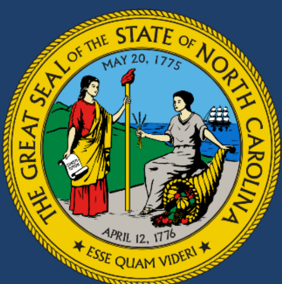
NC TRANSITIONS TO COMMUNITY LIVING

ANNUAL REPORT

State Fiscal Year

2022-2023

(July 2022-June 2023)



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

June 2024

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1. INTRODUCTION AND ACKNOWLEDGEMENTS

In 2012, the North Carolina Department of Health Human Services (NCDHHS) entered into a settlement agreement with the United States Department of Justise (US DOJ). 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."[1] The purpose of this agreement was to ensure that people living with either serious mental illness (SMI) or severe and persistent mental illness (SPMI) who are in, or at risk of, placement in an adult care home are able, if they so choose, to live in communities alongside other North Carolinians. The implementation of this effort is Transitions to Community Living (TCL). On our journey to settlement compliance, North Carolina has assisted over 5,800 people with serious mental illness or severe and persistent mental illness to move out of Adult Care Homes into their communities or remain in the community instead of entering an Adult Care Home.

I would like to thank those who participated in the creation of this year's report and thank them for their continued service in our system:

- LME/MCO TCL Staff
- NC Housing Finance Agency
- Division of Aging and Adult Services
- Division of Health Benefits
- Division of Mental Health, Developmental Disabilities, and Substance Use Services – DMH/DD/SUS
- Division of State Operated Healthcare Facilities
- Division of Employment and Independence for People with Disabilities - EIPD (formerly the Division of Vocational Rehabilitation - DVRS)
- Money Follows the Person
- Olmstead/TCL Staff

The work of TCL will continue long after the settlement agreement is reached. It lives on through the State's Olmstead Plan, through the *Olmstead* values and principles that guide our work; and through the support and advocacy of stakeholders who keep us striving for a system where everyone can live their best lives in the communities of their choice.

Respectfully submitted,

Deborah Goda

Director, Olmstead-TCL

Health Equity Portfolio
Office of the Secretary
North Carolina Department of Health and Human Services

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

2. HOUSING

2.1. SUMMARY

In reflecting on SFY 22-23[2], the NC Department of Health and Human Services (NCDHHS) Transitions to Community Living (TCL) Team continued to face challenges related to ongoing effects from the COVID-19 pandemic. Regardless of this 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.

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)[3] for priority individuals identified by NCDHHS.

2.1.1. ACCOMPLISHMENTS DURING STATE FISCAL YEAR (SFY) 2022 – 2023

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

- Over 3,300 individuals have been stably housed during the ongoing pandemic and changes across the managed care environment.
- TCL continued the implementation of 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. All LME/MCOs participated in this incentive 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[4] units. HFA also continued to work with HUD regarding addressing fair housing practices across landlords in the program, leading to one of the most robust sets of criteria for tenant selection in the country.
- CLIVe[5] 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

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[2] The state fiscal year always starts on July 1 and ends on June 30. In this report, the fiscal year from July 1, 2022, to June 30, 2023, is referred to as SFY 22-23, while the fiscal year from July 1, 2021, to June 30, 2022, is called SFY 21-22. Note that in general, state communications typically just use the last year, like SFY 2023 or SFY 2022.

[3] Retrieved on September 13, 2022 from [Permanent Supportive Housing Definition.]()

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

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

community-based supportive housing.

2.1.2. COORDINATED AND COLLABORATIVE APPROACH TO PERMANENT SUPPORTIVE HOUSING

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, 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 plan will address the housing needs of individuals with disabilities, currently receiving or eligible for NCDHHS-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 on creating and maximizing community-based housing opportunities for identified populations over a five-year horizon.

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

Beginning in May – June of 2021 and continuing to be ongoing, 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 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 (2024 – 2029).

TAC and NCDHHS engaged in over 100 interviews with advocates, service providers and people with lived experience[6] across the state. NCDHHS also developed and disseminated a survey to capture housing needs more fully.

2.2. 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.

[6] 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.

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
- 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[7]

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 incorporating public comments into the plan itself. NCDHHS expects to launch the NC Strategic Housing Plan in 2024 and highlight the first-year action items to be completed during year one.

2.2.1. 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.

Bridge Housing Model

Over the past 10 years, NCDHHS has seen the effectiveness of the Bridge Housing model[8] 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 successfully go on 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 continue to implement and expand an Enhanced Bridge Housing model with additional LME/MCOs: Alliance Health, Partners, Eastpointe, 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 results of the initial eight (8), newly developed programs, along with necessary supports and services, show improved tenancy skills and concomitant, successful transitions to community.

The TCL Voucher

While TCL offers several mechanisms to provide access to affordable apartments and rent assistance for individuals with low incomes, the most common is the Transitions to Community Living Voucher (TCLV).

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

[8] 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.

TCLV provides rental assistance to people with behavioral health disabilities to either be diverted from, or to transition out of, institutional 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. Through the use of the housing incentive plan funding, multiple LME/MCOs have utilized this flexibility to offer landlord incentives of varying types that have greatly expanded the pool of private property owners and improved relationships with them as well.

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[9], there has been significant rental market price inflation along with particularly low vacancy rates for one-bedroom units. The average increase in Fair Market Rent (FMR) for one-bedroom units in the 20 priority counties from SFY 21-22 through SFY 22-23 was 15%. To help reduce housing barriers for TCL participants, the TCLV maximum allowable rent was increased from 100% to 120% FMR during the fiscal year. As a result of housing market and program policy changes, the average monthly TCLV payment increased 11.4% over the course of SFY 22-23. As of the end of SFY 22-23, 2,303 households were utilizing TCLV with an average monthly subsidy of $751. There was a 4.2% increase in the number of TCL participants utilizing TCLV between the end of SFY 21-22 and SFY 22-23. This was in part due to efforts to increase utilization of Targeted Units with Key Rental Assistance and HUD vouchers. HUD Section 8 voucher use increased 14.2% from the end of SFY 21-22 through SFY 22-23 with 116 and 132 TCL participants leasing housing with Section 8, respectively. In this environment, it has been imperative to strengthen efforts and incentives to landlords who are willing to work with TCL participants.

Targeted Units

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 NCDHHS and the NC Housing Finance Agency (NCHFA), the Targeting Program increases access to affordable housing units for individuals 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 for 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

[9] 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.

Program.

Throughout SFY 22-23, NCDHHS and 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 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*[10] (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 SFY 22-23, there were 903 rental developments with executed Targeted Unit Agreements in 85 counties. This represented a total of 7,148 Targeted Units (AMS data[11]). Of the 3,338 TCL participants leasing housing at the end of SFY 22-23: 29% of participants (983) were leasing Targeted Units ; 26% of participants (866) were using Key Rental Assistance (CLIVe data); 11% of participants (363) moved into Targeted Units in SFY 22-23, which is a sixty-three percent (63%) increase in the number of TCL participants moving into Targeted Units compared to SFY 21-22, according to CLIVe.

Responding to New Challenges

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[12] as other rental mechanisms to support individuals in TCL. 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) individuals 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

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[10] See the report "An Assessment of the NCDHHS' System of Services and Supports for Individuals with Disabilities," authored by the Technical Assistance Collaborative and The Human Services Research Institute, dated April 30, 2021, and published on the NCDHHS website, at: https://www.ncdhhs.gov/508-compliant-north-carolina-olmstead-assessment-report

[11] Assessment Management System is a NCHFA online system used by owners and property management companies to enter property information.

[12] 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.

NC Public Housing Authorities under the CARES Act[13] and American Rescue Plan Act[14] 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[15] Mainstream Housing Vouchers
- April 6, 2022, Department of Housing and Urban Development (HUD) announced the non-competitive awards process[16] for HUD's Section 811 Mainstream Housing Choice Voucher Program
- January 4, 2023, non-competitive process, yielded 60 additional Mainstream Housing Vouchers[17] as shown in Table 1

TABLE 1: MAINSTREAM HOUSING VOUCHERS AWARDED

Public Housing Authority Name	Vouchers Awarded	Voucher Funding	EAF Funding
Sandhills Community Action Program, Inc.	10	$50,789	0
Housing Authority of County of Wake	10	$122,225	0
Housing Authority of the City of Greenville	10	$77,360	$23,000
Northwestern Regional Housing Authority	30	$149,807	$70,000
Western Piedmont Council of Governments	0	$0	$123,00

In direct correlation to 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 30, 2023:

- 561 TCL Head of Households were supported in applying for Mainstream Housing Vouchers, with 128 approved and 68 obtaining housing
- 1,025 TCL and non-TCL Heads of Household were supported in applying for Mainstream Housing Vouchers, with 398 approved, and 214 obtaining housing

The State initiated contact with various stakeholders supporting this work including NCHFA; 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 NC Department of Administration's Commission of Indian Affairs Housing Authority to partner in expanding access to the

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[13] 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.

[14] 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.

[15] 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.

[16] U.S. Department of Housing and Urban Development Press Release on January 4, 2023: HUD Awards $24.7 Million to Provide Affordable Housing to Support Community Living for Non-Elderly People with Disabilities: Awards chart retrieved on Feb. 6, 2024, at: https://www.hud.gov/sites/dfiles/PA/documents/2022-MainstreamChart.pdf

[17] PIH Notice 2022-06 (HA): Emergency Housing Vouchers – Reallocation of Awards at: https://www.hud.gov/sites/dfiles/PIH/documents/PIH2022-06.pdf

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 NCDHHS; TAC; and NCHFA.

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.

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[18].

2.2.2. 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.[19] 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

[18] Olmstead preferences refer 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).

[19] 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).

4) Those who were recently homeless or who have a high risk of housing instability.[20]

NC was afforded an extraordinary opportunity when 23 Public Housing Authorities accepted their allocation for 1,296 Emergency Housing Vouchers (EHVs). Of this total, 414 were accepted by the NC Commission of Indian Affairs Housing Authority.

On March 10, 2022, HUD provided a process for reallocating Emergency Housing Vouchers[21] that were voluntarily returned to HUD. NC had a total of 15 EHVs that were subsequently returned to HUD, which resulted in 1,281 as the new total number of EHVs.

According to HUD's Emergency Housing Voucher Dashboard, as of June 8, 2023:

- 1,281 total Emergency Housing Vouchers were awarded
- 1,171 Heads of Household were issued Emergency Housing Vouchers
- 683 or approximately 53.32%[22] Head of Households obtained housing

The work of LME/MCOs to increase the utilization of federally funded housing is inclusive of Emergency Housing Vouchers, and was evident as of June 30, 2023.

In SFY 18–19, NCDHHS partnered with the NCHFA to develop the Integrated Supportive Housing Program[23] 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 four LME/MCO catchment areas. There were 115 TCL participants housed in the Integrated Supportive Housing Program properties as of June 2023. Property management notified NCDHHS of 213 vacancies in SFY 22-23. Forty-nine (49) referrals were forwarded to management for those vacancies resulting in 23 TCL participants moving into Permanent Supportive Housing units in the 15 Integrated Supportive Housing Program properties. Approximately $900,000 remains in the PSH development contract between NCDHHS and NCHFA and will go toward development of integrated units through the Supportive Housing Development Program.

Although, 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, NCDHHS and NCHFA requested a meeting with the Senior Advisor of Housing and Urban Development (HUD), Secretary's Office. In March 2022, HUD granted a meeting with NCDHHS, NCHFA and key NC housing stakeholders. The discussion centered around four (4), broad topic areas:

1) NC housing infrastructure strengths and challenges

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[20] 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.

[21] PIH Notice 2022-06 (HA): Emergency Housing Vouchers – Reallocation of Awards at: https://www.hud.gov/sites/dfiles/PIH/documents/PIH2022-06.pdf

[22] HUD.gov: Emergency Housing Voucher Dashboard updated on July 30, 2022, at: https://www.hud.gov/program_offices/public_indian_housing/ehv/dashboard

[23] 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.

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[24] (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 as we continue moving forward toward improving access to affordable housing.

2.2.3. 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. 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, NCDHHS implemented a Transitions to Community Living Incentive Plan in February 2022.

2.2.4. HOUSING INCENTIVE PLAN

The Transition Incentive Plan rewards LME/MCOs for accomplishing performance goals in accordance with defined outcomes that align with the TCL settlement agreement. 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.

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.

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 - 3.3% 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 SFY 22-23, all six (6) LME/MCOs continued to participate in the Transition Incentive Plan. At the end of SFY 22-23, LME/MCOs made great strides as evidenced by their performance outcomes and implemented strategies:

- Four (4) LME/MCOs exceeded their expected number of transitions
- Three (3) LME/MCOs exceeded their expected number of ACH transitions

[24] 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.

- Five (5) LME/MCOs had 33% of individuals move in or re-house into a Targeted Unit
- One (1) LME/MCO (Partners) was able to decrease their quarterly separation rate below 4% to 3.71%.

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

2.2.5. TRAINING

NCDHHS, NCHFA and NC Justice Center continued to work together during the state fiscal year 2022-2023 to offer free fair housing training virtually and in designated catchment areas across the state. These included:

- Basic Fair Housing Trainings: 28 trainings in total
  - Fourteen (14) for housing providers, 243 attendees
  - Fourteen (14) for service providers, 210 attendees
- Advanced Fair Housing Trainings: six (6) trainings in total (for service providers only)
  - Six (6) for service providers only, 105 attendees

Additionally, NCDHHS and 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 SFY 21-22, 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)[25]
- 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

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

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

2.3. ROBUST DATA AND EVALUATION

NCDHHS and 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. CLIVe is a payment reimbursement system that supports LME/MCO housing activity by providing a mechanism to input data and receive reimbursement consistent with NCDHHS' established program policy and procedures. CLIVe also manages and organizes workflow and serves as the system of record for Transitions to Community Living Voucher (TCLV) tenancies. Ultimately, CLIVe is the system of record for tenancies for all individuals participating in TCL. The system provides oversight functions that 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 addition to the CLIVe system, NCDHHS has entered into a contractual relationship with Mathematica to develop the TCL Dashboard. This Dashboard has many metrics that track NC progress through multiple areas, including housing, discharge, transition, services, in-reach, and diversion. This allows NCDHHS to receive comprehensive updates across multiple measures. The Dashboard also has stratification features that allow NCDHHS to drill down across areas, including by LME/MCO and Target Population.

Regarding housing specific measures, the Dashboard is able to track average days from transition attempt start to initial transition to TCL supportive housing, average time from initial housing slot approval to first transition to TCL housing with a slot, evictions (both by count and percent metrics), individuals housed with a TCL slot for the first time, individuals in TCL housing at three, six, 12, 18, 24 months (by count and percent metrics), separations (by count and percent), percent of individuals of first transitioned to the community with a TCL housing slot within 90 days of initial housing slot approval, number of housing slots issued, number of individuals rehoused, targeted housing unit utilization both by point in time and by reporting period (by count and percent).

These metrics greatly enhance the quality assurance process available to both NCDHHS and the LME/MCOs relevant to specific metrics required in the settlement agreement. It allows NCDHHS to have data to determine progress toward measures and also identifies areas for improvement (both system wide and at the local level).

2.4. 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.

2.4.1. ALLIANCE HEALTH

- A new TCL page with links to performance measures was created on the Alliance intranet to increase communication and collaboration.
- Continued the Tenancy and Employment Collaboratives facilitated by UNC Institute for Best Practices.
- Revamped Separations Committee to include macro- and micro-level meetings to identify trends and root cause analysis.
- High-Risk Case Conference Committee developed to provide more resources to case managers and their supervisors for members with complex barriers.
- Implemented daily report of the current state of moves including separations to inform newly

developed Housing Sustainability Management Group to look at real-time data and adjust new moves and rehouses accordingly.

- A TCL Data Dictionary was developed to facilitate consistency in the meanings of TCL and housing terms.
- Implemented weekly Projected Moves Meeting which includes managers and front-line staff to follow up on steps needed to obtain PSH.
- Developed and implemented a stratification process to improve timely transitions and quality moves.
- Expanded the Community Transition Recovery Program for use in the "Enhanced Bridge Housing program," which offers the additional supports of a part-time nurse and a clinician. It has four (4) dedicated beds for TCL members.
- Continued contract for direct billing with Extended Stay America, throughout the catchment area, for continued use of Bridge Housing.
- Utilized Bridge Housing for 38 TCL members and enhanced bridge housing for 20 members.
- Offered over 30 housing trainings called "Better at Home," which supports providers, staff and other stakeholders regarding tenancy and community living. It was especially helpful for providers to build competencies around housing.
- Purchased a nationally recognized best practice OT assessment: KELS tool for OT staff.
- Developed & Implemented a Medical Escalation process - Utilizes Medical Team for their expertise and support for the most complex members, to explore more opportunities and resources.
- Improved clinical oversight Implemented RN involvement at the referral phase; initiated clinical pre-transition checklist to ensure clinical recommendations are addressed, prior to transition from ACH.
- Updated TCL staff knowledge of Complex Care Management roles and opportunities for members with Complex Needs.
- Development of member educational binders to encourage member engagement and self-advocacy.
- Development of Primary Care Provider (PCP) Packet for members to have easier initial appointments in the community.
- Entered into a food delivery and nutrition contract with NourishedRx that will provide customized meals and nutrition support for six months as people move into housing.
- Entered into a comprehensive Community Inclusion contract with Promise Resource Network that also includes eviction prevention strategies. This contract will also include incentive payments for community tenure and reported improved quality of life.

2.4.2. EASTPOINTE

- Began planning phase of expansion of its community inclusion footprint with the Alliance of Disability Advocates of NC[26] 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 began in SFY 22-23 and to include a peer component and skill building requirement.

[26] 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).

- 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.

2.4.3. PARTNERS HEALTH MANAGEMENT

- Changed Follow Along, who is a Certified Peer Support Specialist (CPSS), process to a Follow Along being assigned in the beginning of transition and remaining with the member for the duration they are housed in the community. They also stay with the member if a separation occurs, and rehousing is necessary. The Follow Along staff are required to see the members face-to-face every 30-45 days and work closely with Property Managers, Transition Supervisors, and Care Managers. This has helped decrease separations and proven to be a proactive response to potential tenancy risk.
- Partners restructured Transition Teams by promoting strong transition coordinators to Transition Supervisors**.** Partners utilized licensed supervisors that were in those roles in other areas of TCL. These measures resulted in increased transition rates and a decrease in separations.
- Enhanced Bridge Housing (EHB) has launched**.** The EHB is in a beautiful apartment complex in Winston-Salem, that has capacity for 4 members. This is a great collaboration with Solutions for Independence, and there are positive expectations about the outcomes as this program continues.
- Expanded the Complex Care team to cover the entire Partners Catchment area. This team works closely with transition teams, In reach, and diversion.
- Strengthened relationships with Individual Placement and Support and Supported Employment (IPS-SE) providers and structured an internal referral process and tracking system through TCL.
- Initiated training on Barriers and created a new agenda and tracking system for our Local Barriers Committees (LBC).
- Partners TCL team is working across departments to develop better reporting mechanisms for more efficient data extractions. This project is ongoing and making progress.

2.4.4. 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[27] 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, a utilization goal of two members per month shifting from

[27] 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.

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.
- 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.

2.4.5. TRILLIUM HEALTH RESOURCES

- NCDHHS reports as of 8/2/2023 Trillium has the best long-term housing retention with 535 in supportive housing for 1000+ days. Trillium's Post Transition team conducts monthly follow up with members who have been in housing over 90 days to identify any issues that could cause the loss of housing and to ensure Social Determinants of Health and complex medical needs are addressed. If issues are identified, collaboration with the member's providers and referrals to appropriate specialty teams within TCL to provide additional support such as Complex Care, Housing, and Clinician is completed.
- Trillium met the Target/Key utilization goal of 33% of the quarterly housing net increase target for each quarter for SFY 22-23. A part of our Housing Specialist workflow is to ensure all members in the housing search phase are offered non-TCLV subsidy options for available Target/Key units in their interested housing locations.
- Trillium had 64 initial transitions to supportive housing in SFY 22-23 which exceeded housing expectations.
- In February 2023 Trillium TCL collaborated with its Housing Department to send out communication to all properties/landlords with housing contracts with Trillium to provide additional education on landlord incentives and when to notify Trillium when changes occur with the sale of the property, vendor name change, rent increases, etc. The goal is to ensure these community partners continue to remain aware when to notify Trillium of changes and how to communicate, so individuals can remain in supportive housing.
- In collaboration with the Trillium Training Department the recording of Fair Housing Training conducted by Legal Aid of NC was made available on their learning platform for both internal staff and external providers in July 2022. The Practice Management team communicated the availability of this training to our Transition Management Service (TMS), Community Support Team (CST), Assertive Community Treatment Team (ACTT), and IPS-SE providers. Trillium continues to have staff participate in NCHFA sponsored Fair Housing Training and makes training available for new hires and allows staff to take a refresher of this training at any time. Trillium ensures staff are well informed and able to educate members regarding their tenancy rights.
- The Complex Care Team has continued to expand its supports of individuals to safely transition to supportive housing in the community by conducting RN and Functional assessments for all TCL populations including a walk-thru/assessment of identified housing prior to lease signing. Below is data for Complex Care engagement for SFY 22-23:
    - RSVP Referrals Reviewed by the RN - 222
    - Population 1-3 Priority - 223 (16 transitioned to supportive housing)
    - Transition and Post Transition Referrals - 150
    - Environmental Assessments - 75

- Implemented Next Step Rehousing Team in October 2022 to provide additional support for individuals who separate from supportive housing and want to be rehoused. The team consists of qualified personnel, Peer, and Peer Extender staff who have a primary goal to rehouse individuals within 90 days of housing separation. The assigned Post Transition Coordinator or Transition Coordinator and Complex Care staff remain involved to collaborate with the Next Step Rehousing team to ensure an assessment regarding the loss of housing, appropriate services/medical/functional needs are in place prior to placement in new housing to include walk-thru/assessment of new housing.
- 20 members rehoused during SFY 22-23. Most were moved to new housing within 30 days of housing separation.

2.4.6. VAYA HEALTH

- **Transition Incentives:**
  - New Landlord Incentive: This $4,000 incentive is offered to landlords that sign their first Housing Assistance Payment (HAP) agreement with Vaya. This incentive helped Vaya onboard 60 new landlords in SFY 22-23 alone.
  - New Unit Incentive: This $2,000 incentive is offered to existing landlords to encourage them to offer new units to Vaya. This incentive allowed Vaya to add 45 new units in SFY 22-23.
  - Capacity bonuses: This $4,000 incentive for 5+ units and $5,000 for 10+ units allowed Vaya to reward landlords who grow their capacity with Vaya. This has been used strategically where Vaya leans in with landlords that they have had particularly good experiences with. In SFY 22-23, two landlords reached 5+ capacity and two reached 10+ capacity.
  - Hard to House Incentive: This $4,000 incentive is offered to landlords when signing a HAP with Vaya for a member with a felony record, on the sex offender registry, or has otherwise been turned down by other landlords and has been waiting for months to find housing. This incentive has turned a “no” to a “yes” and given 42 members an opportunity for housing permanency in SFY 22-23.
  - Annual Inspection bonuses: This $300 grocery delivery has been around long enough that members look forward to it and their Annual Inspection.
- **Enhanced Bridge Homes:**
  - Vaya has operated two Enhanced Bridge Homes in locations where they noted the most need. This has provided a temporary home for members as they prepare for permanency, in some ways just allowing time for things fall into place, other times allowing the member to learn and build skills to ensure success in their new home.
  - One Enhanced Bridge Home offers a TCL Support Group onsite, not only providing a sense of “home”, but also a sense of “community.”
- **Integrating RN/OT as part of the Pod model:**
  - Vaya has invested in its RN/OT program, with RN/OTs providing input from pre-tenancy.
  - This increases our capacity to provide whole-person healthcare, with RN/OTs supporting the process and providing input as to what a member might need to live safely and successfully prior to move in and ongoing.
- **Focus on Separations:** This includes an intentional process for preventing separations for individuals at low/no risk of separation up to an imminent risk of separation (i.e. not only reactive, but also proactive).

- **Internal Inspectors:** Vaya's Internal Inspectors have served as an early warning system, with Inspectors establishing rapport with individuals and gaining access to their homes. This allows Inspectors to identify potential concerns far faster than would have otherwise been feasible if there was reliance upon crisis intervention or providers alone. Inspectors have been able to flag to internal team members and initiate temporary housing solutions the same day if needed, as well as identified landlords with a pattern of poor follow through on regular maintenance.
- **Transition and Housing (T&H) staff and Provider relations:** In addition to Network Management, Vaya maintains strong relationships with providers, from a TCL Community Liaison to T&H staff providing trainings to ACT/CST providers. This allows Vaya staff to shore up areas of concern with providers and highlight providers' roles in supporting members with achieving successful long-term housing.

3. TCL COMMUNITY-BASED MENTAL HEALTH SERVICES

Since its initiation in 2012, Transitions to Community Living has witnessed substantial modifications in policies, service definitions, contract terms, and quality measures. The Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) and the Division of Health Benefits (DHB) have collaboratively implemented these systematic changes to enhance the quality of community-based mental health services throughout North Carolina. To streamline efforts more strategically, the TCL Implementation Plan was created, focusing on key areas such as Assertive Community Treatment, Community Support Team, Transition Management Services, Peer Services/Community Inclusion, and Person-Centered Planning.

3.1. ASSERTIVE COMMUNITY TREATMENT (ACT)

3.1.1. SUMMARY

DMH/DD/SUS, in collaboration with the UNC Institute for Best Practices (IBP), recommenced Tool for Measurement of ACT (TMACT) fidelity evaluations of ACT teams in September 2022, employing an enhanced process. This updated approach integrates remote chart reviews, the utilization of eTMACT, the digital iteration of TMACT, and virtual post-evaluation debriefs. The streamlined desk review process enables providers to securely submit specific team and client data via a dedicated platform, facilitating evaluators to complete the chart review remotely. This streamlined process enhances evaluator readiness for onsite evaluations while reducing onside duration. The use of eTMACT is expediting the delivery of draft reports to the team. Virtual debriefs are being held once the team receives its final report. Virtual debrief sessions, convened subsequent to the receipt of final reports by the teams, engage the ACT Team, agency leadership, NCDHHS staff, UNC evaluators, and representatives from the LME/MCO. The debrief provides an opportunity to review the team’s score, highlight the strengths that were identified, review the recommendations for improvement, and to discuss any issues/barriers impacting the team’s ability to effectively provide quality services.

3.1.2. ACCOMPLISHMENTS DURING STATE FISCAL YEAR 2022 – 2023

- A total of 19 Tools for Measurement of Assertive Community Treatment (TMACTs) were completed
- 93 charts of TCL individuals were reviewed
- Three additional ACT Teams began serving clients in three new LME/MCO’s Southeastern Integrated Care Pembroke, Southeastern Integrated Care Shallotte, Strategic Interventions Durham which increases capacity for individuals needing ACT
- Eastpointe and Vaya received funding to expand ACT services for individuals in rural communities
- ACT and IPS Annual Conference was conducted with 105 attendees
- 44 ACT coaching sessions were conducted across 41 teams on a variety of topics. 270 attendees participated in coaching sessions with topics such as:
  - Scheduling
  - Treatment Planning

    - Evidence-Based Practices
    - Integrated Care

- Held 12 in-person ACT Coalition meetings. Coalition meetings provide opportunities for ACT team members to collaborate with each other, discuss barriers, strategies to remove obstacles, share tools/resources, and receive education from subject matter experts
- Facilitated 7 virtual Specialist Meetings. Specialist meetings provide education and technical assistance centered around the following roles on the ACT team:
    - Program Assistant
    - Housing
    - Peer
    - Nursing
    - Co-Occurring Disorders
    - Employment/Education
    - Therapy
- Conducted New Virtual ACT Team Lead Workshop (4 sessions)

DURING SFY 22-23, UNC IBP PROVIDED:

- Introduction to Motivational Interviewing – four times - 206 participants
- Motivational Interviewing and Promoting Change – 29 participants
- Motivational Interviewing and Permanent Supportive Housing (PSH) – 16 participants
- Motivational Interviewing and Co-Occurring Disorders – 51 participants
- Profile of Participation (PoP) – two times – 50 participants
- Blind Spot Training – recognizing biases – four times – 25 participants
- Recovery-Oriented Cognitive Therapy – two times – 125 participants
- Recovery-Oriented Cognitive Therapy Practice Circle – six times – 30 participants
- Post-training surveys were completed for all trainings offered. Training satisfaction for the fiscal year indicated 98% of participants had a positive experience and found the training helpful while gaining new knowledge.

