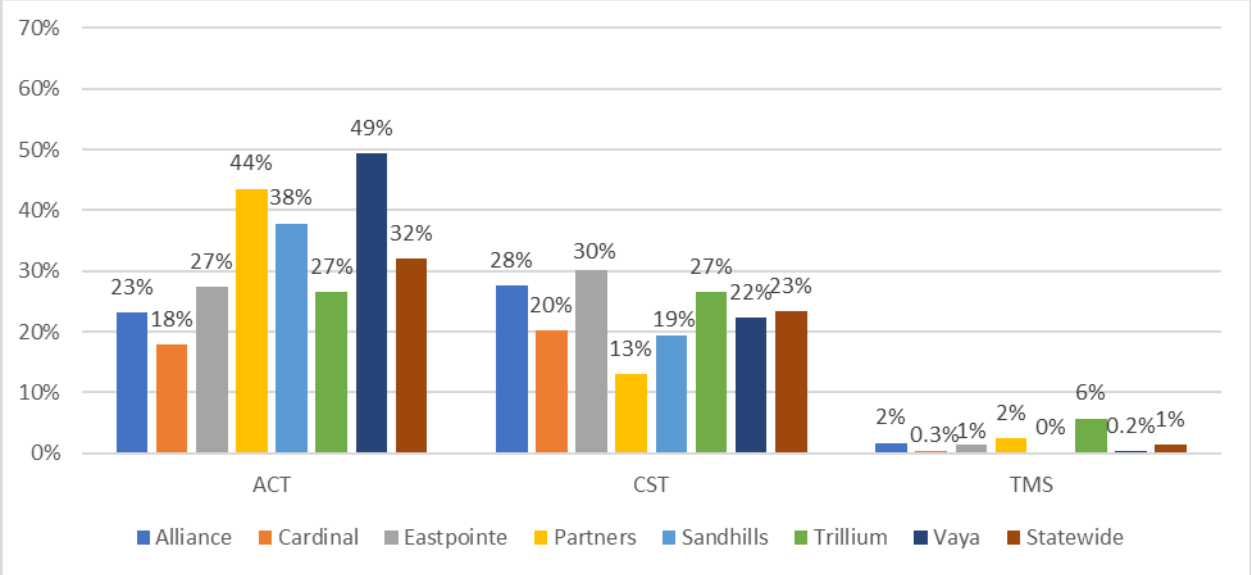
QUARTERLY SERVICE RATES FOR PARTICIPANTS IN DIVERSION, SFY 2021 QUARTER 1 TO SFY 2022 QUARTER 2

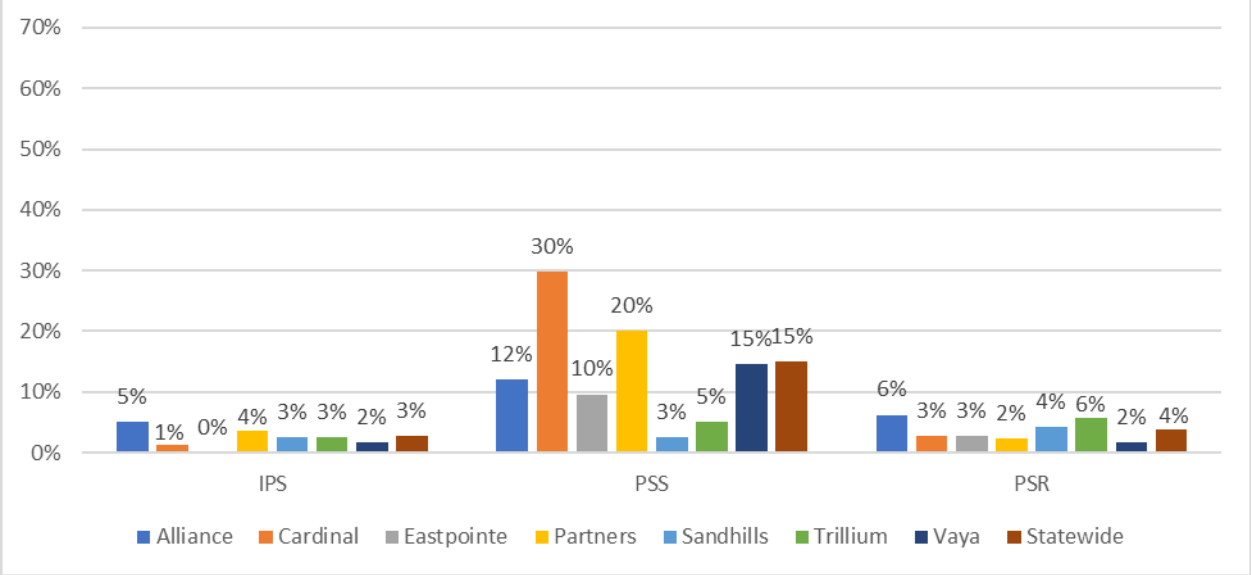


	21Q1	21Q2	21Q3	21Q4	22Q1	22Q2
ACT	28%	31%	34%	37%	36%	33%
CST	17%	20%	20%	21%	19%	22%
TMS	1%	1%	1%	1%	2%	1%
IPS	2%	2%	2%	2%	2%	3%
PSS	11%	13%	11%	11%	11%	10%
PSR	4%	3%	2%	3%	3%	4%
PsyDx/Testing	9%	11%	9%	9%	8%	8%
E&M	17%	16%	16%	13%	14%	16%
Psychotherapy	10%	10%	11%	12%	12%	12%
SUD	3%	3%	3%	3%	3%	4%
MCM	2%	1%	1%	0%	1%	1%
FBC	1%	1%	1.1%	0.8%	1.1%	1.8%

PARTICIPANT SERVICE COUNTS AND RATES, MEMBERS IN DIVERSION, SFY 2021

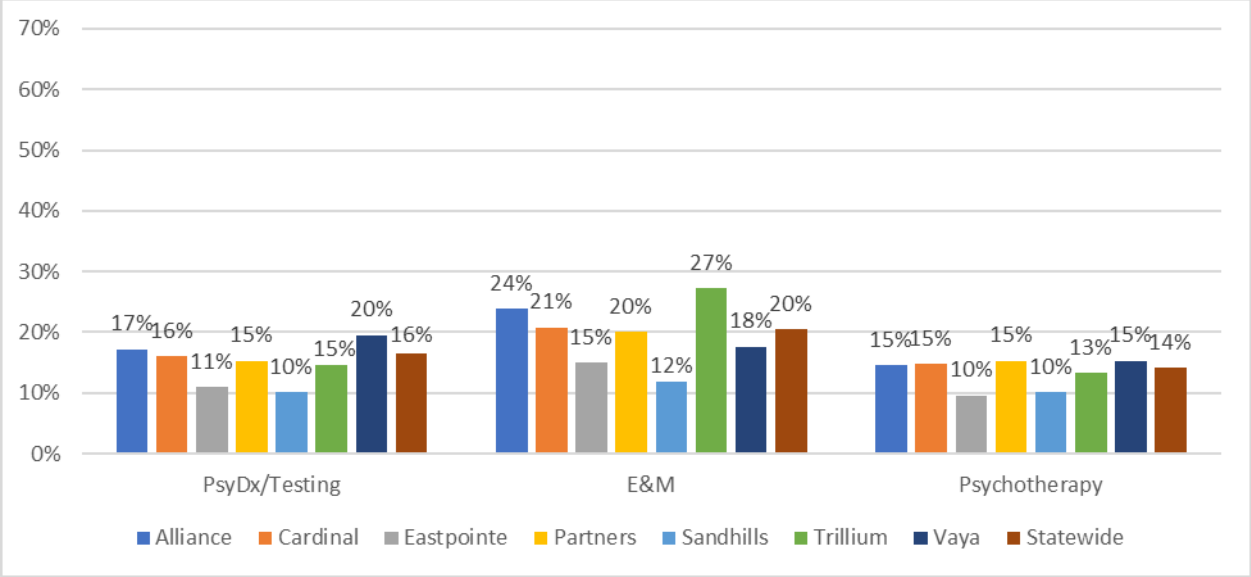
	Total N	ACT	CST	TMS	IPS	PSS	PSR
Alliance	418	97	115	7	21	50	26
Cardinal	298	53	60	1	4	89	8
Eastpointe	73	20	22	1	0	7	2
Partners	85	37	11	2	3	17	2
Sandhills	119	45	23	0	3	3	5
Trillium	158	42	42	9	4	8	9
Vaya	425	210	95	1	7	62	7
Statewide	1,576	504	368	21	42	236	59

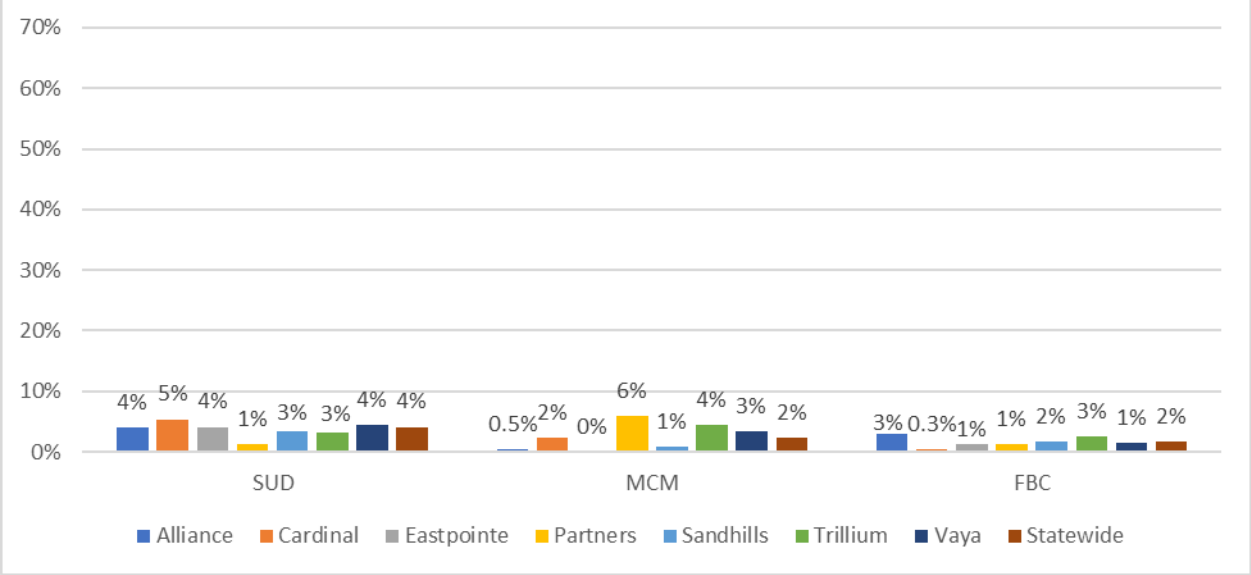




PARTICIPANT SERVICE COUNTS AND RATES, MEMBERS IN DIVERSION, SFY 2021 (CONT.)

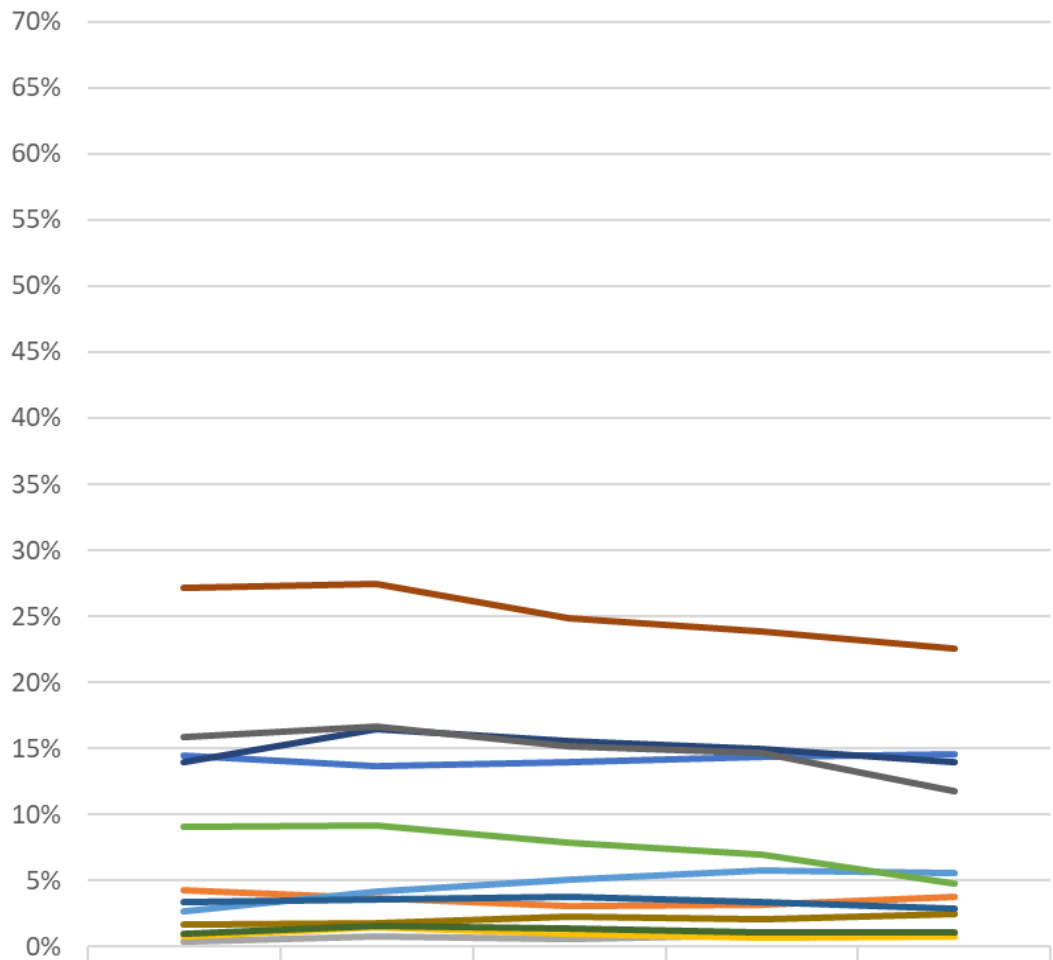
	Total N	PsyDx/ Testing	E&M	Psycho-therapy	SUD	MCM	FBC
Alliance	418	72	100	61	17	2	12
Cardinal	298	48	62	44	16	7	1
Eastpointe	73	8	11	7	3	0	1
Partners	85	13	17	13	1	5	1
Sandhills	119	12	14	12	4	1	2
Trillium	158	23	43	21	5	7	4
Vaya	425	83	75	65	19	14	6
Statewide	1,576	259	322	223	65	36	27





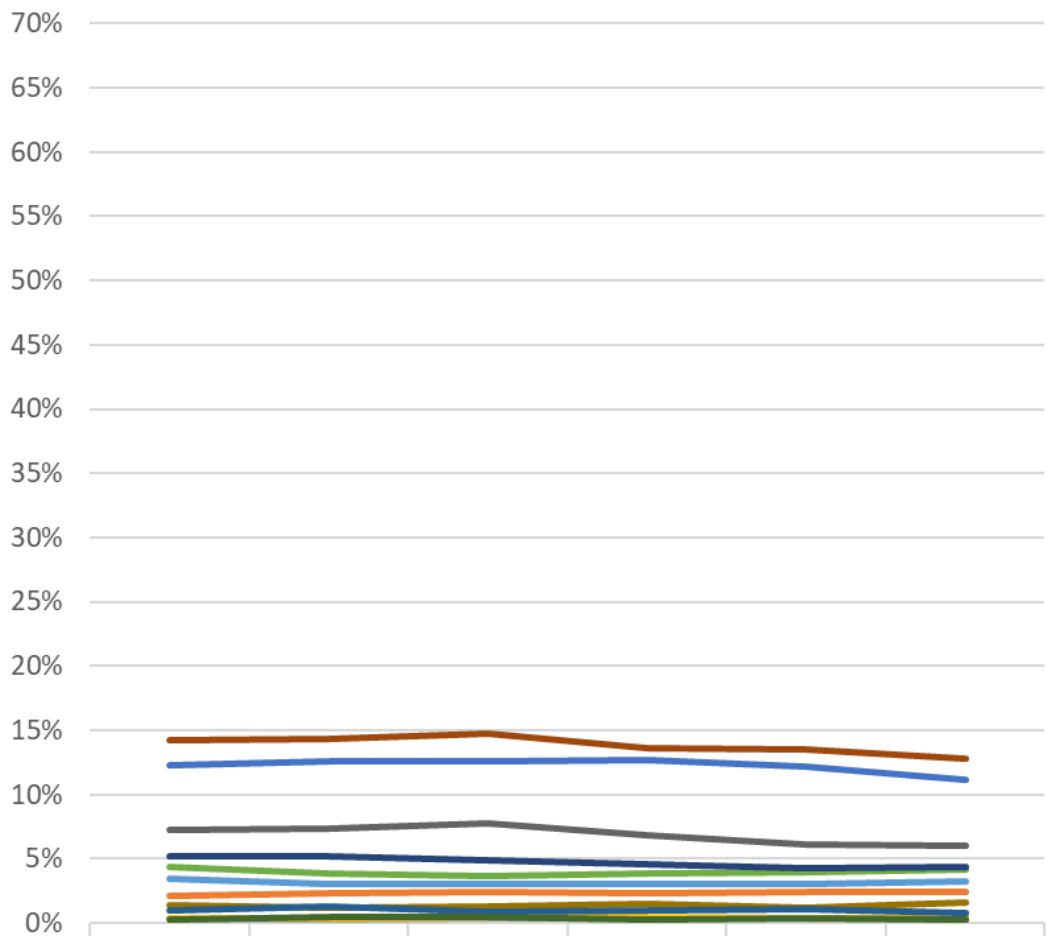
Participants Housed in the Community without a TCL Housing Slot

ANNUAL SERVICE RATES FOR PARTICIPANTS HOUSED IN THE COMMUNITY, SFY 2017 TO SFY 2021



	2017	2018	2019	2020	2021
ACT	15%	14%	14%	14%	15%
CST	4%	4%	3%	3%	4%
TMS	0%	1%	1%	1%	1%
IPS	1%	2%	1%	1%	1%
PSS	3%	4%	5%	6%	6%
PSR	9%	9%	8%	7%	5%
PsyDx/Testing	14%	17%	16%	15%	14%
E&M	27%	28%	25%	24%	23%
Psychotherapy	16%	17%	15%	15%	12%
SUD	2%	2%	2%	2%	3%
MCM	3%	4%	4%	3%	3%
FBC	1%	2%	1%	1%	1%

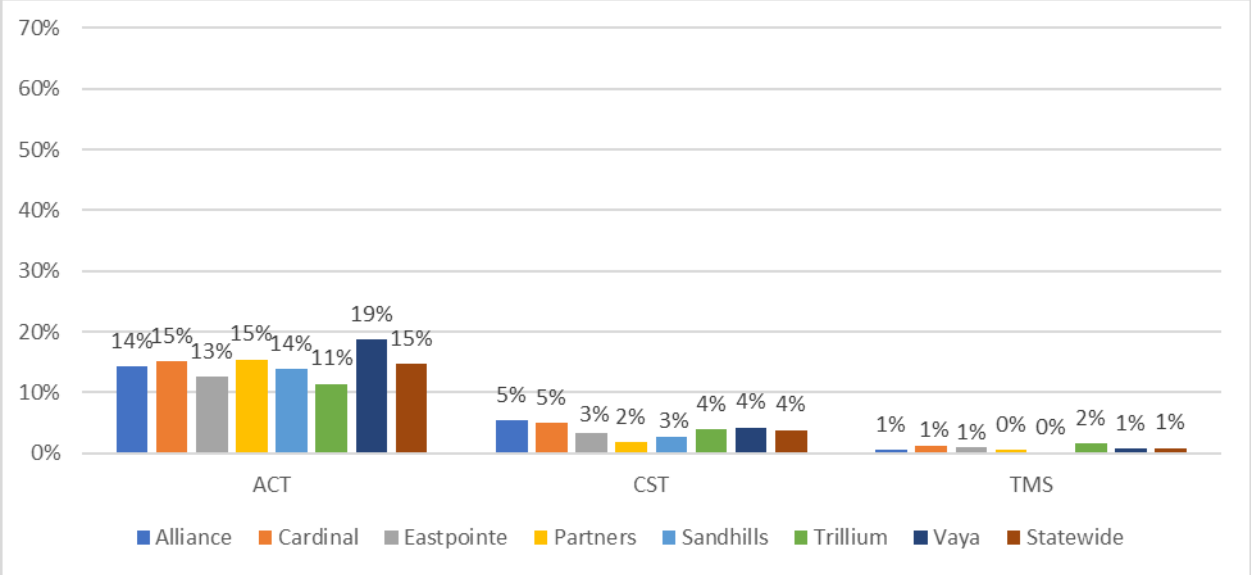
QUARTERLY SERVICE RATES FOR PARTICIPANTS HOUSED IN THE COMMUNITY, SFY 2021 QUARTER 1 TO SFY 2022 QUARTER 2

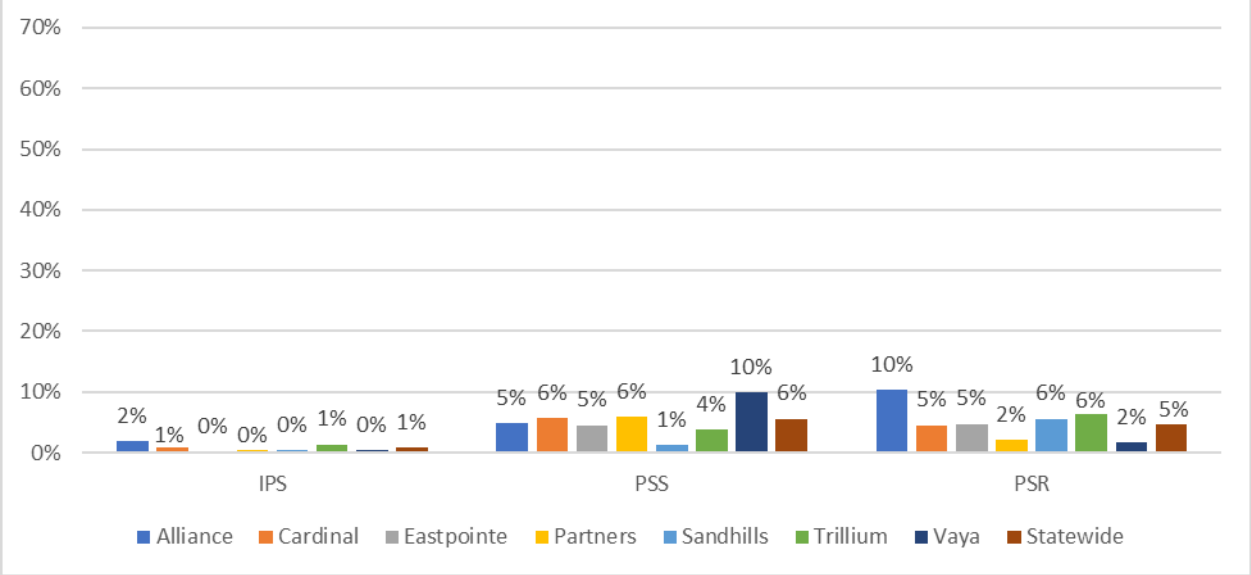


	21Q1	21Q2	21Q3	21Q4	22Q1	22Q2
ACT	12%	13%	13%	13%	12%	11%
CST	2%	2%	2%	2%	2%	2%
TMS	0%	0%	0%	0%	0%	0%
IPS	0%	0%	1%	1%	0%	1%
PSS	4%	3%	3%	3%	3%	3%
PSR	4%	4%	4%	4%	4%	4%
PsyDx/Testing	5%	5%	5%	5%	4%	4%
E&M	14%	14%	15%	14%	14%	13%
Psychotherapy	7%	7%	8%	7%	6%	6%
SUD	1%	1%	1%	2%	1%	2%
MCM	1%	1%	1%	1%	1%	1%
FBC	0%	1%	0.5%	0.3%	0.4%	0.3%

SERVICE COUNTS AND RATES, MEMBERS HOUSED IN THE COMMUNITY, SFY 2021

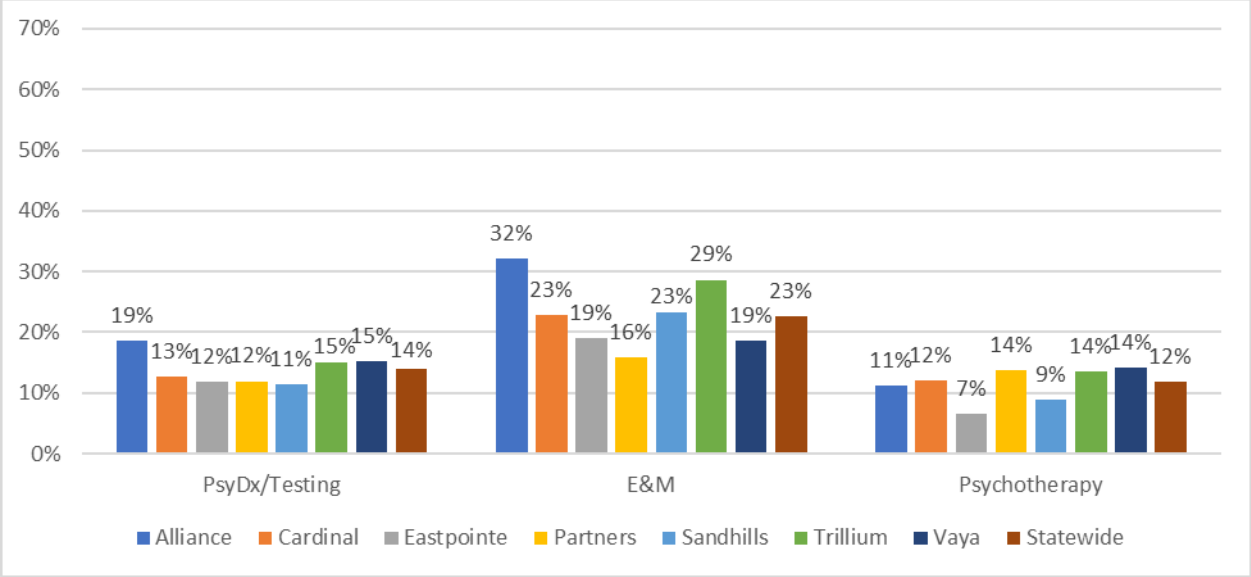
	Total N	ACT	CST	TMS	IPS	PSS	PSR
Alliance	377	54	20	2	7	18	39
Cardinal	442	67	22	5	4	25	20
Eastpointe	484	61	16	5	1	22	23
Partners	428	66	8	2	2	25	9
Sandhills	305	42	8	0	1	4	17
Trillium	597	68	23	9	8	23	38
Vaya	688	129	29	5	3	68	12
Statewide	3321	487	126	28	26	185	158

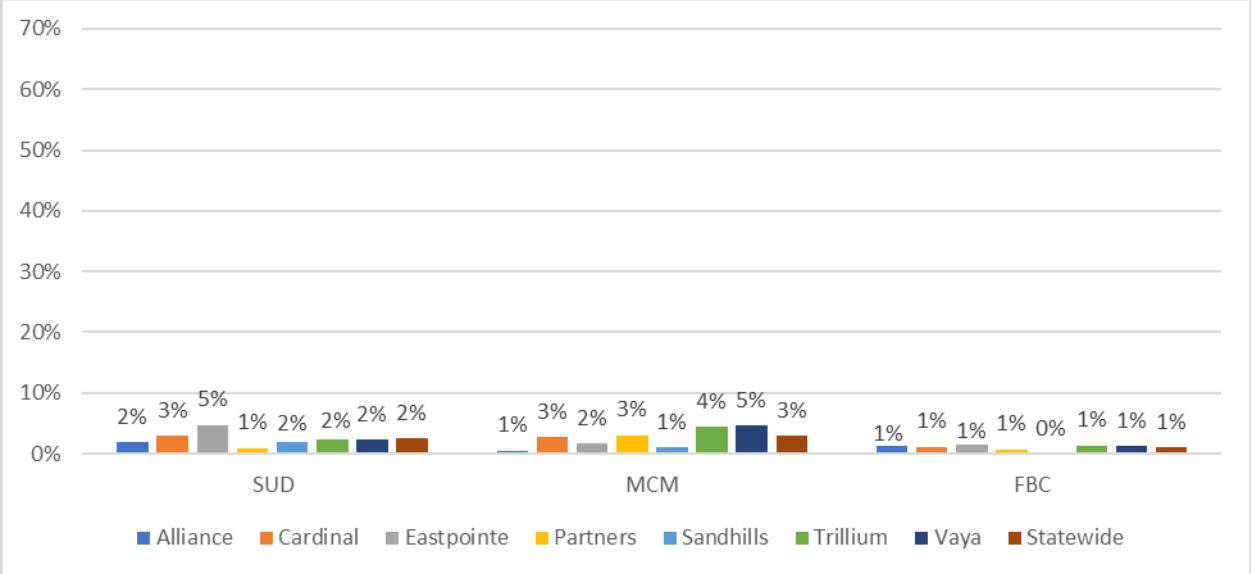




PARTICIPANT SERVICE COUNTS AND RATES, MEMBERS HOUSED IN THE COMMUNITY, SFY 2021 (CONT.)

	Total N	PsyDx/ Testing	E&M	Psycho-therapy	SUD	MCM	FBC
Alliance	377	70	121	42	7	2	5
Cardinal	442	56	101	53	13	12	5
Eastpointe	484	57	92	32	23	8	7
Partners	428	51	68	59	4	13	3
Sandhills	305	35	71	27	6	3	0
Trillium	597	90	171	81	14	26	8
Vaya	688	105	128	97	16	32	9
Statewide	3321	464	752	391	83	96	37





VI. In-Reach, Informed Decision-Making, and Adult Care Homes

In fiscal year (FY) 21 – 22, the Department of Health and Human Services (NCDHHS) continued to work with the Local Management Entities/Managed Care Organizations (LME/MCOs) to oversee the provision of In-Reach and frequent education of individuals and/or guardians about the opportunities to transition into Permanent Supportive Housing (PSH) and receive community-based services and supports. In-Reach and educational efforts are critical to transition planning; supporting individuals to acquire PSH; and successful exits from Adult Care Homes (ACHs) and State Psychiatric Hospitals (SPHs). With a strategic focus on areas in which the State has not yet met the Transitions of Community Living (TCL) settlement agreement standard of substantial compliance, the NCDHHS shifted its efforts in 2022 to reducing the In-Reach list; addressing continuous quality improvement; ensuring public guardians met their obligation to consider PSH; and providing targeted monitoring and guidance, staff training and additional education on informed consent.