3.2. COMMUNITY SUPPORT TEAM (CST)

3.2.1. SUMMARY

The provision of tenancy support services/interventions is still relatively new to Community Support Teams (CST), and it was recognized that some of these teams would benefit from targeted strategic outreach and coaching on Permanent Supportive Housing interventions. To address this need, DMH/DD/SUS partnered with the Technical Assistance Collaborative (TAC) and the UNC Institute for Best Practices to offer coaching, training, and technical assistance to a selected group of CST Teams. LME/MCOs were tasked with identifying potential CST Teams that would derive the most benefit from this coaching, based on specified criteria. Upon receiving a list of providers from each LME/MCO, TAC initiated the engagement process by contacting each team to assess their interest and availability to participate in the project.

Once a team confirmed its availability, they were paired with a coach who commenced the initial assessment. Phase 1 of the coaching project involved 16 CST Teams from 11 different provider agencies. Through the assessment process, coaches identified areas of strength within the teams, areas requiring additional training/coaching, and barriers potentially hindering the teams' ability to deliver

comprehensive PSH interventions. Coaching sessions were conducted through various mediums, including virtual sessions, observation of team meetings, and on-site, face-to-face collaboration with the CST Team. TAC also identified common trends and barriers experienced by multiple teams, which informed the development and delivery of a series of trainings for the participating teams.

Given the relevance of these trainings for any provider offering tenancy supports, recorded versions will be accessible on UNC Behavioral Health Springboard for providers in tenancy support and those working with TCL members to enhance their person-centered skills for better community integration. At the project's conclusion, TAC facilitated webinars with each LME/MCO, during which they presented identified barriers and offered recommendations on addressing them. DMH/DD/SUS intends to extend its collaboration with TAC, UNC, and CST teams through the next contract year.

COMMON BARRIERS THAT WERE IDENTIFIED THROUGH TAC/UNC PROJECT

- Role Confusion/Clarity
- Service Definition/Authorization
- Training & Utilization of Best Practices
- Reimbursement Issues and Sustainability of Services
- Workforce
- Housing Access and Quality

3.2.2. TAC/UNC CST COACHING PROJECT ACCOMPLISHMENTS DURING STATE FISCAL YEAR 2022 – 2023

- 16 CST Teams participated in the coaching project
- 341 total engagements with CST Teams – Engagements include any touchpoint with the teams – introductions, completing initial assessment, observing a weekly meeting, observing the development of a PCP, etc.
- 226 total Targeted Coaching sessions with CST Teams
- Development of 9 Tenancy Support Trainings:
    - A Brief Introduction to the Continuum of Care (CoC) and Coordinated Entry
    - Community Inclusion and Thriving in the Community
    - Housing Rights: Knowledge Bites
    - Landlord Engagement Basics
    - Olmstead Settlement and Understanding of TCL
    - Permanent Supportive Housing (PSH) Refresher
    - Redefining Help
    - Transition to Community Living Engagement in Employment
    - Whole Health and the 8 Domains of Wellness

DURING SFY 22-23, UNC PROVIDED:

- One CST Foundational Workshop – 73 attendees
- 31 CST Coaching sessions – 132 attendees
- Completed Needs Assessment Survey for CST providers to evaluate the specific technical assistance and training requirements to inform training development

3.3. COMMUNITY INCLUSION

3.3.1. SUMMARY

Community Inclusion provides support for adults 18 years and older who are members of Transitions to Community Living (TCL) and who have an SMI/SPMI including co-occurring diagnoses. Community Inclusion assists people in getting connected in their community and maintaining their independent housing. At the inception of the Transitions to Community Living Initiative (TCLI) there was some community inclusion work happening but no direct focus on actively supporting people to become a part of their community. In 2019 TCL made a significant change to enhance its focus on community inclusion. It developed a three-way agreement with the Alliance of the Disability Advocates of North Carolina (ADANC), Eastpointe Local Management Entity-Managed Care Organization (LME/MCOS) and the Division of Mental Health/Developmental Disabilities and Substance Use Services (DMH/DD/SUS). This was the first pilot of its kind. Since then, the Community Inclusion projects have expanded to Partners, Alliance, and Sandhills catchment areas. In 2023, Solutions for Independence (SFI) began contracting directly with Partners to provide community inclusion support and services to members in the catchment area.

ADANC and SFI are federally recognized Centers for Independent Living (CIL) that use Title VII funding to provide their services. By design, CILs are consumer-controlled, community-based, cross-disability, non-residential private non-profit agencies that serve their local communities. Community Inclusion in North Carolina is a peer driven service provided by CILs that assist people to live, work, participate in and contribute to their community. The US Department of Justice (DOJ) has called the partnership between a Center for Independent Living, ADANC, and an LME/MCOS an "innovative approach to addressing the TCL settlement agreement.". The Independent Reviewer for the settlement agreement has noted the positive impact the focus on community inclusion has had on housing retention.

Community inclusion peer staff at ADANC and SFI work one-on-one with consumers who are transitioning or have recently transitioned from congregate living settings into supportive housing. Community inclusion assists people with connecting to resources in the community such as employment, housing, education, health, leisure, or recreation opportunities. It also focuses on increasing natural support as well as establishing valued social roles (e.g., marriage, parenting). Data supports that people return to congregate living due to loneliness, social isolation, and boredom. A Community Inclusion Specialist (CIS) uses a tool called the Temple University Community Participation Measure that helps identify one's community living interests and needs. For some, it may be assisting in getting a library card or joining a gym. For others it could be participating in a community-wide Jazz Night or going to a baseball game. For consumers who are interested in employment and/or education, the CIS will make a referral to a local IPS team. Many of the staff at ADANC are certified Benefits Counselors. This is extremely helpful when a consumer is interested in working and wants to know how their benefits may be affected by working.

ADANC has demonstrated outstanding performance during the year. Among the active consumers served across all LME/MCO's in partnership with ADANC, there have only been three returns to congregate settings and two separations from TCL (one was a death and the other moved out of state) indicating a remarkable success in helping individuals maintain their housing.

A significant contributing factor to this success is the growing confidence and self-awareness among consumers. CIS reports individuals receiving CI supports are increasingly recognizing when they need assistance and actively seeking/asking for help. This positive trend reflects the effectiveness of ADANC's programs in empowering individuals to navigate challenges and maintain independent living.

ADANC conducts face-to-face visits with an average of 103 consumers each month within the TCL

program despite challenges in staffing.

In terms of overall contact, including face-to-face meetings, phone calls, texts, and emails, ADANC averaged an impressive 252 contacts per month. This figure highlights the strong connectivity between consumers and their Community Inclusion Specialists at ADANC. The consistent level of contact, considering the size of the staff, underscores the organization's commitment to fostering meaningful connections within the community. Additionally, ADANC provides a comprehensive range of services and supports, averaging 207 per month. This statistic reflects ADANC's dedication to meeting the diverse needs of its consumers and enhancing their overall quality of life. ADANC's performance metrics clearly illustrate the organization's dedication to supporting individuals in their transition to community living, fostering self-sufficiency, and maintaining a high level of engagement with the consumers it serves.

While SFI has been providing community inclusion services as a subcontractor for a couple of years, in 2023 they contracted directly with Partners to become an independent provider of community inclusion. SFI started the year with 1.2 FTE’s and grew to 3.2 FTE’s. SFI also began providing services in two new counties.

Additional community inclusion focus-areas include work done in the contract with UNC Institute for Best Practice. The Housing First TA Trainer facilitated topic specific discussions focused on community integration. The drop-in discussion sessions were offered twice a month (60 mins each) and involved 20 minutes of topic-specific instruction and 40 minutes of consultation and were open to ACT, CST, TMS, and IPS staff. Occupational Therapy supports (Dr. Bailliard and OT students) assisted with coaching efforts. In total, UNC conducted 18 meetings across the year with 101 total attendees.

Also, The Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities (Temple) has been providing Community Inclusion training and technical assistance to the State for several years. The following outlines some of the major accomplishments Temple has made during SFY 22-23.

1) Eastpointe TCL mini-series on Community Inclusion
2) New Trillium Community Inclusion provider series
3) AHEC[28] presentation
4) NAMI presentation
5) Technical assistance to CIL/TCL programs
6) Freedom funds report
7) Data analysis of ADA/TCL program data and housing retention
8) Developed a Community Inclusion Program Supports Guide

Drs. Mark Salzer and Bryan McCormick from Temple have been engaged in a number of activities over the past year to further enhance the foundation of community activities in the state. These efforts have primarily focused on supporting TCL activities, but also include efforts to assist other programs throughout the state. Brief descriptions of some of these efforts are described below.

Lastly, NAMI NC continued in SFY 22-23 to partner with NCDHHS to implement community inclusion trainings and events:

- NAMI maintains 2 staff who have been trained in the Temple University Community Inclusion model.
- NAMI provided 6 CI training events whose participants included NAMI Cumberland, Harnett, and

[28] The North Carolina Area Health Education Centers (NC AHEC) is a non-profit organization providing educational programs and services to the healthcare workforce. More information available at https://www.ncahec.net/

Lee Counties and the NAMI NC Peer Leadership Council.

- Eight community inclusion grants were implemented in SFY 22-23 and included Let's Talk about Needs (Carolinas Chinese American Civic Center), Places and Spaces and Bringing Culture Together (NAMI High Country), Breaking Barriers and FaithNet (NAMI Union county), Together We Thrive (NAMI Wake County), Healing Through the Arts (NAMI Cumberland Harnett Lee (CHL)), Getting the Power Within (NAMI Cabarrus county) and Peer Power (NAMI CHL and Peer Leadership Council).

3.3.2 TRANSITION MANAGEMENT SERVICES (TMS)

Transition Management Services (TMS) is a state-funded initiative that originated in 2015 as a response to the specific needs of individuals involved in TCL. This service was designed to cater to individuals who did not meet the clinical qualifications for existing services within the Adult Mental Health Service array, yet still required support to maintain their tenancy. Originally known as the Tenancy Supports Team (TST), the program evolved into Transition Management Services (TMS) on June 3, 2016.

TMS operates as a rehabilitation service with the primary goal of enhancing and restoring an individual's capacity to live successfully within the community while maintaining their tenancy. The focus of TMS is to empower individuals to live as independently as possible while effectively managing their mental health condition and reintegrating into various community roles across several life domains. These domains include emotional well-being, social engagement, safety, housing stability, medical and health management, educational pursuits, vocational endeavors, and legal matters.

Structured rehabilitative interventions form the core of TMS services, aimed at addressing the multifaceted needs of program participants. These interventions are tailored to support individuals in achieving stability in their lives, enhancing their skills, and coping mechanisms, and fostering their overall well-being within their community. Interventions include:

1) Assessment
2) Individual Housing & Tenancy Sustaining Services
3) Money Management and Entitlements
4) Activities of Daily Living
5) Personal Health, Wellness and Recovery
6) Promote Community Integration

3.3.3 ACCOMPLISHMENTS

- DMH/DD/SUS recognized the value of providing training and support to TMS providers. As a result, they facilitated TMS provider participation in the established CST collaborative, organized by the UNC Institute for Best Practices. During SFY 22-23, TMS providers began attending CST collaboratives. This opportunity allowed TMS providers to receive specialized training in tenancy supports and engage in a community where they could ask questions and share insights regarding tenancy support practices. As a result of this collaboration, TMS teams were able to actively participate in CST collaboratives, enhancing their capacity to provide effective support to help individuals maintain their tenancy.
- DMH/DD/SUS revised the TMS service definition, in the section Service Exclusions and Limitations, the language was changed to clarify that transportation for tenancy support activities are billable. It was effective on February 17, 2023.
- DMH/DD/SUS collaborated with the UNC Institute of Best Practices to establish a Transition Management Services (TMS) collaborative. This initiative involved developing a scope of work

and setting goals aimed at providing TMS providers with tenancy support training and fostering a community where providers could share knowledge and learn from others.

- The Technical Assistance Collaborative (TAC) began developing a tenancy support series that will be available free, on demand at UNC Behavioral Health Springboard. Topics include community inclusion, whole health, work & recovery, and Permanent Supportive Housing refresher training. NBCC credit will be offered for PSH Refresher training.

3.4. PERSON-CENTERED PLANNING (PCP)

3.4.1. SUMMARY

Since the inception of the previous PCP Manual in 2010, there has been a notable evolution in the understanding of mental illness and the concept of "recovery." This shift prompted the formation of a workgroup in 2016 dedicated to revising the NC PCP Manual and its accompanying PCP Template to align more closely with principles of recovery, individualization, and user-friendliness.

Comprising a diverse array of members including subject matter experts representing various disabilities and age groups, alongside individuals with firsthand experience, the workgroup collaborated to produce a more accessible guidance document. DMH/DD/SUS developed new guidelines for the Person-Centered Planning (PCP) process and began the work of finalizing the new PCP guidance document and related training. This new guidance focuses on self-advocacy and individual and families' desire for change and created a new emphasis on self-determination and choice for individuals receiving services and supports in our system. The Person-Centered Planning process begins with an individual's vision for a preferred life and takes the concept of self-determination from theory to practice. The individual has a primary role in person-centered planning and should be provided the opportunity to participate fully in this process.

The new PCP Guidance Document, updated PCP Template, and enhanced Crisis Plan were finalized in 2022. This document aims to aid anyone involved in crafting person-centered plans, offering a template that embodies the fundamental belief in every individual's right to live, love, work, learn, play, and pursue their aspirations within the community. The purpose of the PCP Guidance Document is to support Qualified Professionals to employ the knowledge and skills necessary in the planning and development of accurate and effective PCPs.

- In June 2022, DMH/DD/SUS contracted with Dr. Janis Tondora[29] to develop a new PCP training. Dr. Tondora developed a 4-hour live virtual training with the following learning objectives:
  - Identify differences between traditional methods of treatment planning and best-practice Person-Centered Planning
  - Increase engagement and partnering skills in the co-creation of PCPs with people/families
  - Gain knowledge of differences in individualized planning based on cultural factors/preferences
  - Learn strategies for respecting strengths-based, person-centered principles in plan documentation while also satisfying regulations/funder requirements
  - Increase familiarity with the NC PCP Guidance Document and PCP template and recommendations

[29] Janis Tondora, Psy.D., is an Associate Professor in the Department of Psychiatry at the Yale School of Medicine. Based at the Program for Recovery and Community Health, her work involves supporting the implementation of recovery-oriented practices that help people with behavioral health concerns and other disabilities to get more control over decisions about their services so they can live a good life as they define it.

- Identify at least two benefits of PCP for service recipients in the DMH/DD/SAS (now DMH/DD/SUS) system of care

During this time of development, DMH/DD/SUS completed focus groups with all LME/MCOS to obtain input and feedback on foundational elements of the new training and guidance. Feedback was overwhelmingly positive as LME/MCOs supported the need for PCPs to be more individualized, person-centered and recovery focused. DMH/DD/SUS also formed a subject matter expert workgroup comprised of experts from all disabilities (MH, IDD/TBI, SUD) and experts on peer support services.

In December of 2022, the new PCP guidance and template were published, and the training schedule and registration were released. Providers and LME/MCOs were informed of the timeframe for provider implementation requirements. Seven trainings were conducted from January through June 2023. All trainings were filled to capacity and an average of 345 individuals attended each session. A special training session was held on May 30, 2023, for only LME/MCO Utilization Management (UM) staff. The focus of this training was not only to provide updated PCP training, but to recommend how UM staff would review future PCPs to ensure quality.

3.4.2. ACCOMPLISHMENTS

- A total of 2,600+ participants participated in the virtual, four-hour training offered on seven different occasions.
- Trainees represented 480 unique agencies from 175 towns and cities, all 100 counties, and five regions across North Carolina reflecting widespread geographic penetration to audiences around the state.
- Similar diversity was found in response to the primary “population served” question. Large numbers of trainees reported serving individuals with IDD or mental/behavioral health concerns, but all nine categories of service populations were represented in the sample.
- In general, training participants expressed a high degree of satisfaction with knowledge and presentation skills of the presenter, content of the program, facility and accommodations, and quality of program materials. The average rating on all items exceeded a mean of 4.6 (on a 5-point scale).
- Individual knowledge of PCP: Before and after the training, participants were asked to indicate whether they believed 11 statements about Person-Centered Planning to be true or false. This pre-post-test assessment of knowledge showed a significant increase in understanding of key components of PCP, including the quality of both the process and its associated documentation.
- Participants reported the following ways the training helped meet their goals: “It helped me to realign my clinical language in a more person-centered way, as well as re-establish how to maintain and protect PCP's that are individualized and empowering,” and “I believe we get so used to focusing on the person as a client instead of as a person. The activity of taking away the second most important thing in my life really drove this idea home; never thought of it like that before,” and “The training helps me with successfully identifying unrealistic short-term goals opposed to short-term achievable goals.”
- Post-training, in April 2023, an FAQ was published encompassing the most frequently asked questions from the trainings. As we looked toward the end of SFY 22-23 and into SFY 23-24, we renewed our contract and partnership with Dr. Tondora and a new scope of work was developed focusing on monitoring of quality PCPs, the peer voice in PCP planning and future in-person trainings.

4. INDIVIDUAL PLACEMENT AND SUPPORT – SUPPORTED EMPLOYMENT

4.1. SUMMARY

The Individual Placement and Support (IPS) service is a fidelity-based model of supported employment for individuals with serious mental illness. SFY 22-23 continued to focus on sustainability of the IPS service. As of June 30, 2023, North Carolina had 31 IPS providers with 1 new provider awaiting baseline fidelity. After COVID-19 flexibilities ended in June 2022, IPS fidelity evaluations resumed in September 2022. Fidelity evaluations helped guide technical assistance and training provided by the UNC Institute for Best Practices, with behavioral health integration and educating a new workforce on IPS practice principles being a few of the main focuses. The Institute has been instrumental in promulgating the service and reinforcing the principle that employment is vital to recovery.

In December 2019, the State implemented the sustainability plan for IPS. The North Carolina Collaborative for Ongoing Recovery through Employment (NC CORE) is an outcome-based, sequential funded model that was piloted in the Vaya Health catchment area and expanded to Alliance Health in December 2021. DMH/DD/SUS, DHB, and EIPD collaborated to provide technical assistance and training on NC CORE implementation to Eastpointe, Sandhills, Partners and Trillium during SFY 22-23. Partners and Trillium successfully implemented NC CORE in April and May, respectively. With variations in milestone structure, requirements, and rates set by each LME/MCO, IPS providers reached out to the Department in June 2023 to report administrative burden and insufficient milestone rates to sustain the service. The Department committed to standardizing NC CORE by establishing a workgroup at the start of SFY 23-24 to include representatives from IPS providers, LME/MCOs, UNC Institute for Best Practices, and cross Divisional staff. Sandhills and Eastpointe agreed to pause their plans for NC-CORE until standardization was achieved.

According to self-reported IPS provider data during SFY 22-23, the average IPS enrollment rate for TCL members and those in or at risk of ACH placement was 14%. To increase IPS enrollment of TCL recipients, DMH/DD/SUS implemented a TCL employment incentive plan in October 2022 with the goal of increasing IPS enrollment 5% for TCL members in pre-housing or community housing and 10% for housed individuals. A third performance target was established to increase the overall TCL Competitive Integrated Employment (CIE) rate to 20%. During SFY 22-23, the LME/MCOs collectively earned six incentive payments for positive outcomes.

4.2. ACCOMPLISHMENTS DURING STATE FISCAL YEAR 2022 – 2023

The State is proud of its many accomplishments with IPS which include:

- Met TCL Settlement requirement for In-At-Risk IPS enrollment with a current LOP count of 2,676 unduplicated individuals as of December 2023.
- According to self-reported IPS provider data, the average CIE rate for TCL members and those In or At Risk of ACH placement was 43%.
- Self-reported IPS provider data showed an increase in shared Vocational Rehabilitation cases to 41% (up 17%) and the CIE rate to 50% (up 6%).
- DMH/DD/SUS, DHB, and EIPD collaborated to establish a revised fee-for-service rate of

$26.40/unit, which will be utilized to revise NC CORE milestone rates.

- DHB, with close collaboration with DMH/DD/SUS, developed the 1915(i) IPS clinical coverage policy. The policy was drafted and posted for public comments and went through several revisions based on comments from stakeholders.
- The EIPD Program Specialist for Behavioral Health continues to provide technical assistance and support to Vocational Rehabilitation counselors, IPS providers, and/or LME/MCO staff.
- All LME/MCOs continue to facilitate provider collaboratives that include IPS, ACT, CST and/or TMS to provide education and assistance toward improved IPS enrollments.
- EIPD increased milestone rates for the current year based on feedback from IPS providers to more closely align with the time spent in each milestone.
- EIPD is revising its IPS policy to align with DHB and DMH/DD/SUS service definitions, clarify roles of team members, and to emphasize best practices.

Additional accomplishments through the UNC IBP contract include:

- 16 IPS fidelity evaluations completed
- 21 workshops on IPS practice principles for IPS staff and leadership
- 20 IPS coaching sessions to 18 IPS providers with a focus on behavioral health integration and the impact of symptomology on employment
- One annual IPS/ACT conference in Winston Salem (105 attendees)
- An inaugural IPS Coalition meeting with 5 IPS provider leadership staff that discussed priorities for the Coalition
- Six shadowing sessions with LME/MCO In-Reach staff and supervisors at Alliance, Partners, Sandhills, and Trillium to assist with identifying potential TCL members to meet with to maximize opportunities to observe and practice motivational interviewing skills for assertive engagement. UNC used direct modeling and post-meetings to provide thorough feedback.
- Two TCL success videos distributed and posted on the UNC Institute for Best Practices website
- One tip sheet on employment engagement strategies and IPS/SE information posted on the UNC website and distributed to LME/MCOs and ACT, CST, and IPS providers
- Trainings that included:
    - Motivational Interviewing for IPS - 67 attendees
    - Supported Education - 58 attendees
    - Twp Employment Peer Mentor trainings - 26 attendees
    - One IPS peer supervision - nine attendees
    - Four Blind Spots training - 25 attendees

5. TCL SERVICE PATTERNS

5.1. OVERVIEW

This annual report section addresses the requirement in 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[30] and DMH/DD/SUS adjudicated behavioral health service claims for the TCL participant populations described in Table 2.

TABLE 2: SFY 22-23 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	3,623
Transition Planning[31]	Individuals with approved TCL supportive housing slots who had an initial transition attempt in progress	928
Rehousing Planning	Individuals separated from TCL supportive housing who had a subsequent transition attempt in progress	194
ACH In-Reach	Individuals residing in an Adult Care Home	4,498
State Psychiatric Hospital (SPH) In-Reach	Individuals residing in a State Psychiatric Hospital or receiving outreach in the community after SPH discharge	1,608
Diversion	Individuals who had and Adult Care Home Diversion attempt in progress	1,223
Housed in the Community without a TCL Housing Slot	Individuals residing in community-based settings other than TCL supportive housing	2,726
Unduplicated Total[32]	**Total count of TCL participants, each counted once regardless of transitions across setting and status**	**12,770**

Data tables in the remainder of this section show, by the TCL statuses and settings described in Table 2, statewide annual and recent quarterly percentages of individuals who received service, and SFY 22-23 numbers and percentages by LME/MCO of individuals who received services within the date range of Table 2 status periods. Table 3 shows the specific services included in each service category.

TABLE 3: SERVICE CATEGORIES

Service Category	Services Included
ACT	• Assertive Community Treatment Team

[30] 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.

[31] 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.

[32] In service summaries that follow, sums of individual counts per setting will exceed the Table 2 unduplicated total. The degree of duplication will be greater for annual versus quarterly measurement periods.

Service Category	Services Included
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
Any Core Service	• Any of ACT, CST, or TMS
AES	• State-Funded Assertive Engagement Service
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 (E&M) Office and Outpatient Visits	• 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 • 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

5.2. 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.

- Annual service rates reflect claims adjudicated through September 2023. Timely filing limits may affect data completeness, especially for services provided in more recent reporting periods.
- Because of the delay between service delivery and the availability of complete service claims data in the NCTracks data warehouse, SFY 21-22 is the most recent full state fiscal year for which service claims summaries are presented.
- 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.

- Statewide service rates for SFY 21-22 and the first two quarters of SFY 22-23 are presented to allow for comparison of quarterly service rates from the most recent full state fiscal year of claims data, SFY 21-22, and the first two quarters of SFY 22-23. Quarterly service rates are sourced from the September 2023 TCL Dashboard release.
- TCL Performance Data Dashboard undergoes continuous quality assurance reviews and is 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.
- Statewide client counts may include a small degree of duplication due to client LME/MCO transfers. As a result of duplication in service rate percentage denominators, reported statewide service rates may slightly underestimate percentages of participants who received services.
- 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 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.

5.3. SUMMARY OF SERVICE TRENDS

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

- An SFY 22-23 increase in CST rates was accompanied by a corresponding decrease in the percentage of individuals receiving TMS, the lowest intensity service with a tenancy supports component.
- Over the years, individuals planning for initial transition were more likely to receive ACT or CST than TMS.
- Over the years, individuals separated from housing and planning for rehousing were substantially more likely to receive ACT than CST or TMS.
- Rates for more intensive and 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.
- Crisis service use remained low across settings and declined slightly over a six-year period for participants in TCL supportive housing.
- An apparent drop in IPS-SE service rates for members in TCL housing may reflect the NC CORE value-based model, in which services are billed only when service milestones are achieved.
- Percentages of individuals receiving ACT during In-Reach or while housed in the community without a TCL housing slot were relatively stable over the six years examined.
- Percentages of individuals receiving ACT, CST, or peer supports while in Diversion status have increased over a six-year period.
- Percentages of participants receiving services in congregate day programming through Psychosocial Rehabilitation Services decreased for individuals in TCL housing and were highest for individuals in ACH In-Reach.
- Rates for Peer Supports and comprehensive services such as ACT and CST trended upward for participants with active diversion attempts.
- Rates for stand-alone services such as Peer Supports, Psychological Diagnosis and Testing, Psychotherapy, and Evaluation and Management visits were higher for individuals in TCL

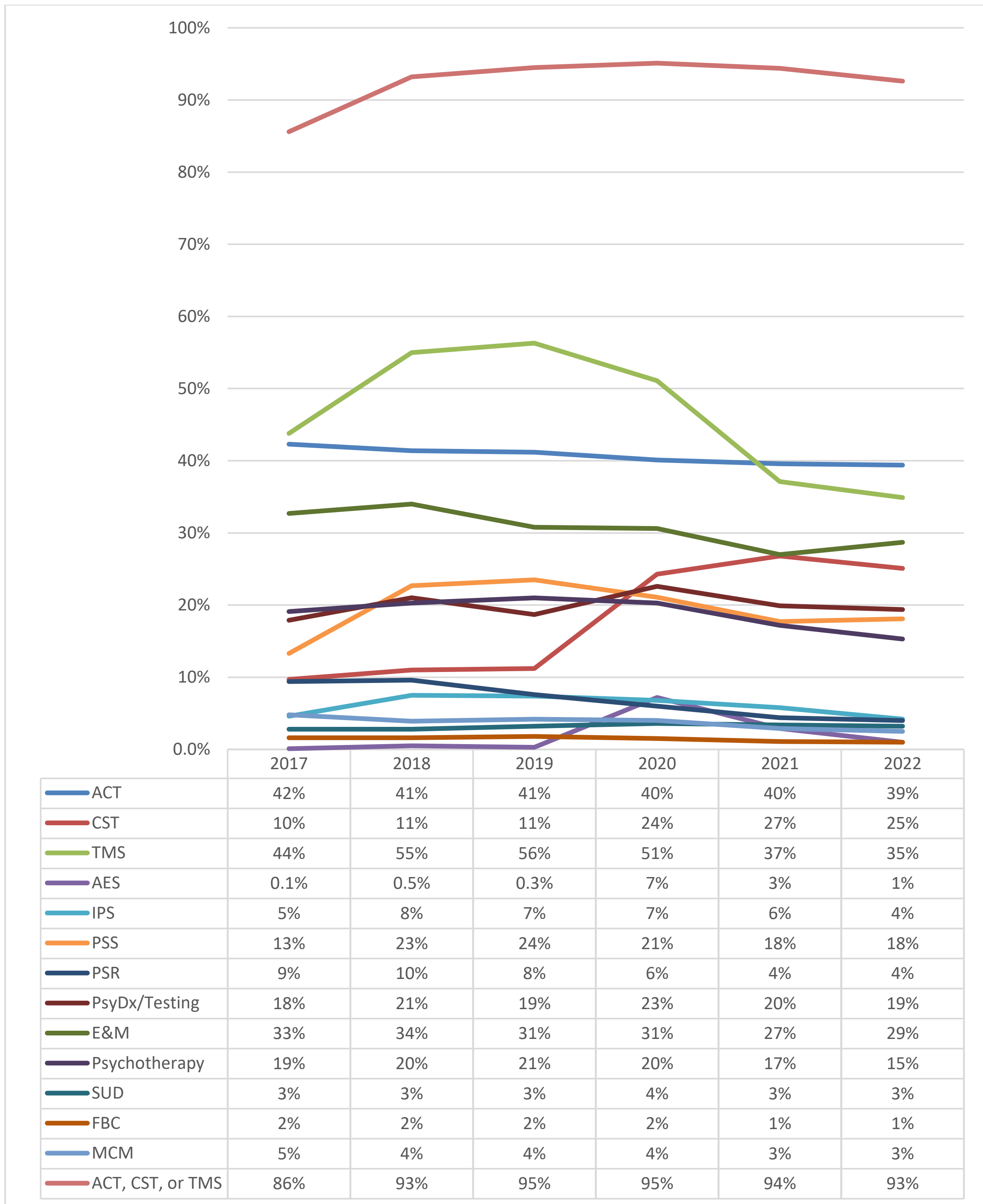
supportive housing compared to participants in pre-transition settings and individuals housed in the community without TCL supportive housing.

5.4. 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 3.

Annual Service Rates, SFY 16-17 to SFY 21-22

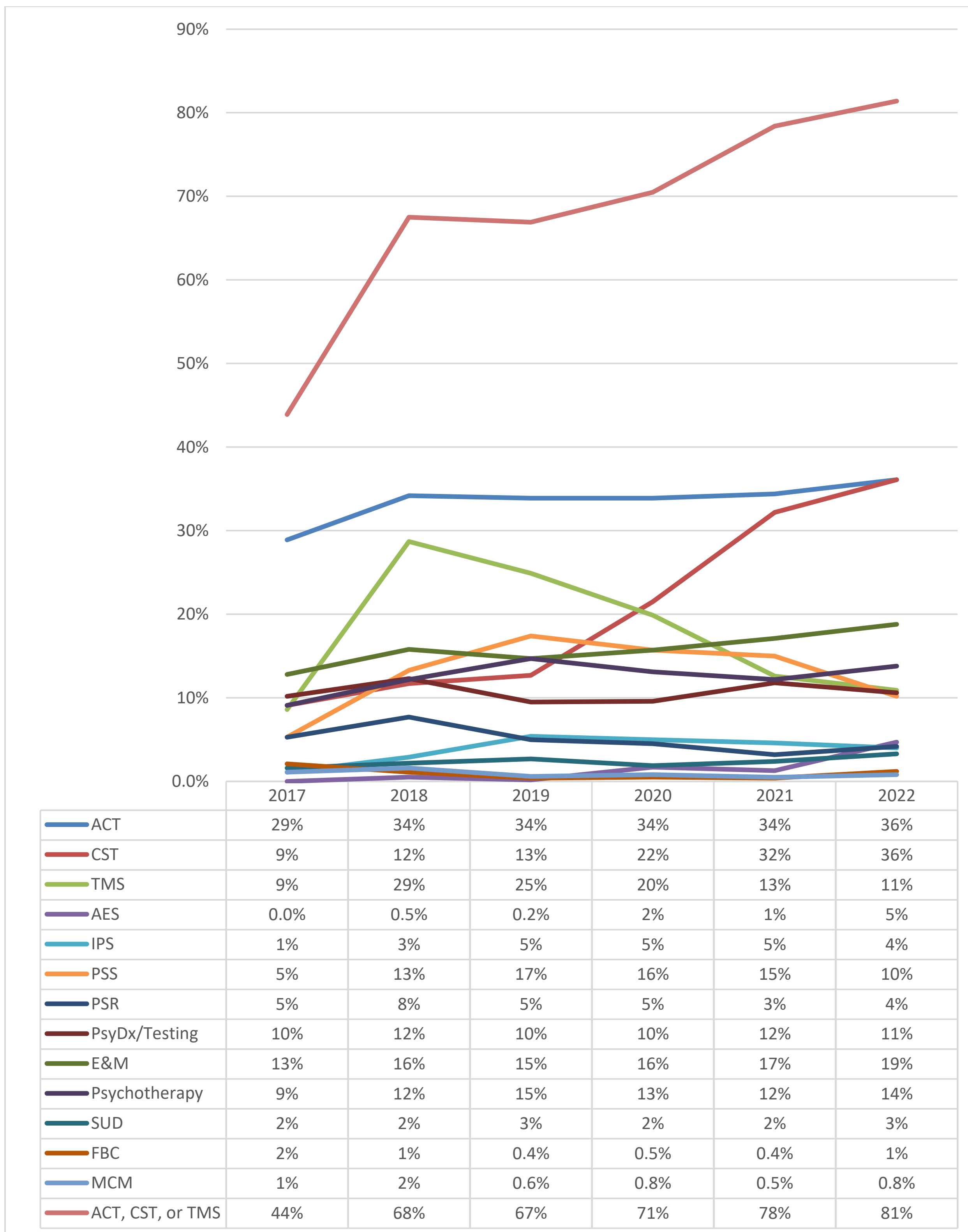
FIGURE 1: PARTICIPANTS IN TCL SUPPORTIVE HOUSING



	2017	2018	2019	2020	2021	2022
ACT	42%	41%	41%	40%	40%	39%
CST	10%	11%	11%	24%	27%	25%
TMS	44%	55%	56%	51%	37%	35%
AES	0.1%	0.5%	0.3%	7%	3%	1%
IPS	5%	8%	7%	7%	6%	4%
PSS	13%	23%	24%	21%	18%	18%
PSR	9%	10%	8%	6%	4%	4%
PsyDx/Testing	18%	21%	19%	23%	20%	19%
E&M	33%	34%	31%	31%	27%	29%
Psychotherapy	19%	20%	21%	20%	17%	15%
SUD	3%	3%	3%	4%	3%	3%
FBC	2%	2%	2%	2%	1%	1%
MCM	5%	4%	4%	4%	3%	3%
ACT, CST, or TMS	86%	93%	95%	95%	94%	93%

Annual Service Rates, SFY 16-17 to SFY 21-22 (Continued)

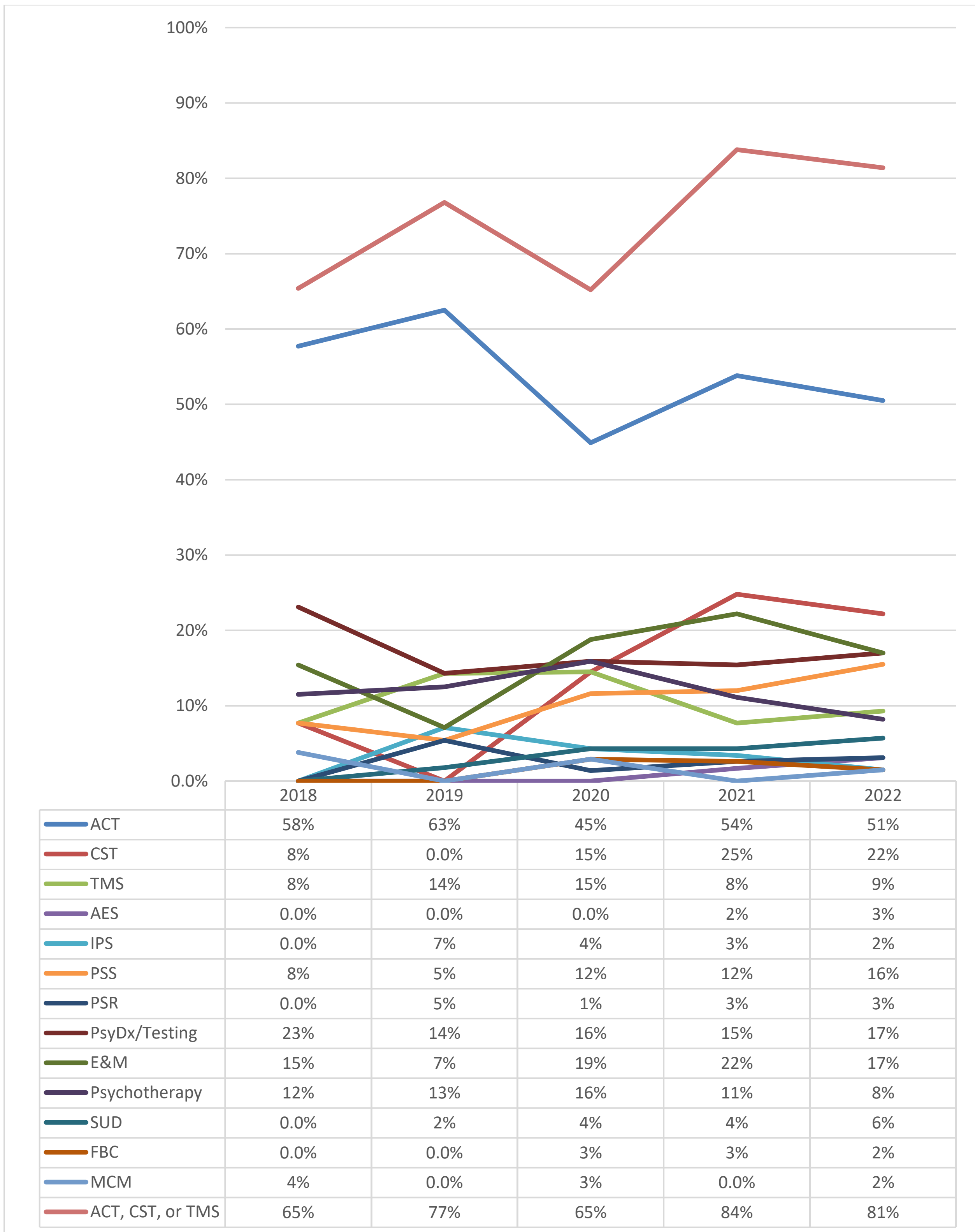
FIGURE 2: PARTICIPANTS IN TRANSITION PLANNING



	2017	2018	2019	2020	2021	2022
ACT	29%	34%	34%	34%	34%	36%
CST	9%	12%	13%	22%	32%	36%
TMS	9%	29%	25%	20%	13%	11%
AES	0.0%	0.5%	0.2%	2%	1%	5%
IPS	1%	3%	5%	5%	5%	4%
PSS	5%	13%	17%	16%	15%	10%
PSR	5%	8%	5%	5%	3%	4%
PsyDx/Testing	10%	12%	10%	10%	12%	11%
E&M	13%	16%	15%	16%	17%	19%
Psychotherapy	9%	12%	15%	13%	12%	14%
SUD	2%	2%	3%	2%	2%	3%
FBC	2%	1%	0.4%	0.5%	0.4%	1%
MCM	1%	2%	0.6%	0.8%	0.5%	0.8%
ACT, CST, or TMS	44%	68%	67%	71%	78%	81%

Annual Service Rates, SFY 16-17 to SFY 21-22 (Continued)

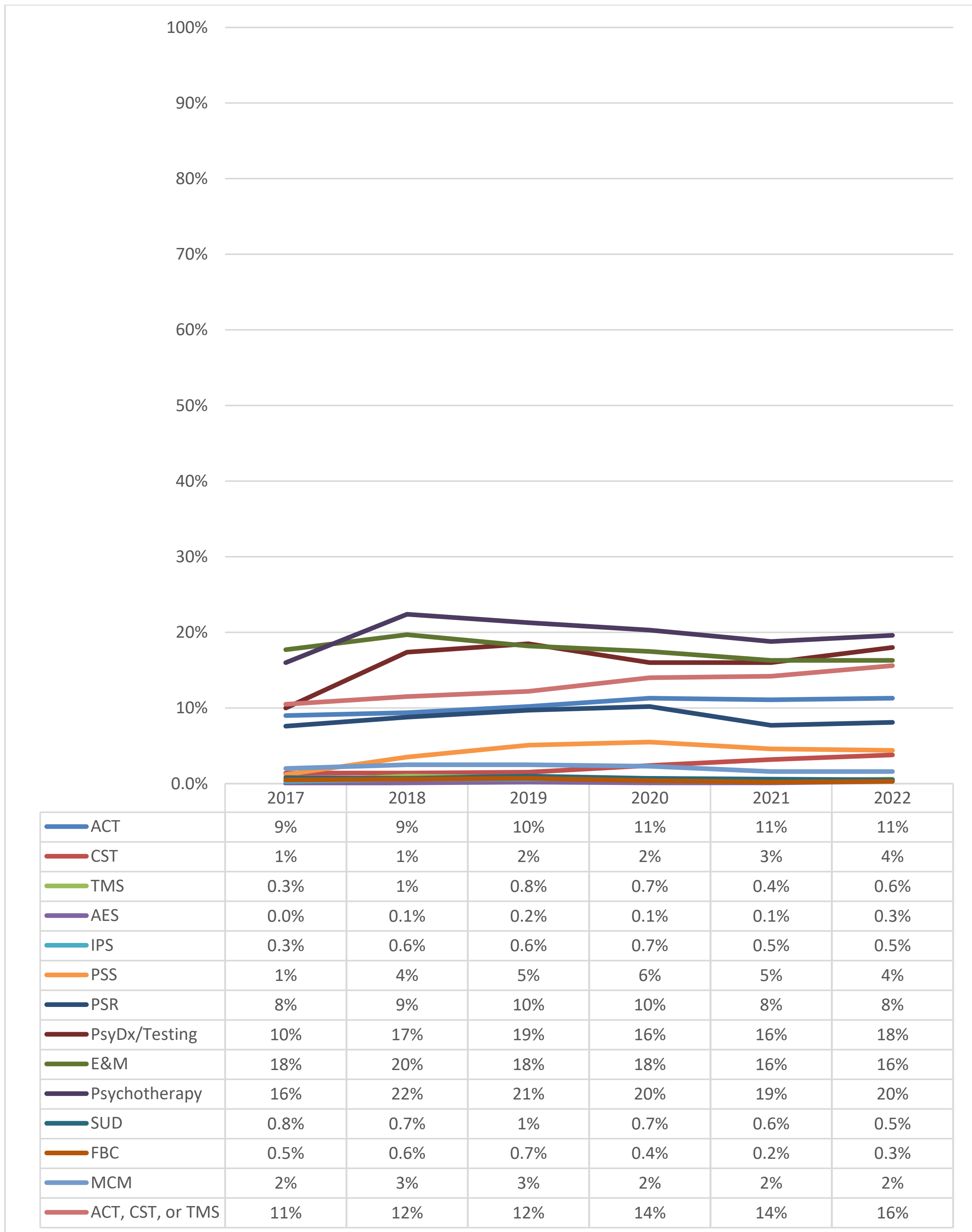
FIGURE 3: PARTICIPANTS IN REHOUSING PLANNING



	2018	2019	2020	2021	2022
ACT	58%	63%	45%	54%	51%
CST	8%	0.0%	15%	25%	22%
TMS	8%	14%	15%	8%	9%
AES	0.0%	0.0%	0.0%	2%	3%
IPS	0.0%	7%	4%	3%	2%
PSS	8%	5%	12%	12%	16%
PSR	0.0%	5%	1%	3%	3%
PsyDx/Testing	23%	14%	16%	15%	17%
E&M	15%	7%	19%	22%	17%
Psychotherapy	12%	13%	16%	11%	8%
SUD	0.0%	2%	4%	4%	6%
FBC	0.0%	0.0%	3%	3%	2%
MCM	4%	0.0%	3%	0.0%	2%
ACT, CST, or TMS	65%	77%	65%	84%	81%

Annual Service Rates, SFY 16-17 to SFY 21-22 (Continued)

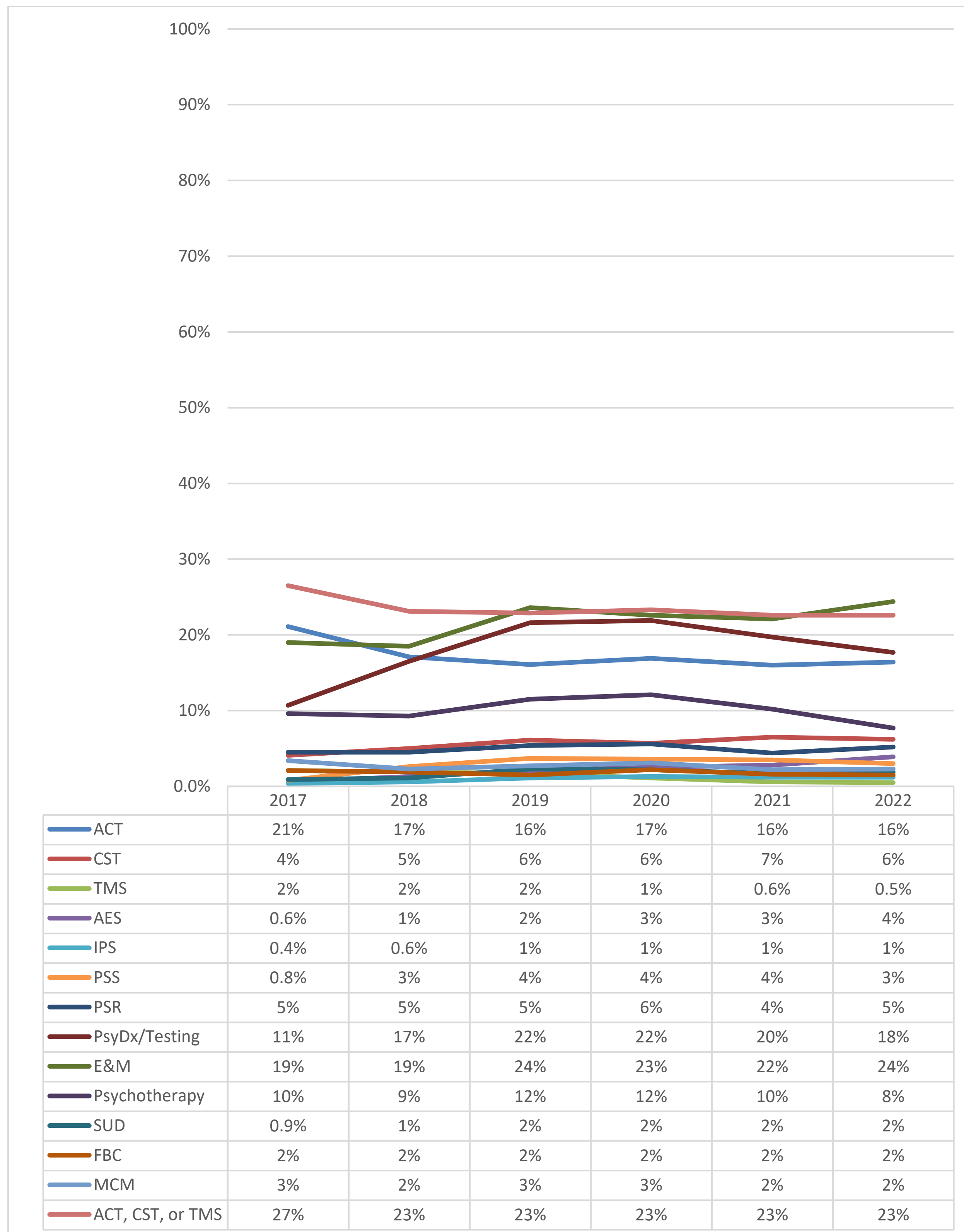
FIGURE 4: PARTICIPANTS IN ACH IN-REACH



	2017	2018	2019	2020	2021	2022
ACT	9%	9%	10%	11%	11%	11%
CST	1%	1%	2%	2%	3%	4%
TMS	0.3%	1%	0.8%	0.7%	0.4%	0.6%
AES	0.0%	0.1%	0.2%	0.1%	0.1%	0.3%
IPS	0.3%	0.6%	0.6%	0.7%	0.5%	0.5%
PSS	1%	4%	5%	6%	5%	4%
PSR	8%	9%	10%	10%	8%	8%
PsyDx/Testing	10%	17%	19%	16%	16%	18%
E&M	18%	20%	18%	18%	16%	16%
Psychotherapy	16%	22%	21%	20%	19%	20%
SUD	0.8%	0.7%	1%	0.7%	0.6%	0.5%
FBC	0.5%	0.6%	0.7%	0.4%	0.2%	0.3%
MCM	2%	3%	3%	2%	2%	2%
ACT, CST, or TMS	11%	12%	12%	14%	14%	16%

Annual Service Rates, SFY 16-17 to SFY 21-22 (Continued)

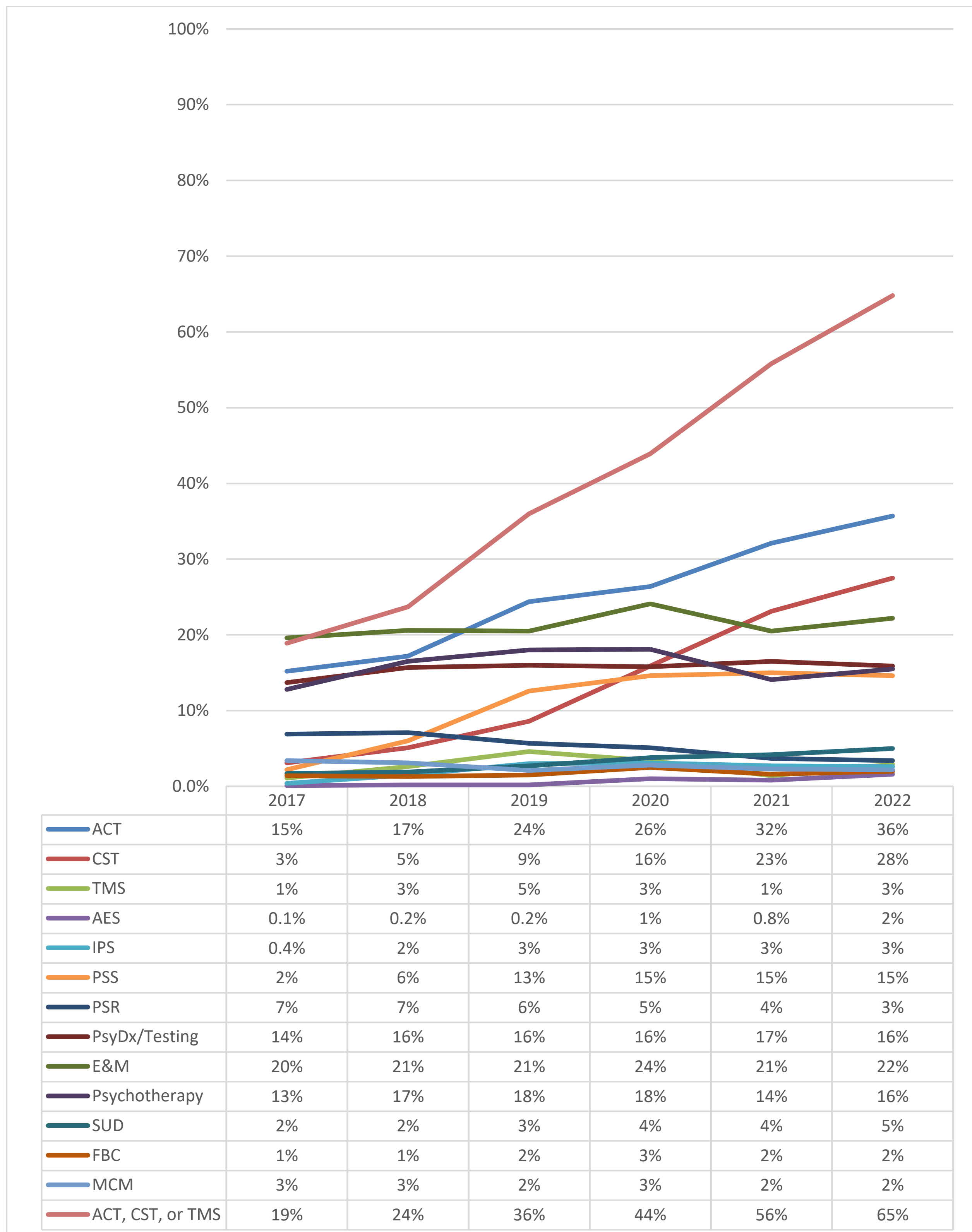
FIGURE 5: PARTICIPANTS IN SPH IN-REACH



	2017	2018	2019	2020	2021	2022
ACT	21%	17%	16%	17%	16%	16%
CST	4%	5%	6%	6%	7%	6%
TMS	2%	2%	2%	1%	0.6%	0.5%
AES	0.6%	1%	2%	3%	3%	4%
IPS	0.4%	0.6%	1%	1%	1%	1%
PSS	0.8%	3%	4%	4%	4%	3%
PSR	5%	5%	5%	6%	4%	5%
PsyDx/Testing	11%	17%	22%	22%	20%	18%
E&M	19%	19%	24%	23%	22%	24%
Psychotherapy	10%	9%	12%	12%	10%	8%
SUD	0.9%	1%	2%	2%	2%	2%
FBC	2%	2%	2%	2%	2%	2%
MCM	3%	2%	3%	3%	2%	2%
ACT, CST, or TMS	27%	23%	23%	23%	23%	23%

Annual Service Rates, SFY 16-17 to SFY 21-22 (Continued)

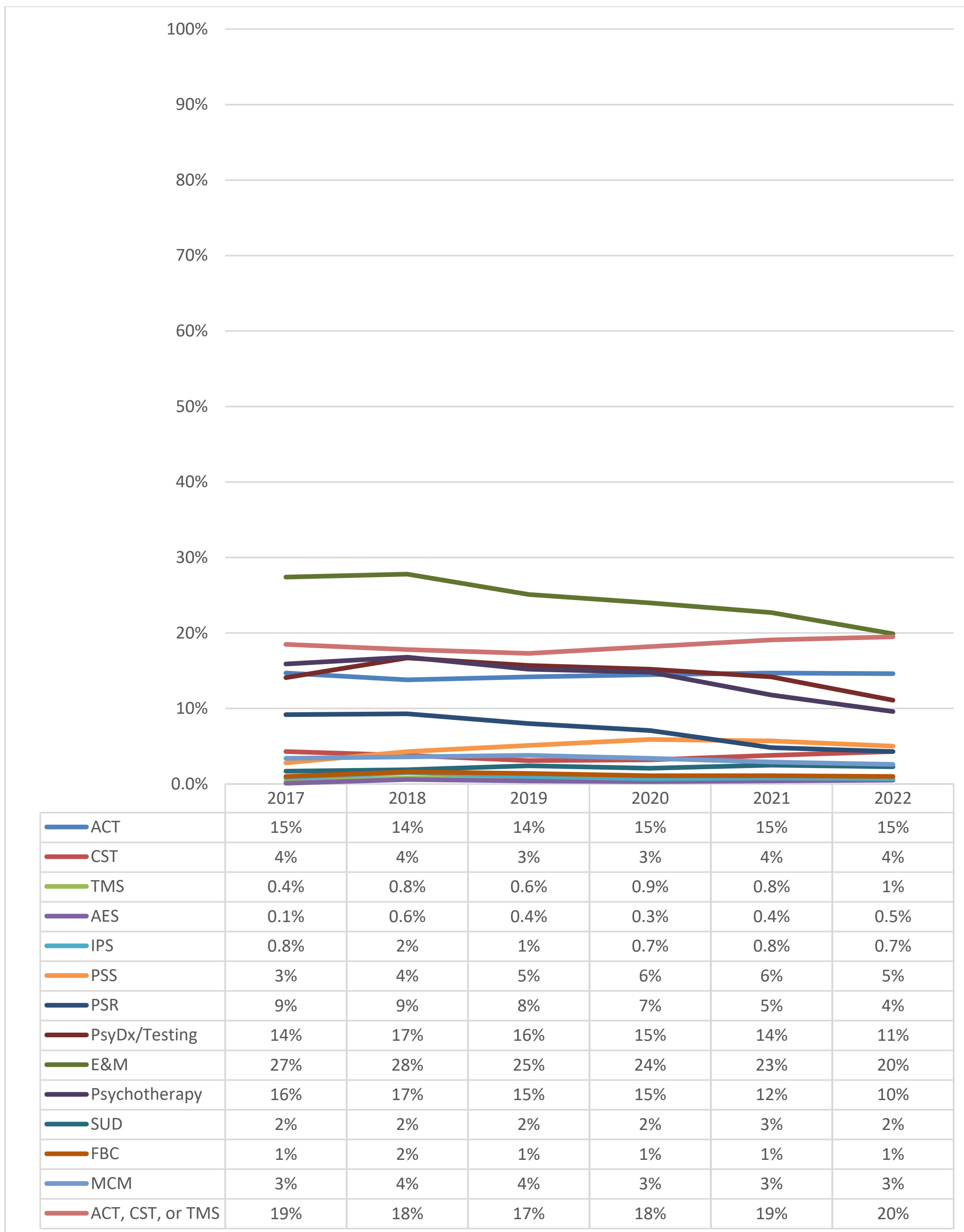
FIGURE 6: PARTICIPANTS IN DIVERSION STATUS