Active monitoring of In-Reach and transitions occurred for individuals residing in ACHs and SPHs. Monitoring ensured that contacts were as frequent as requested, but not less than quarterly. Internal quality reviews provided the NCDHHS an opportunity to assess all phases of TCL, from the determination of eligibility and initiation of In-Reach to the post-transition phase when transitioned individuals are linked with community providers. The NCDHHS implemented documentation to ensure that local transition teams transmitted requests to the State Barriers Committee when there were outstanding barriers for individuals who remained in ACHs after expressing interest in PSH. In addition, the NCDHHS set expectations for LME/MCO transition teams for information gathered during In-Reach and used in the individual's transition plan and initial Person-Centered Plan.

The summer 2020 reassignment of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services' (DMH/DD/SAS) Community Transitions and Integration Team to the Office of the Secretary's TCL Team increased staffing for TCL. Although initially thought to be short-term, the reassignment had entered year three. Gains incident to the change included targeted monitoring; identification of quality improvement activities; development of TCL-specific trainings and quality reviews, leading to a reduction in the In-Reach list; and evidence that more individuals were afforded the opportunity to make informed decisions about Permanent Supportive Housing.

Accomplishments During State Fiscal Year 2021 – 2022

REVISION OF TCL INFORMED DECISION-MAKING TOOL.

NCDHHS first implemented the Informed Decision-Making (IDM) tool on September 1, 2020. After ten (10) months of implementation and feedback from certified peer support specialists, the IDM tool was revised in July 2021. NCDHHS revised the tool in collaboration with all seven (7) LME/MCOs to clarify which individuals should complete the IDM tool and when. The NCDHHS provided a refresher training to interested LME/MCOs in the fall of 2021 and continued to offer ongoing support and technical assistance, as needed. In July 2021, all LME/MCOs were required to begin submitting completed IDM tools to the NCDHHS. The launch of the TCL Incentive Plan in the spring of 2022 additionally required that what were then six (6) LME/MCOs to submit an IDM Tool plan. The IDM Tool plan increased the NCDHHS' ability to monitor the performance of IDM statewide, with each LME/MCO submitting IDM tools monthly. By the end of FY 22 – Quarter 4, the NCDHHS had reviewed 436 of the 445 IDM tools received.

COLLABORATION WITH THE DIVISION OF AGING AND ADULT SERVICES FOR USE OF THE INFORMED DECISION-MAKING TOOL.

The DMH/DD/SAS Community Transitions and Integration Team worked jointly with the Division of Aging and Adult Services (DAAS) to improve outcomes for individuals in TCL that have public guardians. DMH/DD/SAS and DAAS developed and, in July 2021, initiated an internal continuous quality improvement process. After the LME/MCOs have fully educated individuals and/or guardians about TCL and Permanent Supportive Housing, they begin the IDM process. To ensure all individuals have been fully educated about transition to the community and have made a decision that is "fully informed," the IDM tool must be completed. When the LME/MCOs notify DMH/DD/SAS that a public guardian has either refused to allow an In-Reach Specialist to educate an individual directly or, on behalf of an individual, to hear the information themselves, a referral is sent to DAAS for follow-up with the guardian. The NCDHHS recognizes that individuals with disabilities may require a higher level of support to make decisions in their lives. The collaboration with DAAS has ensured that individuals maintain that right to this support, especially when choosing to transition out of Adult Care Homes or institutional settings. By the end of FY 22 – Quarter 4, the NCDHHS had supported nine (9) individuals and their guardians to make an informed decision about Permanent Supportive Housing.

IDM ONLINE LEARNING MODULE WITH NORTH CAROLINA HOUSING FINANCE AGENCY.

In January 2022, the NCDHHS collaborated with the North Carolina Housing Finance Agency (NCHFA) to launch an on-demand, online Informed Decision-Making (IDM) learning module. The module is approximately 19 minutes in length and is accessible to all LME/MCO staff, guardians, and other stakeholders. The collaborative team designed the module to provide ongoing technical assistance to LME/MCOs and offered to familiarize stakeholders with IDM. The NCDHHS recognizes that any advocate and/or professional provider wants to ensure that an individual has been fully educated regarding their choices. In this online training module, individuals gain a better understanding of the importance of IDM and how to use the tool. By the end of FY 22 – Quarter 4, 117 individuals had completed the online learning module.

JOINT COMMUNICATION BULLETIN #J415 - CLARIFICATION OF TCL IN-REACH FUNCTION.

During fiscal year (FY) 22, the NCDHHS continued to monitor the process of engagement, i.e., how In-Reach Specialists form a relationship with a person before initiating a discussion of community living. By the end of FY 22 – Quarter 2, five (5) out of six (6) LME/MCOs reported they had resumed face-to-face/in-person In-Reach contacts. By comparison, all seven (7) LME/MCOs conducted the majority of these contacts for Adult Care Homes (ACHs) virtually for most of FY 21. However, data showed a low frequency of face-to-face/in person In-Reach contacts in ACHs and State Psychiatric Hospitals (SPHs). In FY 22 – Quarter 3, only 13% of contacts with individuals and/or guardians were face-to-face/in-person. During the height of the COVID-19 pandemic, flexibilities were put in place for all services, including the provision of In-Reach activities; this allowed LME/MCOs to perform these services virtually. Upon termination of the COVID-19 flexibilities, the NCDHHS observed extensive, ongoing use of letters and phone calls to fulfill the In-Reach function. On May 13, 2022, NCDHHS released Joint Communications Bulletin #J415 to the LME/MCOs, stating, "Letters are never to be used for In-Reach contact, phone calls are permitted for introductions, scheduling visits and informal conversations, but are not considered an In-Reach contact, and In-Reach requires face-to-face interaction, so peers can engage with each individual and establish rapport." As a result of weekly monitoring and technical assistance, face-to-face/in-person contacts increased. By the end of FY 22 – Quarter 4, 29% of contacts with individuals and/or guardians were face-to-face/in person contacts.

TCL TRAININGS AND RESOURCES.

During the fall and spring of FY 22, DMH/DD/SAS' Community Transitions and Integration Team conducted three (3) trainings and developed four (4) resource documents for In-Reach Specialists and Transition Coordinators.

Employment and Recovery: Working Together was developed with the DMH/DD/SAS Adult Mental Health Team to provide education to In-Reach Specialists and Transition Coordinators about work as an essential part of recovery. The training included a review of the Individual Placement and Support – Supported Employment (IPS-SE) and eligibility criteria; team members' roles with IPS-SE; the IPS-SE referral process; barriers/challenges; and exploring ways to begin the conversation around work. All seven (7) LME/MCOs participated, with a total of 161 attendees.

TCL Transition Planning Best Practices for ACHs covered best practices for ACH transition planning for all TCL staff (e.g., In-Reach Specialists, Transition Coordinators, housing specialists, supervisors, medical staff). Five (5) of the seven (7) LME/MCOs participated, with a total of 159 attendees.

In-Reach Refresher Training was provided to In-Reach Specialists and In-Reach Supervisors. This included reviewing the definition of In-Reach; expectations of In-Reach Providers; the role of In-Reach; engagement and In-Reach; and the review of the In-Reach/Transition TCL and Informed Decision-Making tools. All six (6) LME/MCOs participated for a total of 84 attendees.

Adult Care Home Barriers/Strategies to Address Barriers. This resource assists LME/MCO staff with ACH barriers. Lists of common barriers were compiled during quality reviews, NCDHHS shadowing of In-Reach Specialists and from the state barriers tracking log. The document provides strategies to address these. The resource aligns with the In-Reach/TCL manual and with technical assistance from the State Barriers Committee. Staff are offered a readily accessible document that promotes the initiation of TCL activities.

In-Reach Workflow. This resource covers the steps to take when an individual chooses not to transition into Permanent Supportive Housing or is hesitant to do so. It is a quick reference guide that provides helpful reminders to In-Reach Specialists as they move through the In-Reach process, including which tools to utilize, based on where the individual is in the process of deciding about Permanent Supportive Housing.

Adult Care Home Transition Planning Flowchart provides a visual guide of the four phases of ACH transition planning. The flowchart highlights key tasks/responsibilities during each phase, including In-Reach and transition, both pre- and post-transition. The flowchart does not note specific time frames for each phase, given the unique nature of each individual's transition. This is a useful guide for all TCL staff on how transition planning should occur.

Demonstrated Steps Toward Substantial Compliance: Meeting the Transitions to Community Living Settlement Agreement Standard

Discharge and transition process requirements apply to individuals who are exiting Adult Care Homes (ACHs); are discharged from State Psychiatric Hospitals (SPHs); or are potentially diverted from ACHs. During FY 22, the NCDHHS implemented effective measures to demonstrate substantial compliance with discharge and transition processes. These focused on ACH transitions and In-Reach into ACHs and SPHs.

For individuals residing in ACHs, transition and discharge planning is to be completed within ninety (90) days of assignment to a transition team. The NCDHHS has taken steps to eliminate discharge and transition barriers. In March 2022, the NCDHHS developed an ACH Barriers & Technical Assistance process. When TCL staff identify barriers that prevent them from performing In-Reach and transition functions in ACHs, the DHHS provides technical assistance that includes strategies to address barriers at the LME/MCO level first before referring them to the State Barriers Committee. One of the common barriers is related to timely

transitioning of individuals from ACHs. Since the process has been implemented, DMH In-Reach Coaches have been able to assist LME/MCOs with several barriers such as individuals posing as guardians; guardian refusals to be educated about TCL and PSH; ACH staff interference; and issues with the linkage to providers to initiate community-based services and supports.

The NCDHHS took significant steps, aimed at individuals in ACHs and SPHs, families and community providers, to provide frequent education efforts; information about the benefits of supported housing; visits to such settings; and visits to meet other individuals with disabilities who were living, working, and receiving services in integrated settings. The NCDHHS released Joint Communications Bulletin #J415 on May 13, 2022, to clarify the TCL In-Reach function. It outlined what In-Reach is, what constitutes an In-Reach contact, the frequency upon which In-Reach should occur and the required method to perform In-Reach efforts. NCDHHS' ongoing technical assistance has reinforced that In-Reach Specialists must make direct contact with individuals and/or guardians and not leave voice messages that go unanswered; not talk with ACH staff; or mail letters, since letters are routinely not received by the individual or guardian. The revised Informed Decision-Making tool documents that individuals are offered the opportunity to meet with other individuals living with disabilities who have transitioned into the community.

Discharge and transition begin at admission to an ACH or a SPH, or when an individual is identified as TCL-eligible. The process documents the steps taken to ensure that the decision *not* to transition into the community is an informed one and that individuals will continue to be regularly educated about various community options. Individuals remaining in an ACH or a SPH are re-assessed on a quarterly basis, or more frequently, upon request. The NCDHHS revised the IDM tool so that it provides clear evidence of documented barriers to transition, and the strategies that have been taken to address these. The NCDHHS also released Joint Communications Bulletin #J415 on May 13, 2022, to clarify the TCL In-Reach function and expectations. It outlined what In-Reach is; what constitutes an In-Reach contact; the frequency for In-Reach; and the method of performing In-Reach efforts.

Transition Coordinators are the lead contact for ACH transitions and make attempts to mitigate or remove barriers. The NCDHHS implemented evidence-based practice guidance that outlined Transition Coordinators' responsibilities during pre-transition, transition and post-transition phases. Transition Coordinators' primary role is to arrange and lead all transition meetings, along with monitoring task completion by transition team members.

VII. Pre-Admission Screening and Diversion

Successful community living requires intentional, informed support on the part of the Local Management Entity/Managed Care Organization (LME/MCO), providers, any available natural supports and NCDHHS staff. Pre-Admission Screening and Diversion are key components in successful community living for individuals that are already in the community and who are being considered for admission to an Adult Care Home (ACH). Developing processes such as Community Integration Planning and Informed Decision-Making (IDM), along with monitoring of data systems and processes, staff training and technical assistance, has allowed many individuals who were being considered for ACH admission to live successfully in the community in Permanent Supportive Housing.

Community Integration Planning and Informed Decision Making

Community Integration Planning is the process through which LME/MCO staff assist an individual in developing a plan to achieve growth, well-being and independence through informed decision-making. Person-centered in nature, Community Integration Planning is based on the individual's strengths, needs, goals and preferences, considered in the context of the most appropriate integrated setting, across all domains of the individual's life. As such, the Community Integration Plan is a key component of Transition and Discharge planning. The conversations that inform the Community Integration Planning should begin

during the Diversion, prior to admissions into an ACH. For the planning to be effective, the LME/MCO staff who assist Transitions to Community Living (TCL) participants must be knowledgeable about the resources, supports, services and opportunities available in a community, including community mental health service providers and mental health supports. Working with knowledgeable staff ensures that individuals are fully informed when considering entry into an ACH.

The Department has been monitoring Community Integration Planning process quarterly through quality reviews. It has gathered documentation from each LME/MCO to assess the process and LME/MCOs' utilization of the revised Community Integration Planning guidance document. The LME/MCOs receive an annual tracking spreadsheet that requests feedback about the process. The State analyzes responses to ensure that processes promote individual success and advance substantial compliance with the TCL settlement agreement. The State provided a Diversion Refresher training in February 2022, covering informed decision-making as part of the process. The State also provided opportunity for Diversion staff to participate in the IDM tool online learning module. In addition, a Community Integration Planning and Informed Decision-Making (IDM) for Population Category 5[49] document was developed for the LME/MCOs in February 2022.

Technical Assistance and Monitoring

Monitoring has allowed the Department to continue addressing training needs regarding Community Integration Planning, Informed Decision-Making, Referral Screening Verification Process (RSVP) time frames and data errors. In addition, technical assistance has been provided, post system implementation of RSVP and Transitions to Community Living Database (TCLD) modifications, to address any system issues that resulted. System modifications, implemented in April 2022, have improved data integrity, user friendliness and functionality of the systems. These included adding a community hospital admission date requirement on the referral entry side of RSVP, assisting LME/MCOs to obtain the timeframe between hospital admission and RSVP submission. Other RSVP enhancements have included the ability for LME/MCO staff to change the referral sequencing when a referral is submitted by an ACH on or after admission date. This has ensured that only Population Category 5 referrals are screened. Lastly, for RSVP, we effected system automations to activate a TCLD record for existing TCL individuals that were withdrawn from the In-Reach list for Category 5 individuals, a modification that has improved timeliness of activation and diversion activities.

In addition to the RSVP enhancements, TCLD enhancements included new statuses, new temporary housing locations and automations to improve data integrity and accuracy. Added Diversion Outreach contacts capture these activities and timeframes more effectively, as well as ensuring that diversion contacts were not being captured under In-Reach visits.

Areas of monitoring to track improvements and barriers include RSVP system technical assistance, RSVP to Diversion Workflows, RSVP prompt determination of eligibility and Informed Decision-Making. These are discussed below.

[49] Under TCL's settlement agreement with the Department of Justice, priority for the receipt of Housing Slots is given to the following individuals: 1. Individuals with serious mental illness (SMI) who reside in an adult care home determined by the State to be an Institution for Mental Disease; 2. Individuals with Severe and Persistent Mental Illness (SPMI) who are residing in Adult Care Homes licensed for at least 50 beds and in which 25% or more of the resident population has a mental illness; 3. Individuals with SPMI who are residing in Adult Care Homes licensed for between 20 and 49 beds and in which 40% or more of the resident population has a mental illness; 4. Individuals with SPMI who are or will be discharged from a State psychiatric hospital and who are homeless or have unstable housing; and 5. Individuals diverted from entry into Adult Care Homes pursuant to the preadmission screening and diversion provisions of Section III(F) of this Agreement. These are known as the TCL population categories. Retrieved on August 29, 2022 from SETTLEMENT AGREEMENT (ncdhhs.gov).

RSVP AND TCLD SYSTEM TECHNICAL ASSISTANCE.

The State continues to provide technical assistance for the RSVP, as needed, to LME/MCOs, providers, individuals and referral sources. The State continues to conduct monthly and quarterly monitoring of the RSVP and Diversion data and processes. Additionally, the State conducted Diversion Refresher training in February 2022 with all six (6) LME/MCOs. This training provided LME/MCOs with additional technical assistance, designed to meet substantial compliance with Section III. F of the settlement agreement, Pre-Admission Screening and Diversion.

LME/MCO RSVP TO DIVERSION WORKFLOW.

On an as needed basis, the NCDHHS continued to monitor each LME/MCO's RSVP to Diversion workflow. The Department sends a tracking spreadsheet to the LME/MCOs and analyzes responses to identify gaps or needs. Prior year challenges have included a delay in the RSVP processing timeframes beyond 30 days, as well as a gap in the assignment of staff to perform outreach activities. RSVP timeframes have continued to remain under 30 days and some LME/MCOs have hired diversion and outreach-specific staff. Other LME/MCOs have restructured their internal workflows. This change reduced processing timeframes and removed outreach responsibilities from In Reach staff. In addition, RSVP workflows received, based on individuals' location, were sent to LME/MCOs in April 2022. This effort was in response to survey results and requests by the LME/MCOs following Diversion Refresher training, conducted in February 2022.

RSVP PROMPT DETERMINATION OF ELIGIBILITY.

TCL also monitors promptness, by means of data reviews, of the LME/MCO eligibility determinations. Notification of all "RSVPs pending" goes to the relevant LME/MCO staff monthly with a request for a response, inclusive of actions taken. Department staff review responses and data to ensure that the LME/MCOs are working toward meeting the settlement agreement's substantial compliance standard. As a result of the NCDHHS' training, education and technical assistance with both LME/MCOs and referral sources, the number of individuals in the "RSVP pending" status of over 30 days continued to be reduced.

Improvements are also evident in processing timeframes, eliminating duplications and reducing the volume of requests for individuals not eligible for TCL. Additionally, the number of individuals housed with a TCL housing slot, as well as individuals that remained in the community without a TCL housing slot – participants in Population Category 5[50], "diversions from institutions" – decreased from the prior year. These decreases were primarily due to COVID-19 restrictions being lifted for individuals in facilities and the focus returning to housing for individuals in ACHs. The number of Category 5 TCL-eligible people housed with a TCL slot as well as individuals that remained in the community without a TCL slot decreased from 24% in FY 21 to 18.5% in FY 22. The data continued to demonstrate that RSVP is effective in diverting individuals from restrictive settings. As a result, for FY 22, TCL has exceeded the settlement agreement requirement of 1,000 individuals housed with a TCL housing slot for Population Categories 4 and 5. Final FY 22 data for Population Categories 4 and 5 shows that 1,895 individuals were housed with a TCL housing slot.

INDIVIDUALS NOT DIVERTED FROM ADULT CARE HOMES AND INFORMED DECISION-MAKING.

The Department began quarterly reviews in August 2021 of 100% of RSVP referrals deemed "TCL eligible and Not Diverted from Adult Care Homes (ACHs)." NCDHHS sent findings, barriers, and concerns to each LME/MCO following the review. The Department requested that its partners identify action steps that would lead to the resolution of barriers/concerns.

[50] Under TCL's settlement agreement with the Department of Justice, priority for the receipt of Housing Slots is given to the following individuals: 1. Individuals with serious mental illness (SMI) who reside in an adult care home determined by the State to be an Institution for Mental Disease; 2. Individuals with Severe and Persistent Mental Illness (SPMI) who are residing in Adult Care Homes licensed for at least 50 beds and in which 25% or more of the resident population has a mental illness; 3. Individuals with SPMI who are residing in Adult Care Homes licensed for between 20 and 49 beds and in which 40% or more of the resident population has a mental illness; 4. Individuals with SPMI who are or will be discharged from a State psychiatric hospital and who are homeless or have unstable housing; and 5. Individuals diverted from entry into Adult Care Homes pursuant to the preadmission screening and diversion provisions of Section III(F) of this Agreement. These are known as the TCL population categories. Retrieved on August 29, 2022 from SETTLEMENT AGREEMENT (ncdhhs.gov).

Department staff also began quarterly quality reviews in January 2022 of those individuals referred through RSVP for Population Category 5 who, despite diversion efforts, ultimately entered an ACH. Gaps, barriers, and concerns to meeting Section III. F. 3 of the settlement agreement[51] were individually addressed with each LME/MCO as needed.

The State held a Diversion Refresher Training for each of the six (6) LME/MCOs in February 2022. LME/MCO staff were provided information on use of the Informed Decision-Making (IDM) tool for Population Category 5 as a way to document barriers/objections to Permanent Supportive Housing (PSH). The training included steps to address identified barriers when individuals were not diverted from ACHs. Department staff followed up on all Population Category 5 IDMs submitted.

Data

The Department focused on data integrity and accuracy of the TCLD database during FY 22. This work included removal from the database of deceased individuals. In addition to withdrawing those who were deceased, the "data clean-up" focused on individuals that had moved out of state, moved into skilled nursing facilities, or were unable to be located. The "clean-up" resulted in more accurate and reliable reporting data for Diversion.

CHART A: LME/MCO PRE-ADMISSION SCREENING CUMULATIVE TOTALS FROM JULY 1, 2021 THROUGH JUNE 30, 2022

LME/MCO	Total RSVP Population Category 5 Referrals Submitted	RSVP Screenings Determined TCL Eligible	RSVP Screening Determined TCL Ineligible	RSVP Screenings Pending	RSVP Screenings Withdrawn (duplicate, not considered for admission. other)
Alliance Behavioral Healthcare	1413	269	296	10	838
*Cardinal Innovations	497	0	0	0	497
Eastpointe	461	38	5	3	415
Partners Behavioral Health Management	1027	93	82	4	848
Sandhills Center	654	57	16	0	563
Trillium	1043	116	74	23	830
Vaya Health	1007	185	40	0	782
Total	**6102**	**758**	**513**	**58**	**4773**

*Data source: RSVP.

Prior to October 2019, data was reported monthly. Beginning with the October 2019 report, data began to be reported cumulatively, given the RSVP implementation date of November 1, 2018. Data reported was pulled from RSVP on July 26, 2022.[52]

[51] This section of the TCL settlement agreement states: "If the individual, after being fully informed of the available alternatives to entry into an adult care home, chooses to transition into an adult care home, the State will document the steps taken to show that the decision is an informed one. The State will set forth and implement individualized strategies to address concerns and objections to placement in an integrated setting and will monitor individuals choosing to reside in Adult Care Homes and continue to provide in-reach and transition planning services."

[52] The RSVP process did not begin until 2018 so TCL could not see trends until 2019. Once there were four quarters of data, it was possible to look at all of the data cumulatively and begin to detect trends.

*Note: Cardinal LME/MCO catchment area county disengagement was underway during this period. The wind down of this LME/MCO caused data to fluctuate due to data corrections and transfers of information from one LME/MCO to another. Only those withdrawn from RSVP remained as part of the RSVP data for Cardinal; this information will remain under the portion of the system dedicated to the former LME/MCO for data integrity purposes. Additionally, Bladen County transfers that occurred in February also caused data fluctuations.

CHART B: LME/MCO PRE-ADMISSION SCREENING CUMULATIVE TOTALS FROM NOVEMBER 1, 2018 THROUGH JUNE 30, 2022

LME/MCO	Total RSVP Population Category 5 Referrals Submitted	RSVP Screenings Determined TCL Eligible	RSVP Screening Determined TCL Ineligible	RSVP Screenings Pending	RSVP Screenings Withdrawn (duplicate, not considered for admission/ other)
Alliance Behavioral Healthcare	4347	1310	962	10	2065
*Cardinal Innovations	4047	0	0	0	4047
Eastpointe	1742	281	191	3	1267
Partners Behavioral Health Management	3385	543	658	4	2180
Sandhills Center	2174	447	153	18	1556
Trillium	4038	640	549	23	2826
Vaya Health	4275	1373	810	0	2092
Total	**24008**	**4594**	**3323**	**58**	**15978**

*Data source: RSVP data was reported monthly in prior months. Beginning with the October 2019 report, data began to be reported cumulatively, given the RSVP implementation date of November 1, 2018. Data reported was pulled from RSVP on July 26, 2022.

*Note: Cardinal LME/MCO catchment area county disengagement was still underway during this period and caused data to fluctuate due to data corrections and transfers made. Only those withdrawn from RSVP remain as part of the RSVP data for Cardinal and will remain under Cardinal for data integrity purposes. Additionally, Bladen County transfers that occurred in February also caused data fluctuations.

CHART C: LME/MCO DIVERSION TOTALS FROM JULY 1, 2021 THROUGH JUNE 30, 2022

LME/MCO	Diverted (with and without slots)	Not Diverted	In Process	Withdrawn/ Removed	Total Diversion Attempts
Alliance Behavioral Healthcare	26	8	220	9	263
Cardinal Innovations	0	0	0	0	0
Eastpointe	22	0	13	3	38
Partners Behavioral Health Management	9	14	69	2	94
Sandhills Center	21	5	31	1	58
Trillium	25	6	79	5	115
Vaya Health	30	16	105	21	177
Total	**138**	**49**	**517**	**41**	**745**

***** Data source: TCLD

All six (6) LME/MCOs have implemented data integrity plans, which may cause data fluctuations. Decreases in numbers of overall "Diversion attempts" occurred due to TCL systems changes. Data reported was pulled from RSVP on July 26, 2022.

Individuals in all categories. "Total Diversion attempts" are the screenings that result in a determination of people who are TCL-eligible. "Diversion withdrawn/removed" includes deaths, moves out of the state and those that do not meet criteria for TCL because they do not have SMI/SPMI.

CHART D: LME/MCO DIVERSION CUMULATIVE TOTALS FROM JANUARY 1, 2013 THROUGH JUNE 30, 2022

LME/MCO	Diverted (with and without slots)	Not Diverted	In Process	Withdrawn/ Removed	Total Diversion Attempts
Alliance	1345	1663	305	420	3733
Cardinal Innovations	0	0	0	0	0
Eastpointe	395	718	13	65	1191
Partners Behavioral Health Management	612	1759	94	186	2651
Sandhills Center	475	1008	43	79	1605
Trillium	687	1369	98	165	2319
Vaya Health	1031	2008	164	357	3560
Total	**4545**	**8525**	**717**	**1272**	**15059**

***** Data source: TCLD.

All six (6) LME/MCOs have implemented data integrity plans, which may cause data fluctuations. Decreases in numbers of overall "Diversion attempts" occurred due to TCL systems changes. Data reported was pulled from RSVP on July 26, 2022.

Individuals in all categories. Total "Diversion attempts" are the screenings that resulted in a determination of people who are TCL-eligible. "Diversion withdrawn/removed" includes deaths, moves out of the state and those that do not meet criteria for TCL because they do not have SMI/SPMI.

VIII. State Psychiatric Hospitals

Just before the start of FY 21 – 22, all three (3) State Psychiatric Hospitals (SPHs) and all six (6) Local Management Entity/Managed Care Organization (LME/MCO) and Transitions to Community Living's (TCL) staff serving in those hospitals were trained on best practices and concurrent In-Reach and transition flow. NCDHHS staff then embarked on the first onsite shadowing of the Department of Justice (DOJ) SPH reviews. Staff were trained in the review tools used to record, organize and inform the decisions of the settlement agreement reviewers regarding SPH performance. NCDHHS staff performed desk reviews and attended SPH and LME/MCO staff interviews and debriefings. Preliminary findings from meetings with the Independent Reviewer demonstrated that previous training was modestly improving TCL discharge and transition practices between SPH and LME/MCO TCL staff when In-Reach and transition were undertaken concurrently and in-person. Preliminary findings to improve In-Reach and transition planning were as follows:

- Clearer expectations for services should be in place on the day of discharge.
- Staff at SPHs, due to individuals' forensic issues such as capacity to proceed, need specialized training on the necessity of cooperation, both pre and post discharge, between SPH and LME/MCOs – TCL.
- Trauma-informed care requires more pre- and post-discharge service planning and intervention.
- There is a need for staff to be exposed to advanced case studies of community integration, demonstrating wraparound service configurations and affording the participant the balance of safety and dignity of risk vital to community transition.

Discharge and transition issues and improvements were shared in an ongoing collaborative among a workgroup inclusive of the Office of the Senior Advisor for the ADA - TCL, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and Division of State Operated Healthcare Facilities (DSOHF) staff. Advanced SPH and LME/MCO discharge and transition training will continue in late fall of 2023. The workgroup will reconvene afterwards to consider enhancements to SPH and LME/MCO monitoring, informed by the U.S. Department of Justice Reviewer training.

IX. Complex Care Management

Throughout the settlement agreement, individuals have needed coordinated, physical health and mental health services and supports. Earlier on, personal care services were considered sufficient to support participants' activities of daily living, particularly when these services were combined with transition coordinators who could connect the person with a primary care physician. Over time, however, LME/MCOs began to report a growing number of people who were experiencing, before transition to the community, a significant need of services for multiple, physical conditions. These conditions, for those who transitioned to community, appeared to be related to reports of housing separations. Individuals with medical conditions that exceeded the typical need, or that had conditions that worsened, after transition, appeared to be failing in the community and returning to congregate settings. Further analyses of people who had received In-Reach services but had not been diverted from and were living in an Adult Care Home/Family Care Home ten years into the settlement agreement, indicated that the average age of this cohort was fifty-three. Moreover, many of these individuals had multiple medical conditions. On average, this group was being prescribed an average of nine (9) medications and were experiencing the functional deficits associated with long-term institutionalization. NCDHHS realized that many in this group would need complex medical and functional needs assessments. In short, these people needed more services than could be afforded through the personal care service or standard, office-based medical care.