	2017	2018	2019	2020	2021	2022
ACT	15%	17%	24%	26%	32%	36%
CST	3%	5%	9%	16%	23%	28%
TMS	1%	3%	5%	3%	1%	3%
AES	0.1%	0.2%	0.2%	1%	0.8%	2%
IPS	0.4%	2%	3%	3%	3%	3%
PSS	2%	6%	13%	15%	15%	15%
PSR	7%	7%	6%	5%	4%	3%
PsyDx/Testing	14%	16%	16%	16%	17%	16%
E&M	20%	21%	21%	24%	21%	22%
Psychotherapy	13%	17%	18%	18%	14%	16%
SUD	2%	2%	3%	4%	4%	5%
FBC	1%	1%	2%	3%	2%	2%
MCM	3%	3%	2%	3%	2%	2%
ACT, CST, or TMS	19%	24%	36%	44%	56%	65%

Annual Service Rates, SFY 16-17 to SFY 21-22 (Continued)

FIGURE 7: PARTICIPANTS HOUSED IN THE COMMUNITY WITHOUT A TCL HOUSING SLOT



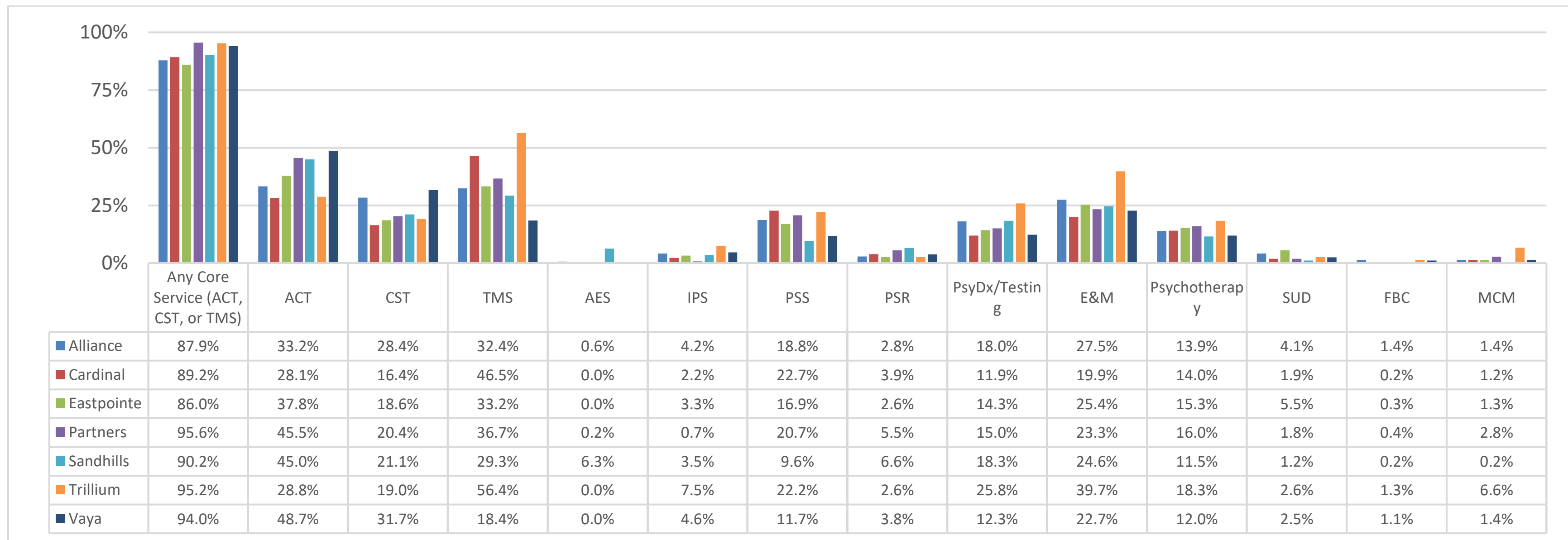
	2017	2018	2019	2020	2021	2022
ACT	15%	14%	14%	15%	15%	15%
CST	4%	4%	3%	3%	4%	4%
TMS	0.4%	0.8%	0.6%	0.9%	0.8%	1%
AES	0.1%	0.6%	0.4%	0.3%	0.4%	0.5%
IPS	0.8%	2%	1%	0.7%	0.8%	0.7%
PSS	3%	4%	5%	6%	6%	5%
PSR	9%	9%	8%	7%	5%	4%
PsyDx/Testing	14%	17%	16%	15%	14%	11%
E&M	27%	28%	25%	24%	23%	20%
Psychotherapy	16%	17%	15%	15%	12%	10%
SUD	2%	2%	2%	2%	3%	2%
FBC	1%	2%	1%	1%	1%	1%
MCM	3%	4%	4%	3%	3%	3%
ACT, CST, or TMS	19%	18%	17%	18%	19%	20%

Annual Client Counts and Service Rates by LME/MCO, SFY 21-22

TABLE 4: PARTICIPANTS IN TCL SUPPORTIVE HOUSING

LMEMCO	Total N	Any Core Service (ACT, CST, or TMS)	ACT	CST	TMS	AES	IPS	PSS	PSR	PsyDx/ Testing	E&M	Psycho-therapy	SUD	FBC	MCM
Alliance	**1,104**	970	367	313	358	7	46	207	31	199	304	154	45	15	15
Cardinal	**908**	810	255	149	422	0	20	206	35	108	181	127	17	2	11
Eastpointe	**307**	264	116	57	102	0	10	52	8	44	78	47	17	1	4
Partners	**545**	521	248	111	200	1	4	113	30	82	127	87	10	2	15
Sandhills	**427**	385	192	90	125	27	15	41	28	78	105	49	5	1	1
Trillium	**546**	520	157	104	308	0	41	121	14	141	217	100	14	7	36
Vaya	**635**	597	309	201	117	0	29	74	24	78	144	76	16	7	9
Statewide	**3,623**	**3,356**	**1,427**	**909**	**1,266**	**35**	**153**	**655**	**146**	**704**	**1,038**	**553**	**117**	**35**	**91**

FIGURE 8: PARTICIPANTS IN TCL SUPPORTIVE HOUSING



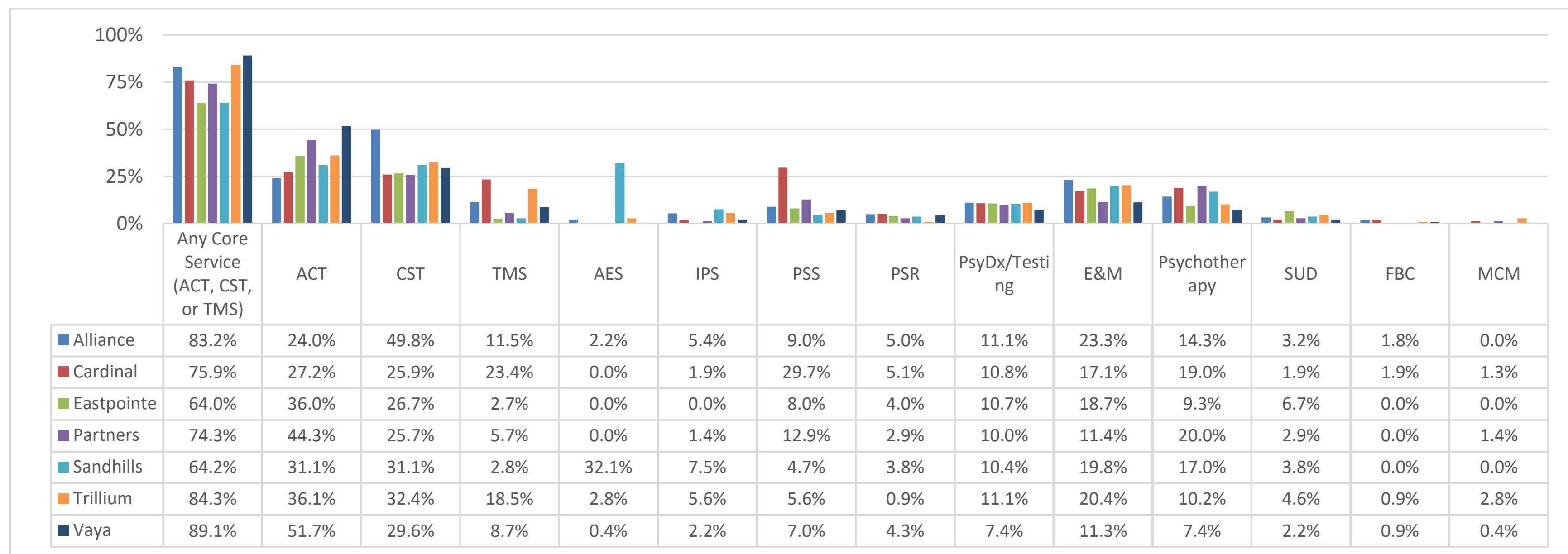
	Any Core Service (ACT, CST, or TMS)	ACT	CST	TMS	AES	IPS	PSS	PSR	PsyDx/Testing	E&M	Psychotherapy	SUD	FBC	MCM
Alliance	87.9%	33.2%	28.4%	32.4%	0.6%	4.2%	18.8%	2.8%	18.0%	27.5%	13.9%	4.1%	1.4%	1.4%
Cardinal	89.2%	28.1%	16.4%	46.5%	0.0%	2.2%	22.7%	3.9%	11.9%	19.9%	14.0%	1.9%	0.2%	1.2%
Eastpointe	86.0%	37.8%	18.6%	33.2%	0.0%	3.3%	16.9%	2.6%	14.3%	25.4%	15.3%	5.5%	0.3%	1.3%
Partners	95.6%	45.5%	20.4%	36.7%	0.2%	0.7%	20.7%	5.5%	15.0%	23.3%	16.0%	1.8%	0.4%	2.8%
Sandhills	90.2%	45.0%	21.1%	29.3%	6.3%	3.5%	9.6%	6.6%	18.3%	24.6%	11.5%	1.2%	0.2%	0.2%
Trillium	95.2%	28.8%	19.0%	56.4%	0.0%	7.5%	22.2%	2.6%	25.8%	39.7%	18.3%	2.6%	1.3%	6.6%
Vaya	94.0%	48.7%	31.7%	18.4%	0.0%	4.6%	11.7%	3.8%	12.3%	22.7%	12.0%	2.5%	1.1%	1.4%

Annual Client Counts and Service Rates by LME/MCO, SFY 21-22 (Continued)

TABLE 5: PARTICIPANTS IN TRANSITION PLANNING

LMEMCO	Total N	Any Core Service (ACT, CST, or TMS)	ACT	CST	TMS	AES	IPS	PSS	PSR	PsyDx/ Testing	E&M	Psycho-therapy	SUD	FBC	MCM
Alliance	**279**	232	67	139	32	6	15	25	14	31	65	40	9	5	0
Cardinal	**158**	120	43	41	37	0	3	47	8	17	27	30	3	3	2
Eastpointe	**75**	48	27	20	2	0	0	6	3	8	14	7	5	0	0
Partners	**70**	52	31	18	4	0	1	9	2	7	8	14	2	0	1
Sandhills	**106**	68	33	33	3	34	8	5	4	11	21	18	4	0	0
Trillium	**108**	91	39	35	20	3	6	6	1	12	22	11	5	1	3
Vaya	**230**	205	119	68	20	1	5	16	10	17	26	17	5	2	1
Statewide	**928**	**755**	**335**	**335**	**101**	**44**	**37**	**95**	**39**	**98**	**174**	**128**	**31**	**11**	**7**

FIGURE 9: PARTICIPANTS IN TRANSITION PLANNING



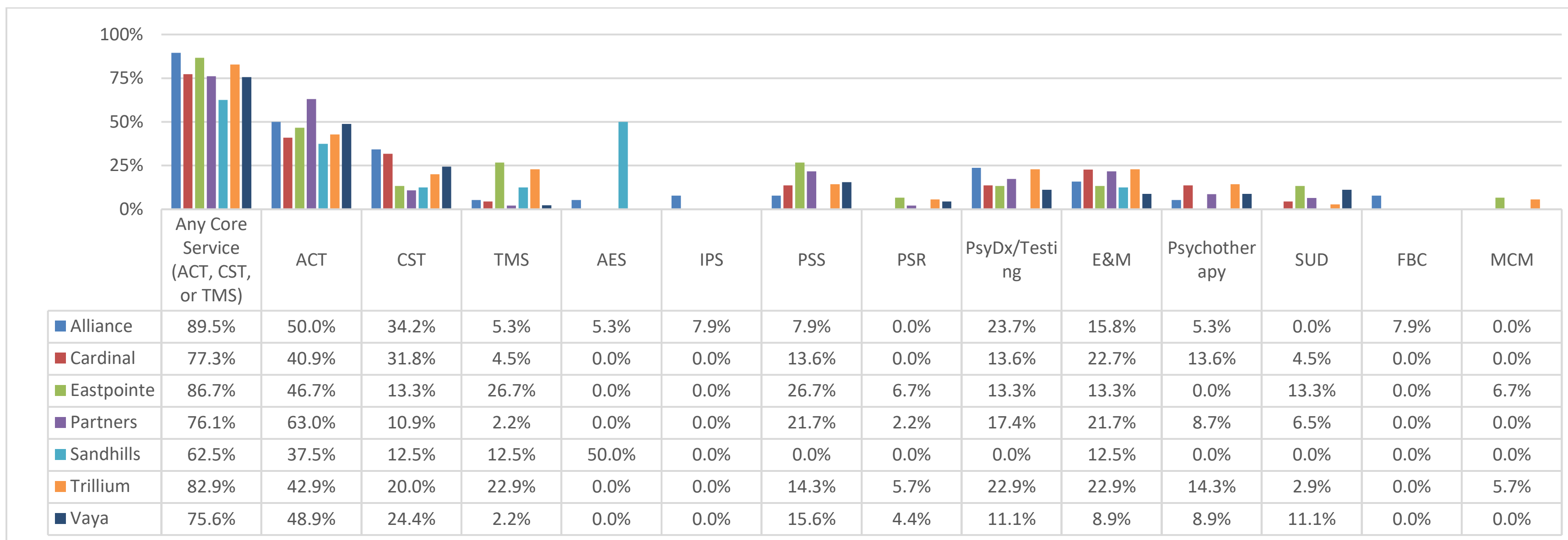
	Any Core Service (ACT, CST, or TMS)	ACT	CST	TMS	AES	IPS	PSS	PSR	PsyDx/Testing	E&M	Psychotherapy	SUD	FBC	MCM
Alliance	83.2%	24.0%	49.8%	11.5%	2.2%	5.4%	9.0%	5.0%	11.1%	23.3%	14.3%	3.2%	1.8%	0.0%
Cardinal	75.9%	27.2%	25.9%	23.4%	0.0%	1.9%	29.7%	5.1%	10.8%	17.1%	19.0%	1.9%	1.9%	1.3%
Eastpointe	64.0%	36.0%	26.7%	2.7%	0.0%	0.0%	8.0%	4.0%	10.7%	18.7%	9.3%	6.7%	0.0%	0.0%
Partners	74.3%	44.3%	25.7%	5.7%	0.0%	1.4%	12.9%	2.9%	10.0%	11.4%	20.0%	2.9%	0.0%	1.4%
Sandhills	64.2%	31.1%	31.1%	2.8%	32.1%	7.5%	4.7%	3.8%	10.4%	19.8%	17.0%	3.8%	0.0%	0.0%
Trillium	84.3%	36.1%	32.4%	18.5%	2.8%	5.6%	5.6%	0.9%	11.1%	20.4%	10.2%	4.6%	0.9%	2.8%
Vaya	89.1%	51.7%	29.6%	8.7%	0.4%	2.2%	7.0%	4.3%	7.4%	11.3%	7.4%	2.2%	0.9%	0.4%

Annual Client Counts and Service Rates by LME/MCO, SFY 21-22 (Continued)

TABLE 6: PARTICIPANTS IN REHOUSING PLANNING

LMEMCO	Total N	Any Core Service (ACT, CST, or TMS)	ACT	CST	TMS	AES	IPS	PSS	PSR	PsyDx/ Testing	E&M	Psycho-therapy	SUD
Alliance	**38**	34	19	13	2	2	3	3	0	9	6	2	0
Cardinal	**22**	17	9	7	1	0	0	3	0	3	5	3	1
Eastpointe	**15**	13	7	2	4	0	0	4	1	2	2	0	2
Partners	**46**	35	29	5	1	0	0	10	1	8	10	4	3
Sandhills	**8**	5	3	1	1	4	0	0	0	0	1	0	0
Trillium	**35**	29	15	7	8	0	0	5	2	8	8	5	1
Vaya	**45**	34	22	11	1	0	0	7	2	5	4	4	5
Statewide	**194**	**158**	**98**	**43**	**18**	**6**	**3**	**30**	**6**	**33**	**33**	**16**	**11**

FIGURE 10: PARTICIPANTS IN REHOUSING PLANNING



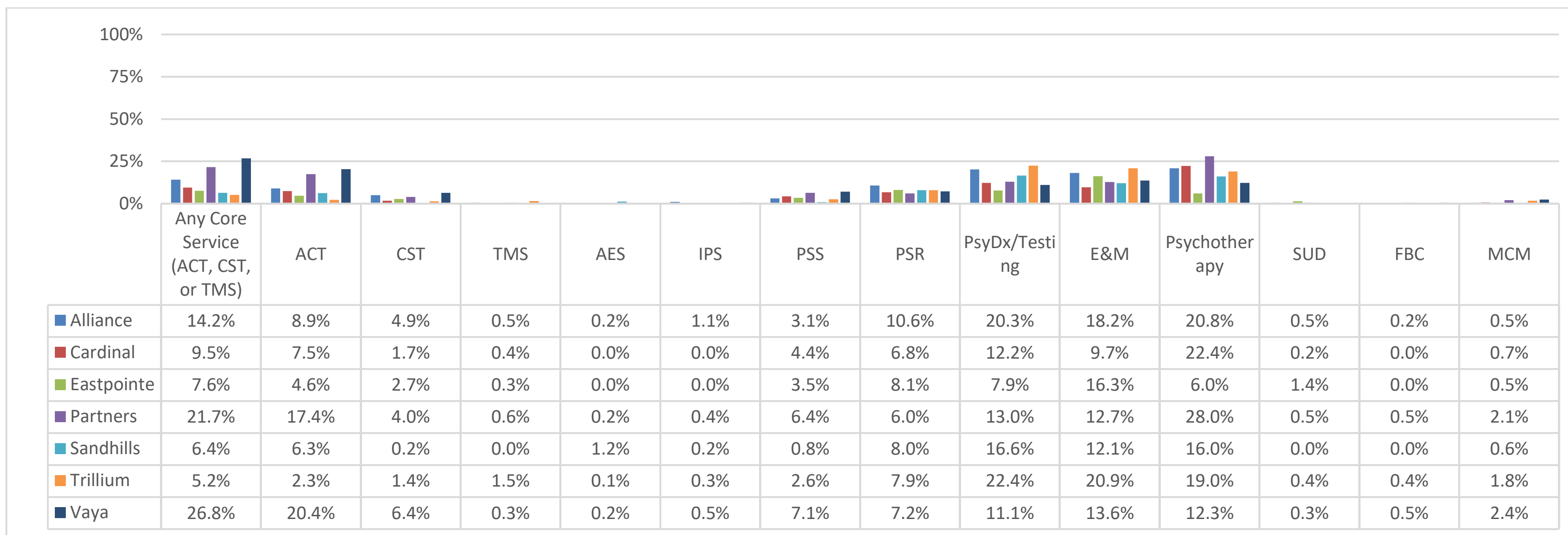
	Any Core Service (ACT, CST, or TMS)	ACT	CST	TMS	AES	IPS	PSS	PSR	PsyDx/Testing	E&M	Psychotherapy	SUD	FBC	MCM
Alliance	89.5%	50.0%	34.2%	5.3%	5.3%	7.9%	7.9%	0.0%	23.7%	15.8%	5.3%	0.0%	7.9%	0.0%
Cardinal	77.3%	40.9%	31.8%	4.5%	0.0%	0.0%	13.6%	0.0%	13.6%	22.7%	13.6%	4.5%	0.0%	0.0%
Eastpointe	86.7%	46.7%	13.3%	26.7%	0.0%	0.0%	26.7%	6.7%	13.3%	13.3%	0.0%	13.3%	0.0%	6.7%
Partners	76.1%	63.0%	10.9%	2.2%	0.0%	0.0%	21.7%	2.2%	17.4%	21.7%	8.7%	6.5%	0.0%	0.0%
Sandhills	62.5%	37.5%	12.5%	12.5%	50.0%	0.0%	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0%
Trillium	82.9%	42.9%	20.0%	22.9%	0.0%	0.0%	14.3%	5.7%	22.9%	22.9%	14.3%	2.9%	0.0%	5.7%
Vaya	75.6%	48.9%	24.4%	2.2%	0.0%	0.0%	15.6%	4.4%	11.1%	8.9%	8.9%	11.1%	0.0%	0.0%

Annual Client Counts and Service Rates by LME/MCO, SFY 21-22 (Continued)

TABLE 7: PARTICIPANTS IN ACH IN-REACH

LMEMCO	Total N	Any Core Service (ACT, CST, or TMS)	ACT	CST	TMS	AES	IPS	PSS	PSR	PsyDx/ Testing	E&M	Psycho-therapy	SUD	FBC	MCM
Alliance	**931**	132	83	46	5	2	10	29	99	189	169	194	5	2	5
Cardinal	**1,123**	107	84	19	4	0	0	49	76	137	109	251	2	0	8
Eastpointe	**369**	28	17	10	1	0	0	13	30	29	60	22	5	0	2
Partners	**849**	184	148	34	5	2	3	54	51	110	108	238	4	4	18
Sandhills	**512**	33	32	1	0	6	1	4	41	85	62	82	0	0	3
Trillium	**784**	41	18	11	12	1	2	20	62	176	164	149	3	3	14
Vaya	**962**	258	196	62	3	2	5	68	69	107	131	118	3	5	23
Statewide	**4,498**	**701**	**510**	**172**	**28**	**13**	**21**	**198**	**365**	**809**	**731**	**881**	**21**	**14**	**73**

FIGURE 11: PARTICIPANTS IN ACH IN-REACH

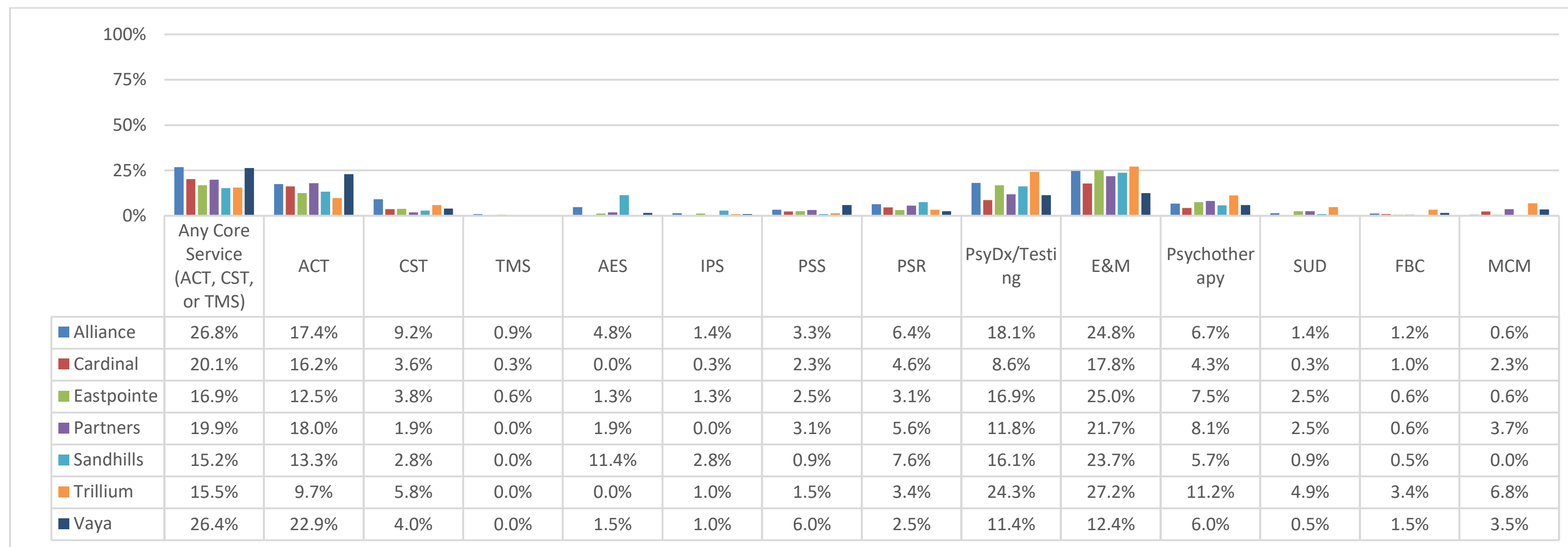


Annual Client Counts and Service Rates by LME/MCO, SFY 21-22 (Continued)

TABLE 8: PARTICIPANTS IN SPH IN-REACH

LMEMCO	Total N	Any Core Service (ACT, CST, or TMS)	ACT	CST	TMS	AES	IPS	PSS	PSR	PsyDx/ Testing	E&M	Psycho-therapy	SUD	FBC	MCM
Alliance	**642**	172	112	59	6	31	9	21	41	116	159	43	9	8	4
Cardinal	**303**	61	49	11	1	0	1	7	14	26	54	13	1	3	7
Eastpointe	**160**	27	20	6	1	2	2	4	5	27	40	12	4	1	1
Partners	**161**	32	29	3	0	3	0	5	9	19	35	13	4	1	6
Sandhills	**211**	32	28	6	0	24	6	2	16	34	50	12	2	1	0
Trillium	**206**	32	20	12	0	0	2	3	7	50	56	23	10	7	14
Vaya	**201**	53	46	8	0	3	2	12	5	23	25	12	1	3	7
Statewide	**1,608**	**364**	**264**	**100**	**8**	**63**	**20**	**49**	**84**	**285**	**392**	**124**	**31**	**24**	**37**

FIGURE 12: PARTICIPANTS IN SPH IN-REACH



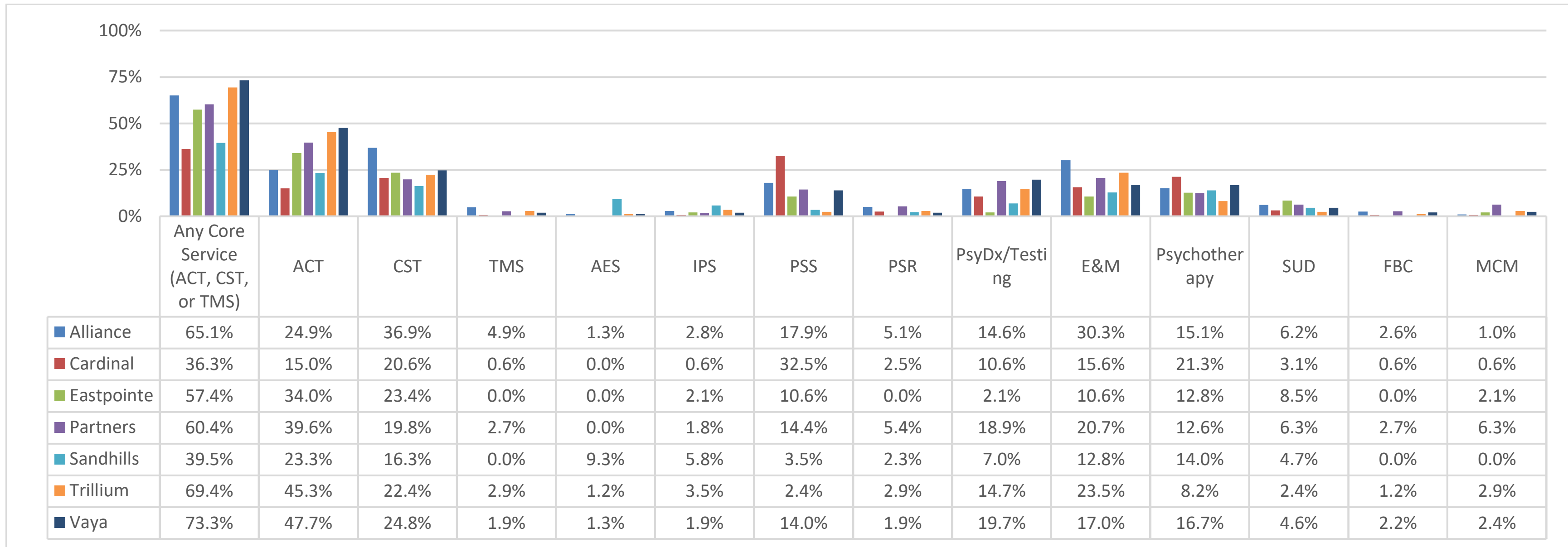
	Any Core Service (ACT, CST, or TMS)	ACT	CST	TMS	AES	IPS	PSS	PSR	PsyDx/Testing	E&M	Psychotherapy	SUD	FBC	MCM
Alliance	26.8%	17.4%	9.2%	0.9%	4.8%	1.4%	3.3%	6.4%	18.1%	24.8%	6.7%	1.4%	1.2%	0.6%
Cardinal	20.1%	16.2%	3.6%	0.3%	0.0%	0.3%	2.3%	4.6%	8.6%	17.8%	4.3%	0.3%	1.0%	2.3%
Eastpointe	16.9%	12.5%	3.8%	0.6%	1.3%	1.3%	2.5%	3.1%	16.9%	25.0%	7.5%	2.5%	0.6%	0.6%
Partners	19.9%	18.0%	1.9%	0.0%	1.9%	0.0%	3.1%	5.6%	11.8%	21.7%	8.1%	2.5%	0.6%	3.7%
Sandhills	15.2%	13.3%	2.8%	0.0%	11.4%	2.8%	0.9%	7.6%	16.1%	23.7%	5.7%	0.9%	0.5%	0.0%
Trillium	15.5%	9.7%	5.8%	0.0%	0.0%	1.0%	1.5%	3.4%	24.3%	27.2%	11.2%	4.9%	3.4%	6.8%
Vaya	26.4%	22.9%	4.0%	0.0%	1.5%	1.0%	6.0%	2.5%	11.4%	12.4%	6.0%	0.5%	1.5%	3.5%

Annual Client Counts and Service Rates by LME/MCO, SFY 21-22 (Continued)

TABLE 9: PARTICIPANTS IN DIVERSION STATUS

LME_MCO	Total N	Any Core Service (ACT, CST, or TMS)	ACT	CST	TMS	AES	IPS	PSS	PSR	PsyDx/Testing	E&M	Psychotherapy	SUD	FBC	MCM
Alliance	**390**	254	97	144	19	5	11	70	20	57	118	59	24	10	4
Cardinal	**160**	58	24	33	1	0	1	52	4	17	25	34	5	1	1
Eastpointe	**47**	27	16	11	0	0	1	5	0	1	5	6	4	0	1
Partners	**111**	67	44	22	3	0	2	16	6	21	23	14	7	3	7
Sandhills	**86**	34	20	14	0	8	5	3	2	6	11	12	4	0	0
Trillium	**170**	118	77	38	5	2	6	4	5	25	40	14	4	2	5
Vaya	**371**	272	177	92	7	5	7	52	7	73	63	62	17	8	9
Statewide	**1,223**	**792**	**436**	**336**	**35**	**20**	**32**	**179**	**41**	**194**	**272**	**189**	**61**	**24**	**27**

FIGURE 13: PARTICIPANTS IN DIVERSION STATUS



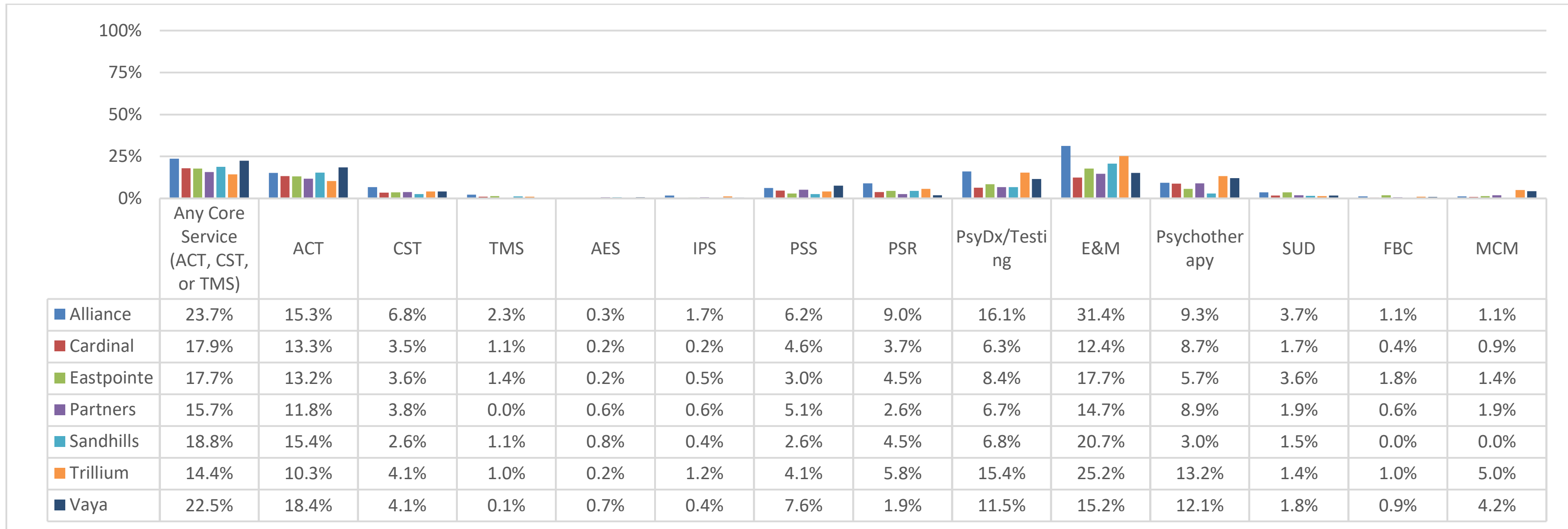
	Any Core Service (ACT, CST, or TMS)	ACT	CST	TMS	AES	IPS	PSS	PSR	PsyDx/Testing	E&M	Psychotherapy	SUD	FBC	MCM
Alliance	65.1%	24.9%	36.9%	4.9%	1.3%	2.8%	17.9%	5.1%	14.6%	30.3%	15.1%	6.2%	2.6%	1.0%
Cardinal	36.3%	15.0%	20.6%	0.6%	0.0%	0.6%	32.5%	2.5%	10.6%	15.6%	21.3%	3.1%	0.6%	0.6%
Eastpointe	57.4%	34.0%	23.4%	0.0%	0.0%	2.1%	10.6%	0.0%	2.1%	10.6%	12.8%	8.5%	0.0%	2.1%
Partners	60.4%	39.6%	19.8%	2.7%	0.0%	1.8%	14.4%	5.4%	18.9%	20.7%	12.6%	6.3%	2.7%	6.3%
Sandhills	39.5%	23.3%	16.3%	0.0%	9.3%	5.8%	3.5%	2.3%	7.0%	12.8%	14.0%	4.7%	0.0%	0.0%
Trillium	69.4%	45.3%	22.4%	2.9%	1.2%	3.5%	2.4%	2.9%	14.7%	23.5%	8.2%	2.4%	1.2%	2.9%
Vaya	73.3%	47.7%	24.8%	1.9%	1.3%	1.9%	14.0%	1.9%	19.7%	17.0%	16.7%	4.6%	2.2%	2.4%

Annual Client Counts and Service Rates by LME/MCO, SFY 21-22 (Continued)

TABLE 10: PARTICIPANTS HOUSED IN THE COMMUNITY WITHOUT A TCL HOUSING SLOT

LMEMCO	Total N	Any Core Service (ACT, CST, or TMS)	ACT	CST	TMS	AES	IPS	PSS	PSR	PsyDx/ Testing	E&M	Psycho-therapy	SUD	FBC	MCM
Alliance	**354**	84	54	24	8	1	6	22	32	57	111	33	13	4	4
Cardinal	**458**	82	61	16	5	1	1	21	17	29	57	40	8	2	4
Eastpointe	**440**	78	58	16	6	1	2	13	20	37	78	25	16	8	6
Partners	**313**	49	37	12	0	2	2	16	8	21	46	28	6	2	6
Sandhills	**266**	50	41	7	3	2	1	7	12	18	55	8	4	0	0
Trillium	**416**	60	43	17	4	1	5	17	24	64	105	55	6	4	21
Vaya	**684**	154	126	28	1	5	3	52	13	79	104	83	12	6	29
Statewide	**2,726**	**532**	**399**	**116**	**27**	**13**	**20**	**136**	**118**	**302**	**542**	**262**	**62**	**26**	**70**

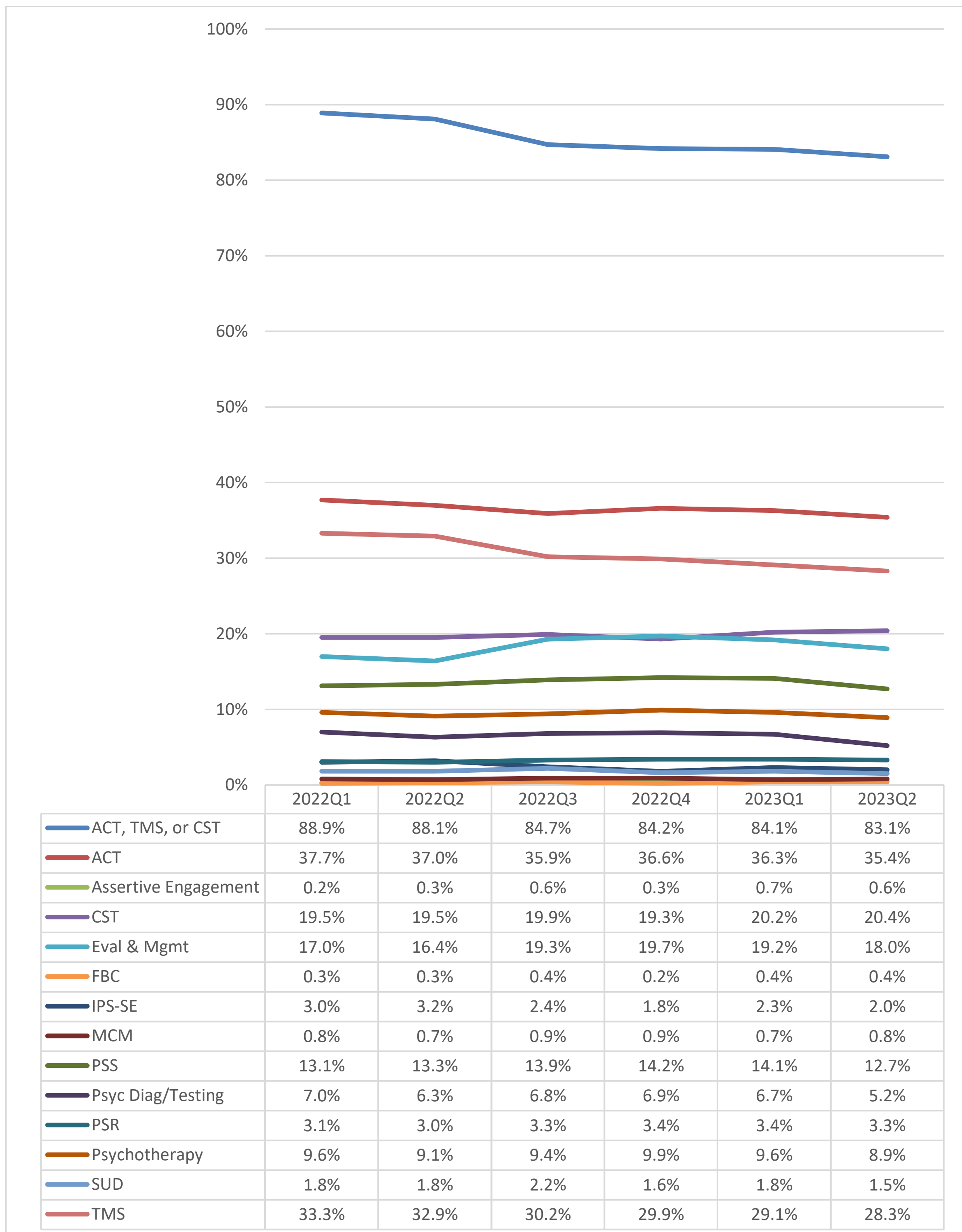
FIGURE 14: PARTICIPANTS HOUSED IN THE COMMUNITY WITHOUT A TCL HOUSING SLOT



	Any Core Service (ACT, CST, or TMS)	ACT	CST	TMS	AES	IPS	PSS	PSR	PsyDx/Testing	E&M	Psychotherapy	SUD	FBC	MCM
Alliance	23.7%	15.3%	6.8%	2.3%	0.3%	1.7%	6.2%	9.0%	16.1%	31.4%	9.3%	3.7%	1.1%	1.1%
Cardinal	17.9%	13.3%	3.5%	1.1%	0.2%	0.2%	4.6%	3.7%	6.3%	12.4%	8.7%	1.7%	0.4%	0.9%
Eastpointe	17.7%	13.2%	3.6%	1.4%	0.2%	0.5%	3.0%	4.5%	8.4%	17.7%	5.7%	3.6%	1.8%	1.4%
Partners	15.7%	11.8%	3.8%	0.0%	0.6%	0.6%	5.1%	2.6%	6.7%	14.7%	8.9%	1.9%	0.6%	1.9%
Sandhills	18.8%	15.4%	2.6%	1.1%	0.8%	0.4%	2.6%	4.5%	6.8%	20.7%	3.0%	1.5%	0.0%	0.0%
Trillium	14.4%	10.3%	4.1%	1.0%	0.2%	1.2%	4.1%	5.8%	15.4%	25.2%	13.2%	1.4%	1.0%	5.0%
Vaya	22.5%	18.4%	4.1%	0.1%	0.7%	0.4%	7.6%	1.9%	11.5%	15.2%	12.1%	1.8%	0.9%	4.2%

Quarterly Statewide Service Rates, SFY 21-22 Quarter 1 through SFY 22-23 Quarter 2

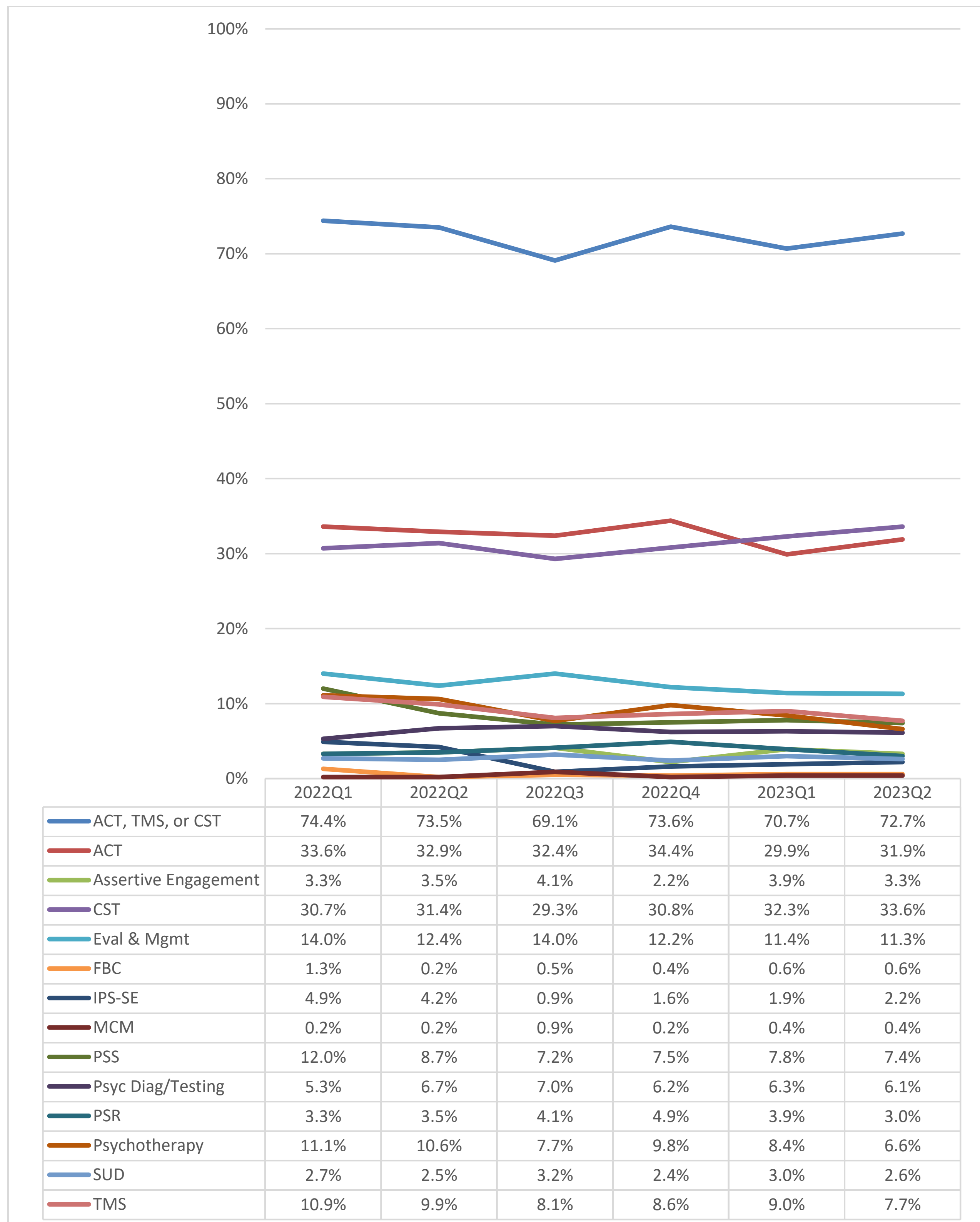
FIGURE 15: PARTICIPANTS IN TCL SUPPORTIVE HOUSING



	2022Q1	2022Q2	2022Q3	2022Q4	2023Q1	2023Q2
ACT, TMS, or CST	88.9%	88.1%	84.7%	84.2%	84.1%	83.1%
ACT	37.7%	37.0%	35.9%	36.6%	36.3%	35.4%
Assertive Engagement	0.2%	0.3%	0.6%	0.3%	0.7%	0.6%
CST	19.5%	19.5%	19.9%	19.3%	20.2%	20.4%
Eval & Mgmt	17.0%	16.4%	19.3%	19.7%	19.2%	18.0%
FBC	0.3%	0.3%	0.4%	0.2%	0.4%	0.4%
IPS-SE	3.0%	3.2%	2.4%	1.8%	2.3%	2.0%
MCM	0.8%	0.7%	0.9%	0.9%	0.7%	0.8%
PSS	13.1%	13.3%	13.9%	14.2%	14.1%	12.7%
Psyc Diag/Testing	7.0%	6.3%	6.8%	6.9%	6.7%	5.2%
PSR	3.1%	3.0%	3.3%	3.4%	3.4%	3.3%
Psychotherapy	9.6%	9.1%	9.4%	9.9%	9.6%	8.9%
SUD	1.8%	1.8%	2.2%	1.6%	1.8%	1.5%
TMS	33.3%	32.9%	30.2%	29.9%	29.1%	28.3%

Quarterly Statewide Service Rates, SFY 21-22 Quarter 1 through SFY 22-23 Quarter 2 (Continued)

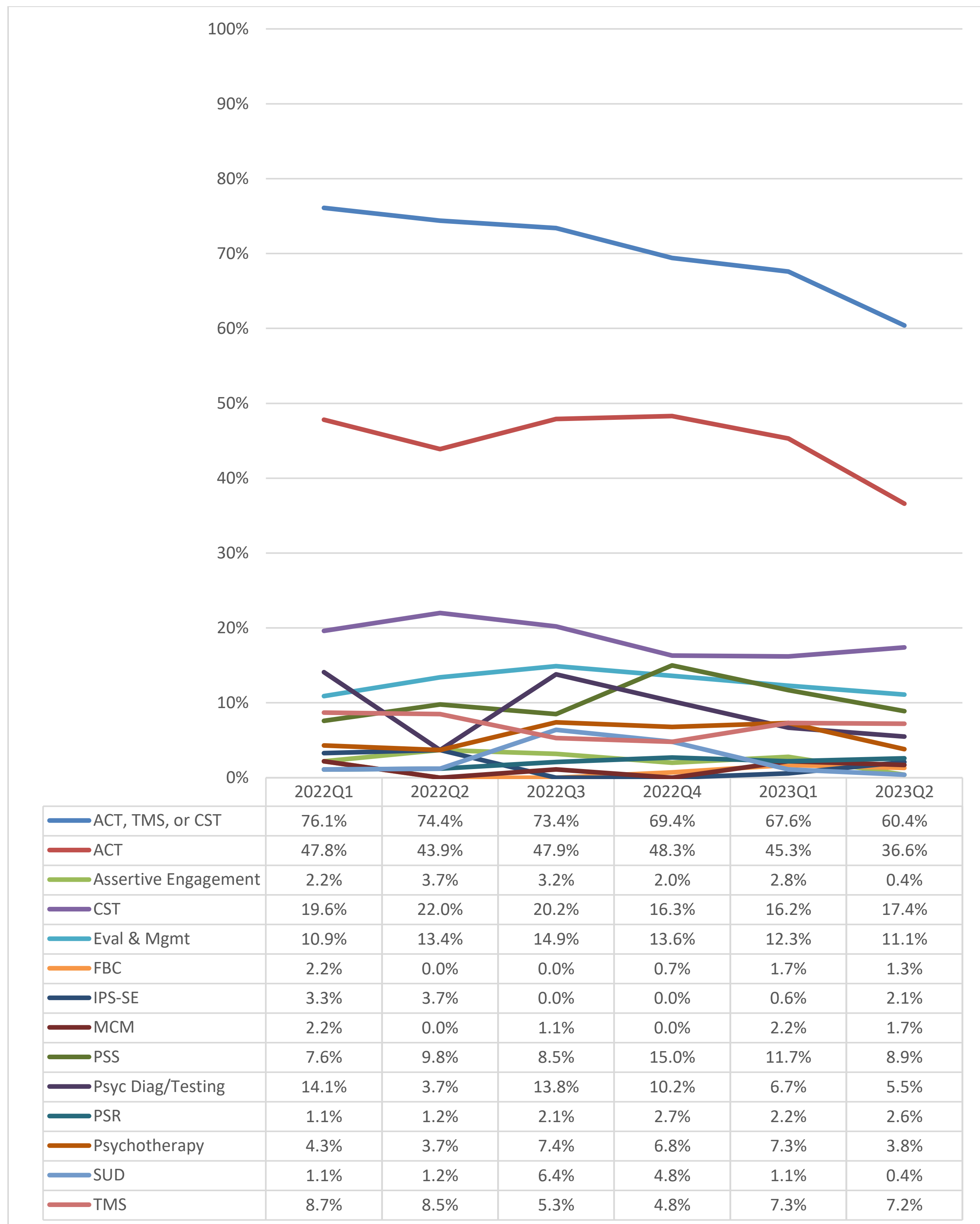
FIGURE 16: PARTICIPANTS IN TRANSITION PLANNING



	2022Q1	2022Q2	2022Q3	2022Q4	2023Q1	2023Q2
ACT, TMS, or CST	74.4%	73.5%	69.1%	73.6%	70.7%	72.7%
ACT	33.6%	32.9%	32.4%	34.4%	29.9%	31.9%
Assertive Engagement	3.3%	3.5%	4.1%	2.2%	3.9%	3.3%
CST	30.7%	31.4%	29.3%	30.8%	32.3%	33.6%
Eval & Mgmt	14.0%	12.4%	14.0%	12.2%	11.4%	11.3%
FBC	1.3%	0.2%	0.5%	0.4%	0.6%	0.6%
IPS-SE	4.9%	4.2%	0.9%	1.6%	1.9%	2.2%
MCM	0.2%	0.2%	0.9%	0.2%	0.4%	0.4%
PSS	12.0%	8.7%	7.2%	7.5%	7.8%	7.4%
Psyc Diag/Testing	5.3%	6.7%	7.0%	6.2%	6.3%	6.1%
PSR	3.3%	3.5%	4.1%	4.9%	3.9%	3.0%
Psychotherapy	11.1%	10.6%	7.7%	9.8%	8.4%	6.6%
SUD	2.7%	2.5%	3.2%	2.4%	3.0%	2.6%
TMS	10.9%	9.9%	8.1%	8.6%	9.0%	7.7%

Quarterly Statewide Service Rates, SFY 21-22 Quarter 1 through SFY 22-23 Quarter 2 (Continued)

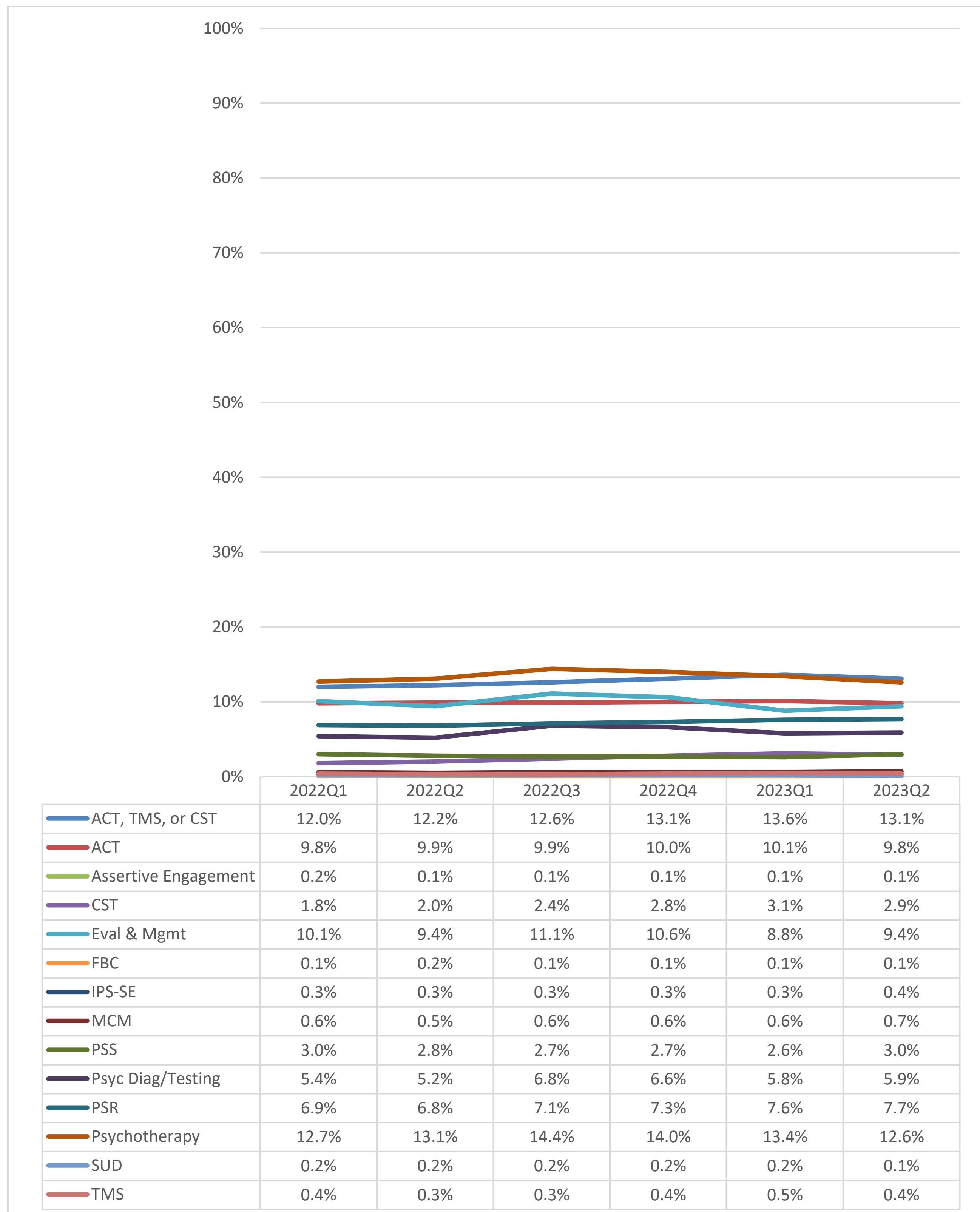
FIGURE 17: PARTICIPANTS IN REHOUSING PLANNING