In cooperation with NC Medicaid and the Office of the Secretary – TCL, during the last fiscal year, the State obtained funding for LME/MCO TCL infrastructure development. The funds addressed physical and functional needs through a service called Complex Care Management. Stable funding came through Per-Member-Per-Month (PMPM) dollar increases specifically targeted for complex care hiring, fringe benefits and travel costs. These were provided to each LME/MCO for the purpose of hiring Registered Nurse Care Managers and for the first time, Occupational Therapists Care Managers serving the TCL participants. Amended contractual language guided LME/MCO program design and development. PMPM funding was added, as part of Incentive Plan funding to LME/MCOs, to augment salaries. The goal was to attract Registered Nurses and Occupational Therapists, often from congregate settings, into community-based TCL care management. Specifically, Complex Care Management targeted counties within an LME/MCO's catchment area where there was a high density of both Adult Care Homes (ACHs) and TCL participants. The strategy was to increase the number, but more importantly, the quality of community transitions for individuals with complex medical conditions and/or functional skill needs.

With NCDHHS implementation support, each LME/MCO - TCL Team developed new job descriptions and scopes of work for Complex Care Management. In addition, each LME/MCO was to identify TCL complex care populations within their ACHs and, in some cases, also identify post-transitioned individuals whose conditions warranted inclusion in Complex Care Management.

The scope of work for both Registered Nurses and Occupational Therapy Care Managers included the following:

- Pre-transition Registered Nurse and Occupational Therapy assessments
- Pre-transition housing walk-throughs to assess the need for accommodations
- Medication reconciliation and post-transition pharmacy planning
- Complex Care Management summary report debriefing for the individual, those offering natural supports and providers
- Assessments, accommodations, medical reconciliations and functional skill needs written into the
- Person-Centered Plan and specifying agreed upon goals and tasks for all people involved in the plan
- Active coordination of care, inclusive of obtaining all recommended medical and functional services, effective the first day of transition
- Post-transition consultation on simple medical self-care and functional skills with the individual, those offering natural supports and the behavioral health provider
- "Warm handoffs" among individual and home health, Occupational Therapy, Physical Therapy, Speech Therapy and other physical health professionals
- Monitoring to maintain frequency, duration, intensity of complex physical and functional services for a minimum of 90 days, post-transition and thereafter for, e.g., re-housing, critical life events, housing and separation prevention
- Tracking within LME/MCOs information such as reductions in housing separations and concurrent increases in community tenure; reduction in avoidable Emergency Department treatment and hospitalizations and concomitant increases in primary, specialty usage; reductions in physical symptoms; and increases in self-care and functional skills

NC Medicaid developed an estimate of PMPM payments for each LME/MCO's Registered Nurse and Occupational Therapy Care Manager hirings. Their calculations were specifically based on the TCL-eligible population and the number of Adult Care Homes (ACHs) in the catchment area and were not solely based on the Medicaid population. This approach allowed seemingly smaller populated LME/MCOs with a high ACH concentration to access Complex Care Management and enhanced transition of the many individuals within the settlement agreement's Category 2 and 3 Adult Care Home populations.[53] By the end of FY 21 – 22, all

[53] Category 2: Individuals with Severe and Persistent Mental Illness (SPMI) who are residing in Adult Care Homes licensed for at least 50 beds and in which 25% or more of the resident population has a mental illness. Category 3: Individuals with SPMI who are residing in Adult Care Homes licensed for between 20 and 49 beds and in which 40% or more of the resident population has a mental illness. Retrieved on August 29, 2022 from SETTLEMENT AGREEMENT (ncdhhs.gov)

LME/MCOs posted Registered Nurses and Occupational Therapy Care Manager positions, and all had at least one of Registered Nurse hired. One LME/MCO had not been able to hire an Occupational Therapy care manager. NCDHHS provided direct assistance, connecting them with Occupational Therapy professional organizations and universities with Occupational Therapy and certified Occupational Therapy Assistant programs. Despite this staff shortage, the LME/MCOs' Registered Nurse Care Manager began their work alongside other Transition Coordinators.

In this fiscal year, five (5) of the six (6) LME/MCOs began pre-transition assessments with TCL participants with complex care needs. Only one LME/MCO had not hired its Registered Nurse and Occupational Therapy Complex Care Managers. In this instance, NCDHHS assisted by connecting the LME/MCO with the UNC Center for Excellence. One LME/MCO was able to rapidly implement Complex Care Management by grafting it to their existing integrated care management model. By the end of the fiscal year, this LME/MCO had 33 individuals in Complex Care Management and had completed assessments; housing walk throughs; and Person-Centered Plan recommendations. Further monitoring and consultation for Complex Care Management will occur as NCDHHS staff, already positioned to liaison regarding the Incentive Plan, will have standing membership in each LME/MCO's Complex Care Management development meetings. Lastly, to afford additional profession-specific consultation the new Registered Nurses and Occupational Therapists, NCDHHS hosted the first, bi-annual Complex Care Manager Registered Nurse and Occupational Therapist Collaborative. NCDHHS, NC Medicaid Long Term Services and Supports Leadership, UNC Center for Excellence and the Association for Home Health and Hospice North Carolina presented topics to augment the implementation of this model.

X. Quality Management

Summary and Overview

The State's Transitions to Community Living (TCL) Quality Assurance and Performance Improvement (QAPI) system is designed to ensure that community-based placements and services provided through TCL are developed and delivered in accordance with the settlement agreement with US Department of Justice (DOJ), and that individuals who receive services or housing slots pursuant to the agreement are provided with the services and supports they need for their health, safety, and welfare.

Data from multiple sources are used to monitor and evaluate progress toward TCL goals, program quality and effectiveness, and the impacts of program changes and performance improvement activities. The purpose of the QAPI system is to ensure that all mental health and other services and supports funded by the State are of good quality and are sufficient to help individuals achieve increased independence and greater community integration, obtain and maintain stable housing, avoid harms, and reduce the incidence of hospital contacts and institutionalization.

The QAPI system is modeled on a Continuous Quality Improvement (CQI) approach and includes compliance and quality assurance processes and data associated with all aspects of TCL and all substantive provisions of the State's settlement agreement with the DOJ. Insights from data collection, analysis, monitoring, reporting, and evaluation are used to inform process and system changes to address and improve performance, service gaps, the quality of various program elements, and participant experiences and outcomes.

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

State oversight and working committees include the TCL Oversight Committee, chaired by the NCDHHS Deputy Secretary for NC Medicaid; the NCDHHS Transition Team and Barriers Committee, which includes representatives from multiple NCDHHS agencies and LMEs/MCOs; the TCL Quality Assurance Committee; and the Intradepartmental Monitoring Team (IMT), led by NC Medicaid with collaboration from DMH/DD/SAS, which provides monitoring and oversight of LME/MCO/Pre-Paid Inpatient Health Plan (PIHP)[54] contract functions.

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

Progress and Accomplishments

In State Fiscal Year (SFY) 2022 the State built considerably on previous progress toward meeting settlement agreement Quality Assurance and Performance Improvement provisions. Since contracting with Mathematica in February 2021 to provide technical assistance related to performance measurement, data management, data dashboard development, and QAPI system enhancements, initial development of the first three tasks is completed and QAPI system and plan development work is underway.

Mathematica's experienced team of health care subject matter experts, researchers, data and system analysts, and programmers has assisted with development of approximately 200 compliance, program operations, and participant outcomes measures with detailed technical specifications; built a data management and analysis platform that integrates data from multiple State systems; and released an automated Performance Data Dashboard for ongoing performance measurement, monitoring, evaluation, and reporting.

Some of the State's key accomplishments during SFY 2022 in the area of QAPI include the following:

- Development of an extensive TCL compliance, performance, and participant outcome measure set and related Performance Measurement Plan
- Development and release of the TCL Performance Data Dashboard
- Planning for a comprehensive QAPI system that includes a coordinating QA committee and standard operating procedures for communication and program monitoring and improvement
- Extension and expansion of the Mathematica contract to include an additional year of support for TCL data management and QAPI System operation and QAPI System development for the Department's broader Olmstead Plan
- Implementation of LME/MCO Housing Incentive Plans (See Section III of this annual report)
- Implementation of an LME/MCO data cleanup project that includes ongoing NCDHHS support to ensure and improve data accuracy, timeliness, and consistency
- Enhancements to State and Local Barriers Committee membership and processes

Positive trends in a number of outcomes monitored as part of the QAPI system also were observed for TCL participants:

- *Continued low inpatient facility readmission rates for individuals in supportive housing* – A total of 3.5% of members in housing experienced an admission in SFY 2021 that was a repeat admission from the previous 12 months, and 4.6% of members in housing experienced more than one admission during the year.

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

- *Reduced inpatient admissions for individuals in supportive housing* – Inpatient admissions were reduced to zero for 66% of individuals with admissions in the previous state fiscal year.
- *Downward annual trend in inpatient length of stay across LME/MCO and TCL setting and status* – Across inpatient settings, length of stay decreased by 33% between SFY 2018 and SFY 2021.
- *Continued low rates of repeat ED visits for individuals in supportive housing* – A total of 4.3% of members in housing experienced an ED visit in SFY 2021 that was a repeat visit from the previous 12 months, and 3.2% experienced more than one ED visit during the year.
- *Reduced ED visits for individuals in supportive housing* – ED visits were reduced to zero for 68% of individuals with ED visits in the previous state fiscal year.
- *Downward annual and quarterly trends in the use of Facility Based Crisis beds for individuals in supportive housing* – The annual rate decreased 31% over the five-year period from SFY 2017.
- *Downward annual trends in the use of the congregate day programming Psychosocial Rehabilitation (PSR) services across LME/MCO and across TCL status and setting* – PSR rates have decreased by 53% for members in supportive housing since SFY 2017 and by 30% across all TCL settings and statuses.
- *Increased housing stability* – Over the life of the program, nearly 70% of individuals ever housed have maintained housing through the two-year milestone. At the end of SFY 2022, nearly a quarter of individuals in supportive housing had initially transitioned 5 or more years ago, and over 60% transitioned 3 or more years ago.
- *Upward annual trend in time spent in supportive and community housing* – Individuals in supportive and community housing in SFY 2022 have maintained their housing more than twice as long as their counterparts in SFY 2018.
- *Downward trend in the average length of diversion attempts* – Average months in diversion status has decreased by more than one-third since SFY 2018.

These trends provide data-based evidence of positive impacts of TCL services and demonstrate the State's significant progress toward objectives related to participants' increased independence, greater community integration, housing stability, harm avoidance, and reduced hospital use and institutionalization.

Considering previous accomplishments as well as advancements made in the most recent state fiscal year, the State's overall progress toward achieving substantial compliance with settlement agreement provisions in the area of QAPI includes the following:

- ***Establishment of a Transition Oversight Committee (TOC) to monitor monthly progress toward implementation of the settlement agreement*.** Examples of SFY 2022 TOC meeting agenda topics included budget and housing updates, challenge and progress related to data integrity, QAPI system development, Olmstead Plan implementation, and local barriers.
- ***Development and implementation of protocols, data collection instruments, databases, and standard reports for ongoing monitoring*.** The TCL Performance Data Dashboard released this year includes measures from a comprehensive set of approximately 200 compliance, performance, and individual outcome measures for enhanced program monitoring. Previously developed were the TCL Database, Referral Screening Verification Process (RSVP) system, and NC Housing Finance Agency Community Living Verification (CLIVe) centralized housing subsidy reimbursement and data system, which are dedicated databases for tracking and monitoring requirements related to housing, In-Reach, diversion, transitions, and community tenure. Institutional census and outcomes including length of stay, discharge, and readmissions are tracked through the State's Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) database and NCTracks claims system.
- ***Development and implementation of a decision support dashboard*.** Information in the dashboard embedded within the CLIVe housing management system is used by LMEs/MCOs to monitor targeted housing unit availability. The State also has produced monthly dashboards of key performance measures in the past and distributed these to LMEs/MCOs for decision support.

- ***Development and utilization of a template for published annual progress reports*.** The report template is expanded and refined as needed each year, and all annual progress reports have been published as required using the template.
- ***Development and utilization of personal outcomes measures protocols and data collection*.** The following required personal outcomes measures are reported in the State's annual progress reports: incidents of harm; readmissions to State hospitals and inpatient psychiatric facilities; housing separations resulting in Adult Care Home admission or readmission; use of crisis beds and community hospital admissions; repeat emergency room visits; time spent in congregate day program; and maintenance of chosen living arrangement, including tenure in housing. The length of time individuals spend per TCL setting and status is now monitored via the Performance Data Dashboard. This monitoring includes sub-populations of individuals in TCL supportive housing, living in the community without a TCL housing slot, receiving In-Reach in Adult Care Homes and State Psychiatric Hospitals, with active diversion attempts, and planning for transition or rehousing to supportive housing. Data on engagement in community life is collected through Quality of Life Surveys and the State's NC-TOPPS client assessment and outcomes system. Employment status and school enrollment data also are collected via NC-TOPPS assessments.
- ***Establishment of a State Barriers Committee*.** As required, this committee regularly collects, aggregates, and analyzes data related to In-Reach and person-centered discharge and community placement efforts.
- ***Implementation of voluntary Quality of Life (QoL) Surveys*.** These surveys are administered, as required, before individuals transition out of facilities or into supportive housing and 11 and 24 months after transitioning. Survey results are reported in an appendix to each annual progress report. Survey data also are shared with each LME/MCO for internal monitoring, analysis, and quality assurance activities. Aggregate measures based on the State's QoL survey questions are sensitive to individual differences between participants and have proved useful for identifying individual and system level challenges and obstacles to quality of life and satisfaction. While the State may choose to implement different survey measures and administration methods in the future, such as peer-facilitated interviews with greater focus on community inclusion, the State's consistent use of one tool and survey administration method throughout the life of TCL has supported assessment of year-over-year changes, demonstration of improvement over time and from pre- to post-transition, and identification of persistent challenges.
- ***Completion of annual External Quality Reviews (EQR)*.** As described above, these comprehensive reviews cover LME/MCO policies and processes for the State's mental health service system, including TCL functions and services.
- ***Annual publication on the NCDHHS website of TCL progress reports*.** As required, these reports provide numbers of people served per TCL setting and service and detail the quality of services and supports using performance and personal outcomes data.
- ***Development of solutions and elimination of barriers for the effective use of data for program monitoring and performance improvement*.** With the SFY 2022 release of the TCL Performance Data Dashboard, the State QAPI system now features centralized monitoring of TCL data from diverse systems and sources, integrated into a single platform. The Dashboard includes standard and precisely defined measures covering a wide range of settlement agreement requirements, areas of program operations and performance, and participant outcomes. Data are refreshed each quarter and measure production is automated. The dashboard offers a finer level of granularity compared to previous monitoring and reporting, including the option to produce annual, quarterly, and monthly measures and to stratify by participant setting and status, participant age group, LME/MCO, and county. With regular aggregation and analysis of TCL data now occurring, the State has made significant progress in addressing obstacles in the area of QAPI previously noted by the Independent Reviewer, including diffusion of responsibility, limited data integration and access, data integrity issues, and insufficient standardization and documentation of quality and performance measures.

- ***Planning and blueprint development for a comprehensive QAPI system with standard operating procedures for monitoring and reporting, communication, and QAPI activities and projects*.** The State, together with Mathematica, in SFY 2022 completed initial planning for design enhancements to more fully develop the larger system by which data will be reviewed and used to determine if intended program outcomes are being met, and to identify areas and strategies for improvement and evaluate the effectiveness of those strategies. This work has included defining the scope and structure of a Quality Assurance Committee and QAPI activities, and processes to incorporate dashboard data and measures into QAPI process and projects. Documentation of QAPI system scope, structure, and processes in a written QAPI Plan will be a primary focus early in SFY 2023, with the goal of full implementation in SFY 2023.

Departmental Monitoring of TCL Functions and Services

SFY 2022 systems-level monitoring of TCL services managed by LMEs/MCOs included quarterly Intradepartmental Monitoring Team reviews conducted jointly by the Division of Health Benefits and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) reviews, annual External Quality Reviews (EQR), and ongoing work of the State Barriers Committee. EQR Organization evaluation of LME/MCO TCL functions was conducted through review of TCL member records, program processes, and documentation; performance improvement project and performance measure validation; and care coordination interviews. Detailed findings from each review are documented in final reports produced by the EQR Organization.[55]

INTRADEPARTMENTAL MONITORING TEAM REVIEWS

Quarterly Intradepartmental Monitoring Team meetings included enhanced monitoring of TCL services. Each quarter, an Interdepartmental State Team reviewed LME/MCO documentation submitted in response to TCL agenda items and identified questions and areas for further dialogue and technical assistance. This team then held discussions with LME/MCO cross-functional team representatives in follow-up debriefing meetings.

The Intradepartmental Monitoring Team TCL review team includes members of the Division of Health Benefits (DHB) Behavioral Health Policy Team and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) Adult Mental Health and Quality Management Teams, DHB Contract Managers, and DMH/DD/SAS LME/MCO Liaisons. SFY 2022 Intradepartmental Monitoring Team TCL agenda items emphasized two broad areas of needed improvements: Employment and Community-Based Mental Health Services.

SFY 2022 INTRADEPARTMENTAL MONITORING TEAM TCL AGENDA ITEMS

Individual Placement and Support-Supported Employment (IPS-SE) and Employment Outcomes

- Monitoring and effectiveness of efforts to engage individuals in employment and education during In-Reach, discharge planning, and person-centered planning
- Monitoring and activities to increase behavioral health provider referrals to IPS-SE, impacts on member enrollments
- Activities to increase percentages of members receiving IPS-SE and follow-along services
- Activities to increase competitive employment rates
- Monitoring and strategies to ensure IPS-SE providers draw down maximum Division of Vocational Rehabilitation Services funding, impact, and plans for value-based contracting
- Activities to assist and progress of underperforming IPS-SE teams

[55] External Quality Review Reports are posted and available on the NCDHHS website at https://medicaid.ncdhhs.gov/providers/programs-and-services/behavioral-health-idd/lmemco-contracts-and-reports.

Community-Based Mental Health Services

- Housing separation rates related to service trends, including identified issues and interventions
- Community Support Team (CST) provision of Permanent Supportive Housing interventions, identified barriers, and LME/MCO strategies to address
- LME/MCO monitoring and efforts to improve CST client outcomes
- Monitoring and efforts to improve percentages of Assertive Community Treatment (ACT) recipients receiving employment services and competitively employed
- Areas identified for ACT provider improvement and LME/MCO strategies to address
- LME/MCO strategies and activities to require improvement and assist providers scoring in Tool for Measurement of ACT (TMACT) Provisional Certification range
- Monitoring to ensure sufficiency of services during transitional periods such as pre-tenancy, post-tenancy, and post-rehousing; identified obstacles and LME/MCO strategies to address with providers
- Monitoring to ensure Person-Centered Plans reflect members' chosen community inclusion goals and progress, and identified issues and LME/MCO strategies to address

The quarterly schedule and cyclical nature of Intradepartmental Monitoring Team reviews reinforce the State's Continuous Quality Improvement approach to quality assurance and performance improvement by facilitating identification of obstacles and strategies for improvement and promoting ongoing monitoring and assessment. The intradepartmental review format also encourages communication, coordination, and feedback between NCDHHS agencies and LMEs/MCOs.

LME/MCO submissions and the State review team's summary documentation are shared with the Office of the Senior Advisor on the ADA to inform discussion with LME/MCO leadership and TCL teams. Documentation from SFY 2022 IMT reviews also was used to develop detailed summaries of barriers identified, and of strategies and solutions for addressing them, to be shared through the TCL State Barriers Committee.

STATE BARRIERS COMMITTEE

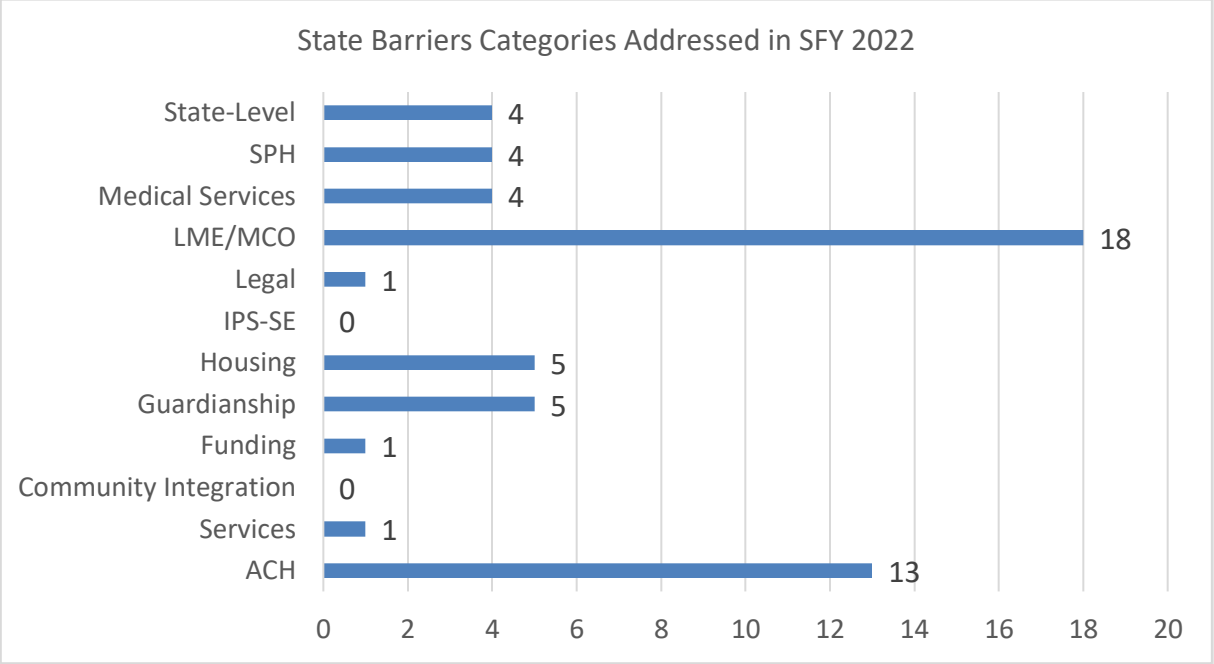
The TCL State Barriers Committee solidified its membership and solution process in SFY 2022. Though present throughout the settlement agreement, this improved iteration of the committee used multiple pathways through which barriers were referred, recorded, and addressed. The major change came when Local Barriers Committees improvements were mandated as part of the greater TCL Housing Incentive Plan.

All six LME/MCOs were required to improve their Local Barriers Committees first by meeting at least monthly but immediately sending emergent barriers to the State Barriers Committee point of contact. Regional Ombudsmen served as standing members in all Local Barriers Committees throughout the State. This was accomplished through greater collaboration with the State Long-term Care Ombudsmen's Office. That collaboration began as email descriptions of the Local Barriers Committees and Ombudsmen expectations and culminated in NCDHHS TCL staff training all 32 Ombudsmen during their statewide meeting.

Additional Incentive Plan Local Barriers Committees improvement requirements included mandating cross-functional standing membership of LME/MCO staff such as those from the Provider Network, Clinical Operations, and QA/PI. Strongly suggested LME/MCO ad hoc roles included Medical Director, Finance, Utilization Management, and Legal. External to an LME/MCO, ad hoc recommendations included staff of the National Alliance for Mental Illness of NC, County Departments of Social Services, and Housing Authorities.

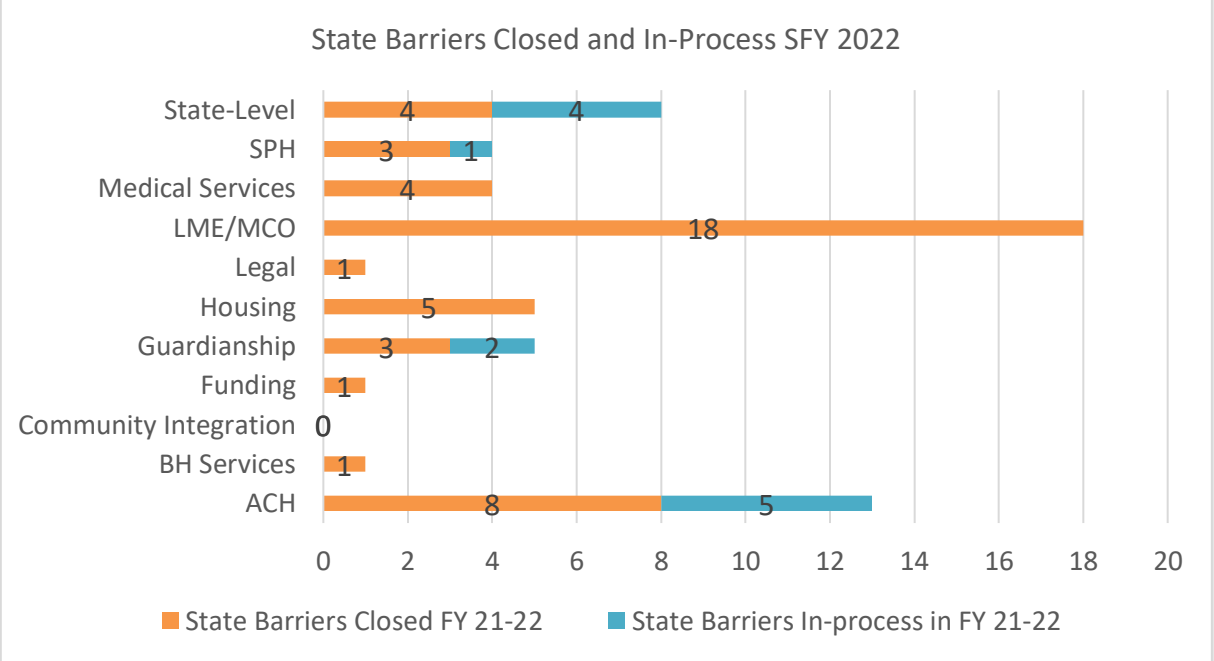
A Local Barriers Tracker template was provided in which were recorded the dozens of local barriers solved or mandated, with unsolved barriers sent quarterly to the State Barriers Committee. In addition to that State Barriers Committee referral source, larger systemic or emergent individual member barriers came through the existing Olmstead Barriers email.

Lastly, many State Barriers Committee referrals arose from DOJ Spring Reviews. Below is a summary of barriers referred to the State during the year:



Many of the State Barriers Committee referrals were of an emergent nature. NCDHHS afforded multiple divisions to convene on an ad hoc basis. LME/MCO and NCDHHS divisions including the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), Division of Health Benefits (DHB), Division of Aging and Adult Services, and Division of Health Services Regulation were consulted. NCDHHS TCL/Olmstead, DMH/DD/SAS, and DHB staff worked closely with the LME/MCO TCL, Housing, Provider Network, and other staff to solve barriers immediately affecting TCL participants.

Below is a chart of State Fiscal Year 21 – 22 barriers referred to the state in which their resolution that "closed" or solved the barrier and barriers that are "in-process" of being solved:



Improving the frequency, membership, intensity, and cross-divisional attention to barriers, on both local and state levels, resulted not only in individual participant solutions but also solutions benefitting all TCL participants. Larger system improvements during the last fiscal year included:

- Joint Communication Bulletins affirming the settlement agreement's broad eligibility for participants with co-occurring SPMI and or SMI and Substance Use, Intellectual/Developmental Disability, and complex medical disorders
- Fair Market Rent (FMR) reductions in key urban areas sought by participants addressed through lessening barriers to go 120% over FMR across the NC, and audience with HUD officials
- Mutual development of discharge and TCL transition expectations with State Psychiatric Hospital and LME/MCO TCL staff, and an increase in complex transition staffing for individuals petitioned for removal from TCL
- Clarification of Medicaid Standard Plan transfer expectations and technical assistance to LME/MCOs
- With NCDHHS brokering, DHB offered direct attention to home health needs for Adult Care Home transitions, and the inclusion of funding not only for Registered Nurse Complex Care Managers but also for Occupational Therapist (OT) Care Managers at all LME/MCOs. These individuals offer care management to participants with complex physical health and/or multiple functional deficits, acquired incident to congregate living

Local Barriers Committees will be sending mandatory quarterly reports beginning in SFY 2023. Their data should demonstrate that numerous barriers are addressed at the local level. An increase in State Barriers Committee referrals also is expected because the process is improved and is more defined.

Personal Outcome Measures

The State's approach to measurement of TCL participant outcomes reflects the best practice principle articulated in the TCL settlement agreement that services are to "be flexible and individualized to meet the needs of each individual." TCL personal outcomes measures emphasize fundamental objectives related to participant health, safety, and welfare; independence and community integration; housing stability; harm avoidance; and reduced incidence of hospital contacts and institutionalization.

TIME IN TCL STATUS AND SETTING

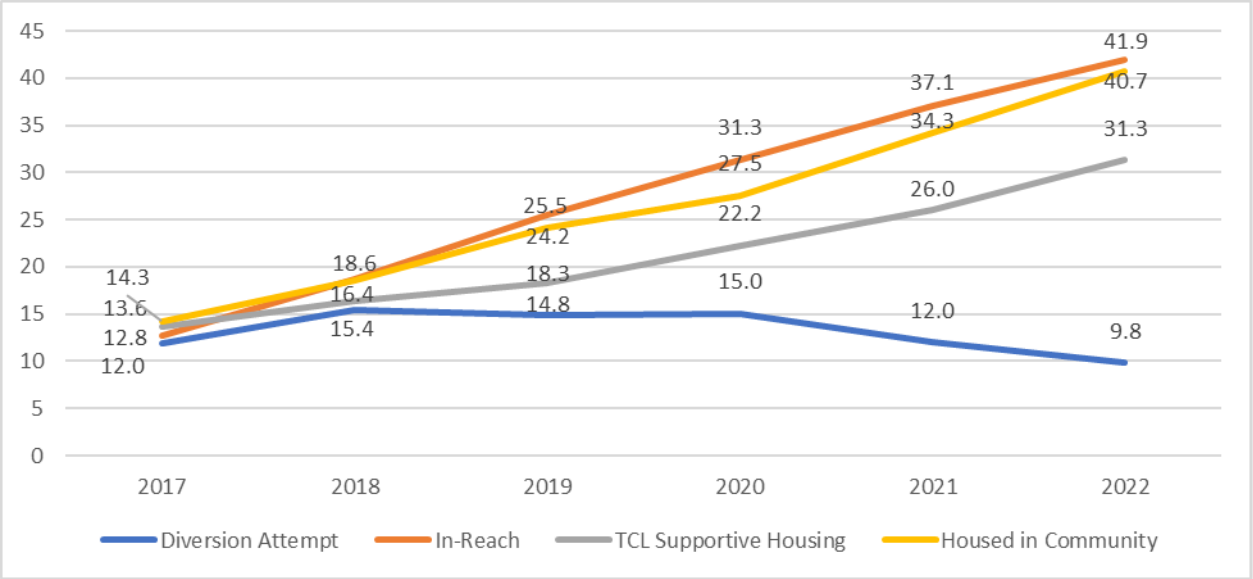
Figure 1 shows annual trends in the average number of months TCL participants have been in various settings and statuses. Average number of months in supportive housing or housed in the community without a TCL slot has increased with the life of the program. Individuals in TCL housing in SFY 2022 maintained their housed status for more than 2.5 years, more than a two-fold increase compared to those in housing in SFY 2017.[56]

Average months in In-Reach status shows a similar upward trend, while the average length of a diversion attempt has decreased by 35 percent since SFY 2020. Not shown, the average number of days from housing slot approval to the transition to supportive housing in SFY 2022 was 139 days (4.6 months), up slightly from 131 days in SFY 2021 and still higher than the target of 90 days.[57]

[56] The increase in average housing tenure likely reflects a combination of members' improved stability and an increase in the number of members housed further in the past.