	2022Q1	2022Q2	2022Q3	2022Q4	2023Q1	2023Q2
ACT, TMS, or CST	76.1%	74.4%	73.4%	69.4%	67.6%	60.4%
ACT	47.8%	43.9%	47.9%	48.3%	45.3%	36.6%
Assertive Engagement	2.2%	3.7%	3.2%	2.0%	2.8%	0.4%
CST	19.6%	22.0%	20.2%	16.3%	16.2%	17.4%
Eval & Mgmt	10.9%	13.4%	14.9%	13.6%	12.3%	11.1%
FBC	2.2%	0.0%	0.0%	0.7%	1.7%	1.3%
IPS-SE	3.3%	3.7%	0.0%	0.0%	0.6%	2.1%
MCM	2.2%	0.0%	1.1%	0.0%	2.2%	1.7%
PSS	7.6%	9.8%	8.5%	15.0%	11.7%	8.9%
Psyc Diag/Testing	14.1%	3.7%	13.8%	10.2%	6.7%	5.5%
PSR	1.1%	1.2%	2.1%	2.7%	2.2%	2.6%
Psychotherapy	4.3%	3.7%	7.4%	6.8%	7.3%	3.8%
SUD	1.1%	1.2%	6.4%	4.8%	1.1%	0.4%
TMS	8.7%	8.5%	5.3%	4.8%	7.3%	7.2%

Quarterly Statewide Service Rates, SFY 21-22 Quarter 1 through SFY 22-23 Quarter 2 (Continued)

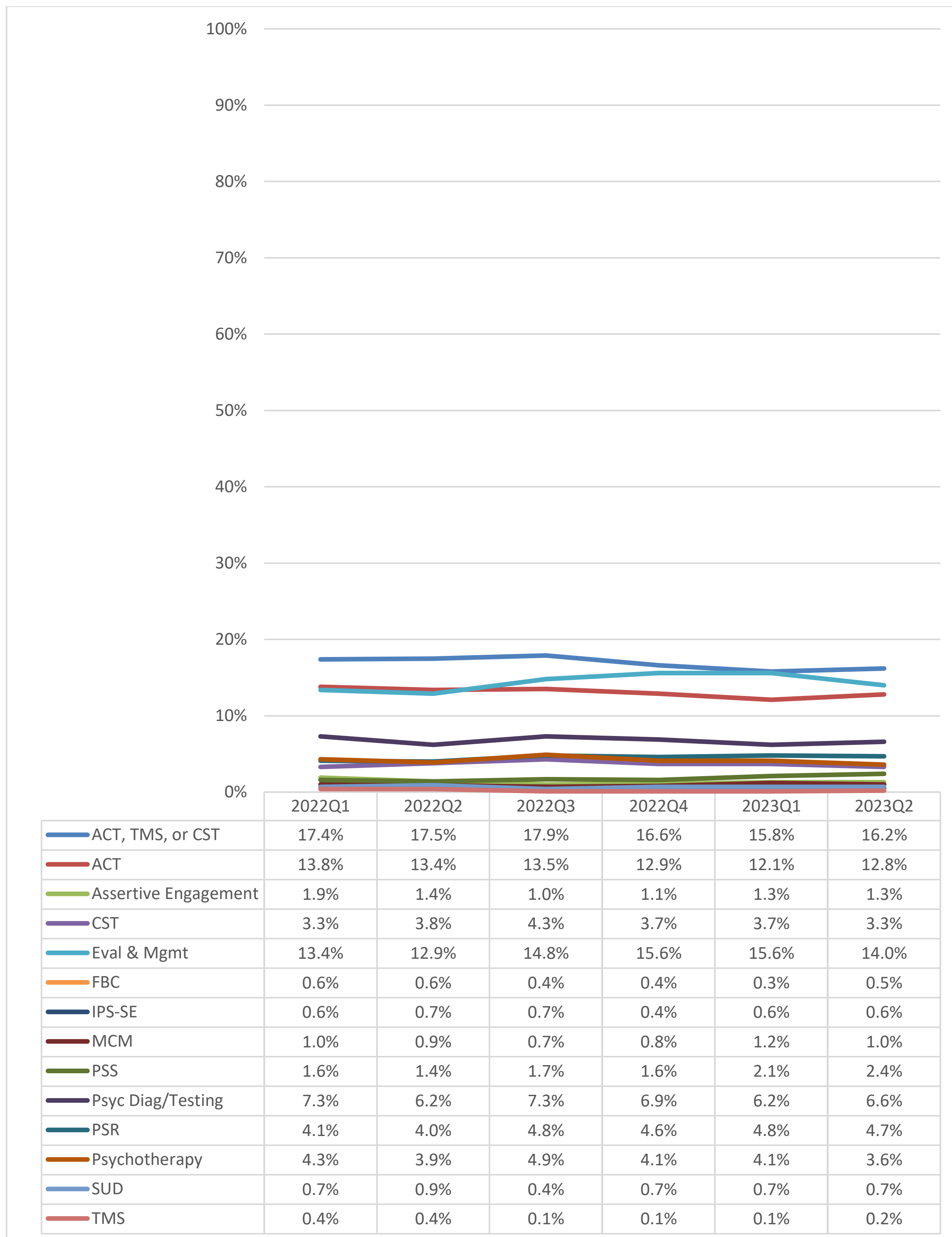
FIGURE 18: PARTICIPANTS IN ACH IN-REACH



	2022Q1	2022Q2	2022Q3	2022Q4	2023Q1	2023Q2
ACT, TMS, or CST	12.0%	12.2%	12.6%	13.1%	13.6%	13.1%
ACT	9.8%	9.9%	9.9%	10.0%	10.1%	9.8%
Assertive Engagement	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%
CST	1.8%	2.0%	2.4%	2.8%	3.1%	2.9%
Eval & Mgmt	10.1%	9.4%	11.1%	10.6%	8.8%	9.4%
FBC	0.1%	0.2%	0.1%	0.1%	0.1%	0.1%
IPS-SE	0.3%	0.3%	0.3%	0.3%	0.3%	0.4%
MCM	0.6%	0.5%	0.6%	0.6%	0.6%	0.7%
PSS	3.0%	2.8%	2.7%	2.7%	2.6%	3.0%
Psyc Diag/Testing	5.4%	5.2%	6.8%	6.6%	5.8%	5.9%
PSR	6.9%	6.8%	7.1%	7.3%	7.6%	7.7%
Psychotherapy	12.7%	13.1%	14.4%	14.0%	13.4%	12.6%
SUD	0.2%	0.2%	0.2%	0.2%	0.2%	0.1%
TMS	0.4%	0.3%	0.3%	0.4%	0.5%	0.4%

Quarterly Statewide Service Rates, SFY 21-22 Quarter 1 through SFY 22-23 Quarter 2 (Continued)

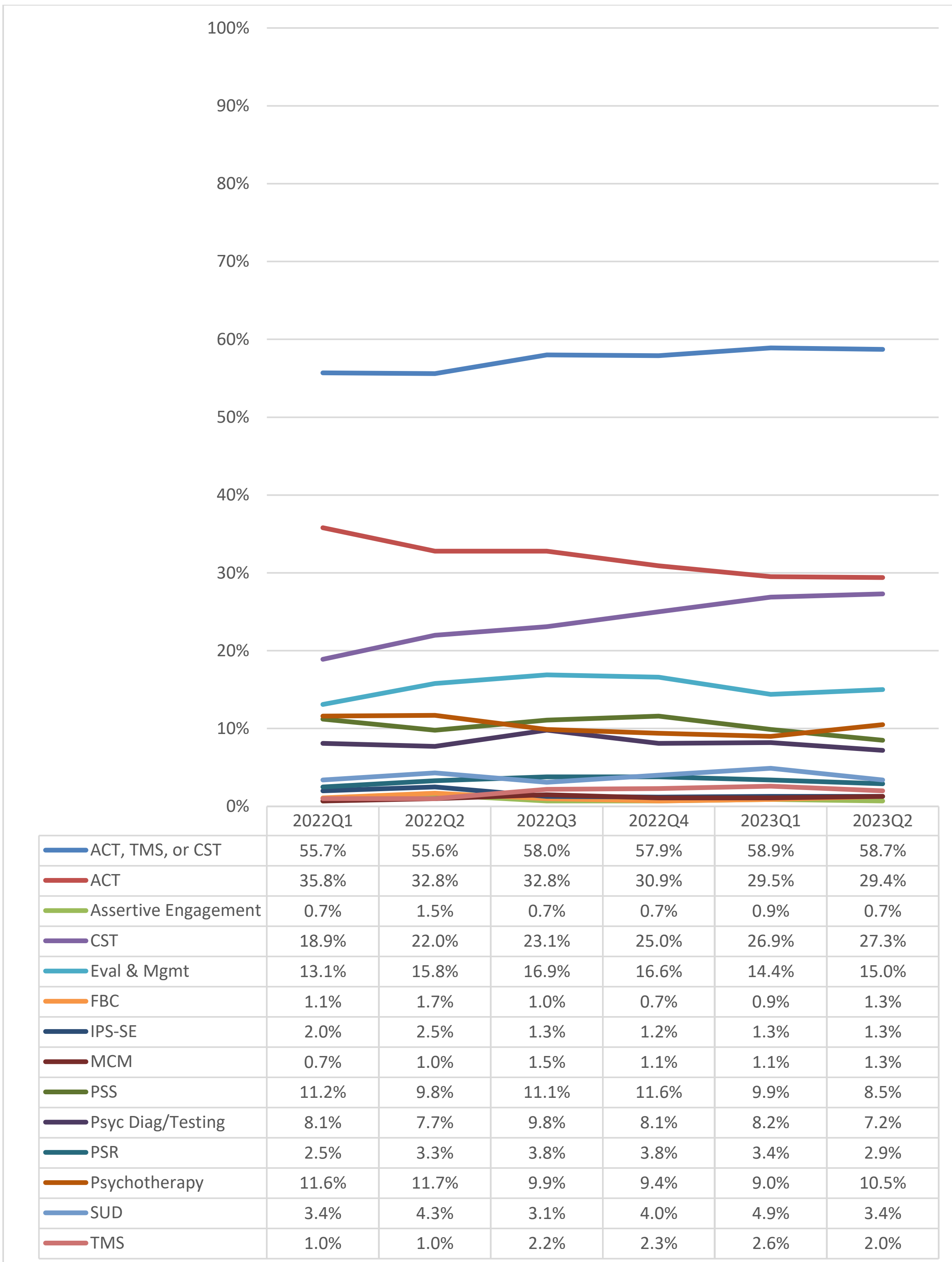
FIGURE 19: PARTICIPANTS IN SPH IN-REACH



	2022Q1	2022Q2	2022Q3	2022Q4	2023Q1	2023Q2
ACT, TMS, or CST	17.4%	17.5%	17.9%	16.6%	15.8%	16.2%
ACT	13.8%	13.4%	13.5%	12.9%	12.1%	12.8%
Assertive Engagement	1.9%	1.4%	1.0%	1.1%	1.3%	1.3%
CST	3.3%	3.8%	4.3%	3.7%	3.7%	3.3%
Eval & Mgmt	13.4%	12.9%	14.8%	15.6%	15.6%	14.0%
FBC	0.6%	0.6%	0.4%	0.4%	0.3%	0.5%
IPS-SE	0.6%	0.7%	0.7%	0.4%	0.6%	0.6%
MCM	1.0%	0.9%	0.7%	0.8%	1.2%	1.0%
PSS	1.6%	1.4%	1.7%	1.6%	2.1%	2.4%
Psyc Diag/Testing	7.3%	6.2%	7.3%	6.9%	6.2%	6.6%
PSR	4.1%	4.0%	4.8%	4.6%	4.8%	4.7%
Psychotherapy	4.3%	3.9%	4.9%	4.1%	4.1%	3.6%
SUD	0.7%	0.9%	0.4%	0.7%	0.7%	0.7%
TMS	0.4%	0.4%	0.1%	0.1%	0.1%	0.2%

Quarterly Statewide Service Rates, SFY 21-22 Quarter 1 through SFY 22-23 Quarter 2 (Continued)

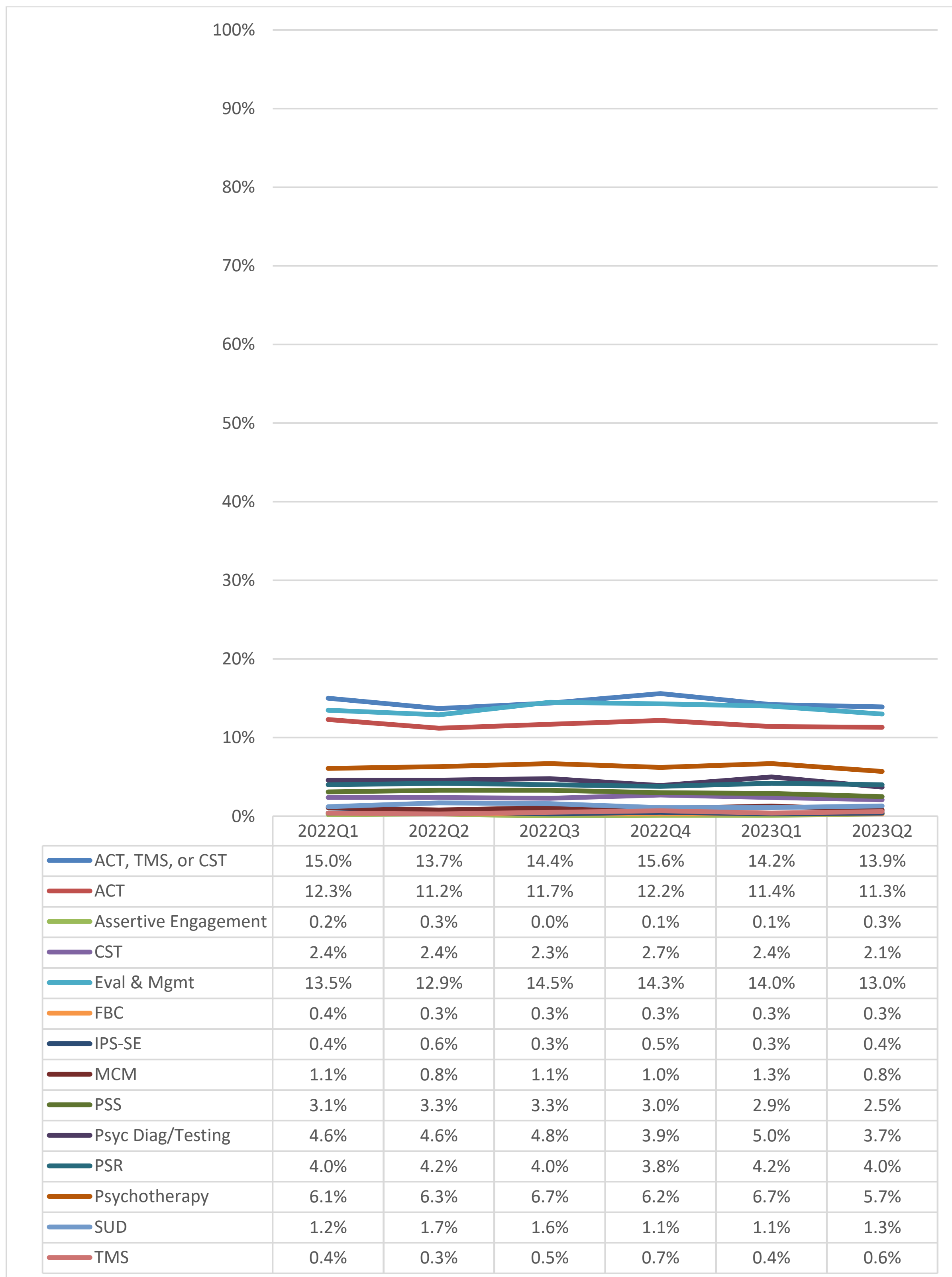
FIGURE 20: PARTICIPANTS IN DIVERSION STATUS



	2022Q1	2022Q2	2022Q3	2022Q4	2023Q1	2023Q2
ACT, TMS, or CST	55.7%	55.6%	58.0%	57.9%	58.9%	58.7%
ACT	35.8%	32.8%	32.8%	30.9%	29.5%	29.4%
Assertive Engagement	0.7%	1.5%	0.7%	0.7%	0.9%	0.7%
CST	18.9%	22.0%	23.1%	25.0%	26.9%	27.3%
Eval & Mgmt	13.1%	15.8%	16.9%	16.6%	14.4%	15.0%
FBC	1.1%	1.7%	1.0%	0.7%	0.9%	1.3%
IPS-SE	2.0%	2.5%	1.3%	1.2%	1.3%	1.3%
MCM	0.7%	1.0%	1.5%	1.1%	1.1%	1.3%
PSS	11.2%	9.8%	11.1%	11.6%	9.9%	8.5%
Psyc Diag/Testing	8.1%	7.7%	9.8%	8.1%	8.2%	7.2%
PSR	2.5%	3.3%	3.8%	3.8%	3.4%	2.9%
Psychotherapy	11.6%	11.7%	9.9%	9.4%	9.0%	10.5%
SUD	3.4%	4.3%	3.1%	4.0%	4.9%	3.4%
TMS	1.0%	1.0%	2.2%	2.3%	2.6%	2.0%

Quarterly Statewide Service Rates, SFY 21-22 Quarter 1 through SFY 22-23 Quarter 2 (Continued)

FIGURE 21: PARTICIPANTS HOUSED IN THE COMMUNITY WITHOUT A TCL HOUSING SLOT



	2022Q1	2022Q2	2022Q3	2022Q4	2023Q1	2023Q2
ACT, TMS, or CST	15.0%	13.7%	14.4%	15.6%	14.2%	13.9%
ACT	12.3%	11.2%	11.7%	12.2%	11.4%	11.3%
Assertive Engagement	0.2%	0.3%	0.0%	0.1%	0.1%	0.3%
CST	2.4%	2.4%	2.3%	2.7%	2.4%	2.1%
Eval & Mgmt	13.5%	12.9%	14.5%	14.3%	14.0%	13.0%
FBC	0.4%	0.3%	0.3%	0.3%	0.3%	0.3%
IPS-SE	0.4%	0.6%	0.3%	0.5%	0.3%	0.4%
MCM	1.1%	0.8%	1.1%	1.0%	1.3%	0.8%
PSS	3.1%	3.3%	3.3%	3.0%	2.9%	2.5%
Psyc Diag/Testing	4.6%	4.6%	4.8%	3.9%	5.0%	3.7%
PSR	4.0%	4.2%	4.0%	3.8%	4.2%	4.0%
Psychotherapy	6.1%	6.3%	6.7%	6.2%	6.7%	5.7%
SUD	1.2%	1.7%	1.6%	1.1%	1.1%	1.3%
TMS	0.4%	0.3%	0.5%	0.7%	0.4%	0.6%

6. IN-REACH, INFORMED DECISION-MAKING, AND ADULT CARE HOMES

6.1. SUMMARY

In SFY 22-23, NCDHHS continued to work with the 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 transitions 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, NCDHHS continued its efforts in 2023 to reduce 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 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. 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, 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 Community Transitions and Integration Team has continued to focus on continuous quality improvement activities through targeted monitoring, on identification of performance improvement activities, and on development of TCL-specific trainings and quality reviews. This led 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. In the winter of 2023, the Office of the Secretary's TCL Team expanded by adding two additional temporary staff, a clinical psychologist to serve on the In-Reach clinical review team (CRT) and a data assistant to assist with reduction in the In-Reach list.

6.2. ACCOMPLISHMENTS DURING STATE FISCAL YEAR 2022–2023

- **Reimplementation of TCL Informed Decision-Making Tool:** In early December 2022, there was a temporary hold on utilization of the Informed Decision-Making (IDM) tool. In early 2023, NCDHHS implemented a four-phase project to implement new strategies for frequent engagement during In-Reach and to re-educate the LME/MCOs on the purpose of the IDM tool and its application to document individuals' informed choice about where they want to live, work, play, and worship. The four-phase project began in January 2023 and ended in June 2023. Over a duration of six months NCDHHS developed and released a Joint communication bulletin (JCB) #442 to clarify best practices and procedures when performing In-Reach and transition planning in ACHs; facilitated a series of structured LME/MCO peer to peer IDM trainings for In-Reach Specialists (IRS); presented at the Spring 2023 IR Collaborative Professional Development Conference; and conducted group and

individual role play sessions with the LME/MCOs. There were 163 attendees across four IDM peer-led sessions. The IDM tool was resumed on March 1, 2023. By the end of SFY 22-23, Quarter 4, NCDHHS had reviewed 57 IDM tools. The TCL In-Reach CRT was developed in the winter of 2023 to implement a streamlined IDM review process for approval of informed choice. The approved IDM review process was vetted with DOJ and the independent reviewer in June 2023 to approve informed choice. The IDM review process includes frequent individual/guardian in-person engagement during in-reach to educate about PSH and provide opportunities for individuals to participate in community visits; quarterly reassessments to identify barriers to transitioning and time to implement individualized strategies to address the barriers; documentation of the transition decision on the IDM tool; and the review by the TCL In-Reach CRT to validate informed choice.

- **IDM-Online learning module:** In SFY 22-23, NCDHHS continued to utilize the online Informed Decision-Making (IDM) learning module to provide ongoing technical assistance to LME/MCOs and other stakeholders. By the end of SFY 21-22 – Quarter 4, 117 individuals had completed the online learning module. By the end of SFY 22-23-Quarter 4, 259 individuals had completed the online learning module. This was an increase of 142 participants in one year.
- **Joint Communication Bulletin #J415 - Clarification of TCL in-reach function:** During SFY 22-23, NCDHHS continued to monitor the process of engagement, i.e., how an In-Reach Specialist forms a relationship with a person before initiating a discussion of community living. As a result of weekly monitoring and technical assistance, face-to-face/in-person contacts increased. By the end of SFY 22-23 – Quarter 4, 57% of contacts with individuals and/or guardians were face-to-face/in person contacts. This showed a 28% increase from SFY 22-23 Q3 to SFY 22-23 Q4.
- **Joint Communication Bulletin #J442 - Clarification of TCL Discharge and transition process from adult care homes:** The joint communication bulletin (JCB) for Discharge & Transition Process from ACHs was developed and released on 2/3/23. This bulletin outlines expectations of the Discharge and Transition process for Transitions to Community Living (TCL). These procedures are designed to assist with transitioning individuals from ACHs into permanent supportive housing in compliance with the requirements of the TCL Settlement Agreement with the US Department of Justice (DOJ) dated August 23, 2012 (Settlement Agreement).
- **In-Reach Collaborative Professional Development Conference 2023:** The 2023 NC In-Reach Professional Development Conference took place in March 2023 in Morrisville, NC and was the first in-person conference since COVID-19.
  - All LME/MCOs participated in the planning and implementation with approximately 100 people in attendance including In-Reach Specialists (IRS), In-Reach Supervisors, presenters, and NCDHHS staff. The theme of the conference was Emerging Together: Resilience, Recovery, and Renewal. The topics during the two-day conference included the value of Peer Support Specialist (PSS) recovery and experience, Peer Support Certification, Harm-Reduction, and IDM. Also, there were opportunities for small break-out sessions such as Yoga, National Alliance on Mental Illness (NAMI), Boundaries, and Compassion Fatigue.
  - The conference provided an effective platform for IRSs to network with other peers as well as learn valuable information for their roles. Feedback from the surveys was very positive with many stating they enjoyed meeting in-person again, collaborating and networking with other peers, and learning new information. The conference planning committee had a post-conference meeting to discuss outcomes, feedback, and begin the planning of the 2024 In-Reach Collaborative Professional Development Conference.
- **Collaboration with adult mental health team and UNC Institute for Best Practices:** During SFY 22-23, the NCDHHS Community Transitions and Integration (CTI) team collaborated with the Adult

Mental Health (AMH) team to coordinate ride-along/shadowing visits with University of North Carolina (UNC) Institute for Best Practices staff, In-Reach Specialists, and individuals in In-Reach.

- The goal of the ride-along with UNC staff was to help In-Reach staff better understand and strengthen efforts and connections to supportive employment services. The purpose of each shadowing visit was for In-Reach staff to observe the UNC staff engaging with an individual as well as UNC staff to observe In-Reach Staff engage with individuals.
- Four LME/MCOs participated in the ride-along which included Alliance, Partners, Sandhills, and Trillium. Ten IRSs participated and 24 individuals visited. Information provided during visits included rapport building and education on PSH, services/supports, community resources, and Individual Placement and Support-Supported Employment (IPS-SE). Motivational Interviewing (MI) techniques were implemented during the rapport building sessions in addition to discussing what a referral to IPS looks like and the process.
- There was positive feedback from the participating LME/MCOs and UNC staff. UNC staff provided feedback after each visit and during post-meeting calls. The feedback included observation of great rapport building/engagement skills, demonstrating the MI spirit, and connecting with individuals, and included discussion on the challenges that In Reach staff encounter with ACHs and individuals. In addition, feedback from the In Reach Staff included enjoying the opportunity to learn from UNC staff and receiving feedback about their own skills. All participating In-Reach Staff voiced that the ride-alongs were very helpful and appreciated the experience and support that was provided.

6.3. TCL TRAININGS AND RESOURCES

During SFY 22-23, the NCDHHS CTI Team conducted NCDHHS In-Reach trainings for new hires and current staff for three LME/MCOs, In-Reach Extender trainings for two LME/MCOs and updated the In-Reach Workflow document for the TCL Manual revision.

The NCDHHS In-Reach training for new hires and current staff included In-Reach/Outreach Functions, Exploring Engagement, Informed Decision-Making, and TCL Transition Planning Best Practices for ACHs.

- In-Reach/Outreach Functions covered a review of priority populations (1-5); defined In-Reach function; and reviewed expectations of In-Reach function, In-Reach reminders, Outreach vs In-Reach Functions, and Outreach reminders.
- Exploring Engagement covered a review of what engagement is; highlighted key components of engagement; getting to know the person; and challenges to engagement.
- Informed Decision-Making covered a review of the In-Reach workflow; defined informed decision-making; highlighted the role of engagement when using informed decision-making; explored informed-decision making within transitions to community living; and reviewed the TCL Informed decision-making tool.
- 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).
- In-Reach Extender training was provided to In-Reach Extenders with Sandhills and Alliance LME/MCOs. This training included reviewing the definition of In-Reach; role and expectations of In-Reach; In-Reach reminders; engagement and In-Reach; and the review of the In-Reach Workflow and In-Reach/TCL and IDM tools.
- In Reach (IR) Workflow update –The IR Workflow 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. The update included a text box stating: ***REMINDER:** If Individual/guardian is unsure about PSH continue In-Reach and address why individual/guardian is unsure until they make an informed decision of “yes” or “no”.

6.4. 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 SFY 22-23, 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. NCDHHS has taken additional steps to eliminate discharge and transition barriers. In May 2023, NCDHHS revised ACH Barriers & Technical Assistance process. When TCL staff identify barriers that prevent them from performing In-Reach and transition functions in ACHs, NCDHHS provides technical assistance that includes strategies to address barriers at the LME/MCO level first before referring them to the State Barriers Committee. All LME/MCOs have local barrier committees (LBCs) that In-Reach staff have been educated about. One of the common barriers continues to be 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 prompt methods to verify guardianship for individuals that are on the In-Reach list; engagement strategies for 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.