[57] Where the transition to supportive housing occurred fewer than 90 days after housing slot approval, the TCL Performance Data Dashboard transition planning status period is defined as the 90 days preceding an initial lease start date. For this reason, average months in the calculated TCL Transition Planning status may exceed the length of the period from housing slot approval to transition and is not used to assess performance related to a 90-day transition standard.

FIGURE 1: AVERAGE MONTHS IN TCL STATUS, ANNUAL TRENDS SFY 2017-SFY 2022



USE OF INSTITUTIONAL SETTINGS BY INDIVIDUALS IN TCL SUPPORTIVE HOUSING

Institutional census tracking and length of stay are monitored through the State Psychiatric Hospital (SPH) Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) data system and the NCTracks[58] claims data warehouse. The SPH census, admissions, and discharge data are reported in other sections of this report.

Institutional admissions and readmissions and Emergency Department (ED) visits and repeat visits reported here are based on NCTracks Medicaid community hospital and inpatient psychiatric facility and emergency department claims and HEARTS SPH and Alcohol and Drug Abuse Treatment Center (ADATC) admissions data.[59] For all institutional data reported in this section, participant admission and visit rates are expressed as percentages of the total numbers of individuals in these categories during the reporting period.

INPATIENT ADMISSIONS

Table 1 shows statewide annual trends in numbers of individuals in TCL supportive housing who had admissions to Alcohol and Drug Treatment Centers (ADATC), community hospitals or psychiatric units (CH/IPU), or State Psychiatric Hospitals (SPH).

TABLE 1: INDIVIDUALS IN TCL SUPPORTIVE HOUSING WITH INPATIENT ADMISSIONS, SFY 2017-2021

Facility Type	2017	2018	2019	2020	2021
Alcohol and Drug Treatment Center (ADATC)	4	7	4	9	7
Community Hospital/Inpt Psyc Unit (CH/IPU)	121	207	267	343	341
State Psychiatric Hospital (SPH)	13	28	31	28	25
All Facility Types[a]	133	227	294	371	360
Total in TCL Housing During Period	*1,199*	*1,807*	*2,468*	*2,939*	*3,411*

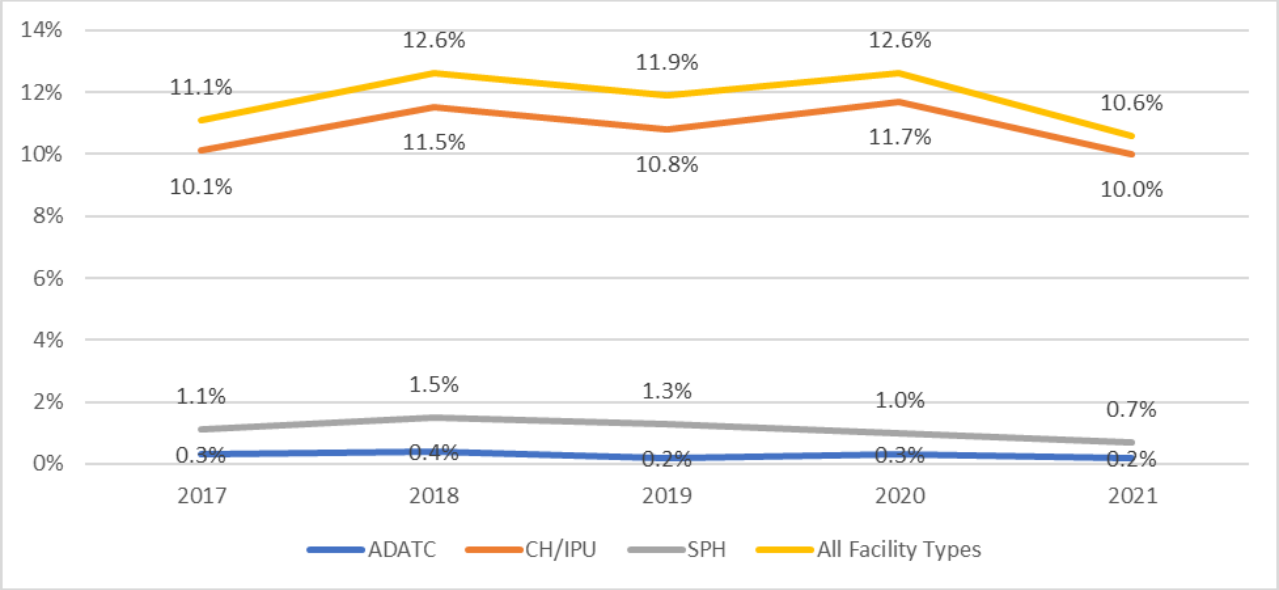
a- Counts for all facility types may include individuals with admissions to more than one type of facility.

Figure 2 shows statewide admission rates for each type of facility.

[58] NCTracks is the multi-payer Medicaid Management Information System for the NC Department of Health and Human Services (NCDHHS). Retrieved from Home of NCTracks - Home of NCTracks on September 12, 2022.

[59] Institutional admission measure values were calculated using standardized TCL Performance Data Dashboard specifications.

FIGURE 2: PERCENTAGES OF INDIVIDUALS IN TCL SUPPORTIVE HOUSING WITH INPATIENT ADMISSIONS, 2017-2021



The average number of individuals with admissions who were admitted to the same facility type within the previous 12-month period has remained relatively consistent, averaging 46 percent for individuals with community hospital or inpatient psychiatric unit admissions. Individuals with ADATC and SPH admissions were much less likely to have had previous admissions of the same type within the preceding year (0.1% and 3.3%, respectively).

Individuals with community hospital or inpatient psychiatric unit admissions also were more likely to have repeat admissions within each state fiscal year, averaging 1.6 per year over the five-year period shown, compared to 1.1 for individuals with ADATC admissions and 1.2 for individuals with SPH admissions.

Table 2 shows counts by LME/MCO of individuals with inpatient facility admissions from TCL supportive housing during SFY 2021. A measure of repeat admissions, the average number of admissions per person, also is shown in Table 2.

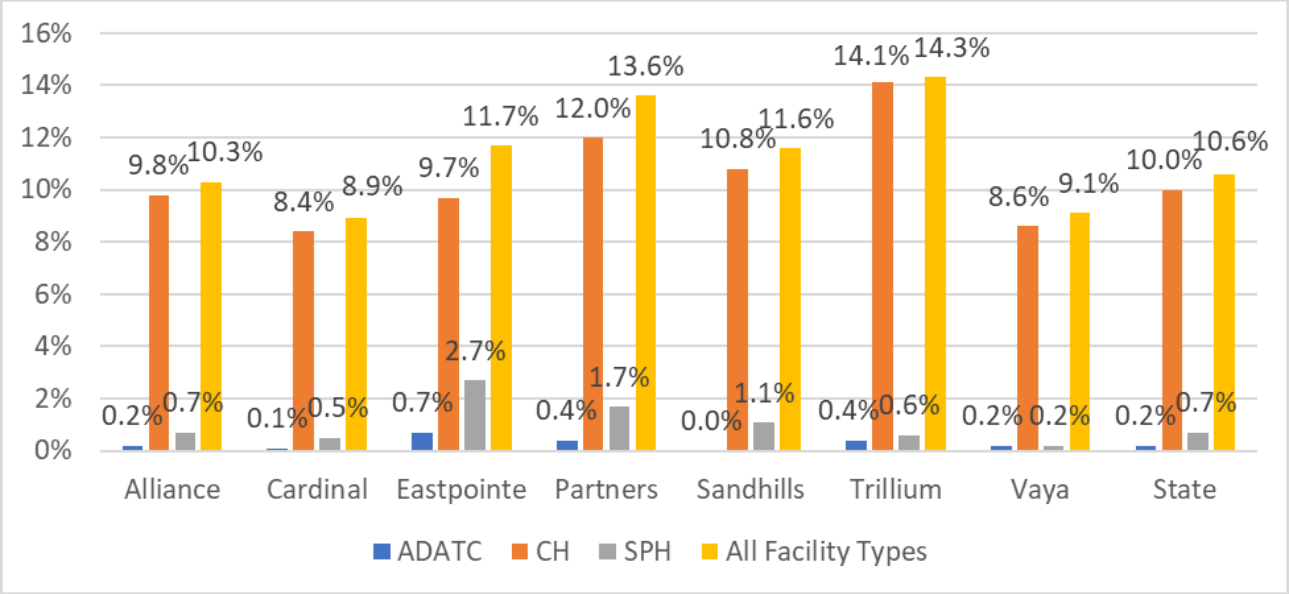
TABLE 2: INDIVIDUALS IN TCL SUPPORTIVE HOUSING WITH INPATIENT ADMISSIONS, AND AVERAGE ADMISSIONS PER PERSON WITH ADMISSIONS, SFY 2021

		ADATC		CH/IPU		SPH		All Facility Types[a]	
LME/MCO	N	Count	Avg	Count	Avg	Count	Avg	Count	Avg
Alliance	*580*	1	1.0	57	1.6	4	1.0	60	1.6
Cardinal	*760*	1	1.0	64	1.5	4	1.0	68	1.5
Eastpointe	*300*	2	1.5	29	1.5	8	1.9	35	1.7
Partners	*411*	0	0.0	37	1.5	1	1.0	37	1.6
Sandhills	*370*	0	0.0	40	1.7	4	1.5	43	1.7
Trillium	*516*	2	2.5	73	1.5	3	1.0	74	1.6
Vaya	*474*	1	1.0	41	1.4	1	1.0	43	1.4
Statewide	*3,411*	7	1.6	341	1.5	25	1.4	360	1.6

a- Counts across facility types may include individuals with admissions to more than one facility type.

Figure 3 shows percentages by LME/MCO of members in TCL housing with each type of inpatient admission.

FIGURE 3: SFY 2021 PARTICIPANT INPATIENT ADMISSION RATES FROM TCL SUPPORTIVE HOUSING



Not shown, of the 360 individuals with inpatient admissions, 33 percent (3.5% of housed) had more than one; 74 individuals (2.2% of housed) had two admissions, 26 (less than 1% of housed) had three, and 20 (less than 1% of housed) had four or more. The remaining 240 (67% of all with admissions, 7% of housed) had a single inpatient admission during the year.

Approximately 51 percent of individuals with SFY 2021 admissions (5.3% of housed) also had an admission to the same type of facility within the previous 12 months. Admissions within the previous 12 months were most likely for individuals with SFY 2021 community hospitals or inpatient psychiatric unit admissions (48%, 4.8% of housed). Only three percent of individuals admitted to SPHs in SFY 2021 (less than 1% of housed) had an SPH admission and less than one percent with SFY 2021 ADATC admissions had a similar admission in the previous 12 months.

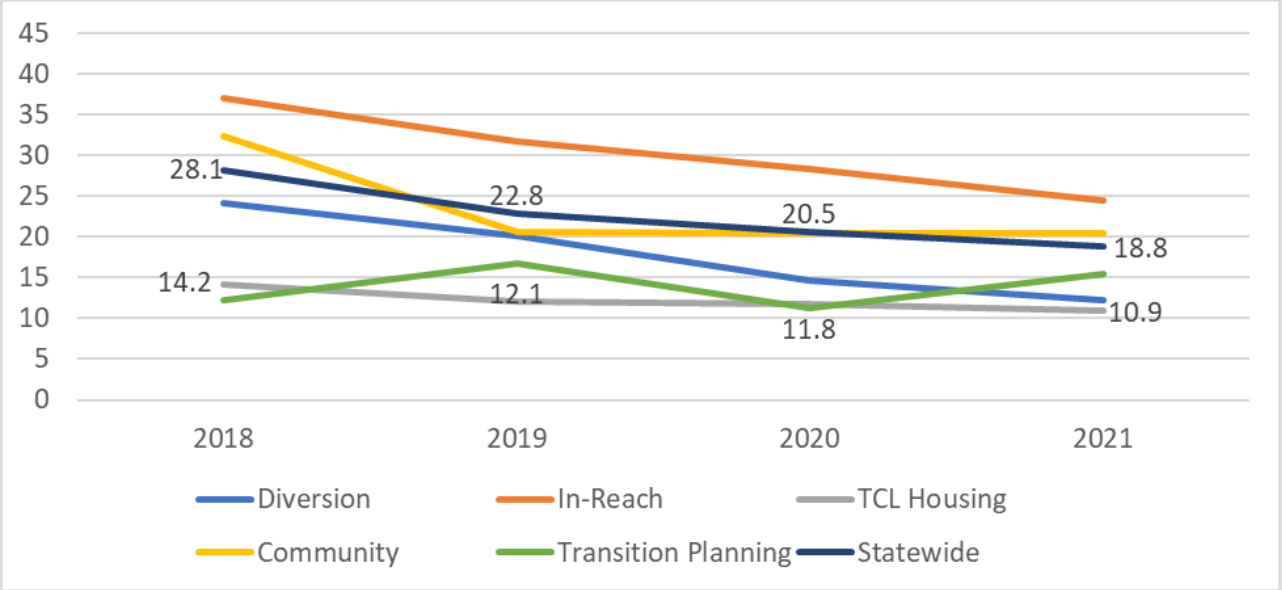
Of 3,411 individuals in housing during SFY 2021, 462 (14% of housed) had inpatient facility admissions in the previous state fiscal year.[60] Of those individuals, 157 (34%, 4.6% of housed) had repeat admissions in SFY 2021. For the remaining 66 percent with previous inpatient admissions (9% of housed), SFY 2021 admissions were reduced to zero.

A downward annual trend in inpatient length of stay beginning in SFY 2018 also was noted. Figures 4 and 5 show that this trend applied across all TCL population groups and all LMEs/MCOs. As illustrated above, community hospitals and inpatient psychiatric units accounted for more than 90 percent of housed participants' inpatient admissions, and the observed downward annual trend was primarily due to decreasing lengths of stay in these facilities.[61] Figure 4 also demonstrates fewer days spent in inpatient settings for members in supportive housing compared to other settings.

[60] The total number of individuals in housing in SFY 2021 with previous year admissions includes individuals who had not yet transitioned to supportive housing.

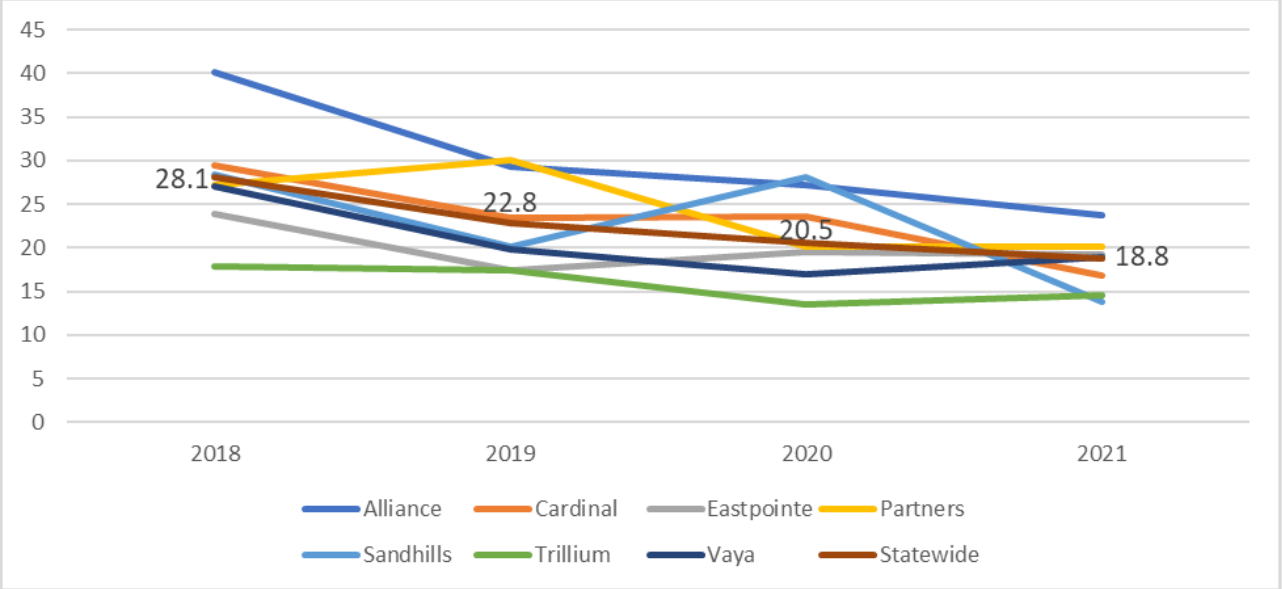
[61] More variable length of stay averages in ADATC and SPH settings may reflect smaller numbers of admissions and larger impacts of outliers.

FIGURE 4: PARTICIPANT AVERAGE INPATIENT LENGTH OF STAY (DAYS) BY TCL STATUS, ALL FACILITY TYPES



a- Averages shown are for TCL participants in all settings and for individuals in supportive housing.

FIGURE 5: PARTICIPANT AVERAGE INPATIENT LENGTH OF STAY (DAYS) BY LME/MCO, ALL TCL SETTINGS



a- Averages shown are statewide across TCL participant status and setting.

In SFY 2021 average lengths of stay for members in TCL supportive housing were 10.4 days in Alcohol and Drug Abuse Treatment Centers, 10.9 days in community hospital or inpatient psychiatric units, and 69.1 days in State Psychiatric Hospitals. Figure 6 show some variation across LME/MCO in the average number of days in community hospitals and inpatient psychiatric units.

FIGURE 6: SFY 2021 AVERAGE LENGTH OF STAY (DAYS) IN COMMUNITY HOSPITALS AND INPATIENT PSYCHIATRIC UNITS, TCL MEMBERS IN SUPPORTIVE HOUSING

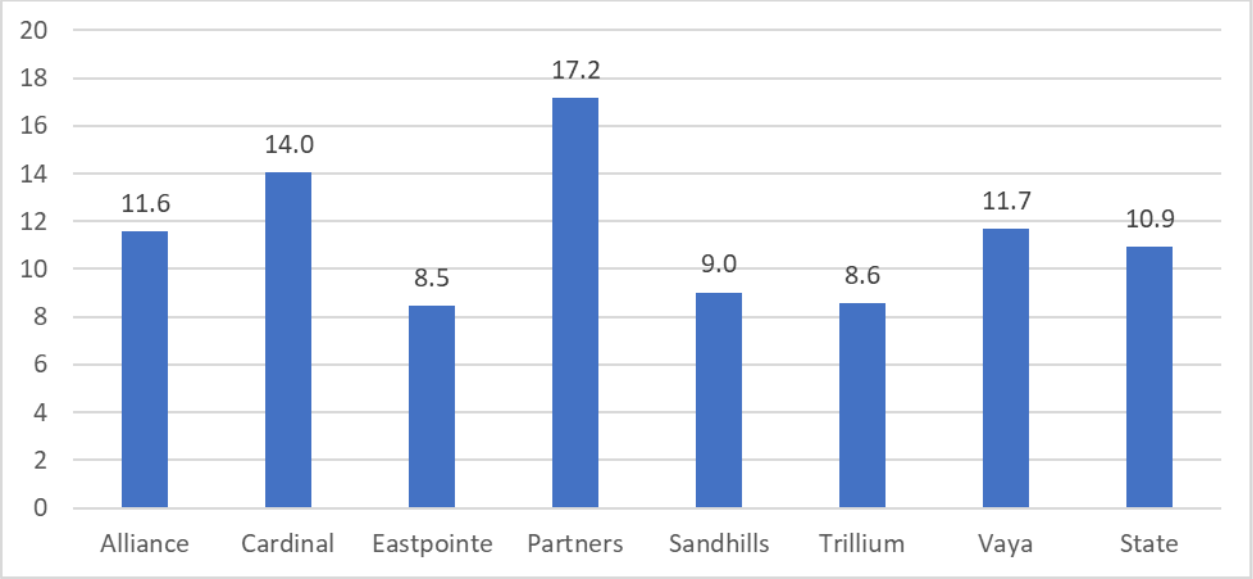


Table 3 shows statewide quarterly counts and percentages of individuals with inpatient admissions during SFY 2021 and the first two quarters of SFY 2022. On average, 40 percent of individuals with any admissions during SFY 2021 had admissions during any quarter of the same state fiscal year, reflecting the fact that one-third of individuals with admissions had more than one. SFY 2022 quarterly admission rates are similar to the previous year.[62]

TABLE 3: STATEWIDE QUARTERLY COUNTS AND PERCENTAGES OF INDIVIDUALS WITH INPATIENT ADMISSIONS, SFY 2021 Q1 TO SFY 2022 Q2

	Q1 2021		Q2 2021		Q3 2021		Q4 2021		Q1 2022		Q2 2022	
	N	%	N	%	N	%	N	%	N	%	N	%
ADATC	1	0.0%	1	0.0%	4	0.1%	4	0.1%	0	0.0%	4	0.1%
CH/IPU	107	3.9%	95	3.3%	124	4.2%	126	4.1%	127	4.1%	96	3.1%
SPH	7	0.3%	4	0.1%	7	0.2%	12	0.4%	7	0.2%	7	0.2%
All	114	4.2%	99	3.5%	133	4.5%	141	4.6%	134	4.3%	105	3.4%
Housed Total	2,727		2,869		2,987		3,078		3,123		3,127	

EMERGENCY DEPARTMENT VISITS AND REPEAT VISITS

Table 4 shows statewide annual numbers of individuals in TCL supportive housing who had Emergency

[62] Institutional claims data may be incomplete for recent quarters due to timely filing limits and claims lag.

Department (ED) visits.[63,64]

TABLE 4: ANNUAL COUNTS AND PERCENTAGES OF INDIVIDUALS IN TCL SUPPORTIVE HOUSING WITH EMERGENCY DEPARTMENT VISITS AND REPEAT VISITS, SFY 2017-2021

	2017	2018	2019	2020	2021
One or more ED visit	137	262	282	320	315
Percent of housed	*11.4%*	*14.5%*	*11.4%*	*10.9%*	*9.2%*
Visit was repeat from previous 12 months	60	129	143	160	148
Percent of housed	*5.0%*	*7.1%*	*5.8%*	*5.4%*	*4.3%*
Average number of visits per person with visits	1.9	1.9	1.8	1.8	1.9
Total in TCL Housing During Period	*1,199*	*1,807*	*2,468*	*2,939*	*3,411*

Across the five-year period, an average of 11.5 percent of individuals in supportive housing experienced ED visits per state fiscal year. Nearly half of individuals with any ED visits (48.5%, 5.5% of housed) had also experienced a visit in the previous 12 months, and this percentage was relatively consistent across years. Overall, these members experienced an average of 1.9 ED visits per year.

Table 5 shows counts by LME/MCO of individuals with ED visits while in TCL supportive housing during SFY 2021. Three measures of repeat admissions also are shown.

TABLE 5: INDIVIDUALS IN TCL SUPPORTIVE HOUSING WITH ED VISITS AND REPEAT VISITS, SFY 2021

LME/MCO	N Housed	N with ED Visits	*Percent of Housed*	Visit was Repeat from Past 12 Months	*Percent of Housed*	More than one ED Visit during Period	*Percent of Housed*	Avg Number ED Visits
Alliance	*580*	53	*9.1%*	27	*4.7%*	22	*3.8%*	2.5
Cardinal	*760*	79	*10.4%*	37	*4.9%*	26	*3.4%*	1.8
Eastpointe	*300*	25	*8.3%*	9	*3.0%*	8	*2.7%*	1.5
Partners	*411*	27	*6.6%*	10	*2.4%*	7	*1.7%*	1.4
Sandhills	*370*	43	*11.6%*	28	*7.6%*	22	*5.9%*	2.1
Trillium	*516*	62	*12.0%*	28	*5.4%*	20	*3.9%*	1.7
Vaya	*474*	27	*5.7%*	10	*2.1%*	5	*1.1%*	1.6
Statewide	*3,411*	315	*9.2%*	148	*4.3%*	110	*3.2%*	1.9

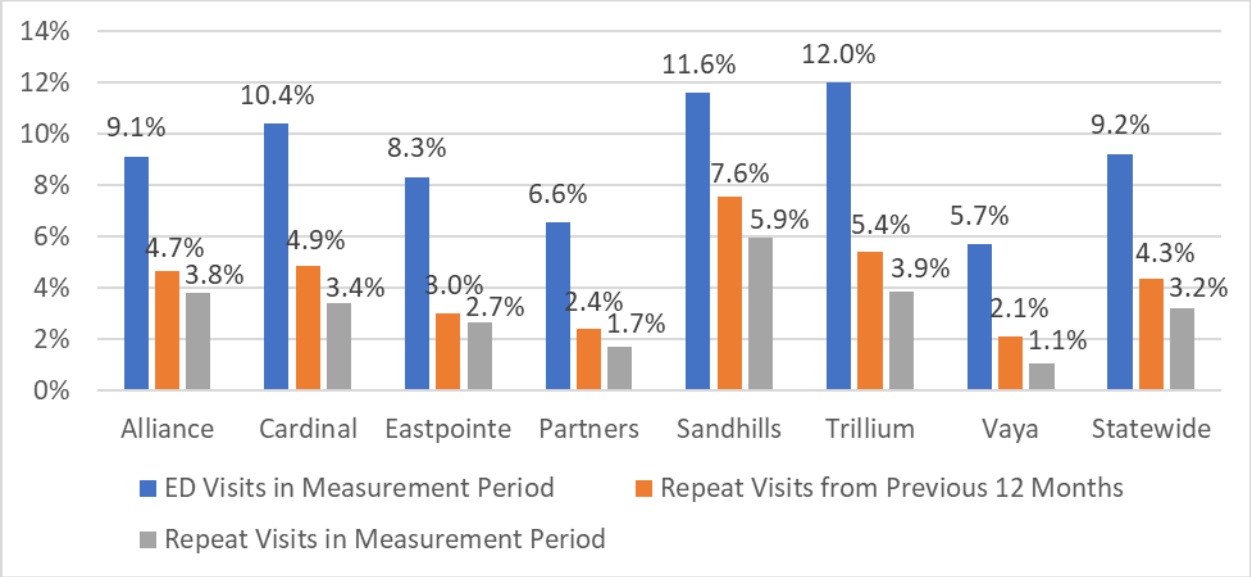
Figure 7 shows percentages by LME/MCO of members in TCL housing with ED visits and repeat visits. Some variation is seen across LMEs/MCOs in the overall percentage of members with ED visits during the year. Two similar patterns also were observed. A relatively large proportion of individuals with ED visits during SFY 2021 were experienced by individuals with previous visits, and somewhat smaller proportions of

[63] Emergency Department claims with consecutive service dates are counted as single visits. Each new series of claims with consecutive dates is counted as a repeat visit if the date of service is more than three days after the previous service end date. This method may result in overestimates due to claims lag and missing data and/or in underestimates in cases of true repeat visits within three days. Completeness of ED visit claims data also may be affected by timely filing limits.

[64] This analysis is limited to stand-alone behavioral health-related ED visits that do not overlap or immediately precede or follow psychiatric inpatient admissions reported in the previous section. Adjoining ED and inpatient claims are interpreted as inpatient admissions and discharges through the ED.

individuals with any ED visits experienced two or more.

FIGURE 7: SFY 2021 ED VISIT AND REPEAT VISIT RATES FROM TCL SUPPORTIVE HOUSING



Of the 315 individuals with ED visits, 35 percent (3.2% of housed) had more than one visit during the state fiscal year; 58 individuals had two visits, 24 had three, and 27 had four or more. The remaining 206 (65%, 6% of housed) had a single ED visit during the year. Also of the 315 individuals with ED visits, 148 (47%, 4.3% of housed) had experienced an ED visit in the previous 12 months.

Of 3,411 individuals in housing during SFY 2021, 381 (11%) had ED visits in the previous state fiscal year.[65] Of those individuals, 122 (32%, 3.6% of housed) had repeat admissions in SFY 2021. For the remaining 68 percent with previous visits (7.6% of housed), SFY 2021 visits were reduced to zero.