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. NCDHHS released Joint Communications Bulletin #J 422 on February 3, 2023, to clarify the TCL Discharge & Transition process in ACHs. It outlined what the discharge and transition process is, how to initiate in-reach in ACHs; what frequent engagement is; information discussed during a transition meeting; the composition of the transition team and who is required to lead and facilitate those meetings; how to complete the IR/TCL tool so all vital information provided by individuals’ during In-Reach is incorporated into the person-centered plan; and how to report emergency situations observed in ACHs to the appropriate state agency. NCDHHS’ ongoing technical assistance has reinforced that In-Reach staff must initiate in-reach with individuals and/or guardians before arriving at the ACH and utilize the TCL introductory letters provided by DHHS; engage with ACH staff to acquire guardianship and medical information; or contact the LBC to address barriers timely when unable to communicate with guardians. The 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 BEFORE they make an informed choice.

Discharge and transition planning begins 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 reassessed on a quarterly basis, or more frequently, upon request. The IDM tool provides clear evidence of documented barriers to transition, and the strategies that have been taken to address these. NCDHHS also released Joint Communications Bulletin #J422 on February 3, 2023, to clarify the TCL discharge and transition process in

ACHs. Transition Coordinators are the lead contact for ACH transitions and make attempts to mitigate or remove barriers. 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.

7. PRE-ADMISSION SCREENING AND DIVERSION

7.1. SUMMARY

Successful community living requires intentional, informed support on the part of the LME/MCO, providers, 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.

7.2. 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 the 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 Pre-Admission Screening and Diversion training in April/May 2023 for Population Category 5[33] covering informed decision-making as part of the process.

7.3. TECHNICAL ASSISTANCE AND MONITORING

Monitoring has allowed the Department to continue addressing training needs and to identify gaps and barriers regarding Community Integration Planning, Informed Decision-Making, Timely Diversions, Referral

[33] 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).

Screening Verification Process (RSVP) time frames, and data errors. In addition, technical assistance has been provided, for both RSVP and Transitions to Community Living Database (TCLD) modifications, to address questions and provide guidance when errors are discovered.

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

7.3.1. 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 bi-monthly, monthly, and quarterly monitoring of the RSVP and Diversion data and processes. Additionally, the State conducted Pre-Admission Screening and Diversion Training in April and May 2023 with all LME/MCOs. This training provided LME/MCOs with additional technical assistance, designed to meet substantial compliance with Section III. E and F of the settlement agreement, Discharge and Transition process and Pre-Admission Screening and Diversion. The State also created an updated RSVP webinar in November 2022. Additionally, RSVP resources Frequently Asked Questions (FAQ) and Fact Sheet were also updated in November 2022 and January 2023 to reflect changes in the referral submission system and clarify diversion process for referral sources.

7.3.2. LME/MCO RSVP TO DIVERSION WORKFLOW

On an as needed basis, 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. Challenges in SFY 20-21 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. After the LME/MCOs made changes to their RSVP to Diversion workflow in SFY 21-22, diversion screening timeframes improved to an average of 17.39 days from the referral submission date to TCL determination date. In SFY 22-23, RSVP timeframes have continued to remain under 30 days with an average of 18.29 days from the referral submission date to TCL determination date. Additionally, some LME/MCOs have hired diversion and outreach-specific staff while other LME/MCOs have restructured their internal workflows to further efforts of decreasing processing timeframes.

7.3.3. 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. In February 2023, NCDHHS requested and received a community education plan from each LME/MCO. The plans included steps for educating community referral sources such as community hospitals and providers on TCL criteria for referring individuals, the referral process including documentation needed, and guidance on submitting referrals. As a result of 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[34], "diversions from institutions" increased from the prior year. This increase was primarily due to data reconciliation and LME/MCOs refocusing on diversion post COVID-19 restrictions being lifted for individuals. 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 increased from 18.5% in SFY 21-22 to 27.7% in SFY 22-23. The data continued to demonstrate that RSVP is effective in diverting individuals from restrictive settings. As a result, for SFY 22-23, TCL has exceeded the settlement agreement requirement of 1,000 individuals housed with a TCL housing slot for Population Categories 4 and 5. Final SFY 22-23 data for Population Categories 4 and 5 shows that 2,009 individuals were housed with a TCL housing slot.

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

The Department began monthly reviews in January 2023 of 100% of diversion referrals deemed "TCL eligible and Not Diverted from Adult Care Homes (ACHs)." NCDHHS sent findings, barriers, and concerns to each LME/MCO following each monthly review. The Department requested that its local barriers committee identify action steps that would lead to the resolution of barriers/concerns.

Department staff also began monthly quality reviews in January 2023 of 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[35] were individually addressed with each LME/MCO as needed.

On March 7, 2023, the state presented on informed decision-making at the 2023 In-Reach Professional Development Conference. The state engaged in role play scenarios to display effective engagement techniques for individuals with mental illness and best practice for communicating with guardians that are hesitant about utilizing TCL housing slots for PSH. There were approximately 100 people in attendance including In-Reach Specialists (IRS), In-Reach Supervisors, presenters, and NCDHHS staff. During SFY 22-23, state staff reviewed and followed up on all eight Population Category 5 IDM tools submitted. Informed choice for individuals diverted from an ACH admission is also documented in the referral screening system or TCLD where screeners record pre-admission conversations with individuals and evidence of informed choice before they choose to enter an ACH.

The State held a Pre-Admission Screening and Diversion Training for all LME/MCOs in April and May 2023. LME/MCO staff were provided information on use of the 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.

7.3.5. TIMELY DIVERSION OUTREACH

[34] 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).

[35] 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."

The Department began monthly Timely Diversion Outreach reviews in August 2023 to review 100% of individuals with an open diversion attempt to ensure individuals receive the appropriate frequency of outreach and maintain housing in the least restrictive environment. In February 2023, the Department increased the frequency of the review to bi-monthly to provide more immediate technical assistance to LME/MCOs for individuals screened as TCL eligible. The frequency of diversion outreach contacts has significantly improved. In July 2022, out of the 41 individuals reviewed 35 (85%) showed evidence of a diversion outreach contact being made within seven days of the TCL determination and 17 (41%) received at least one face-to-face contact within the seven-day period. In June 2023, out of the 27 individuals reviewed 25 (93%) showed evidence of a diversion outreach contact being made within seven days of the TCL determination and 16 (59%) received at least one face-to-face contact within that seven-day period. In addition, face-to-face diversion contacts have improved which resulted in an increase in the number of individuals that have said "yes" to permanent supportive housing. Further monitoring included the utilization of bridge housing for individuals being diverted from ACHs who were in immediate need of housing while they initiated or reengaged with service providers, before transitioning into PSH.

7.3.6. BRIDGE HOUSING UTILIZATION

The Department began quarterly monitoring of bridge housing utilization in March 2023. In April 2022, a modification was made to the TCL database to include a temporary housing type, Bridge Housing. This data point allowed NCDHHS to establish a baseline of bridge housing utilization and data for subsequent quarterly monitoring for all population categories. Monitoring included the review of TCL individuals in all population categories with a temporary location type of bridge housing at the time of the review. This data also included individuals previously housed in TCL PSH. At baseline in February 2023, there were 115 individuals (52 previously housed) utilizing bridge housing. Of the 115 individuals that utilized bridge housing, 70 individuals (61%) were population Category 5. In May 2023, there was a decrease in utilization to 88 (46 previously housed) individuals. Of the 88 total individuals that utilized bridge housing, 46 (52%) individuals were population Category 5.

7.4. DATA

The Department focused on data integrity and accuracy of the TCL database during SFY 22-23. This work included removal from the database of deceased individuals. In addition, 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.

TABLE 11: LME/MCO PRE-ADMISSION SCREENING CUMULATIVE TOTALS JULY 1, 2022 - JUNE 30, 2023[36]

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	1,627	68	197	0	1,362
Eastpointe	561	46	5	0	510
Partners Behavioral Health Management	1,384	123	9	3	1,249
Sandhills Center	1,013	61	42	11	899
Trillium	1,183	66	61	2	1,054
Vaya Health	1,557	148	30	0	1,379
Total	**7,325**	**512**	**344**	**16**	**6,453**

TABLE 12: LME/MCO PRE-ADMISSION SCREENING CUMULATIVE TOTALS NOVEMBER 1, 2018 - JUNE 30, 2023[37]

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	5,953	1,365	1,153	0	3,435
Cardinal Innovations (no longer active)	4,046	0	0	0	4,046
Eastpointe	2,303	325	196	0	1,782
Partners Behavioral Health Management	4,765	657	671	3	3,434
Sandhills Center	3,198	518	196	11	2,473
Trillium	5,217	707	609	2	3,899
Vaya Health	5,799	1,490	834	0	3,475
Total	**31,281**	**5,062**	**3,659**	**16**	**22,544**

[36] Data source: Pre-admission Screening and Diversion Monthly Report - June 2023. Data for the report was pulled on August 17, 2023. 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.

[37] Data source: Pre-admission Screening and Diversion Monthly Report - June 2023.

TABLE 13: LME/MCO DIVERSION TOTALS JULY 1, 2022 - JUNE 30, 2023[38]

LME/MCO	Diverted (with and without slots)	Not Diverted	In Process	Withdrawn/ Removed	Total Diversion Attempts
Alliance Behavioral Healthcare	4	14	42	5	65
Eastpointe	27	1	18	0	46
Partners Behavioral Health Management	39	18	69	2	128
Sandhills Center	14	3	38	5	60
Trillium	20	9	37	0	66
Vaya Health	36	23	70	12	141
Total	**140**	**68**	**274**	**24**	**506**

TABLE 14: LME/MCO DIVERSION CUMULATIVE TOTALS JANUARY 1, 2013 - JUNE 30, 2023[39]

LME/MCO	Diverted (with and without slots)	Not Diverted	In Process	Withdrawn/ Removed	Total Diversion Attempts
Alliance Behavioral Healthcare	1,484	1,689	156	489	3,818
Eastpointe	428	737	19	71	1,255
Partners Behavioral Health Management	709	1,817	110	195	2,831
Sandhills Center	487	1,023	52	100	1,662
Trillium	749	1,389	65	198	2,401
Vaya Health	1,159	2,053	99	416	3,727
Total	**5,016**	**8,708**	**501**	**1469**	**15,694**

[38] Data source: Pre-admission Screening and Diversion Monthly Report - June 2023. 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.

[39] Data source: Pre-admission Screening and Diversion Monthly Report - June 2023. 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.

8. STATE PSYCHIATRIC HOSPITALS

DHHS continued to work with the Division of State Operated Healthcare Facilities (DSOHF) and the LME/MCOs to improve the quantity and quality of transitions from the three SPHs to the community through TCL. To align new SPH and LME/MCO staff, NCDHHS performed onsite Population 4 TCL transition training at all three SPHs. After this training, NCDHHS developed an SPH TCL Transition Team Checklist. NCDHHS then asked to be invited by the LME/MCOs to virtually attend SPH TCL transition teams. The checklist was directly built upon the TCL Settlement Agreement discharge and transition expectations as well as improvements suggested by previous DOJ reviews. Each checklist included summary contacts and were forwarded to TCL leadership for improvements to their SPH transition team staff.

Connected to the training and monitoring of TCL transitions was the increase in assertive engagement with TCL members in SPHs. Other initial promising improvements as checklists were aggregated was improvement in LME/MCO staff leadership in transition planning, and broader onsite and real-time virtual participation in transition teams by member, social worker, and assertive engagement provider. More complete aggregation of monitoring data will inform the next set of SPH staff and LME/MCO training on TCL transition.

The need for broader system improvement to overcome barriers to efficient in-reach, discharge, and transition led to the development of Barriers and Solutions Committee meetings at all three SPHs. These semi-monthly 90-minute meetings involve LME/MCO TCL managers of TCL staff working in SPHs, SPH social work supervisors and directors, DSOHF managers, and NCDHHS staff. Standing agenda items included discussing and solving barriers in: in-reach, transition, guardianship, assertive engagement and pre-discharge community visitation. Unresolved barriers were either addressed with smaller ad hoc leadership groups or elevated to the State Barriers Committee. Out of this process, DSOHF leadership has diligently worked on policies and procedures to improve transition efficiency and continues to work on standardizing these efficiencies across the three SPHs.

9. RN/OT EVALUATOR TEAM (COMPLEX CARE MANAGEMENT)

Due to the success of the Complex Care Management pilot program, NCDHHS funded a near doubling of registered nurses (RNs) and occupational therapists (OTs) embedded in all LME/MCO TCL teams, rebranding this formerly piloted model the ongoing RN and OT Evaluator Team. Instead of selected counties, once fully staffed this team can serve across all an LME/MCO's catchment for transitions out of Adult Care Homes as well as provide occasional complex case consultation for individuals discharging from state psychiatric hospitals. The RN and OT Evaluator Teams assess the physical health and functional skills needs of the TCL participants in the ACH before they transition into the community.

The assessments consist of face-to-face interviews, physical health screenings, occupational assessment tools, records review, and collateral reports. The RN and OT also perform a pre-tenancy walkthrough of the proposed community housing to review accessibility and accommodations. Their assessment recommendations are expected to be woven into the individual's person-centered plan. In addition, the RN and OT present pre-tenancy consultation, medical selfcare, and functional skill practice recommendations to the individual and the behavioral health provider. The RN and OT Evaluator Team also works with transition team members to help the individual acquire medically necessary physical health and specialty care providers, and ensure services are in place the day of community transition. Post-transition, this team would periodically review, monitor, and ensure service providers maintain the frequency, duration, and intensity of care agreed upon in the care plan. RN and OT Evaluator Team members would also provide post-transition consultation of selfcare and functional skill recommendations to augment the behavioral health provider's tenancy support and psychosocial rehabilitation skill work already within the service definition. More than 400 individuals receiving TCL in-reach or transitions have been served by the LME/MCOS's RN and OT Evaluator Teams.

To provide the needed and ongoing training and technical assistance of these expanded RN and OT Evaluator Teams, the Department expanded its contract with the UNC Center for Excellence in Community Mental Health. This year an RN was hired to join the Ph. D.-level OT by UNC. They perform bi-annual training for all LME/MCO teams, quarterly collaboratives for LME/MCO and behavioral health providers, and onsite LME/MCOS-specific technical assistance. The UNC team also worked closely with the Department to develop measurement of the RN and OT Evaluation Team outcomes and to improve its effectiveness in increasing the community tenure of individuals transitioning to the community through TCL. Improved community tenure through this intervention in TCL could lead to the application of this novel managed care model to other Olmstead populations. Improvements already in process are the greater inclusion of team recommendations into the individual's person-centered plan, and the increased behavioral health consultation and engagement in their recommended tenancy support and psychosocial rehabilitation ideas into the daily provision of services to the person.

10. QUALITY MANAGEMENT

10.1. SUMMARY

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 the 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.

System data are used to monitor and evaluate progress toward TCL goals, program quality and effectiveness, and impacts of program changes and performance improvement activities. The purpose of the QAPI system is to ensure that all 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 hospital contacts and institutionalization.

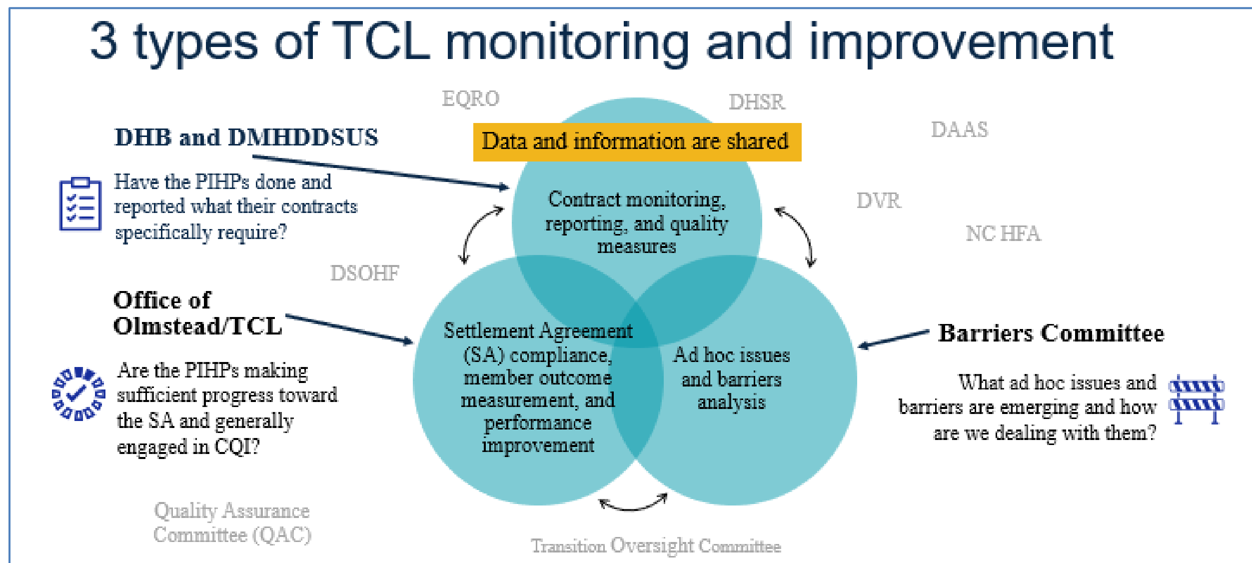
The QAPI system is modeled on a Continuous Quality Improvement (CQI) approach. It encompasses compliance and quality assurance processes and data associated with all aspects of TCL and all substantive provisions of the State's settlement agreement with the DOJ. Insights from data collection, analysis, and evaluation 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 Olmstead Director 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 (NCHFA), and the State's Local Management Entities-Managed Care Organizations (LME/MCOs).

State oversight and working committees within the TCL QAPI system include the TCL Transition Oversight Committee (TOC), the TCL Quality Assurance Committee (QAC), and an intradepartmental team focused on monitoring and oversight of LME/MCO/Pre-Paid Inpatient Health Plan (PIHP)[40] TCL quality assurance and performance improvement processes and activities and other contracted services and 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.

[40] 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.

FIGURE 22: THREE TYPES OF STATE-LEVEL MONITORING AND IMPROVEMENT IN THE NCDHHS TCL QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT SYSTEM



10.2. PROGRESS AND ACCOMPLISHMENTS

Since contracting with Mathematica in February 2021 to provide technical assistance and instrumental support, work is ongoing related to performance and outcomes measurement and monitoring, data management, data dashboard development, and QAPI system development.

Key Accomplishments

SFY 22-23 accomplishments in the area of QAPI built on the prior year's progress. Largely through the support of the Mathematica contract team, advances included continued improvements in TCL data quality and reliability, enhanced functionality and increased usability of the TCL Dashboard, implementation of additional performance and outcomes measures, development and implementation of a formal performance measure review and QAPI cycle, outreach and training for NCDHHS staff, expanded ad hoc support in the area of data analytics, convening of a new TCL Quality Assurance Committee, refinement of barriers reporting and escalation processes, engagement of LME/MCOs through QAPI technical assistance, and planning for LME/MCO views and access to the TCL Dashboard. A sample of key accomplishments are described in greater detail below.

- **Continued quarterly TCL Performance Data Dashboard releases and enhancements.** The integrated dashboard Mathematica developed and released in SFY 21-22 for ongoing performance measurement, monitoring, evaluation, and reporting was updated with refreshed data, new measures, and/or enhanced functionality each quarter. SFY 22-23 releases included more than 80 new or improved performance and member outcome measures, including measures related to community mental health services, housing stability, targeted unit utilization, duration of transition planning, institutional contacts and repeat contacts, diversion, and in-reach, as well as new measures of member quality of life and community integration derived from member community mental health service outcomes assessments.
- **Developed and implemented Barriers Committee process improvements.** SFY 22-23 barriers reporting, and resolution process improvements included development of a standard definition of "barriers," and refinement of committee workflows, including processes related to barrier identification, monitoring and reporting, and administration of barriers elevation training

statewide.

- **Drafted NCDHHS TCL QAPI Plan outline.** Input from the Independent Reviewer will be used to finalize a written plan.
- **Developed and implemented standard operating procedures for conducting performance measure monitoring and QAPI cycles.** Performance measure review cycles are now conducted with TCL subject matter experts (SMEs) on a quarterly basis. Process and outcome measures for prioritization and review are selected based upon their utility as indicators of success in achieving TCL program objectives and/or compliance with settlement agreement requirements. Measure values are reviewed against established standards, target values, or statistical thresholds. Where these are not met, additional analysis is conducted, and results are used to inform evaluation of quality and performance patterns that require action and improvement, implementation of those actions, and follow-up monitoring.
- **Developed report template for quarterly updates on performance measure monitoring and QAPI cycles.** Written quarterly updates on performance measure review and QAPI cycles are part of the overall TCL QAPI system and are intended primarily for NCDHHS leadership and TCL SMEs communication and awareness. These reports demonstrate the systematic nature of the State's data reviews and quality improvement planning. They also serve as a mechanism for creating transparency and accountability within NCDHHS for taking focused quality improvement action on identified quality issues and tracking the effect of those actions over time.
- **Developed and implemented NCDHHS TCL Strategic Implementation Plan goals, objectives, and actions to achieve substantial compliance with settlement agreement provisions.** Implementation Plan QAPI goals relate to improved TCL member personal outcomes reporting; enhancements and implementation of new tools and procedures for performance measurement, data analysis and reporting, and monitoring of PIHP/TP QAPI activities and contracted services and functions; and analysis and use of QAPI system data for continuous quality improvement, including systematic review and evaluation of program data to evaluate progress toward intended program outcomes, and implementation of strategies and quality improvement initiatives to address and resolve barriers and performance deficits that impact member outcomes and experiences.
- **Convened new TCL Quality Assurance Committee.** The Department's TCL Quality Assurance Committee convened in February 2023. Its purposes include fielding and troubleshooting emergent and urgent TCL quality and performance issues, providing QAPI consultation and data support to TCL SMEs, brainstorming strategies to address Implementation Plan challenges identified by leads of all TCL pillars, and carrying out required settlement agreement functions related to the aggregation, analysis, and use of TCL data to evaluate program success in achieving intended objectives and to determine when quality and performance improvement actions are required.
- **Developed Medicaid PIHP/TP contract language and new requirements related to TCL QAPI Plans and reporting.** With the execution of the related contract amendment, PIHPs are required to implement mechanisms including member outcomes monitoring to assess and ensure the quality and sufficiency of TCL services and supports, and the delivery, effectiveness, and outcomes of other contracted TCL functions.
- **Initiated planning for intradepartmental PIHP/TP contracted TCL services monitoring.** Planning for intradepartmental monitoring of contracted PIHP/TP TCL services and functions began in SFY 22-23 and included key representatives from DHB Program Evaluation and Quality, DMH/DD/SUS Quality, and NCDHHS Office of the Secretary Olmstead/TCL team.
- **Provided technical assistance to LME/MCOs around TCL quality assurance and performance improvement planning and activities.** SFY 22-23 LME/MCO TCL Technical Assistance calls included presentations from Mathematica team members on the NCDHHS TCL QAPI system and the TCL Data Dashboard. Planning also began planning for LME/MCO views/access to the NCDHHS TCL

Performance Data Dashboard.

Progress toward Substantial Compliance

Considering previous accomplishments as well as SFY 22-23 initiatives and enhancements, the State has achieved or progressed toward substantial compliance with each settlement agreement provision in QAPI, as described below.

- **The State has developed and implemented fundamental components of a TCL quality assurance and performance improvement system.** The details of QAPI system elements described in succeeding settlement agreement provisions are summarized in the remainder of this section.
- **The Department's previously established Transition Oversight Committee (TOC) continues to monitor monthly progress toward implementation of the settlement agreement.** Progress and developments in SFY 22-23 included increasing the frequency of TOC meetings from quarterly to monthly, refining the TOC standing agenda and focus to reflect greater emphasis on proactively addressing risks and barriers, and planning for increased LME/MCO participation and required reporting related to topics such as discharge and transition.
- **Protocols, data collection instruments, and databases for ongoing monitoring and evaluation were previously developed and phased in, and enhancements are ongoing.** The TCL Performance Data Dashboard released in SFY 21-22 includes a comprehensive set of over 100 compliance, performance, and individual outcome measures for enhanced program monitoring. Previously developed were the TCL Database (TCLD), Referral Screening Verification Process (RSVP) system, and NCHFA Community Living Verification (CLIVe) centralized housing subsidy reimbursement and data system. TCLD, RSVP, and CLIVe are dedicated databases for tracking and monitoring requirements related to housing, In-Reach, diversion, transitions, and community tenure and to inform discharge planning. Institutional census and outcomes including length of stay, discharge, admissions, and readmissions are tracked through the State's Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) database and NCTracks claims system. The TCL Dashboard integrates data from each of these separate databases, as well as from the NC Treatment Outcomes and Program Performance System (NC-TOPPS) database of mental health and substance use client interview-based outcome assessments.[41]
- **Dashboards for daily decision support were developed and implemented in previous state fiscal years.** Information in the dashboard embedded within the CLIVe housing management system is used by LME/MCOs to monitor targeted housing unit availability. The dashboard embedded within TCLD also includes real time measures and alerts for daily decision support related to open diversion and transition attempts and individuals with due in-reach visits.
- **The State developed and used 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.
- **The State is now collecting data, monitoring, and reporting on all required personal outcomes measures.** These include incidents of harm; repeat admissions to State hospitals, adult care homes, and inpatient psychiatric facilities; use of facility-based crisis beds and community hospital admissions, and readmissions; emergency room visits and repeat visits; time spent in congregate day programming ; Psychosocial Rehabilitation Services; people employed, attending school, and or engaged in community life; and maintenance of chosen living arrangement.
- **The State regularly collects, aggregates, and analyzes data related to in-reach, discharge and**

[41] Find more information about the NC Treatment Outcomes and Program Performance System (NC-TOPPS) on the NCDHHS website dedicated pages: https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/reports/nc-topps-reports/nc-treatment-outcomes-and-program-performance-system-nc-topps

transition, and community placements. These data are reviewed more frequently than the semi-annual basis required. Barriers referred and resolved are summarized in this annual report.

- **The State implemented Quality of Life (QOL) Surveys early in the life of the TCL program.** Quality of Life surveys are administered before individuals transition out of facilities or into supportive housing and 11 and 24 months after transitioning, as required.
- **External Quality Reviews (EQR) are completed annually.** These comprehensive reviews cover LME/MCO policies and processes for the State's mental health service system, including TCL functions and services.
- **The State is actively using program and system data to evaluate success in achieving intended program outcomes, identify quality and performance issues, and inform quality and performance improvement activities.** Examples of systematic data analysis and evaluation activities include quarterly performance measure review and QAPI cycles; Barriers Committee processes; Incentive Plan reporting and measure monitoring; and QAC program data presentations to support data aggregation, analysis, program evaluation, and identification of quality and performance improvement opportunities. This annual report includes summary data and evaluation related to the State's success in achieving intended program outcomes, including, and not limited to increased community integration, stable integrated housing, and decreased hospitalization and institutionalization.
- **The State publishes on the NCDHHS website required annual reports that, among other things, identify the number of people served in each type of setting and service described in the settlement agreement.** With this annual report, services are reported for TCL member populations in each of the following statuses and settings: TCL supportive housing, Diversion, ACH in-reach, SPH in-reach/out-reach, transition planning and rehousing planning, and living in the community without a housing slot.

Member Outcomes Highlights[42]

Positive trends in numerous TCL member outcomes monitored as part of the QAPI system were observed in SFY 22-23. The following trends provide data-based evidence of the beneficial impacts of TCL services and supports and demonstrate the State's significant and continued progress toward objectives related to participants' increased independence, greater community integration, housing stability, harm avoidance, and reduced hospital use and institutionalization.

- **Continued housing stability.** Over the life of the program as of SFY 22-23, 82% of individuals ever housed were in supportive housing at their one-year milestone, and 69% were in supportive housing at their two-year milestone. At the end of SFY 22-23, more than half of individuals in supportive housing had initially transitioned 3 or more years ago.
- **Low housing separation rates.** While the number of individuals in supportive housing has more than doubled since 2018, average housing separation rates have remained low. In SFY 22-23, the average quarterly separation rate was 4.8%, compared to 5.6% in both SFY 17-18 and SFY 18-19, prior to the pandemic.
- **Decreased time in in-reach status.** Average months in ACH in-reach status decreased for the first time in SFY 22-23, by 22 percent compared to the previous SFY.
- **Continued low inpatient facility readmission rates for individuals in supportive housing.** A total of 3.1% of members in housing experienced more than one inpatient admission during SFY 21-22,

[42] In the interest of data completeness, claims-based outcome measures are reported with additional lag compared to administrative measures. Whereas administrative measure such as time in TCL status are reported for the full SFY 22-23, annual claims-based measures reflect SFY 21-22, and quarterly trends are reported through the second quarter of SFY 22-23.

down from 4.5% the previous year.