Table 6 shows SFY 2021 statewide quarterly counts and percentages of individuals with ED visits during SFY 2021 and the first two quarters of SFY 2022. On average, 40 percent of individuals with any visits during SFY 2021 had visits during any quarter of the same state fiscal year, reflecting the fact that approximately one-third of individuals with ED visits had more than one. SFY 2022 quarterly ED visit rates are similar to the previous year.[66]

TABLE 6: STATEWIDE QUARTERLY COUNTS AND PERCENTAGES OF INDIVIDUALS WITH ED VISITS, SFY 2021 Q1 TO SFY 2022 Q2

	Q1 2021		Q2 2021		Q3 2021		Q4 2021		Q1 2022		Q2 2022	
	N	%	N	%	N	%	N	%	N	%	N	%
	107	3.9%	94	3.3%	110	3.7%	121	3.9%	102	3.3%	93	3.0%
Housed Total	2,727		2,869		2,987		3,078		3,123		3,127	

OTHER CRISIS BED USE

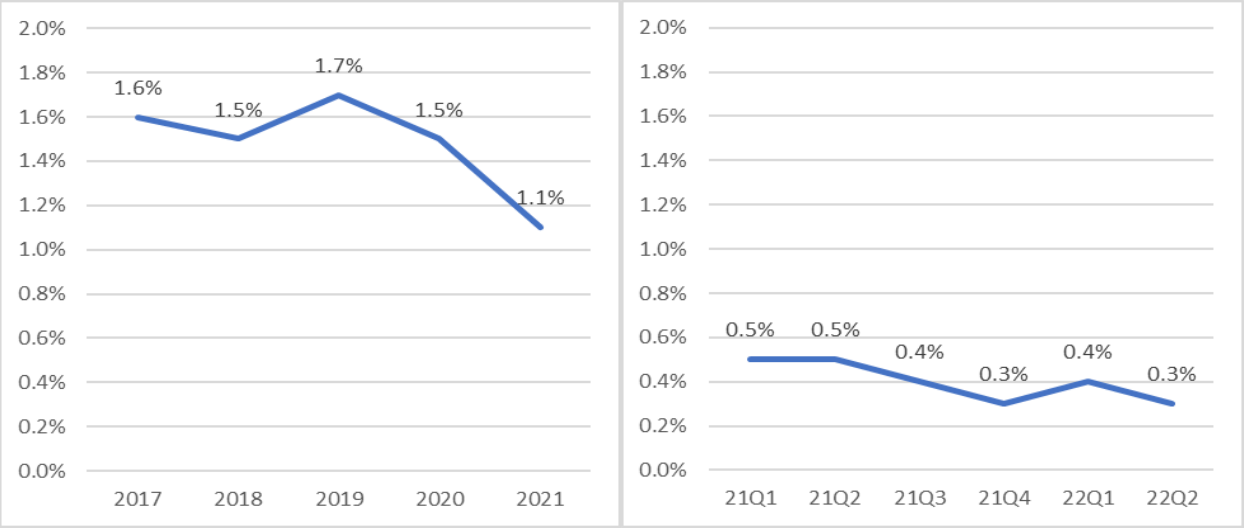
A total of 39 individuals (1.1% of housed) received Facility Based Crisis services during SFY 2021. As shown

[65] The total number of individuals in housing in SFY 2021 with previous year ED visits includes individuals who had not yet transitioned to supportive housing.

[66] Institutional claims data may be incomplete for recent quarters due to timely filing limits and claims lag.

in Figure 8, five-year annual and recent quarterly rates of housed individuals receiving Facility Based Crisis services show downward trends.

FIGURE 8: ANNUAL AND QUARTERLY TRENDS IN HOUSED MEMBER USE OF FACILITY BASED CRISIS BEDS, SFY 2017 TO SFY 22 QUARTER 2



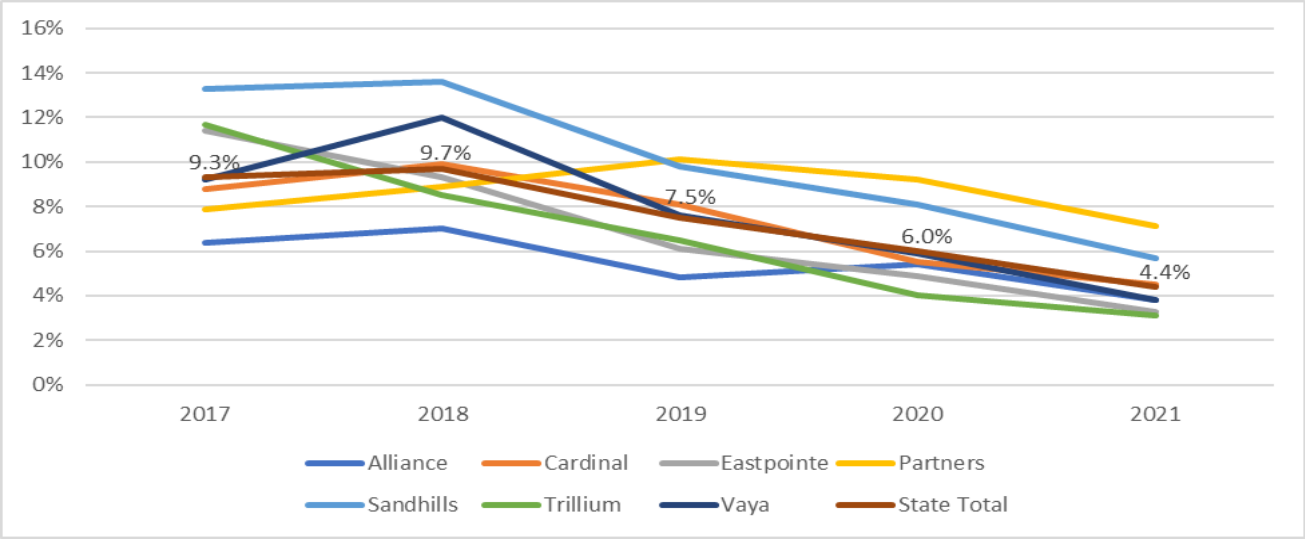
COMMUNITY INTEGRATION AND QUALITY OF LIFE

Transitions to Community Living (TCL) participant quality of life is assessed through structured interviews administered to individuals during the transition planning period and again at 11 and 24 months after transition. In each state fiscal year (SFY) through 2021, participants surveyed in follow-up interviews after 11 and 24 months in supportive housing have reported improvements in quality of life. They also reported more positive assessments of their life circumstances than did individuals who had not yet transitioned from congregate living facilities and other settings to supportive housing. These patterns have been observed across LME/MCO catchment areas as well as over time. Appendix A to this annual report is an updated summary of results for surveys administered through SFY 2022. (See Appendix A.)

TIME SPENT IN CONGREGATE DAY PROGRAMMING

Psychosocial Rehabilitation (PSR) service rates are shown in Section V of this annual report. Figure 9 demonstrates that the state total percentage of individuals in TCL supportive housing receiving services in congregate day programming settings has declined steadily over a five-year period, and this general pattern is observed across LME/MCO.

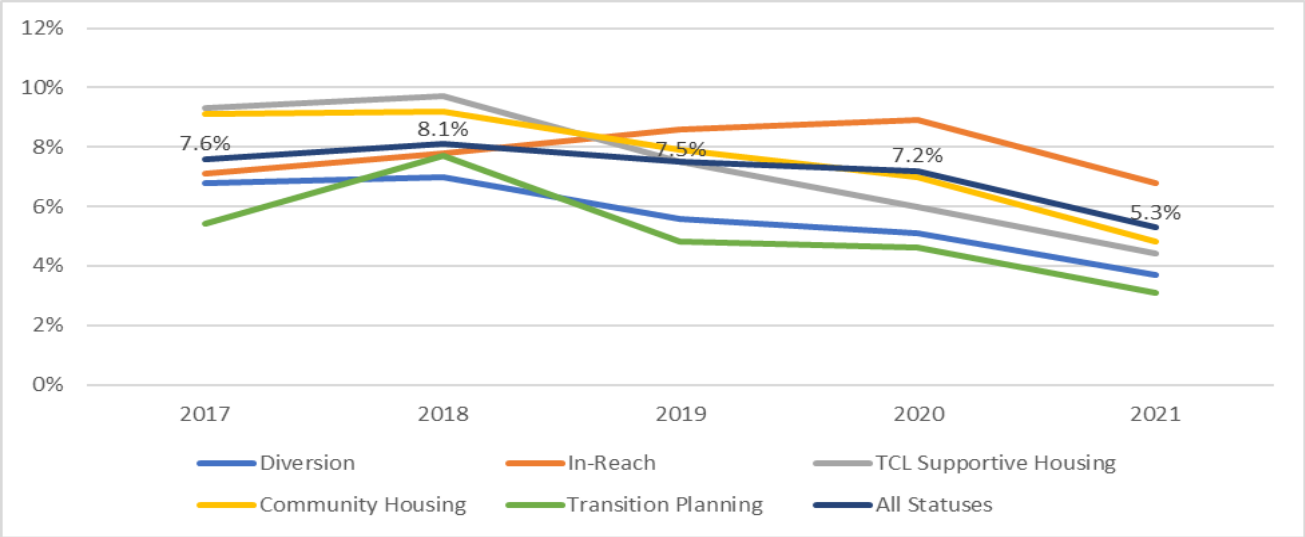
FIGURE 9: PSYCHOSOCIAL REHABILITATION SERVICE RATES FOR INDIVIDUALS IN TCL SUPPORTIVE HOUSING, ANNUAL TRENDS, SFY 2017 TO SFY 2021



a- Values shown are statewide totals for members in supportive housing.

Although the trend is less pronounced for individuals in In-Reach services, the percentages of participants in all settings and TCL statuses receiving Psychosocial Rehabilitation services in congregate day program settings has declined over time, as shown in Figure 10.

FIGURE 10: TCL MEMBER PSYCHOSOCIAL REHABILITATION SERVICE RATES BY SETTING, ANNUAL TRENDS, SFY 2017 TO SFY 2021



a- Values shown are statewide totals across TCL statuses and settings.

Results of additional analysis of paid NCTracks claims for Psychosocial Rehabilitation Services provided during Calendar Year 2021 are shown in Table 7.[67] These results address the requirement in Section III.G.3.g.v. of the settlement agreement with U.S. DOJ for the State to collect and monitor data on time spent in congregate day programming.

[67]Psychosocial Rehabilitation service claim details, including minimum and maximum service dates and total numbers of 15-minute service units per member, were retrieved directly from the NCTracks claims data warehouse in July 2022 with a six-month lag to allow for adjudication of Calendar Year 2021 professional service claims.

TABLE 7: CALENDAR YEAR 2021 TIME SPENT IN CONGREGATE DAY PROGRAMMING (PSYCHOSOCIAL REHABILITATION, PSR), INDIVIDUALS IN TCL SUPPORTIVE HOUSING

LME/MCO	N with PSR[a, b]	% of Housed[b]	Average Duration[c] (Weeks)	Average Hours/ Week[d]
Alliance	23 (29)	2.4%	18.3	11.2
Cardinal	45 (1)	4.7%	25.9	13.8
Eastpointe	8 (7)	2.8%	30.0	12.1
Partners	32 (34)	6.2%	25.5	9.1
Sandhills	28 (30)	7.1%	29.5	17.4
Trillium	16 (17)	3.2%	21.9	10.7
Vaya	14 (30)	3.1%	33.2	9.3
State Total	148	4.3%	25.8	12.4

a- The State Total is the unduplicated client count. County realignments during CY2021 resulted in higher than typical duplication of clients across LME/MCO per year, approximately 12 percent.
b- Clients are assigned based on the LME/MCO that submitted the claim.
c- Duration is calculated as the length of the interval between the earliest and latest PSR service claim dates of service within the calendar year and during the period the individual was in TCL housing supported by the LME/MCO. Average service duration per client statewide, regardless of LME/MCO managing the service, was 13 percent higher, 29.6 weeks, reflecting total service duration across client LME/MCO transfers.
d- Hours per week is expressed as the average number of PSR hours per week for the duration of the service while in TCL housing supported by the LME/MCO.

Community Tenure and Separations

For the life of the program, 60.7 percent of individuals who transitioned to supportive housing were in supportive housing at the end of SFY 2022, with an average of 896 days (2.5 years) from their initial transition dates. Table 8 shows numbers and percentages of individuals in housing three months to two years after the initial transition date. Life-of-program percentages of individuals reaching each milestone increased in SFY 2022.

TABLE 8: LIFE OF PROGRAM MAINTENANCE OF HOUSING

Threshold	Total Possible	Number Housed This Long	Percent Meeting Threshold
Not applicable (housed less than 3 months)	136	N/A	N/A
3 Months	4961	4772	96%
6 Months	4770	4415	93%
1 Year	4498	3747	83%
1.5 Years	4084	3098	76%
2 Years	3599	2485	69%

Table 9 shows attrition rates by year.

TABLE 9: HOUSING ATTRITION RATES BY STATE FISCAL YEAR AND YEAR HOUSED

SFY Housed	Number Housed	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
2013	46	2%	15%	11%	11%	8%	9%	11%	9%	13%	2%
2014	201	-	10%	21%	11%	9%	9%	4%	3%	2%	3%
2015	210	-	-	7%	16%	11%	14%	10%	5%	5%	1%
2016	331	-	-	-	10%	16%	14%	11%	7%	6%	3%
2017	600	-	-	-	-	10%	21%	14%	10%	7%	6%
2018	692	-	-	-	-	-	8%	21%	10%	7%	6%
2019	971	-	-	-	-	-	-	8%	14%	11%	7%
2020	836	-	-	-	-	-	-	-	7%	15%	12%
2021	852	-	-	-	-	-	-	-	-	7%	15%
2022	590	-	-	-	-	-	-	-	-	-	5%

Figure 11 is derived from the values in Table 9 and shows the percentages of individuals in housing at SFY 2022 year end relative to the number of years since their initial transitions to supportive housing. Of individuals who remained in housing at SFY 2022 end, 13.7% initially transitioned between 6 and 10 years ago. Nearly one-quarter (24%) have maintained housing across five state fiscal years, 43% across four years, and 61% across three years. The remaining 39% in housing initially transitioned within the past two state fiscal years.

FIGURE 11: FULL OR PARTIAL YEARS IN TCL SUPPORTIVE HOUSING, MEMBERS HOUSED AT END OF SFY 2022

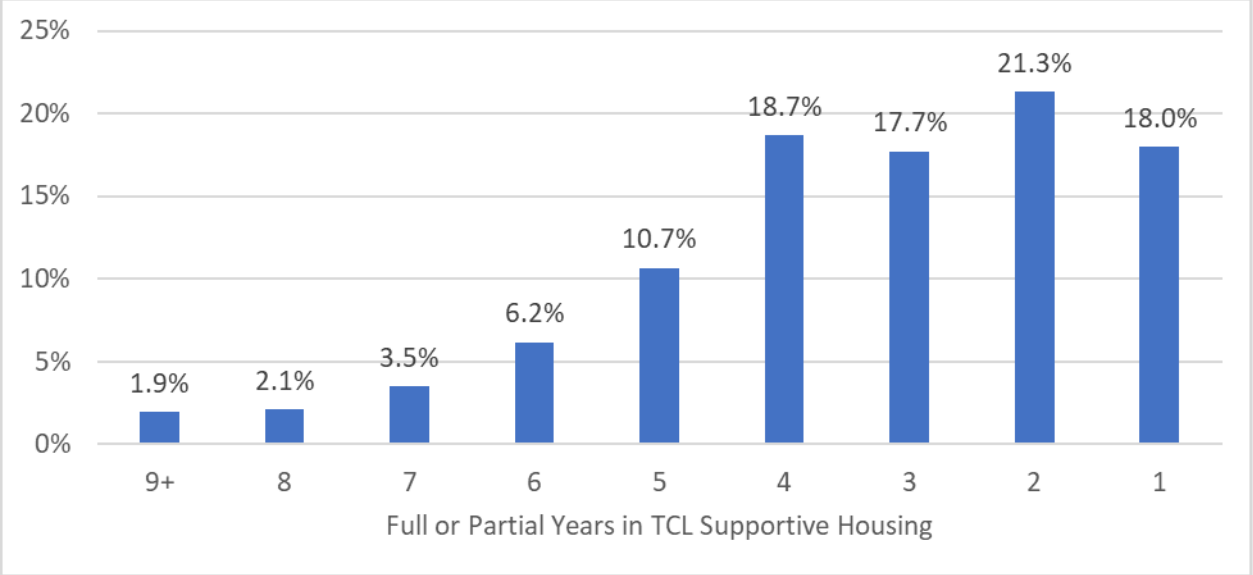


Figure 12 illustrates average quarterly separation rates by LME/MCO and statewide for the five most recent state fiscal years, as well as overall averages across the five-year period.[68] Statewide, an average of 4.2 percent of members in housing have separated each quarter during the period examined.[69] The 5-year

[68] Separation rate estimates are calculated via the TCL Performance Data Dashboard and are based on retrospective analysis of member leasing and tenancy data from the NC Housing Finance Agency Community Living Verification (CLIVe) system. LME/MCO is assigned based on the Transitions to Community Living Database (TCLD) using the managing agency on record at the end of each measurement period.

[69] Separation rates are adjusted on an ongoing basis to exclude members with short-term lapses between leases of 30 days or less. The SFY 2022 fourth quarter separation rate may be adjusted in subsequent analyses for any individuals rehoused within 30 days. Significant impact of this

average annual statewide separation rate for this period was 14.0 percent. Quarter-to-quarter rates vary substantially both within and across LME/MCOs, and this may reflect individualized factors that contribute to member housing separations. However, recent-year data shows some evidence of reduced variation by LME/MCO.

FIGURE 12: AVERAGE QUARTERLY ANNUAL AND 5-YEAR HOUSING SEPARATION RATES, SFY 2018 TO SFY 2022

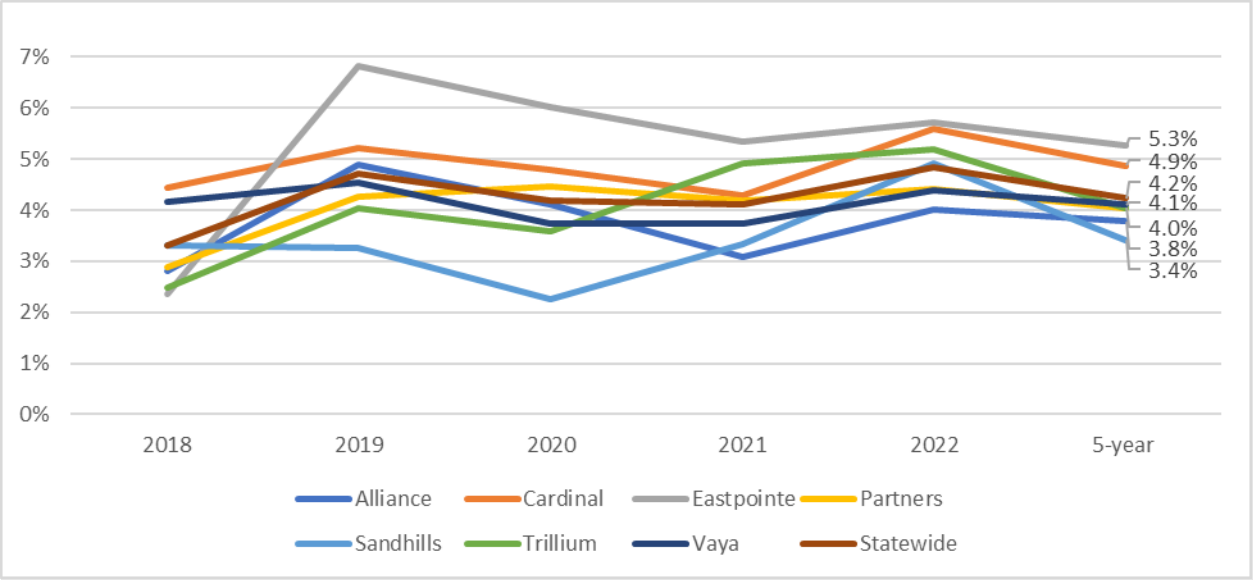


Table 10 shows the total number of individuals who have left housing over the life of the program, including numbers and percentages deceased or who returned to Adult Care Homes (ACH) or other facilities.

TABLE 10: LIFE OF PROGRAM HOUSING SEPARATION OUTCOMES AND DESTINATIONS

Outcome or Destination	Number	Percent
Adult Care Home	415	20.8%
Alternative Family Living (Unlicensed)	9	0.5%
Adult Living Facility	21	1.1%
Deceased	474	23.7%
Family/Friends	282	14.1%
Hospice	3	0.2%
Independent	481	24.1%
Jail/ Prison	94	4.7%
Medical Hospital	50	2.5%
Mental Health Group Home	40	2.0%
Skilled Nursing Facility	46	2.3%
State Psychiatric Hospital	32	1.6%
Substance Use Facility	34	1.7%
Unknown	15	0.8%
Total	1995	100%

reconciliation on the SFY 2022 average quarterly rate or the 5-year overall average is not anticipated.

INCIDENTS OF HARM

The State's Incident Response and Improvement System (IRIS) is a web-based system for reporting and documenting responses to adverse incidents involving individuals receiving mental health, developmental disabilities and/or substance use services. Incidents are defined as "any happening which is not consistent with the routine operation of a facility or service or the routine care of a consumer and that is likely to lead to adverse effects upon a consumer."

Level II includes any incident which involves a consumer death due to natural causes or terminal illness, or results in a threat to a consumer's health or safety or a threat to the health or safety of others due to consumer behavior. Level III includes any incident that results in (1) a death, sexual assault or permanent physical or psychological impairment to a consumer; (2) a substantial risk of death, or permanent physical or psychological impairment to a consumer; (3) a death, sexual assault or permanent physical or psychological impairment caused by a consumer; (4) a substantial risk of death or permanent physical or psychological impairment caused by a consumer; or (5) a threat caused by a consumer to a person's safety.

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

Incidents involving TCL participants are retrieved, reviewed, and reported in aggregate on a monthly basis and at the end of the full fiscal year. Table 11 summarizes by LME/MCO the number of incidents reported in SFY 2022 by the reported month of the incident.[70]

TABLE 11: AGGREGATE NUMBER OF INCIDENTS REPORTED IN IRIS, SFY 2022

LME/MCO	Jul-2021	Aug-2021	Sep-2021	Oct-2021	Nov-2021	Dec-2021	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Total
Alliance				1	1		1	3	1	3	5	7	**22**
Eastpointe	1	1			1		1	1	1				**6**
Sandhills	1	2	2	1	1	3	1	5	2	1		3	**22**
Trillium	1	1		1									**3**
Vaya	2	3	6	3	3	4	4	2	9	5	6	10	**57**
Total	**5**	**7**	**8**	**6**	**6**	**7**	**7**	**11**	**13**	**9**	**11**	**20**	**110**

*Note. IRIS incident query by member Common Name Data Service (CNDS) unique identifier returned zero incidents for Partners TCL participants.

XI. Olmstead Plan Initiative

In January 2022, the North Carolina Department of Health and Human Services (NCDHHS) released the State's initial Olmstead Plan (the Plan), a cross-population blueprint addressing the health and well-being of children and families, youth, adults and elders with disabilities. The Plan responds to the United States Supreme Court case *Olmstead v. L. C.* (1999) and covers Calendar Years (CY) 2022 to 2023. The Plan incorporates much work the State has already undertaken, both providing guidance for a changing system

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

and deepening North Carolina's commitment to independence, contribution, integration, inclusion and self-determination for individuals with disabilities and their families.

The Olmstead Plan has eleven (11) priority areas of focus. Each priority area includes strategies that are essential for North Carolinians with disabilities to live as fully included members of their communities. In CY 2022, targeted divisions and offices within NCDHHS, working with other state agencies, began producing the agency work plans that inform overall Plan implementation. These quarterly work plans identify the high-level action steps and timeframes that implement the Plan's strategies. The work plans are compiled into quarterly progress reports, under the leadership of Office of the Senior Advisor for the Americans with Disabilities Act (ADA), with support from the Technical Assistance Collaborative (TAC). The progress reports capture changes in strategies and in implementation activities. Collectively, the reports, which will issue throughout CY 2022 and 2023, provide the foundation for measuring progress toward Plan implementation.

This year, NCDHHS Secretary Kody Kinsley appointed a new iteration of the Olmstead Plan Stakeholder Advisory (OPSA) specific to Plan implementation. The 46-member OPSA, comprised of NCDHHS leadership, diverse external stakeholders and inclusive of people with lived experience, meets quarterly under the leadership of the Departmental Co-Chair and the Community Co-Chairs. The OPSA reviews progress on measures and benchmarks to ensure that what is reported reflects what people with disabilities are experiencing. The Advisory also flags new opportunities or trends impacting the Plan and supports the Plan's visibility through communications with its broad networks.

North Carolina made notable progress with a number of Olmstead Plan strategies within the first quarter of 2022, many attributable to the Department's transformation of its services and system to better support community inclusion for individuals with disabilities. Progress included strategy attainment as well as significant progress toward attainment. The following are highlighted as examples of accomplishments in each of the eleven (11) priority areas for the first reporting period. For more detailed information, see *North Carolina Olmstead Plan Implementation: First Quarter Summary Report, January 1 – March 31, 2022*.[71]

Accomplishments Under the Olmstead Plan, First Quarterly Report

PRIORITY AREA 1: STRENGTHEN INDIVIDUALS' AND FAMILIES' CHOICE FOR COMMUNITY INCLUSION THROUGH INCREASED ACCESS TO HOME- AND COMMUNITY-BASED SERVICES AND SUPPORTS

The Division of Health Benefits (DHB) added Innovations waiver slots for people with intellectual and other developmental disabilities (I/DD); additional Community Alternatives Program for Disabled Adults (CAP/DA) and Community Alternatives Program for Children (CAP/C) waiver slots were reported as in process. The slots were funded with enhanced Federal Medical Assistance Percentage (FMAP) and newly appropriated state funds.

NCDHHS progressed with its expansion of eligibility for the Traumatic Brain Injury (TBI) waiver. Reducing the age of eligibility to 18 years old and increasing the income limit to 300% of the federal poverty level have been completed. Moreover, work continues on expanding waiver eligibility to additional counties.

PRIORITY AREA 2: ADDRESS THE DIRECT SUPPORT PROFESSIONAL CRISIS

The DHB allocated enhanced FMAP funds to increase Direct Support Professional (DSP; direct service workforce) wages, effective April 1, 2022. Increases for DSPs working with the I/DD population will be sustained on an ongoing basis as a result of the General Assembly's appropriation of additional funds.

Between August 2021 through March 2022, the Aging and Disability Resource Center; Division of Aging and Adult Services (DAAS); and NC Assistive Technology Project collaboratively provided assistive technology to an additional 1,287 individuals with disabilities, a 59.9% increase over the baseline of 2,147 people with

[71] Retrieved on September 13, 2022 from https://www.ncdhhs.gov/media/17494/download?attachment.

disabilities who accessed assistive technology from April 2020 through August 2021.

PRIORITY AREA 3: DIVERT AND TRANSITION INDIVIDUALS FROM UNNECESSARY INSTITUTIONAL AND SEGREGATED SETTINGS

NCDHHS collaborated with the NC Housing Finance Agency (NCHFA) to develop an online, e-learning course on the Informed Decision-Making (IDM) consumer engagement tool and posted information on the NCDHHS Transitions to Community Living (TCL) website to expand and monitor the use of the IDM tool beyond TCL.

The State Developmental Centers hired an Olmstead Specialist at the Murdoch Center in December 2021; a specialist was targeted for hire at Caswell Center in April 2022; and a specialist was targeted for hire at Joseph Iverson Riddle Developmental Center in July 2022. A second specialist is targeted for hire at the Murdoch Center in October 2022. These specialists implement enhanced transition planning to ensure that individuals with memorandums of agreement are planning, from the time of admission to the Centers, a return to the community.

The State Developmental Centers also explored, and will continue to explore, opportunities to partner with community peer support networks. Through these networks, individuals with disabilities in the Centers can learn from peers in the community about opportunities for community inclusion. Connections will occur, at a minimum, once per quarter.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) is on track to select five (5) sites and award funds to implement enhanced mobile crisis for children and families by August 2022.

The North Carolina Council on Developmental Disabilities is partnering with the Alliance of Disability Advocates and the NC Department of Public Safety to reduce the recidivism rate of individuals with I/DD by providing individualized, long-term support upon release from prison. By the end of the first quarter, the project had received 83 referrals and completed 71 Individualized Reentry Plans.

PRIORITY AREA 4: INCREASE OPPORTUNITIES FOR SUPPORTED EDUCATION AND PRE-EMPLOYMENT TRANSITION SERVICES FOR YOUTH WITH DISABILITIES, AND COMPETITIVE INTEGRATED EMPLOYMENT FOR ADULTS WITH DISABILITIES

The Division of Vocation Rehabilitation Services' Transition Team developed a Pre-Employment Transition Services curriculum for adjudicated youth in Youth Development Centers and trained Center staff on delivery of the curriculum, completing the training in March 2022.

The NCDHHS is solidifying Medicaid coverage for supported employment through submission of a 1915(i) Medicaid State Plan Amendment, anticipated to go live on December 1, 2022, and is aligning its supported employment service definition across funding streams.

PRIORITY AREA 5: INCREASE OPPORTUNITIES FOR INCLUSIVE COMMUNITY LIVING

The DHB sent letters to the Local Management Entities/Managed Care Organizations (LME/MCOs), with copies to their Care Coordinators and other agencies, clarifying the criteria that allows individuals with I/DD receiving Supported Living Level 3 to exceed the $135,000 cap for the Innovations waiver.

In February 2022, the Department implemented an incentive plan with set performance measures for each LME/MCO to increase the number of successful transitions from Adult Care Homes (ACHs) to Permanent Supportive Housing (PSH). Each LME/MCO met its performance measure for the first quarter.

The NCDHHS, system partners, external stakeholders and TAC began meeting in the fall of 2021 and held monthly meetings to identify draft Strategic Housing Goals, Objectives and Strategies. The draft was shared for public comment in July 2022.

NCCDD, in partnership with Money Follows the Person (MFP)/NC Medicaid, and others, convened a Supported Living Level 2 and 3 Action Team to discuss barriers to Supported Living and solutions to

overcome these barriers. The Action Team established three (3) workgroups that have been meeting monthly and discussing barriers related to the DSP Workforce, Housing, and the Program Coordinators' role.

PRIORITY AREA 6: ADDRESS GAPS IN SERVICES

NCDHHS received approval in March 2022 to expand research-based, behavioral health treatment services for adults with autism.

NCDHHS convened a Child Welfare Family Wellbeing Transformation Team in the fall of 2021, charged with developing a Coordinated Action Plan. The Coordinated Action Plan will expand access to community-based services, reducing reliance on out-of-home placements. By the end of the first quarter, the Team was on course to release the Coordinated Action Plan in May 2022.

In quarter one, NCDHHS was awaiting approval from the Centers for Medicare and Medicaid Services (CMS) to allow a parent to retain Medicaid eligibility when their child is being served temporarily by the foster care system, regardless of the type of out-of-home placement if the parent is making reasonable efforts to comply with a court-ordered plan of reunification.

PRIORITY 7: EXPLORE ALTERNATIVES TO FULL GUARDIANSHIP

TCL and DMH/DD/SAS staff secured baseline data (fiscal year (FY) 21) on adults with a primary diagnosis of I/DD or mental illness who are served by a public guardian in North Carolina. Establishing this baseline is necessary to quantify the impact of strategies proposed in the Olmstead Plan to promote alternatives to guardianship.
In March 2022, DMH/DD/SAS presented a webinar on alternatives to guardianship to the I/DD Stakeholder Workgroup.

A broad-based stakeholder workgroup, Reinventing Guardianship, has drafted detailed, proposed reforms to NC General Statute 35A, Incompetency and Guardianship. The group has engaged the NC Bar Association and the NC Conference of Clerks of Superior Court in crafting language to inform legislators about the need for reforms to NC General Statute 35A to promote alternatives to guardianship.

PRIORITY AREA 8: ADDRESS DISPARITIES IN ACCESS TO SERVICES

DMH/DD/SAS provided allocations to the LME/MCOs to increase access to Community Support Team (CST) and Assertive Community Treatment (ACT) programs in rural and underserved communities by June 2022.

In quarter one, DMH/DD/SAS was anticipating execution of a contract with the Governor's Institute in June 2022 to engage emerging leaders in the substance use disorder (SUD) field. The contract funds will assist in reimbursing costs for standardized tests (i.e., licensure and certification) and for registration fees for SUD trainings and conferences, with a priority on supporting historically marginalized and rural populations.

PRIORITY AREA 9: INCREASE INPUT FROM INDIVIDUALS WITH LIVED EXPERIENCE

NCDHHS has attained a 51% representation of individuals with lived experience on the Olmstead Plan Stakeholder Advisory Committee (OPSA).

DMH/DD/SAS is developing a written inventory of consumer-operated services that support individuals with serious mental illness (SMI), I/DD, TBI and co-occurring SUD, to be completed by December 2022.

PRIORITY AREA 10: REDUCE TRANSPORTATION BURDENS FOR INDIVIDUALS WITH DISABILITIES

In the first quarter, DHB reported it had submitted a request to CMS and was awaiting approval to use enhanced FMAP to add remote technology support to the CAP/C and CAP/DA waivers to increase access to services for individuals living in rural areas of the state.

PRIORITY AREA 11: USE DATA FOR QUALITY IMPROVEMENT

NCDHHS staff are working with Mathematica to enhance TCL data quality and integration, performance measurement, and use of program data for evaluation and decision-making, and to establish a framework to assist in developing a quality assurance structure for the State's Olmstead Plan.

Current and Emerging Challenges, First Quarterly Report

The Olmstead Plan quarterly reports include TAC's identification of current and emerging challenges. The following were addressed in the first report.

The Workforce Crisis

The NC Health and Human Services system reported a lack of sufficient qualified staff is reported at all levels, consistent with shortages experienced across the nation. The NCDHHS has had significant turnover among staff with the subject matter expertise necessary to lead implementation of changes requisite to a continued systems transformation. Among providers, there were also pressing staff shortages, inclusive of both clinical professionals and frontline workers, each essential for effective services. Efforts to increase wages for direct service workers were underway, initially supported with enhanced federal matching funds and also with funds approved by the General Assembly. It is the TAC's assessment that the increased wages have not been applied consistently across state-operated and private community-based provider staff. Additional workforce solutions are necessary, TAC states, to expand and strengthen community-based services.

The "Lack" of Data

The NCDHHS subject matter experts for the Olmstead Plan, reports TAC, are often well-versed in policy and program content but are less familiar with existing data that could be used to support baseline benchmarks and targeted measures and to assess progress. To address the issue, the Department expanded its contract with Mathematica. Building on work with TCL, Mathematica will develop an Olmstead Plan data management system, analytic platform and data dashboards. This will provide a stronger framework for quality assurance and performance improvement as Plan implementation goes forward.

Engaging LME/MCOs

The State's LME/MCOs are key partners in implementing the Olmstead Plan. Their engagement with the specific requirements for Olmstead Plan implementation has been limited to date, in large part as a result of their preparation for transitioning to Tailored Plans. As reported by the TAC, LME/MCO contracts have contained few requirements related to the Olmstead Plan. The Department intends to clarify Olmstead-related roles and responsibilities in its Tailored Plan contracts.

Lack of a Unified Vision among Stakeholders

Based on TAC's experience, any Olmstead Plan that addresses community inclusion for people with all disabilities will encounter differences in priorities among its stakeholders. In North Carolina, however, TAC notes a greater difficulty identifying consensus among stakeholders. TAC has observed "wide variation" in perspectives on key issues relevant to *Olmstead* compliance, including approaches to advancing independent living, supporting the direct service workforce, implementing competitive integrated employment, and developing alternatives to full guardianship.

Lack of Safe, Decent, and Affordable Housing

North Carolina is experiencing a "housing crisis," as are most other states across the country. Access to safe, decent, and affordable housing is especially difficult in urban areas and academic centers in the state, whereas services and supports are more available in these same areas. Conversely, housing in rural areas may be available, but the necessary services and supports may not be. The Department is engaged in development of a NC Strategic Housing Plan, but housing development takes time. At present, the lack of availability of units is an issue for Olmstead Plan implementation.

Next Steps in Olmstead Plan Implementation

1) NCDHHS staff and staff from other agencies will continue to provide work plans and related information on the status of implementation strategies and action steps. TAC will continue to work with staff to clarify, refine and strengthen work plans, as needed.
2) TAC and Mathematica began collaborating to identify additional, baseline data and targeted measures to assess progress with Olmstead Plan implementation.
3) NCDHHS, system partners, external stakeholders and TAC will continue drafting NCDHHS Strategic Housing goals, objectives and strategies; these were made available for public comment in July 2022.
4) The Department, through its contract with TAC, will develop a plan to provide training for leadership, staff and stakeholders, across systems, to conduct their work through "an Olmstead lens."
5) TAC will work with policymakers and program staff at the state, regional and provider levels, to advance an array of evidence-based practices that promote community inclusion. Efforts will include the direct service workforce.
6) The second, third and fourth quarterly reports on the Olmstead Plan, covering April 1 through December 31, 2022, will be due, respectively on September 15, 2022; December 15, 2022; and March 15, 2023.

XII. Budget

For SFY 21 - 22, TCL completed the following budget activities for ongoing monitoring, optimization, and performance improvements.

- Monthly budget reporting for leadership staff and LME/MCOs
- Quarterly reviews for reallocation of funds in a timely manner
- Implementation of the TCL Incentive Plan

TCL launched the TCL Incentive Plan to reward LME/MCO performance and foster continued progress in achieving compliance with the settlement agreement. The implementation included requirements compliance for eligibility, the issuance of startup funds and measures incentive payments based on the LME/MCOs meeting requirements and achieving outcomes. The TCL Incentive Plan will continue throughout SFY 22 – 23.

TCL expenditures, continue to increase due to rising costs of rental assistances and other needed areas to sustain progress. In comparison to the previous year, SFY 21 – 21 budget reflects the following:

- TCL SFY 20 – 21 Budget = $60,348,988
- TCL SFY 21 – 22 Budget = $67,549,899

KEY EXPENDITURES COMPARISON TABLE

Cost Category	Expenditures	
	SFY 20/21	SFY 21/22
Rental Assistance	$21,923,370	$24,104,385
DMH LME/MCO	$19,344,145	$15,909,008
Medicaid LME/MCO	$16,403,147	$10,550,566
DHHS Staffing and Admin	$1,546,997	$1,412,693
Contracts	$996,278	$1,637,396
Olmstead Planning	$135,051	$159,825
TCL Incentives	-	$9,285,250
	$60,348,988	**$63,059,019**

As a result of expenditures in SFY 21 – 22 , $4,490,775 in funds were reverted to the Housing Finance Agency (HFA).

XIII. Conclusion

As we conclude FY 2021 – 2022, some valiant efforts across the State were made, but we were unable to meet the standard of substantial compliance as set out in the Transitions to Community Living (TCL) settlement agreement, by the end of June of 2022. Consequently, our work will be extended until June of 2023. While we did not achieve the key benchmark of 3,000 individuals with "serious mental illness"[72] housed by June of 2022, we did attain and maintain that number soon after, in the summer of 2022. Unfortunately, our difficulties in reaching the numerical requirements of TCL populations 1-3[73] – people with serious and persistent mental illness transitioning into housing with wrap around support – kept us from meeting both the requisite count for number of people and our housing requirements. There are many reasons why this occurred, but largely, the disengagement of the State's largest local management entities (LME/MCOs); the reintegration of people into other LME/MCOs following the wind down of the Cardinal LME/MCO; the workload incident to the advent of Tailored Plans; and the on-going restrictions incident to the pandemic that lingered well into 2022 made the focus on transitions into housing very difficult, especially for people moving out of a congregate setting and into a community of their choice.

We would, however, be remiss if we didn't talk about some of the important system change accomplishments that Transitions to Community Living (TCL) has produced to date. In housing, the July report indicated that over 3000 people are now living in Permanent Supportive Housing. Over the life of the program, over 4,500 people with serious mental illness or severe and persistent mental illness have experienced the pride of having an address, being a part of the community and steering their lives toward recovery. In services, over 5,000 people have benefitted from the stabilizing work of Assertive Community Teams (ACT) across our state. Community Support Teams now include a tenancy support component and can now be accessed as long as a person needs the service. Transition Management Services, largely provided by peers, helps people continue to manage their housing and community integration as an initial service or to continue their recovery journey even after ACT or Community Support Teams are no longer medically necessary. Individual Placement Support-Supported Employment (IPS-SE), an evidence-based employment service, not only helps people pursue meaningful employment but socially redefines them as co-worker, teammate, and friend.

The State created an Informed Decision-Making tool (IDM) so people could fully understand their rights to live and receive services in the community. The tool has now been updated so that guardians and the person can document their desires, decisions or concerns about community living. When Guardians express concerns about community transition for the person, In-Reach Specialists, who administer the tool, can address the concerns immediately with individualized strategies for overcoming any barriers to community living. Local Barriers Committees have been established across the state; Regional Ombudsman attend these meetings so that they can understand barriers to community that may exist for people exiting Adult Care Homes or State Psychiatric Hospitals. In Reach staff has been trained to submit barriers to their Local Barriers Committee for resolution; however, if concerns cannot be addressed at the local level, they can be elevated to the State's own Barriers Committee, made up of cross-divisional, subject matter experts who set out to resolve the barriers that inhibit community life. If the State Barriers Committee cannot resolve a systemic issue, it is raised to the Transition Oversight Committee, along with recommendations for resolution. Many systemic barriers have been overcome in this manner. A barriers log is maintained, with each barrier submitted and followed through to resolution. Barriers are retained on the log even after closure.

[72] The TCL settlement agreement uses the term "serious mental illness" for both those with serious or severe and persistent mental illness.

[73] Populations 1 – 3 are as follows: 1. Individuals with serious mental illness (SMI) who reside in an adult care home determined by the State to be an Institution for Mental Disease; 2. Individuals with Severe and Persistent Mental Illness (SPMI) who are residing in Adult Care Homes licensed for at least 50 beds and in which 25% or more of the resident population has a mental illness; 3. Individuals with SPMI who are residing in Adult Care Homes licensed for between 20 and 49 beds and in which 40% or more of the resident population has a mental illness. Retrieved on September 13, 2022 from https://www.ncdhhs.gov/media/1646/download.

Protocols for State Psychiatric Hospital discharges are in place and training across all hospitals and LME/MCOs was conducted again this year. Transition times are improving, and we continue to monitor movement from Adult Care Homes. One of the barriers to community living, addressed in the last two years, was the need for improved transition planning and focused complex medical support. Again, with a cross-divisional team, TCL has created a Complex Medical Care Management process. Using this process, Occupational Therapists and Registered Nurses assess each person for medical and functional needs; develop a plan of care before the person leaves an institution; and convey the plan to the housing transition team. These staff, along with behavioral health providers, implement the plan while the person is in transition and after they enter housing. In addition, when needed, training can also be provided so that a person can better manage his/her own health status once in their own home. Before the person leaves the institution, they are introduced to their behavioral health provider and, when needed, the physical health provider. These individuals further train a person, including after they are in their home, around making healthy decisions; understanding medications; how to perform at-home medical care; and more.

Complex Care was rolled out across the state to all LME/MCOs. This is a critical component of TCL's work to move people out of Adult Care Homes, where the typical age of people transitioning is much higher than with any other settlement agreement priority population. Individuals from this population category often experience multiple medical conditions that create the need for ongoing care. The Complex Care process was included in Medicaid contracts and is now moving into Tailored Care Plan contract amendments.

We have made great strides in reducing reliance on institutions and expanding the array of services and supports for people to lead successful lives in the community. We have developed and are tracking an action plan for the next 18 months to meet compliance by the June 2023 deadline and are in "countdown" mode.

Our LME/MCO partners have developed plans to ensure their own success as well as the success of their members. Elements of TCL and Money Follows the Person (MFP) are now architected into the new Tailored Plans, our Olmstead Plan and the newly-submitted Medicaid 1115 waiver, with its 1915(i) option. The intention of moving forward with the core elements of TCL and Money Follows the Person (MFP) for *all* disability groups is a cornerstone for the NCDHHS. The Olmstead Plan, which overarches both TCL and MFP, will, as a result of this work, become a "blueprint" for the way that NCDHHS and its partners will make decisions central to improving the lives of people with disabilities.

The Olmstead Plan rests on the careful implementation of both the Transitions to Community Living and Money Follows the Person. This cross-disability plan expands work of the NCDHHS' Healthy Opportunities initiative; incorporates efforts well underway, across the NCDHHS, to refine and re-define policies and programs to align with Olmstead's imperative of community integration; and commits North Carolina to a future where all people with disabilities can access the services that they need to live "an everyday life – even, an enviable life – side-by-side with friends, family and neighbors."

Transitions to Community Living, in summary, is no longer a stand-alone initiative. It is not a pilot. It is a carefully constructed framework of housing and supports from which all disability groups will ultimately benefit. It is a way of approaching North Carolina's work to see that people with disabilities live and thrive in communities, with friends, family and neighbors, throughout North Carolina.

XIV. Appendix

Appendix A: TCL Quality of Life Survey Summary Report

"I would [like to] have my own place. Eventually I would love to have my own place where my whole family can be together, fiancé, dog, yard, with a fence. One day I would like to be able to buy my own place so I can paint my walls pink if I want to."
TCL participant, pre-transition

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

LME/MCO staff and community mental health services providers administer the surveys during the transition planning period and again 11 and 24 months after the individual transitions to supportive housing.[74] Together with regular provider-facilitated interviews administered through the NC Treatment Outcomes and Program Performance System (NC-TOPPS)[75], TCL QOL Surveys are used to monitor key participant outcomes, including community integration, natural supports network development, and other factors vital for maintaining stable housing and avoiding harms.

The surveys are administered using a structured interview format and are designed to directly assess participant perceptions, satisfaction, and outcomes related to housing and daily living, supports and services, and well-being. Approximately 30 survey questions are presented with defined response options. At 12 points throughout the interview, individuals are invited to provide additional information, elaborate on earlier responses, discuss what they would like to change, and identify and discuss unmet needs, factors limiting daily choice and control, and obstacles to community integration and receiving needed services.

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

At the participant level, providers and LME/MCO staff can identify obstacles and problems that require immediate follow-up and solutions. Open-ended survey questions provide a structured opportunity for service providers and LME/MCO contacts to assess individual preferences, needs, and goals during transition planning, and to identify, explore, and discuss with individuals in supportive housing any factors related to their services and supports, daily activities, and housing that need attention, adjustment, or intervention. For example, open-ended questions address and encourage deeper exploration and discussion of participant obstacles to community integration, impediments to self-direction, additional service and support needs, and problems and sources of dissatisfaction with current living arrangements.

[74] In general, 24-month surveys are administered two SFYs after the transition year, such that 24-month surveys for individuals who transitioned in 2020 occurred in 2022. Follow-up surveys may be administered substantially later than 11 and 24 months after the initial transition for individuals who leave and later return to supportive housing.

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

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

Survey responses are submitted by the LME/MCO or service provider through the State's secure, web-based survey application. As of June 30, 2022, almost 10,500 surveys for nearly 5,500 TCL participants had been administered and submitted. With this annual report, responses to more than 5,000 Pre-Transition surveys; 3,000 11-month surveys; and 2,000 24-month surveys have been analyzed.[76] (See Figures 1 and 2.)

FIGURE 1: PARTICIPANT SURVEYS BY STATE FISCAL YEAR

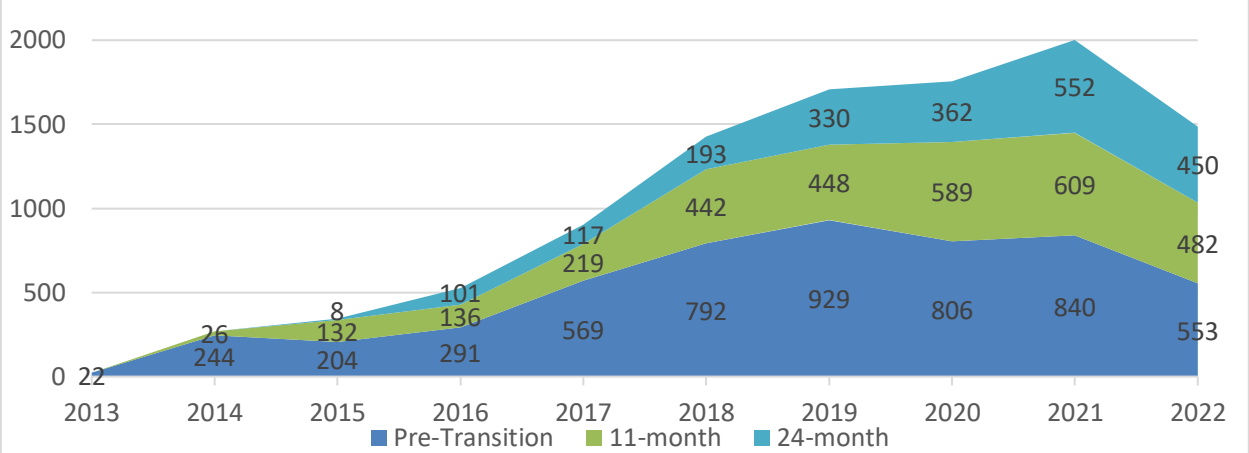
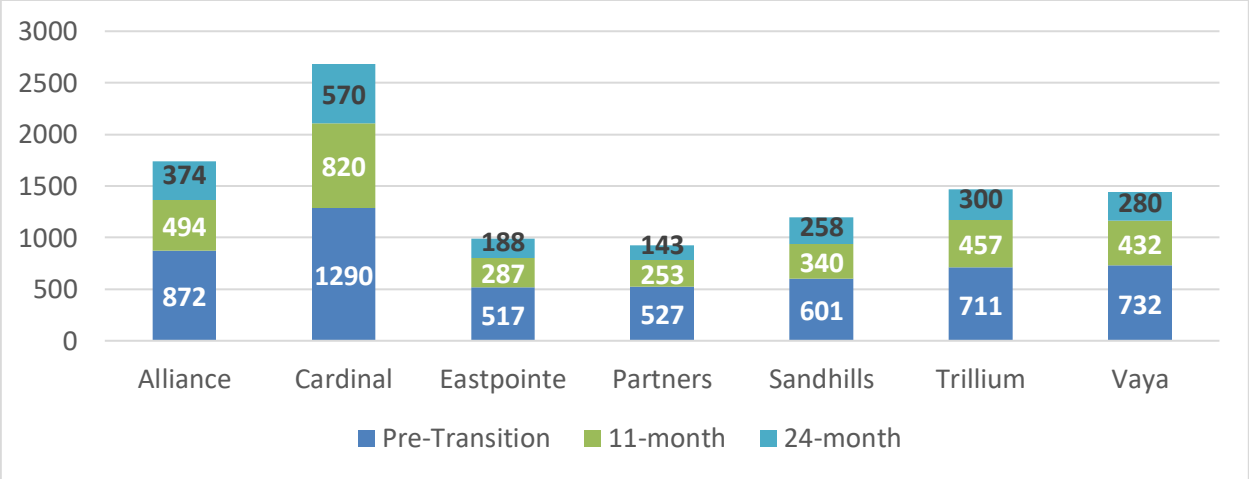


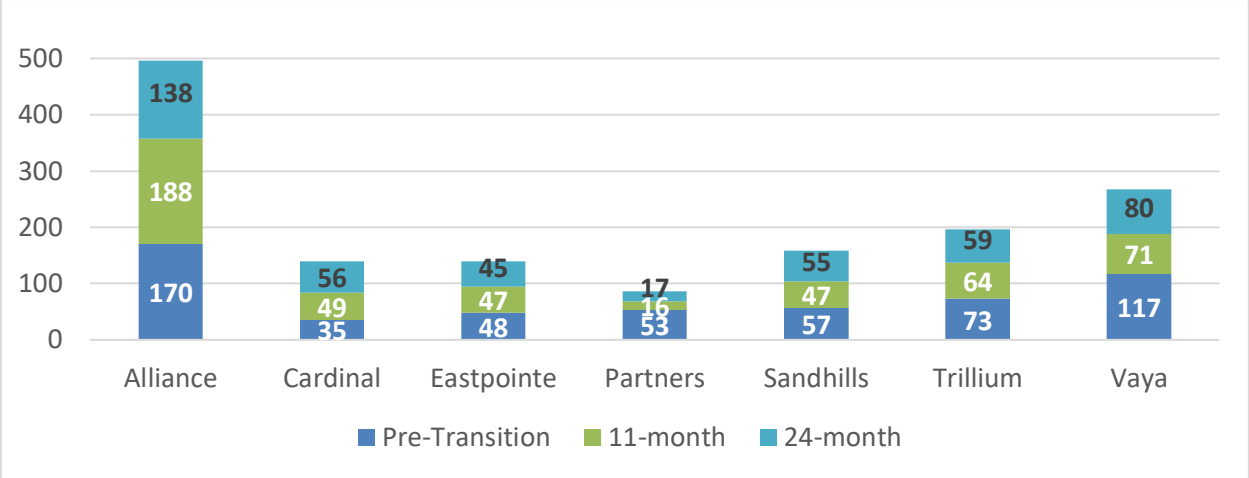
FIGURE 2: COMPLETED PARTICIPANT SURVEYS BY SUBMITTING LME/MCO, SFY 2013-2022



Analyses of SFY 2022 data reported in this annual update are based on 1,485 surveys, including 553 pre-transition, 482 11-month, and 450 24-month surveys, as shown in Figure 3.

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

FIGURE 3: SFY 2022 COMPLETED PARTICIPANT SURVEYS BY SUBMITTING LME/MCO



LME/MCO compliance with the Quality of Life survey requirement is an area of ongoing State team performance monitoring. Over the life of the TCL program, 85% of surveys for individuals housed and/or reaching 11 or 24 months in housing have been submitted. This includes pre-transition surveys for 93% of individuals housed and follow-up surveys for 78% of individuals in housing at 11- and 24-month follow-ups. Because individual survey participation is voluntary, a 100 percent submission rate is not expected.[77]

The overall submission rate for surveys due in the 2022 State Fiscal Year was 78 percent. Surveys were submitted for 94 percent of all individuals who transitioned to supportive housing during the year, and 73 and 72 percent, respectively, of individuals in housing at 11 and 24 months.[78]

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

Over the life of the program, pre-transition participants have responded on average to 10.8 of 38 (28%) defined-response survey questions with an answer that indicates less than the most positive experience or level of satisfaction, compared to 7.3 out of 38 (19%) questions for individuals in supportive housing. More than half of all surveys, both pre- and post-transition, include 8 or more of these "flags," and more than one-quarter include 13 or more.

In surveys administered in SFY 2022, participants in supportive housing selected defined response options indicating less than the most positive experience or level of satisfaction at slightly higher rates than in previous years: 8.2 (29%) response flags at 11-month follow-ups, and 7.7 (28%) at 24-month follow-ups, compared to 10.4 (37%) among pre-transition respondents. Although approximately one-quarter of surveys of individuals in supportive housing included three or fewer flags, approximately one-quarter included 12 or more responses indicating potentially actionable issues, problems, or concerns.

[77] Life-of-program survey counts reported for each LME/MCO operating in SFY 2022 include surveys submitted by legacy LMEs/MCOs that later merged as well as surveys administered to participants who later transferred to different catchment areas. In cases of county realignments and participant LME/MCO transfers, survey counts for the original LME/MCO may not include surveys that were subsequently readministered by the receiving LME/MCO.

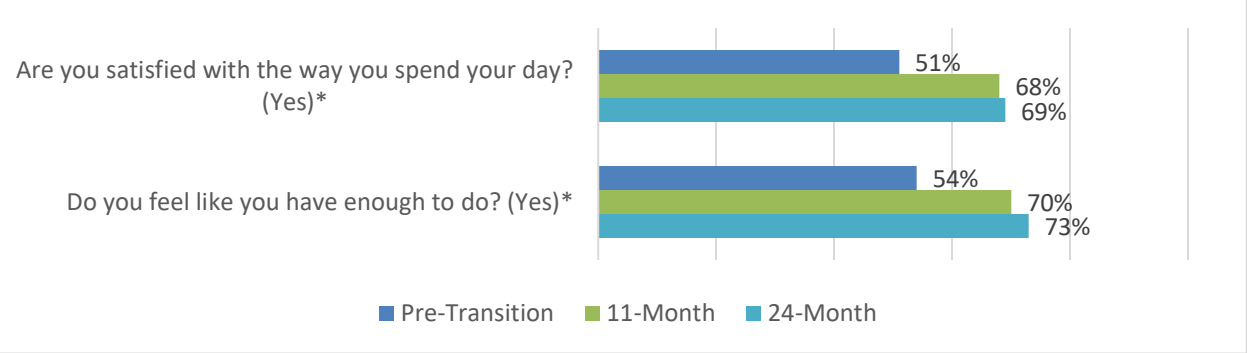
[78] Aggregate annual and life of program submission rates presented here are not precise estimates of LME-MCO compliance or performance.

Quality of Life Domains

"My life is completely different than it's ever been. I have a real, functional life"
TCL participant at 11-month follow-up

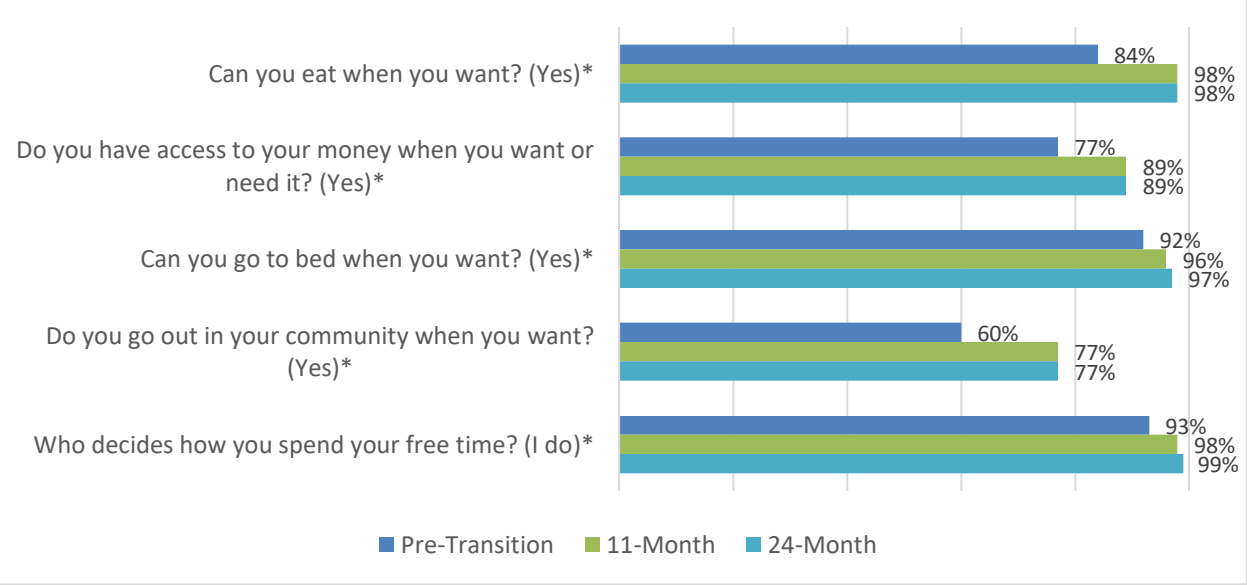
Figures 4A through 4H show percentages of participants surveyed in SFY 2022 who reported positive experiences related to eight Quality of Life domains.[79,80] Pre- and post-transition responses follow a similar pattern to previous years, with more individuals in supportive housing reporting positive experiences in most non-service related domains compared to their pre-transition peers. However, percentages of individuals reporting positive experiences were somewhat lower overall than in previous years, and this difference was slightly more pronounced for participants in supportive housing. Also in contrast to prior year patterns, in the Service Planning domain, post-transition participants were less likely to report that they knew who to contact if they had a problem with their services.

FIGURE 4A: MEANINGFUL DAY



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

FIGURE 4B: CHOICE AND CONTROL

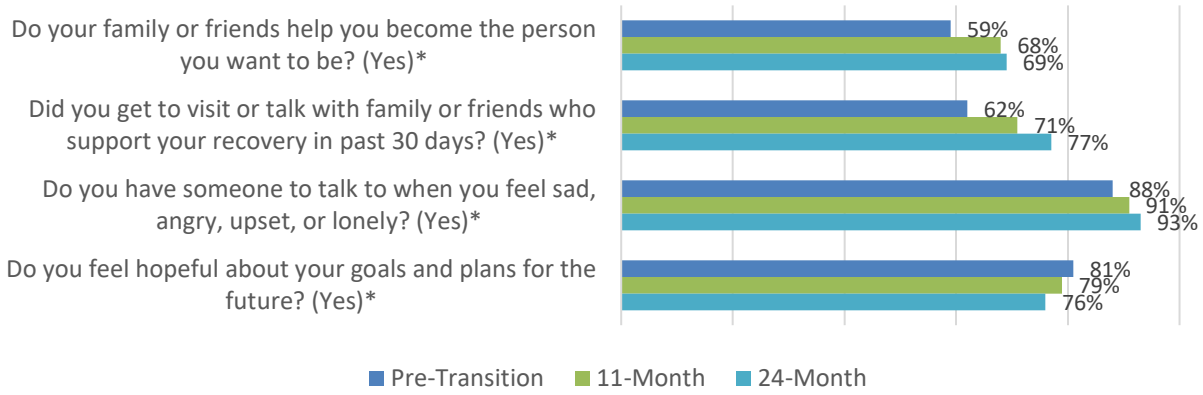


*Pre-transition and post-transition percentages are significantly different.

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

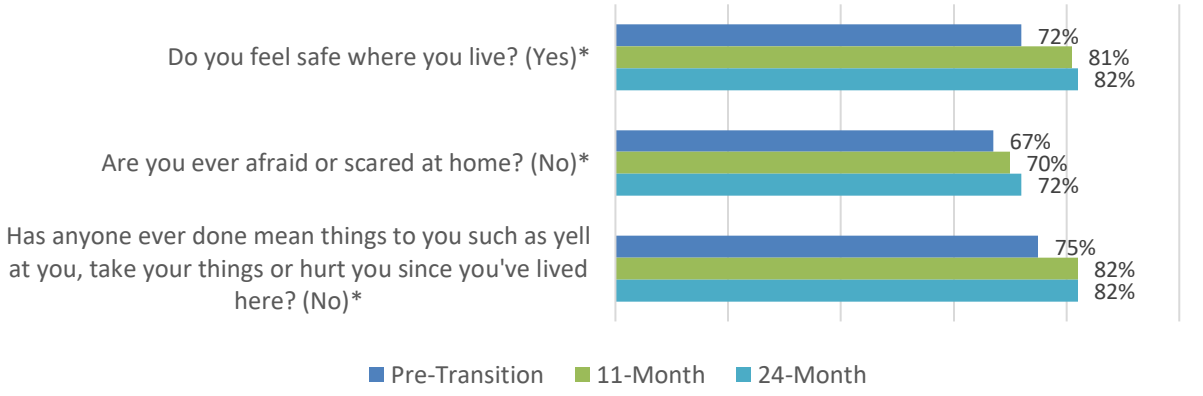
[80] "No Response" and "Unsure" responses are excluded from all percentage denominators.

FIGURE 4C: NATURAL SUPPORTS



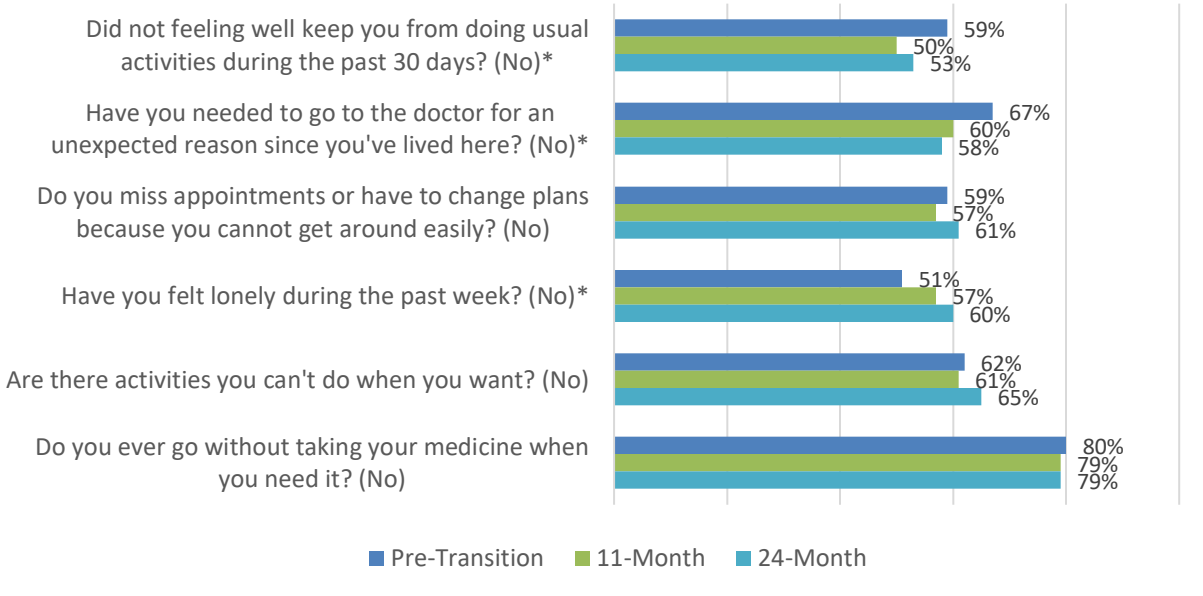
*Pre-transition and post-transition percentages are significantly different.

FIGURE 4D: SAFETY



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

FIGURE 4E: HEALTH AND WELLNESS



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

FIGURE 4F: SATISFACTION WITH SERVICES AND STAFF SUPPORT

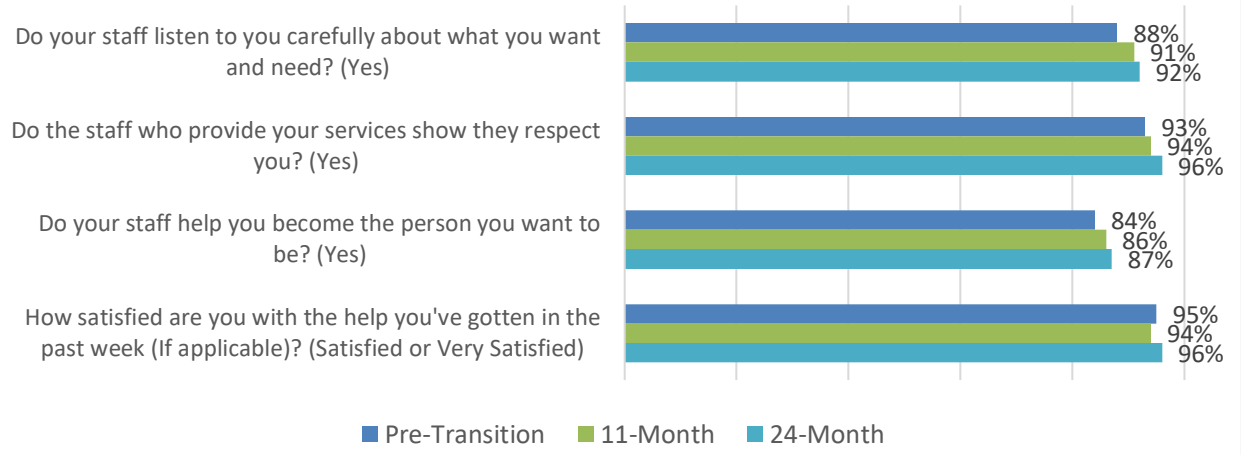


FIGURE 4G: SERVICE PLANNING CONTACTS

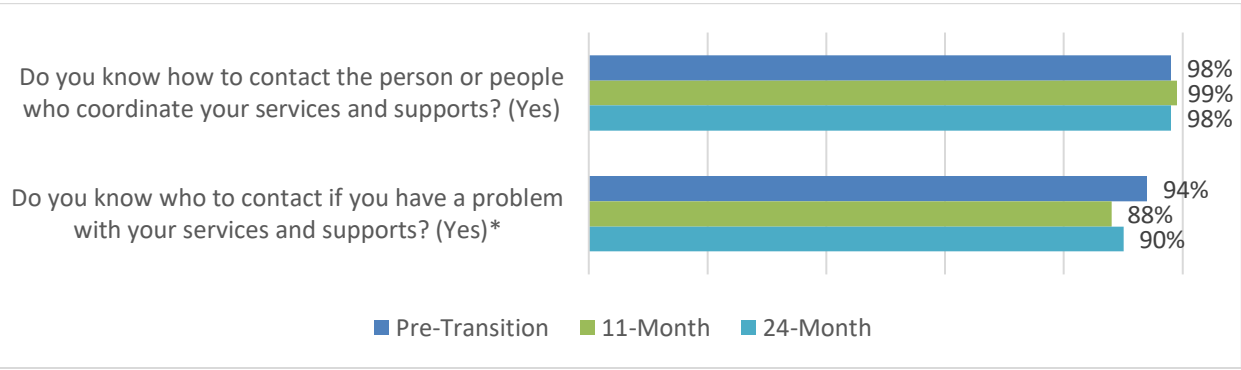
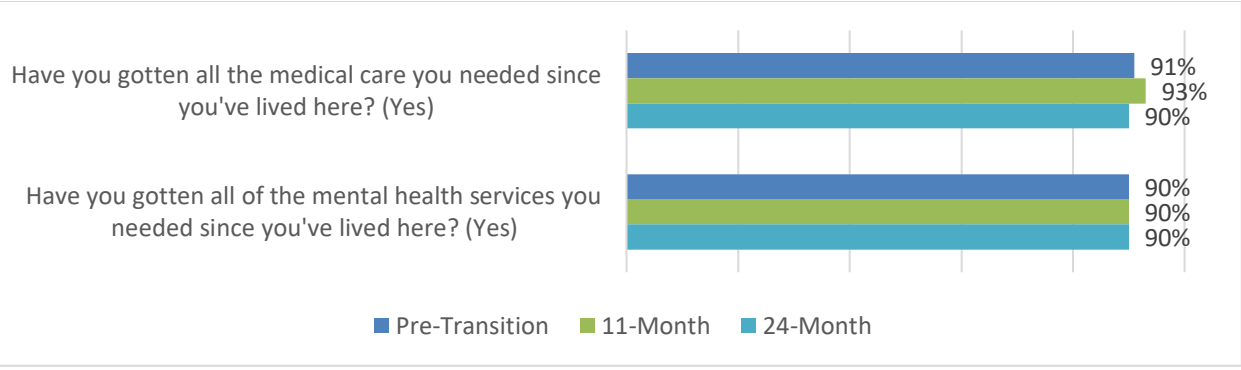


FIGURE 4H: SERVICE SUFFICIENCY

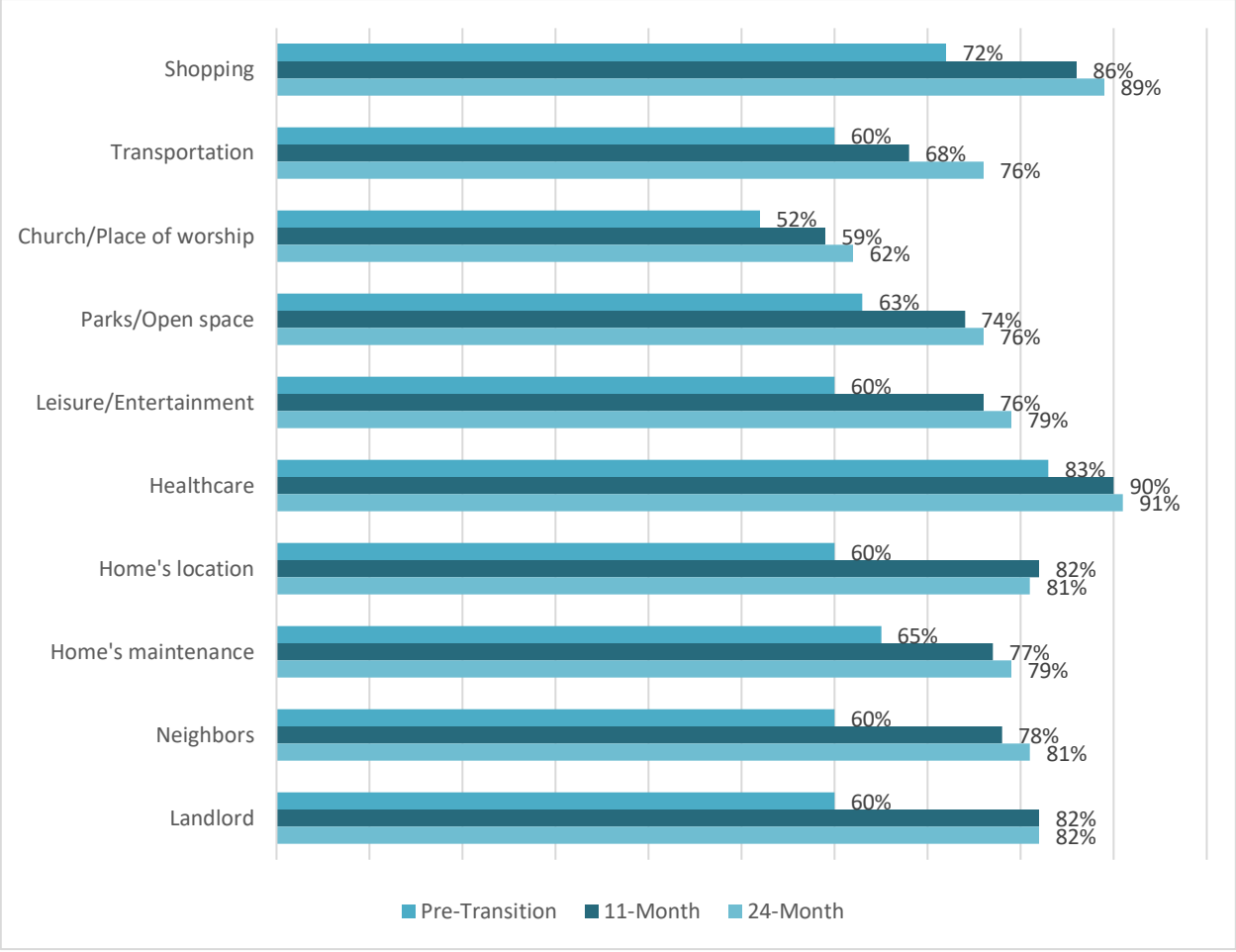


Satisfaction with Housing and Community

"I will be contacting Wheels of Hope to see about a vehicle. With my health problems I am blessed to have my own place. This gives me a peace of mind to have the key to my own place and do what I want to do when I want to do it."
TCL participant at 24-month follow-up

Figure 5A shows percentages of SFY 2022 survey respondents who reported being satisfied with various resources in their communities and aspects of their housing. As in previous years, significantly larger percentages of individuals in supportive housing reported satisfaction in each of the 10 areas compared to individuals who had not yet transitioned. Also as in past years, at all three points respondents were most likely to report satisfaction with their Healthcare. Responses indicate somewhat lower overall rates of satisfaction than in previous years, and this difference is more pronounced for individuals in supportive housing.

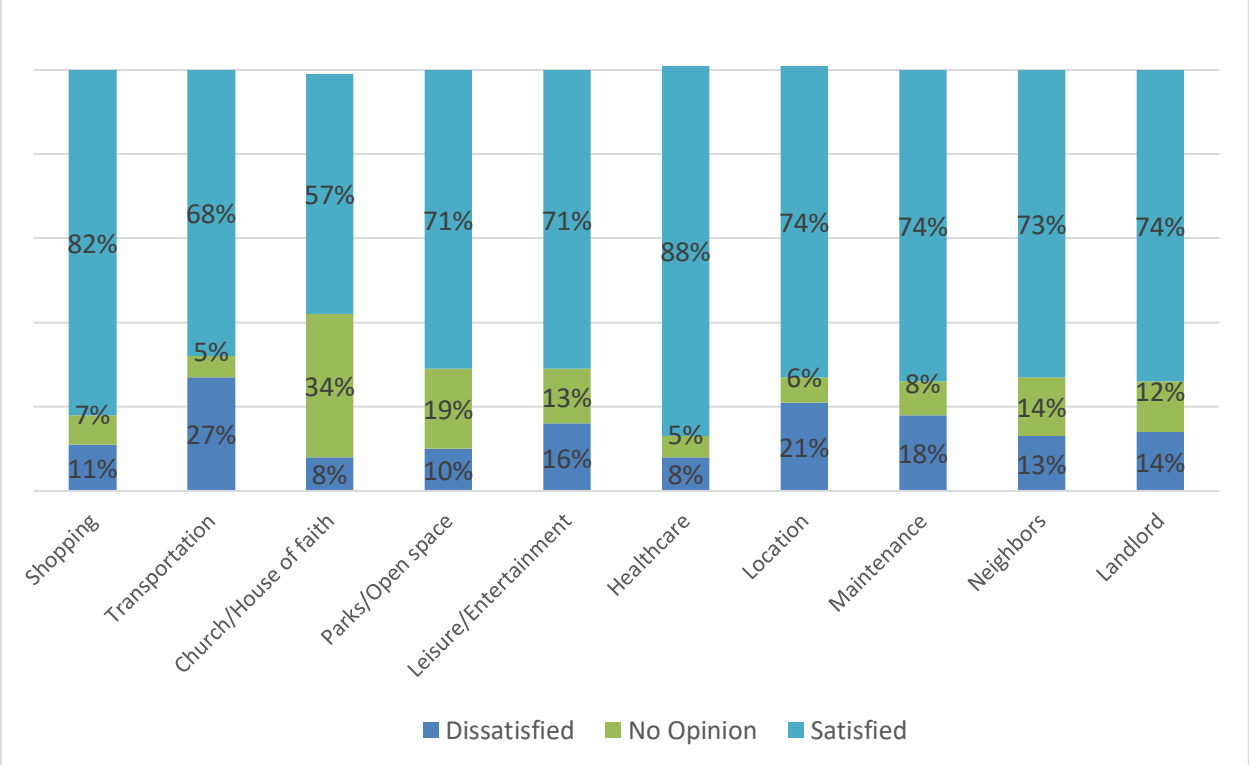
FIGURE 5A: SATISFACTION WITH HOUSING AND COMMUNITY RESOURCES



Values shown are percentages of respondents who selected "Satisfied" rather than "Dissatisfied" or "No opinion." Non-responses are excluded from percentage denominators. Significantly larger percentages of post-transition respondents reported being satisfied with all 10 aspects of housing and community resources.

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

FIGURE 5B: SATISFACTION VS. DISSATISFACTION IN SUPPORTIVE HOUSING



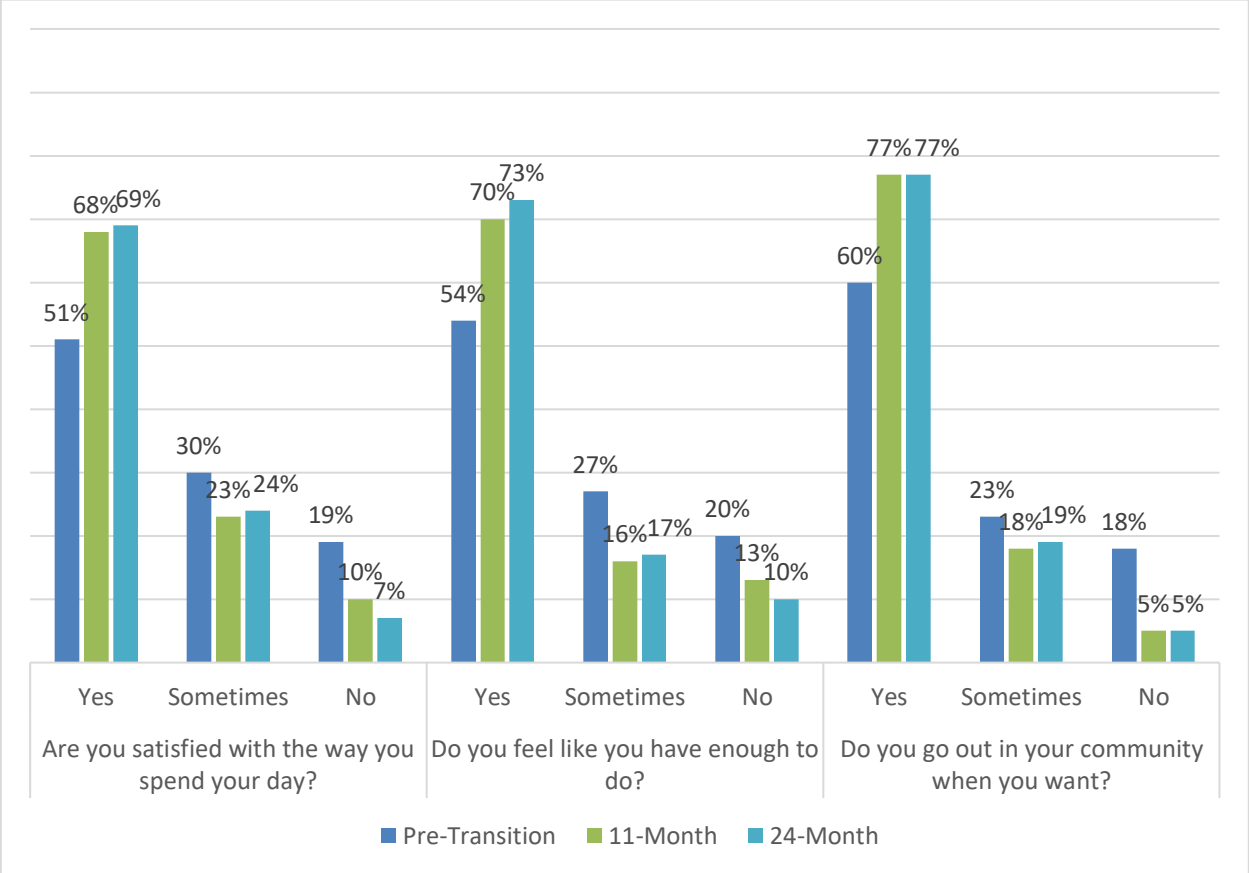
Includes all SFY 2022 11-month and 24-month follow-up surveys.

Community Integration and Natural Supports

"I enjoy taking care of my small dog. I order my groceries online and have them delivered. I will be checking with my CST team about assisting with locating a gym that accepts my insurance and getting assistance with monitoring my blood pressure and diabetes. I love my home. I feel like crying for joy. I have neighbors who check on me and are friendly." TCL participant at 11-month follow-up

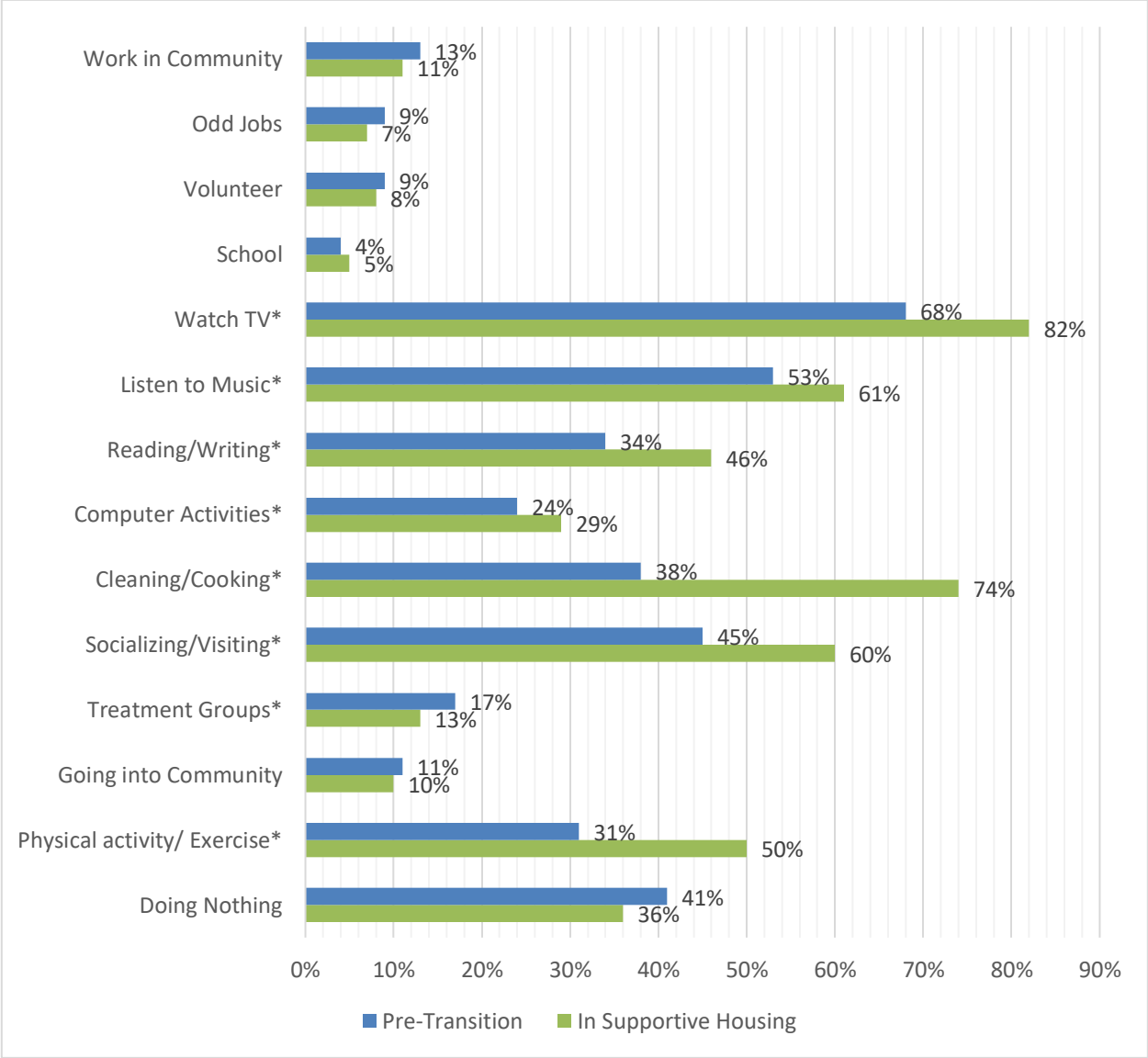
Figure 6 shows detailed response distributions to survey questions related to participant community integration and engagement. Pre-transition and post-transition respondents differed significantly in their reports of satisfaction with daily activities, having enough to do, and going into the community when desired. However, noticeably lower percentages of individuals in TCL housing reported satisfaction with how they spend their day compared to previous years, although these respondents were one-third more likely to report satisfaction in this area than pre-transition respondents.

FIGURE 6: COMMUNITY INTEGRATION AND ENGAGEMENT AT PRE-TRANSITION, 11 AND 24 MONTHS



Pre- and post-transition respondents also differed in their reports about their typical daily activities. Participants in supportive housing selected 4.5 activities on average, a relative difference of 29 percent more than the 3.5 activities selected on average by individuals in congregate living and other pre-transition settings.[81] For all activities selected at significantly different rates between pre- and post-transition respondents, percentages for individuals in supportive housing were substantially higher compared to the previous year.

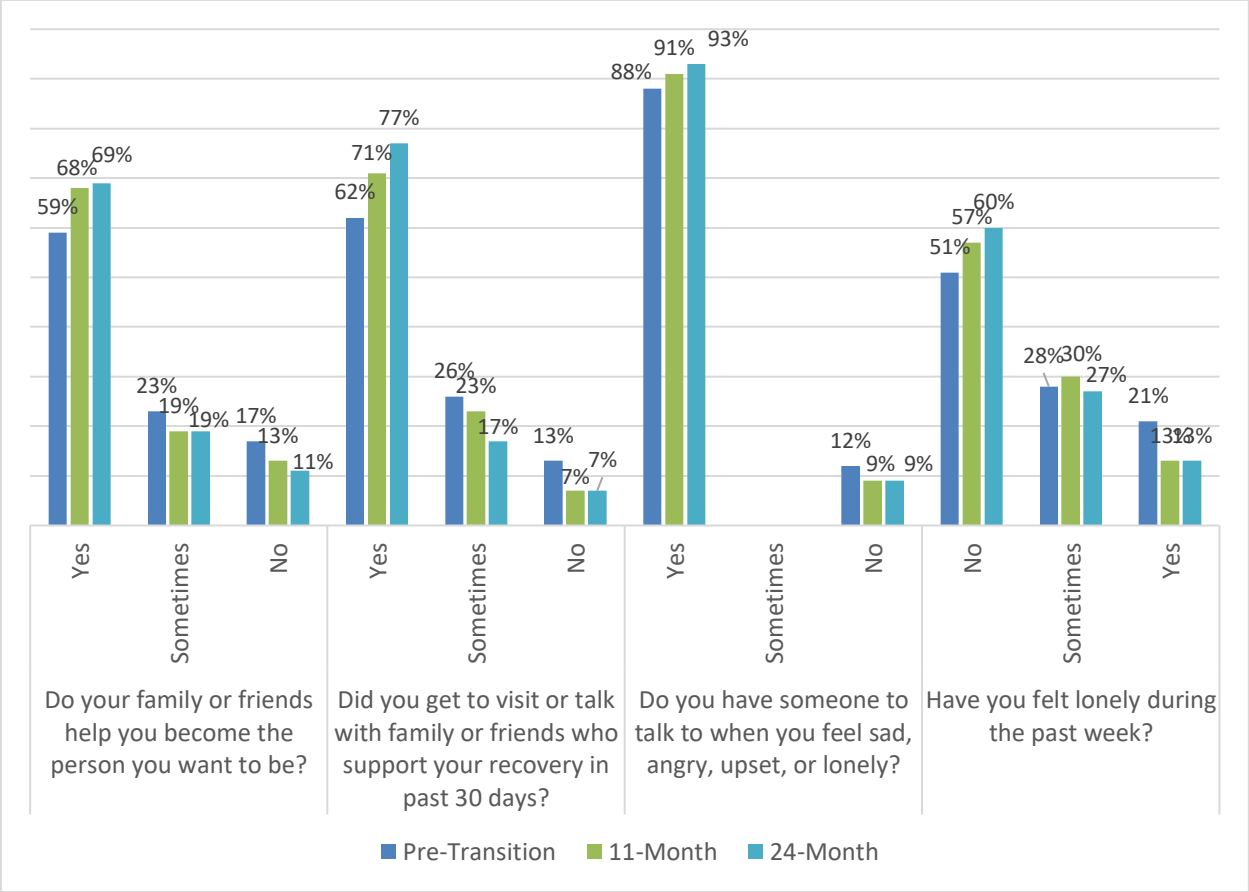
FIGURE 7: HOW DO YOU USUALLY SPEND YOUR DAY?



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

Figure 8 shows detailed response distributions to survey questions related to participants' natural support networks and relationships with friends and family. Significantly larger percentages of post-transition respondents reported positive experiences in response to each of these questions. Differences between pre- and post-transition respondents for all but, "Do you have someone to talk to…" are somewhat smaller than in the previous survey year, and this is primarily attributed to lower percentages of individuals in supportive housing who reported positive experiences.

FIGURE 8: NATURAL SUPPORTS AT PRE-TRANSITION, 11 AND 24 MONTHS

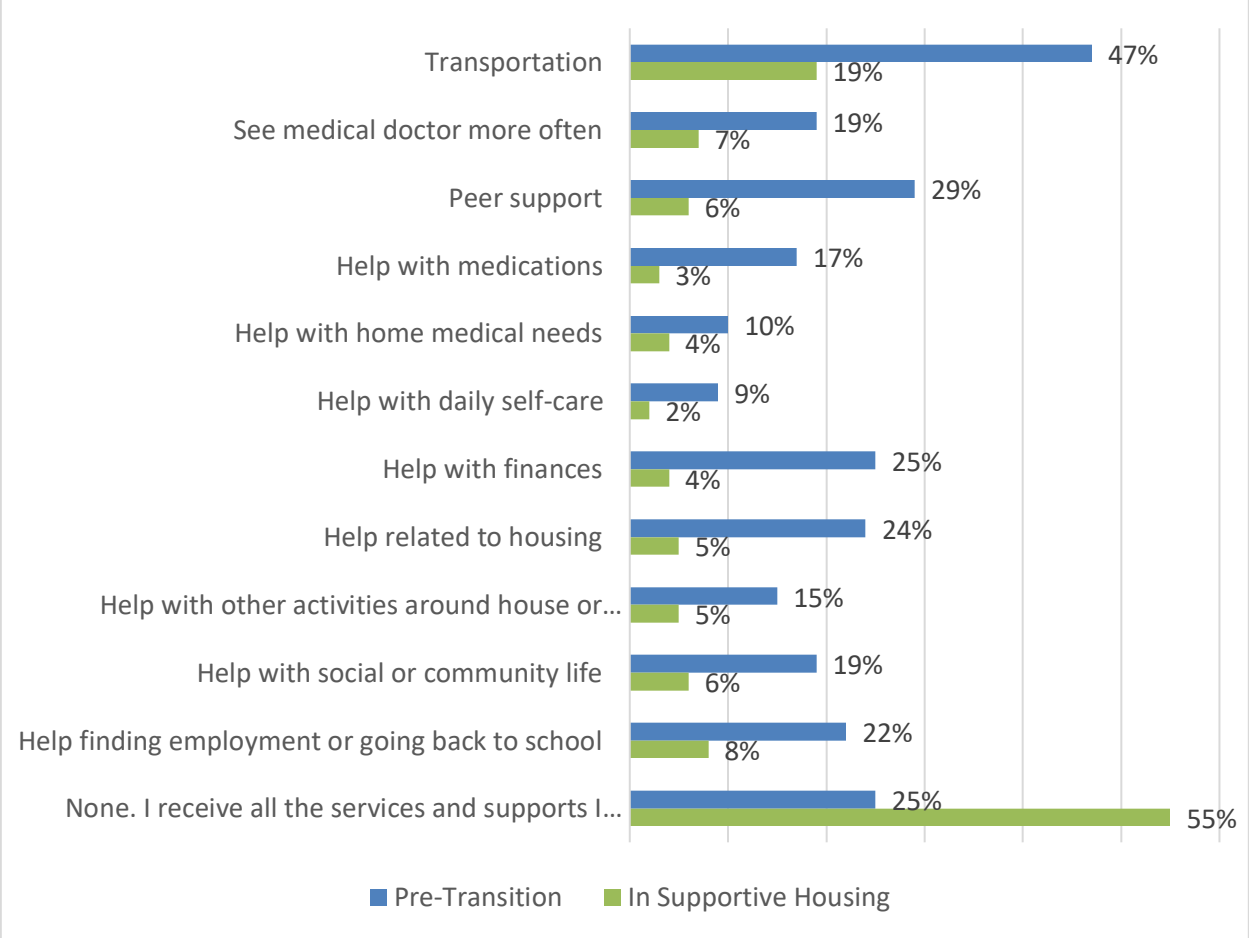


Unmet Needs and Challenges to Community Integration

"I am going through some legal aspect to get my name changed. I want to accomplish my goals going to college and getting a part-time job. I want to do more in the community and get out of the building. I know this will come with time."
TCL participant at 11-month follow-up

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

FIGURE 9: OTHER NEEDED SERVICES AND SUPPORTS



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

Pre-transition and post-transition respondents were slightly more likely to report each of the obstacles assessed compared to the previous year, with the exceptions of social reasons, not knowing about things to do, and not feeling comfortable for individuals in TCL housing. Lack of transportation was again the most commonly identified obstacle to going out into the community when desired.

FIGURE 10: OBSTACLES TO COMMUNITY INTEGRATION

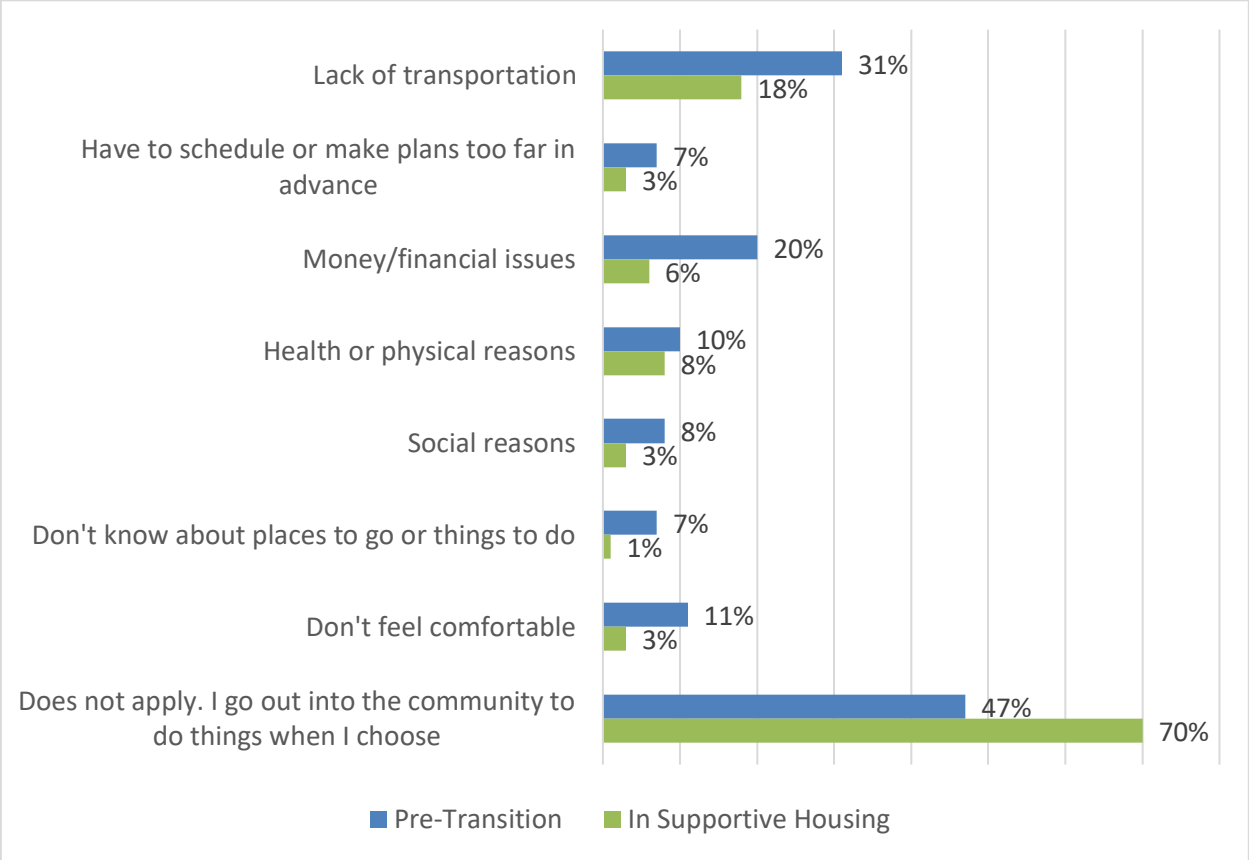
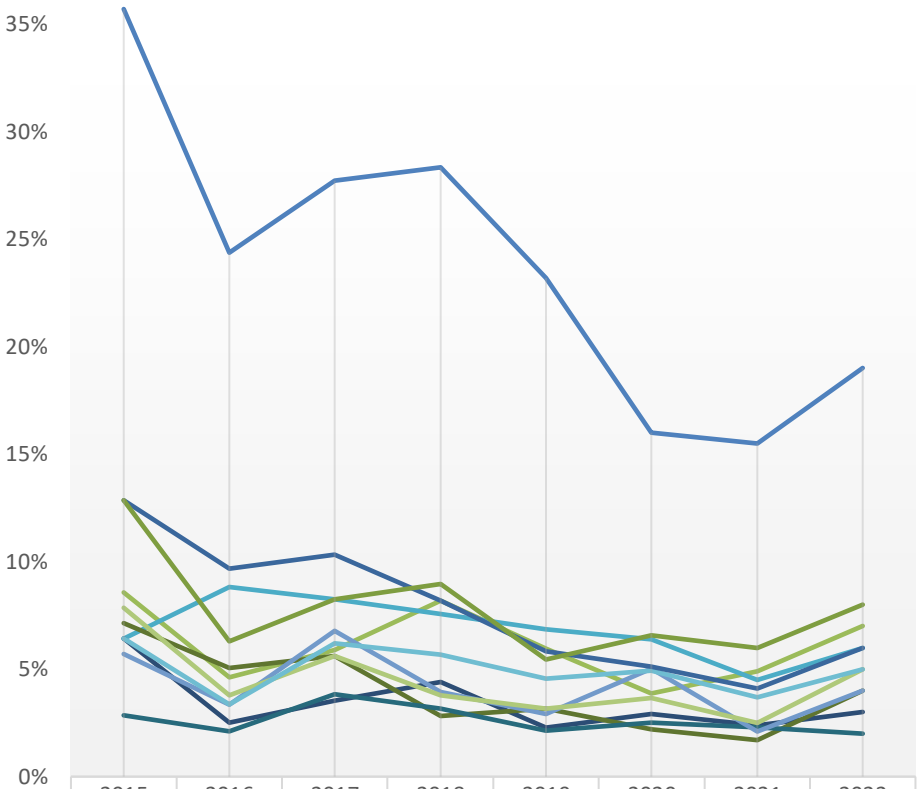


Figure 11 shows annual trends in obstacles to community integration reported by individuals in supportive housing. Compared to the previous survey year, a three percent increase was observed in percentages of respondents reporting obstacles related to transportation. One to two percent more individuals reported obstacles in all other areas assessed except for daily self-care.

FIGURE 11: ANNUAL TRENDS IN REPORTED OBSTACLES TO COMMUNITY INTEGRATION IN SUPPORTIVE HOUSING



	2015	2016	2017	2018	2019	2020	2021	2022
Transportation	36%	24%	28%	28%	23%	16%	16%	19%
See MD more often	9%	5%	6%	8%	6%	4%	5%	7%
Peer support	6%	9%	8%	8%	7%	6%	5%	6%
Medication assistance	6%	3%	4%	4%	2%	3%	2%	3%
Home medical needs	7%	5%	6%	3%	3%	2%	2%	4%
Daily self-care	3%	2%	4%	3%	2%	3%	2%	2%
Finances	6%	3%	7%	4%	3%	5%	2%	4%
Housing	8%	4%	6%	4%	3%	4%	3%	5%
Other daily living activities	6%	3%	6%	6%	5%	5%	4%	5%
Social or community life	13%	10%	10%	8%	6%	5%	4%	6%
Employment or school	13%	6%	8%	9%	5%	7%	6%	8%

Annual Trends and LME/MCO Patterns

Aggregate Quality of Life (QOL) Index and Satisfaction (SAT) Index scores are based on the 28 survey questions listed in Figures 4A through 4H and the 10 housing and community satisfaction ratings in Figure 5. Scores are calculated as the average score of the applicable items (positive experience/satisfied = 3, neutral/middle/no opinion = 2, negative experience/dissatisfied = 1) and rescaled to a zero to 100 scale. Score interpretation is comparable to a percentage. A score of 50 would indicate that respondents reported the most positive experience or satisfaction in response to about half of the questions.

As in previous years, quality of life and participant satisfaction reports were higher among respondents surveyed after the transition to supportive housing. While differences between pre- and post-transition respondents are significant in both areas, the difference in satisfaction with housing and community resources was again larger than the between-groups difference in aggregated QOL survey items. As shown in Table 1, 24-month respondents also reported slightly greater quality of life and satisfaction with home and community resources on average compared to11-month respondents.

TABLE 1: SFY 2022 TCL PARTICIPANT QUALITY OF LIFE AND SATISFACTION INDEX SCORE MEANS

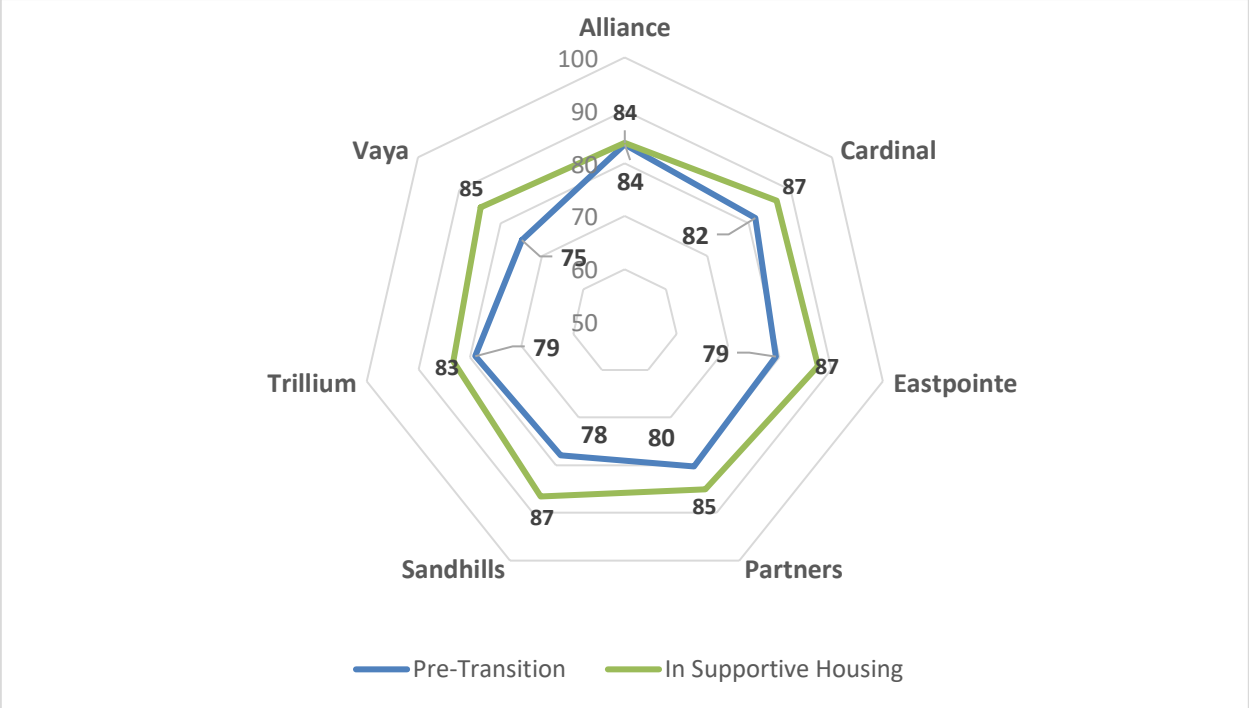
	Pre-Transition	11 Month Follow-Up	24-Month Follow-Up
Quality of Life	80.9 (13.5)	83.6 (13.3)	84.7 (13.2)
Satisfaction	72.2 (25.5)	82.5 (19.5)	83.9 (18.9)

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

Figures 12 and 13 show LME/MCO life of program average Index scores. Both are somewhat more variable across LME/MCO catchment area pre-transition than post-transition respondents.[82] In catchment areas with smaller observed gains from pre- to post-transition, pre-transition averages also tend to be higher compared to other catchment areas.

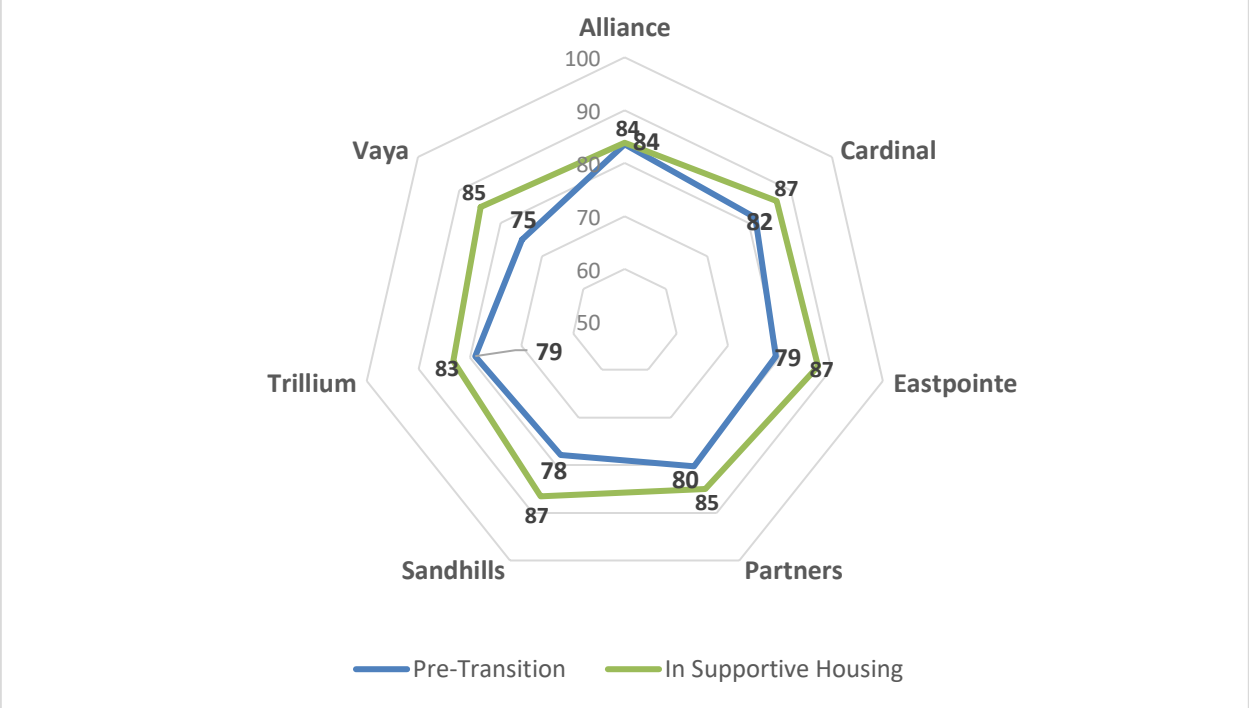
[82] For analyses reported by LME-MCO catchment area, each survey is assigned to the LME-MCO that submitted it or, in the case of legacy LMEs/MCOs no longer included in this report, to the LME-MCO with which the submitting LME-MCO merged.

FIGURE 12: QUALITY OF LIFE BY LME/MCO CATCHMENT AREA, LIFE OF PROGRAM



Index scores may range from 0 to 100.

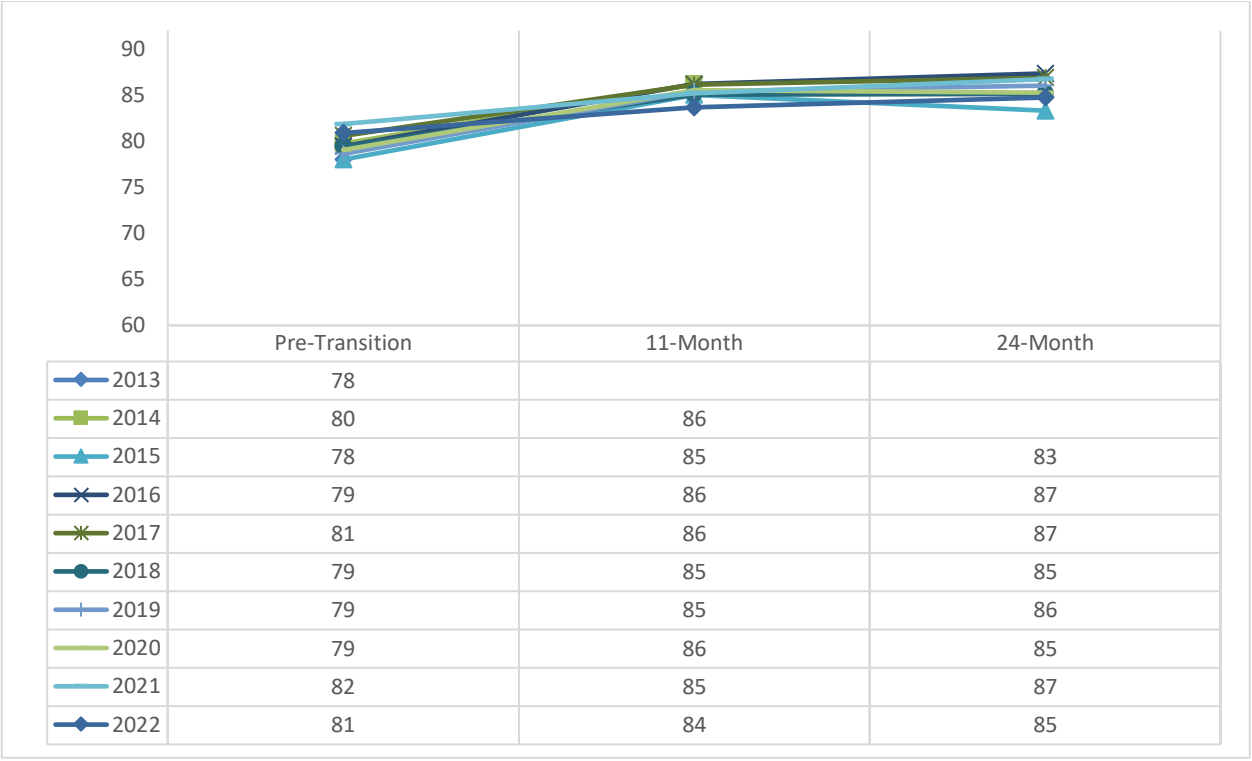
FIGURE 13: SATISFACTION INDEX BY LME/MCO, LIFE OF PROGRAM



Index scores may range from 0 to 100.

Figures 14 and 15 show average Index scores by survey type and SFY. Observed trends demonstrate significant increases over the life of the program in reported quality of life and satisfaction after the transition to supportive housing, and additional small gains between 11 and 24-month follow-up surveys.

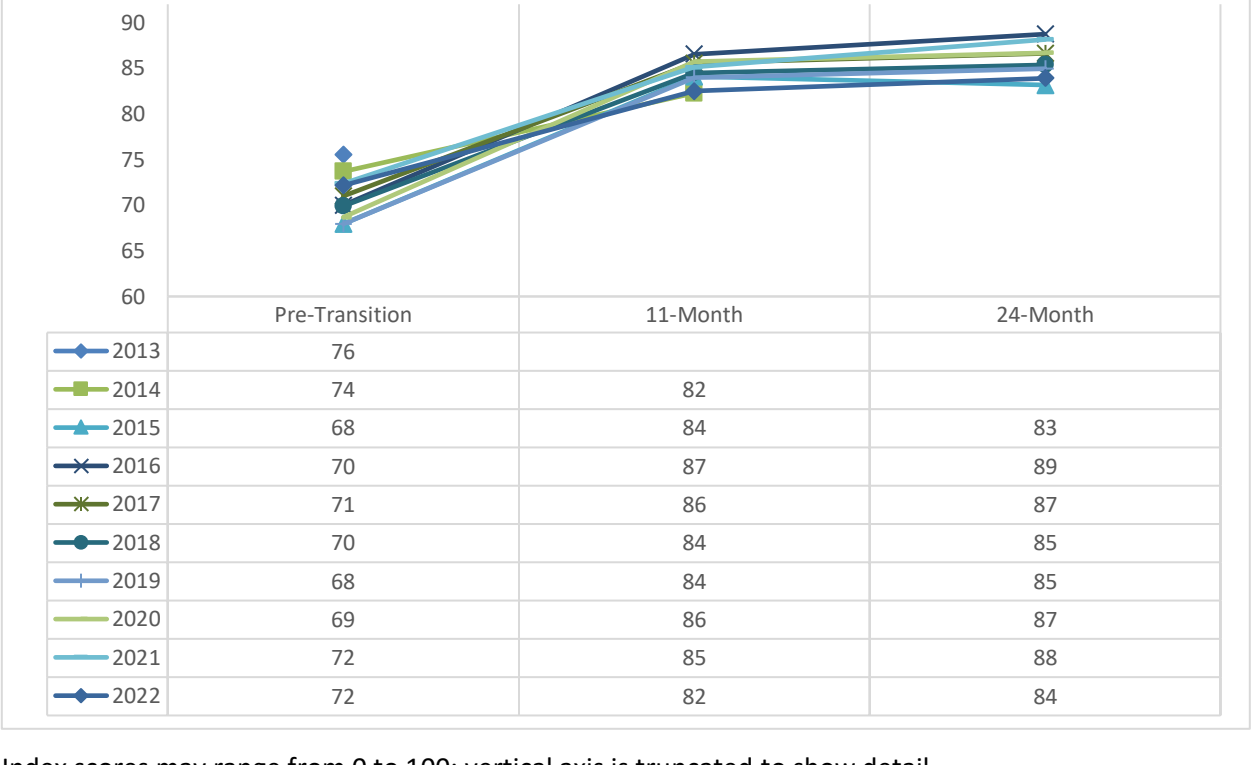
FIGURE 14: ANNUAL TRENDS IN QUALITY OF LIFE BY SURVEY STATE FISCAL YEAR



	Pre-Transition	11-Month	24-Month
2013	78		
2014	80	86	
2015	78	85	83
2016	79	86	87
2017	81	86	87
2018	79	85	85
2019	79	85	86
2020	79	86	85
2021	82	85	87
2022	81	84	85

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

FIGURE 15: ANNUAL TRENDS IN SATISFACTION BY SURVEY STATE FISCAL YEAR



	Pre-Transition	11-Month	24-Month
2013	76		
2014	74	82	
2015	68	84	83
2016	70	87	89
2017	71	86	87
2018	70	84	85
2019	68	84	85
2020	69	86	87
2021	72	85	88
2022	72	82	84

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

Summary

"I thank God that I picked the ball back up and the…team was there to help me and did not judge me. I am back in classes. I thank [LME/MCO] for helping me to maintain this place. I never had anything like this before."
TCL participant at 24-month follow-up

Reported quality of life and satisfaction among individuals surveyed in SFY 2022 generally resembled prior year patterns with some noticeable differences. As in previous years, post-transition reports were significantly more positive in most areas assessed, with additional small gains between 11 and 24 months in supportive housing. In general, the transition to supportive housing was associated with more positive experiences related to participant choice and control, community integration, positive engagement with natural supports, and satisfaction with housing and other community resources.

One difference from previous years was noted in reported daily activities of participants. Pre- and post-transition participants who reported going into town or the community remained lower than earlier program years, 11 and 10 percent, respectively, possibly indicating ongoing influence of the COVID-19 pandemic. However, group differences in other reported activities that either reversed the pre- to post-transition pattern or were more pronounced compared to SFY 2021 may reflect easing of social distancing restrictions and primarily appear to have affected individuals in TCL housing. For example, 60 percent of individuals in housing compared to 45 percent of pre-transition respondents reported socializing/visiting was a regular daily activity, compared to 42 percent of both respondent groups in SFY 2021.

Also different from previous years, individuals in supportive housing were less likely than their pre-transition counterparts to report that they know who to contact about problems with their services and supports. Housed participants also reported somewhat lower satisfaction related to housing and community resources in SFY 2022 compared to the previous year.

Although individuals in housing were again more than twice as likely to indicate they received all needed services and supports as pre-transition respondents, that percentage was lower than in the previous survey year, 55 compared to 66 percent. For most service and support areas assessed, one to two percent more SFY 2022 respondents than in SFY 2021 indicated additional needs. Similarly small increases were noted in obstacles to community integration such as transportation, finances, and physical health.

These observed patterns were reflected in slightly lower aggregate QOL and SAT Index scores, both for pre-transition and post-transition respondents. Pre-transition Index scores were approximately one point lower compared to SFY 2021. This change was more pronounced for housed participants; QOL scores were nearly two points lower, and SAT scores were more than three points lower in SFY 2022.

With the SFY 2022 dissolution of Cardinal Innovations LME/MCO and related merger and county realignments, approximately one-third of individuals in TCL supportive housing experienced LME/MCO transfers, which, may have contributed to these differences. This interpretation is consistent with the drop in the SFY 2022 survey rate of housed participants, which at 73 percent was lower by approximately 13 percentage points than in SFY 2022.

Additional explanatory factors may include broader statewide and nationwide trends, including an ongoing rental housing crisis and high rates of provider staff turnover, which may have negative impacts on participant experiences and the quality of available housing, services, and supports. Monitoring to determine whether trends identified in SFY 2022 continue, level, or reverse will be an area of State focus in SFY 2023.

Appendix B: Breakdown of Budget by LME/MCOs -SFY 2021 – 2022

TCL Service	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
Transition Year Stability Resources (TYSR)	$537,812	$189,188	$146,879	$257,259	$113,852	$222,825	$335,838
Community Living Assistance (CLA)	$692,708	$220,967	$183,177	$366,177	$688,128	$417,515	$404,321
Emergency Housing Funds	$48,393	$12,208	$11,288	$73,801	$32,131	$31,722	$27,551
Bridge Housing	$657,937	$131,691	$123,248	$273,108	$452,743	$246,595	$342,168
Mental Health Services	$140,158	$391,252	$350,445	$717,624	$417,787	$655,351	$811,458
Supported Employment	$153,379	$209,594	$329,858	$224,061	$233,619	$229,246	$451,550
Alliance of Disability Advocates NC Pilot	$114,645		$30,000				$8,300
Subsidy Administration	$190,709	$58,577	$90,000	$90,000	$50,001	$90,001	$190,709
Diversion	$712,109	$217,323	$292,120	$462,401	$196,735	$508,748	$842,883
Assertive Engagement	$159,457		$53,126	$112,880	$104,922	$52,898	$107,640
TCL Incentive Payments	$2,843,750		$937,500	$1,275,000	$900,000	$850,000	$1,050,000
Totals	**$6,251,057**	**$1,430,800**	**$2,547,641**	**$3,852,311**	**$3,189,918**	**$3,304,901**	**$4,572,418**