- **Reduced inpatient admissions for individuals in supportive housing.** Inpatient admissions were reduced to zero for 64% of individuals who had admissions in the previous state fiscal year.
- **Continued downward annual trend in inpatient length of stay across TCL settings and statuses.**
- TCL member population state psychiatric hospital average length of stay decreased by 41 percent from SFY 18-19 through SFY 21-22. From SFY 17-18 to SFY 20-21, average length of stay in community hospitals and inpatient psychiatric units decreased by 18 percent.
- **Shorter inpatient stays for members in TCL supportive housing compared to other TCL statuses.** In SFY 21-22, inpatient lengths of stay for members admitted to community hospital or inpatient psychiatric units from TCL supportive housing were half as long compared to those for members admitted from in-reach, 10.7 versus 23.5 days, and less than half as long compared to those for members admitted from housing in the community without a TCL slot, 10.7 versus 21.4 days. Members in diversion status and those planning for transition or rehousing also experienced shorter stays when admitted, 11.5 and 14.2 days on average, compared to members in in-reach or housed in the community without a slot.
- **Continued low rates of repeat ED visits for individuals in supportive housing.** A total of 3.7% of members in supportive housing experienced an ED visit in SFY 21-22 that was a repeat visit from the previous 12 months, down from 4.3% in SFY 20-21; 2.5% experienced more than one ED visit during the year, down from 3.2% in SFY 20-21.
- **Reduced ED visits for individuals in supportive housing.** ED visits in SFY 21-22 were reduced to zero for 72% of individuals who had ED visits in the previous state fiscal year.
- **Continued low rates of congregate day programming Psychosocial Rehabilitation (PSR) service.** PSR rates for members in TCL housing decreased by an additional 9% in SFY 21-22 compared to the previous year and remained low across all TCL statuses and settings.
- **Upward annual trend in percentage of members in supportive housing reporting in NC-TOPPS interviews that they have been doing "excellent" or "good" in the area of employment/education.** This percentage has ticked upward consistently since 2017, from 21% to 33% in SFY 22-23.
- **Upward trend in percentage of members in supportive housing reporting in NC-TOPPS interviews that their services have been very helpful.** Gradual increases since 2017 are observed in percentages of respondents reporting services have been very helpful for increasing control over one's life, improving educational status, improving housing status, and improving quality of life.
- **Downward annual trends in percentages of members in supportive housing reporting in NC-TOPPS interviews behavioral health or environmental barriers to treatment.** From SFY 16-17 to SFY 22-23, members reporting behavioral health barriers such as mental health symptoms or substance use decreased from 41% to 29%, and members reporting environmental barriers such as housing instability, transportation, and distance to provider decreased from 13% to 6%.

10.3. DEPARTMENTAL MONITORING OF TCL FUNCTIONS AND SERVICES

SFY 22-23 systems-level monitoring of member outcomes and TCL services and functions managed by LME/MCOs included annual EQR of LME/MCO TCL functions. EQRs encompass 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 EQRO.[43]

[43] 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.

Additional state-level monitoring is carried out by the NCDHHS TCL Transition Oversight Committee (TOC), State Barriers Committee (SBC), and the newly formed Quality Assurance Committee (QAC). Planning also began in SFY 22-23 for intradepartmental monitoring of PIHP/TP contracted TCL services and functions.

10.3.1. TRANSITION OVERSIGHT COMMITTEE

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

The Transition Oversight Committee (TOC) continued in SFY 22-23 to monitor monthly progress of implementation of the settlement agreement. The TOC meets monthly and follows a standing agenda that includes key programs and progress updates, as well as transition barriers and risks and related data.

Ongoing work of the TOC is focused on the identification of action items and mitigation of issues, including resolution of systemic transition barriers which are unable to be resolved through the State Barriers Committee, and which may require changes in policies and practices throughout the state, such as developing and improving housing opportunities, increasing staffing levels and workforce expansion, and providing support for informed decision-making. The TOC also addresses the impact of state budget on the work and implementation of TCL and collaborates with NCDHHS budget officials to address challenges or needs for re-alignment of allocations to accomplish settlement agreement goals.

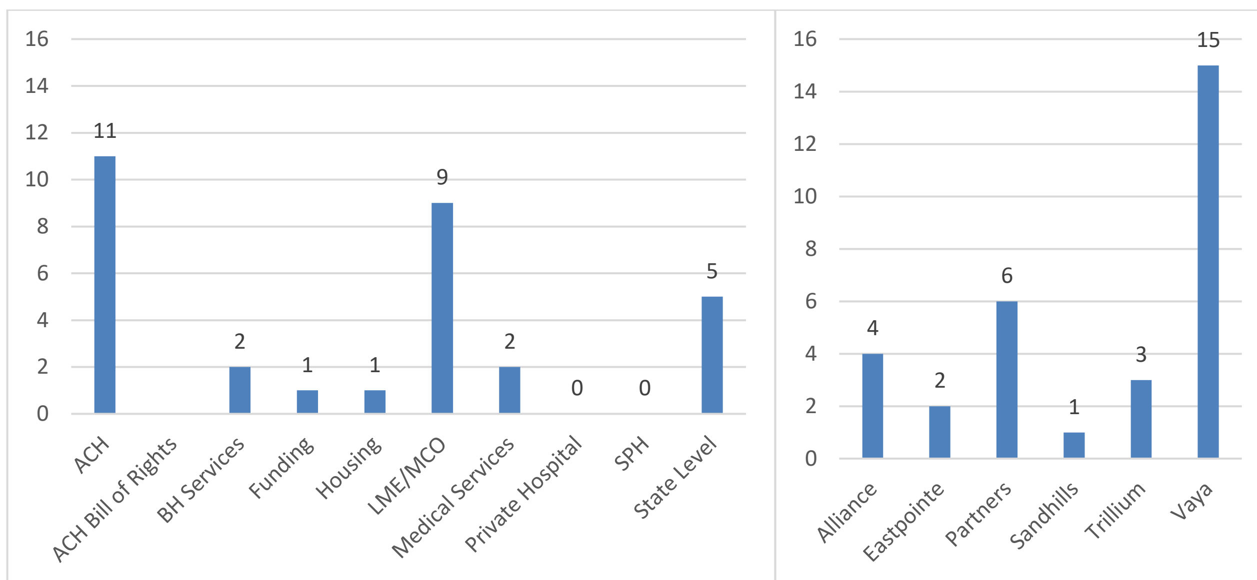
Examples of specific monitoring areas in SFY 22-23 included Implementation Plan priorities to achieve substantial compliance, refinements in the State Barriers Committee process for escalating issues to TOC, TCL budget impacts, LME/MCO contract amendments, LME/MCO contract monitoring, housing pilot and housing incentive plan, challenges related to transitioning individuals from ACHs, risks and barriers related to transitioning individuals with complex medical issues, interventions to increase face-to-face in-reach contacts, supported employment and community mental health services, public guardian process improvement, and QA/PI system progress and improvements.

10.3.2. STATE BARRIERS COMMITTEE

With support from TCL Quality Assurance and Performance Improvement contractor, Mathematica, NCDHHS revised the State Barriers process in SFY 22-23. Significant improvements included the development of a State Barriers Intervention Team, adjustment of Transition Oversight Committee (TOC) meetings to a monthly cadence, an expanded role of State Barriers Subcommittee support in TOC decision-making, a new requirement for NCDHHS staff attendance at all Local Barriers Committees (LBCs), and clarification and streamlining of the State Barriers elevation progress. Objectives and expected outcomes of these process improvements include increased frequency and efficiency in barriers reporting and resolution.

A total of 31 barriers were referred in SFY 22-23 to the State Barriers lead, logged for tracking, and addressed. Of those, 24 (77%) were resolved and seven (23%) are in-process.

FIGURE 23: SFY 22-23 STATE BARRIERS ADDRESSED BY CATEGORY AND LME/MCO



Over one-quarter (8, or 25%) of reported transition barriers were referred by outside sources and related to obstacles that required LME/MCO intervention and solutioning. The majority of these concerned transition coordination process lags, leading to the Department's wider efforts to urge all LME/MCOs to engage transition coordination earlier in the TCL process.

Over one-third (11, or 35%) of reported barriers related to Adult Care Home access issues. The subject of access barriers to ACHs was escalated to the NCDHHS TCL Transition Oversight Committee and was addressed in written communications to all ACHs, Ombudsman offices, DSSs, and LME/MCOs outlining ACH legal obligations to fully cooperate with in-reach, discharge, and transition efforts. In February 2023, NCDHHS also issued LME/MCO Joint Communication Bulletin # J442[44], which outlines expectations related to ACH in-reach, discharge, and transition, including TCL teams' responsibilities to cooperatively in-reach within an ACH.

DHHS also reinstated the TCL Barriers and Solutions Committee for state psychiatric hospitals in SFY 22-23. This committee brings together leadership from LME/MCO State Psychiatric Hospital (SPH) transition teams, SPH Social Workers, and NCDHHS Division of State Operated Healthcare Facilities (DSOHF) and Office of the Secretary Olmstead/TCL teams. The committee meets every other month and follows a set agenda focused on identifying solutions to discharge and transition barriers as required by the settlement agreement.

In January 2023, NCDHHS issued LME/MCO Joint Communication Bulletin # J441[45], which outlines requirements for TCL in-reach, transition, and discharge processes for individuals in State Psychiatric Hospitals. This communication covered requirements related to TCL eligibility screening and use of a newly developed NCDHHS SPH Transition Team Checklist, orientation for LME/MCO staff who perform on-site in-reach and/or discharge and transition planning, roles, and responsibilities of the LME/MCO Transition Coordinator/Hospital Liaison and transition teams, and the conduct of transition team meetings. It also outlined requirements for the development of individualized strategies to address member transition

[44] As mentioned in the February 2023 Joint Communication Bullet # J442 - https://www.ncdhhs.gov/joint-communication-bulletin-j442-transitions-community-living-discharge-and-transition-process/download?attachment

[45] As mentioned in the January 2023 Joint Communication Bulletin # J441 - https://www.ncdhhs.gov/joint-communication-bulletin-j441-transitions-community-living-discharge-and-transition-process/download?attachment

barriers, as well as guidelines for reporting to Local Barriers Committees (LBC) barriers that cannot be resolved and systematic barriers to the SBC.

Taken together, barriers reporting, discussions with LME/MCOs, and collaborative work with NC Medicaid in SFY 22-23 informed larger departmental initiatives to expand LME/MCO transition staff and other positions key to increasing TCL community transitions. This work also contributed to the development of ongoing system change flags involving home health expansion requests to NC Medicaid still under review, ongoing PCP recovery-oriented improvement trainings, and NC CORE standardization. NCDHHS also implemented a requirement for LME/MCO training on the identification and reporting of barriers to LBCs, the LBC process and resolution, and the LBC to State Barriers elevation process.

10.3.3. QUALITY ASSURANCE COMMITTEE

The new TCL Quality Assurance Committee (QAC) is an intradepartmental committee supported by the Office of the Secretary, with cross-divisional representation from DMH/DD/SUS, DHB, DSOHF, and the Division of Employment and Independence for people with Disabilities (EIPD) (formerly the Division of Vocational Rehabilitation Services). The QAC is co-chaired by the TCL Quality lead and the TCL Clinical Project Manager, with participation of TCL housing, in-reach, diversion, transition and discharge, and Services and Employment Leads as well as the NCDHHS Olmstead Director.

The committee meets quarterly, and a standing agenda covers settlement agreement requirements and the State's progress toward substantial compliance, TCL program and services quality and performance improvement, and TCL member outcomes. The role of QAC is consultative as well as action oriented. Members are invited to share obstacles and identified quality and performance issues for collaborative planning and troubleshooting and to request data support and assistance with quality assurance and performance improvement action planning and monitoring.

QAC members also play an active role in the use of data to identify quality and performance issues, and in the development and implementation of QAPI actions and impact monitoring and evaluation through subject matter expert-led presentations of TCL program data crucial for assessing program success. Examples of planned topics for data presentation and evaluation include housing and separation, transition and discharge barriers, employment and community mental health services, in-reach, EQRO findings, Tailored Plan quality measures, and member quality of life and community integration, adverse incidents, and institutional contacts.

In keeping with a "no wrong door" approach, the QAC also may serve as a resource for fielding and troubleshooting emergent and urgent TCL quality and performance issues. Issues may be referred, or consultation requested through committee co-chairs or the NCDHHS Olmstead Director, at any time.

10.3.4. PIHP/TP CONTRACT MONITORING

SFY 22-23 work in the area of contract monitoring included development of additional PIHP contract requirements related to TCL services and functions and to TCL QAPI planning and reporting. Representatives from DHB, DMH/DD/SUS, and the Office of the Secretary Olmstead/TCL team participated in joint planning for intradepartmental contract monitoring and technical assistance for PIHPs around QAPI planning. Development and implementation of robust mechanisms for contract monitoring is a central focus for SFY 23-24.

10.4. PERSONAL OUTCOME MEASURES

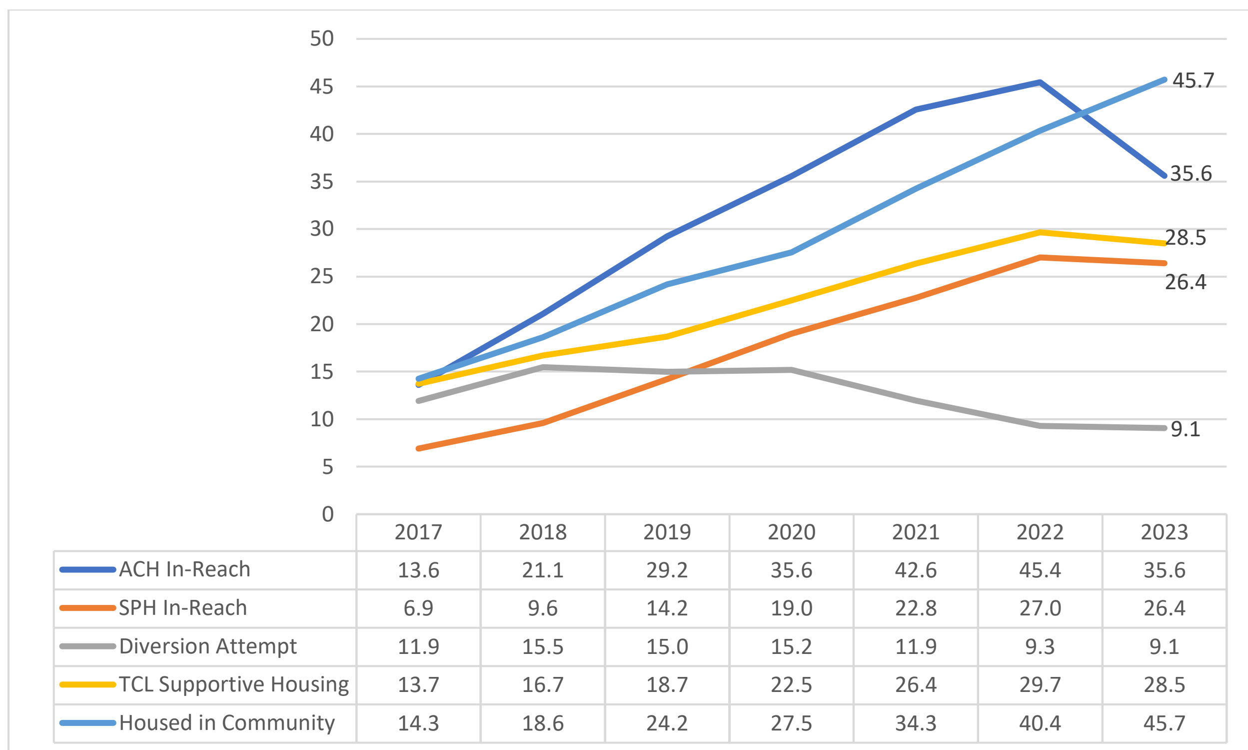
The State's approach to the measurement of TCL participant outcomes reflects the best practice principle articulated in the TCL settlement agreement that services are to "be flexible and individualized to meet the

needs of each individual." Key activities of the State's Quality Assurance System include collecting, monitoring, evaluating, and reporting data on a variety of personal outcomes, which emphasize fundamental objectives related to increased participant health, safety, and welfare; independence and community integration; quality of life; housing stability; and reduced hospital contacts, institutionalization, and incidents of harm.[46,47]

10.4.1. TIME IN TCL STATUS AND SETTING

Figure 24 shows annual trends in the average number of months TCL participants have been in various settings and statuses. The average number of months in supportive housing has more than doubled compared to SFY2 16-17. Individuals in TCL housing in SFY 22-23 had maintained their housing on average for nearly 2.5 years. Average months in housing for individuals housed in the community without a TCL slot continues to increase, and average months in diversion status decreased slightly compared to SFY 21-22. Average months in in-reach status decreased in SFY 22-23 for the first time, by 22% compared to SFY 21-22 in adult care home (ACH) settings, and by 2% for the state psychiatric hospital (SPH) member population.[48]

FIGURE 24: AVERAGE MONTHS IN TCL STATUS, ANNUAL TRENDS SFY 16-17 TO SFY 22-23



	2017	2018	2019	2020	2021	2022	2023
ACH In-Reach	13.6	21.1	29.2	35.6	42.6	45.4	35.6
SPH In-Reach	6.9	9.6	14.2	19.0	22.8	27.0	26.4
Diversion Attempt	11.9	15.5	15.0	15.2	11.9	9.3	9.1
TCL Supportive Housing	13.7	16.7	18.7	22.5	26.4	29.7	28.5
Housed in Community	14.3	18.6	24.2	27.5	34.3	40.4	45.7

[46] In the interest of data completeness, claims-based outcome measures are reported with additional lag compared to administrative measures. Whereas administrative measure such as time in TCL status are reported for the full SFY 22-23, annual claims-based measures reflect SFY 21-22, and quarterly trends are reported through the second quarter of SFY 22-23.

[47] Cardinal Innovations LME/MCO was fully dissolved, and its counties transferred during the second quarter of SFY 21-22. Where SFY 21-22 outcomes and services measures are reported for Cardinal Innovations, they include the July through October 2021 reporting period for Forsyth and Davie counties (transferred to Partners Health Management); July through November 2021 for Orange and Mecklenburg (Alliance Health), Warren (Eastpointe), Halifax (Trillium Health Resources), and Davidson and Rockingham (Sandhills Center) counties; and July through December 2021 for Alamance, Caswell, Chatham, Franklin, Granville, Person, Rowan, Stokes, and Vance (Vaya Health) counties.

[48] The SPH priority population includes individuals receiving in-reach while residing in state psychiatric hospitals, as well as individuals discharged from SPH settings and receiving TCL out-reach in community settings.

Not shown, the average number of days from housing slot approval to the transition to supportive housing in SFY 22-23 was 186 days.[49] State transition timeline guidelines call for a warm hand-off from In-Reach Worker to Transition Coordinator within 10 days of housing slot assignment, and a first Transition Planning meeting within an additional 10 days. Average time to transition from the first Transition Plan meeting in SFY 22-23 thus may have been closer to 166 days, which still is substantially longer than the settlement agreement standard that discharge should occur within 90 days of transition team assignment.

Also, in SFY 22-23, 41 percent of individuals had transitioned to supportive housing by the 90th day after the housing slot approval date. Slightly higher percentages of individuals transitioned by the 100th day (45.7%) or the 110th day (48.1%).

Some individuals also experience more than one attempt before transitioning. The number of days from the most recent transition attempt start date to the date of the transition to supportive housing in SFY 22-23 was 132 days. This is approximately 30% lower than the length of time from initial housing slot approval, although still nearly 1.5 times the target length of 90 days.

10.4.2. 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[50] claims data warehouse. SPH census, admissions, and discharge data are summarized 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 psychiatric facility inpatient and emergency department claims and HEARTS SPH and Alcohol and Drug Abuse Treatment Center (ADATC) admissions data.[51] For all institutional data reported in this section, admission and visit rates are expressed as percentages out of the total numbers of individuals in the TCL statuses referenced or served by each LME/MCO during the reporting period.

10.4.3. INPATIENT ADMISSIONS

Table 15 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/PU), or State Psychiatric Hospitals (SPH).

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[49] When 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 the initial lease start date. For this reason, average months in the calculated Transition Planning status exceeds average months from housing slot approval to transition and is not used to assess performance related to a 90-day transition standard.

[50] 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.

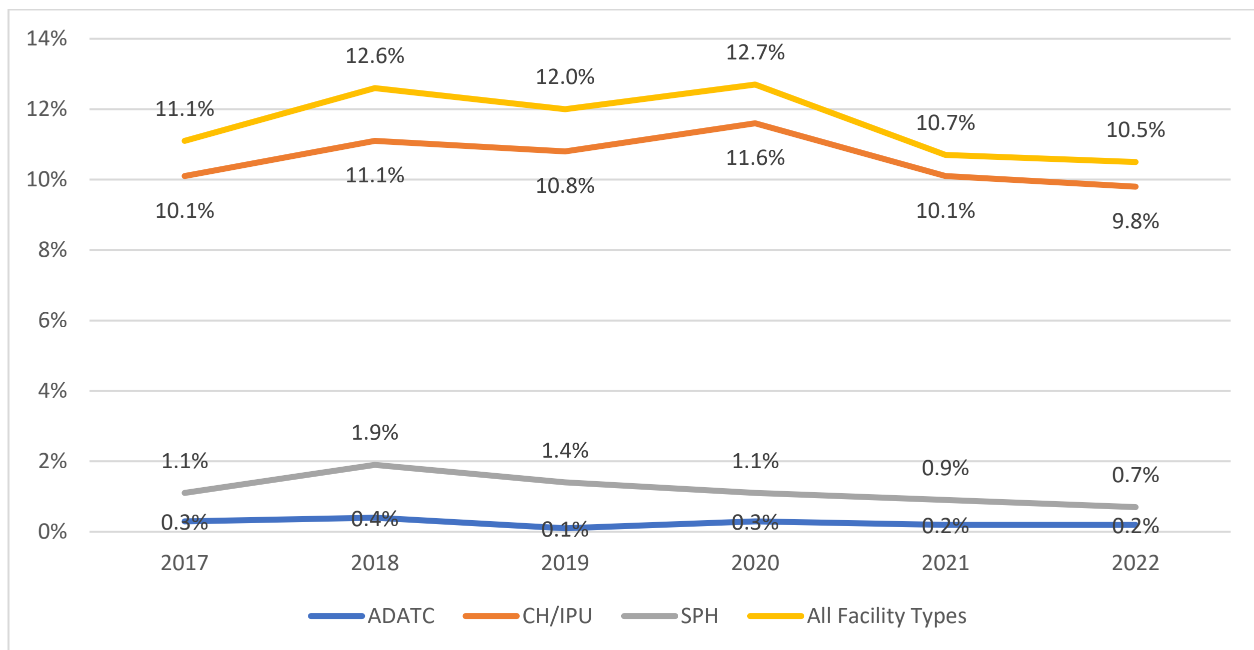
[51] Institutional admission measure values were calculated using standardized TCL Performance Data Dashboard specifications.

TABLE 15: INDIVIDUALS IN TCL SUPPORTIVE HOUSING WITH INPATIENT ADMISSIONS, FROM SFY 16-17 TO SFY 21-22

Facility Type	SFY 16-17	SFY 17-18	SFY 18-19	SFY 19-20	SFY 20-21	SFY 21-22
Alcohol and Drug Treatment Center (ADATC)	4	8	3	9	6	8
Community Hospital/Inpatient Psych Unit (CH/IPU)	124	202	267	341	345	356
State Psychiatric Hospital (SPH)	14	34	34	33	32	27
All Facility Types[52]	136	230	296	373	366	382
Total in TCL Housing During Period	**1,228**	**1,825**	**2,476**	**2,947**	**3,413**	**3,623**

Figure 25 shows statewide admission rates for each type of facility.

FIGURE 25: PERCENTAGES OF INDIVIDUALS IN TCL SUPPORTIVE HOUSING WITH INPATIENT ADMISSIONS, FROM SFY 16-17 TO SFY 21-22



In SFY 21-22, 52 percent of individuals with inpatient admissions of any type also had one or more inpatient admissions within the preceding 12 months. Table 16 shows counts by LME/MCO of individuals with inpatient facility admissions from TCL supportive housing. A second measure of repeat admissions, the average number of admissions per person with admissions, also is shown. Together, these measures demonstrate that while the number of individuals with inpatient admissions is relatively low, approximately half of all inpatient admissions are repeat admissions within a one-year period.

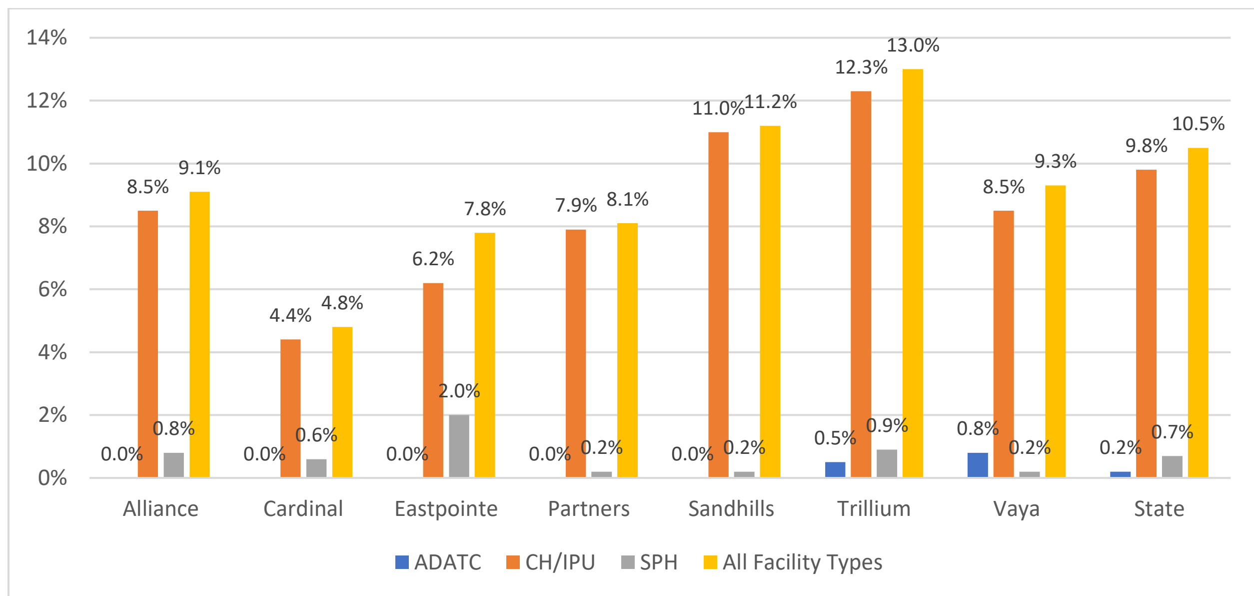
[52] Counts for all facility types may include individuals with admissions to more than one type of facility.

TABLE 16: INDIVIDUALS IN TCL SUPPORTIVE HOUSING WITH INPATIENT ADMISSIONS, AND AVERAGE ADMISSIONS PER PERSON WITH ADMISSIONS, SFY 21-22

		ADATC		CH/IPU		SPH		All Facility Types[53]	
LME/MCO	N	Count	Avg	Count	Avg	Count	Avg	Count	Avg
Alliance	*1,104*	0	0	94	1.5	9	1.1	101	1.5
Cardinal	*908*	0	0	40	1.2	5	1.0	44	1.2
Eastpointe	*307*	0	0	19	1.6	6	1.8	24	1.6
Partners	*545*	0	0.0	43	1.7	1	1.0	44	1.7
Sandhills	*427*	0	0.0	47	1.4	1	1.0	48	1.4
Trillium	*546*	3	1.3	67	1.6	5	1.0	71	1.6
Vaya	*635*	5	1.0	54	1.4	1	1.0	59	1.4
Statewide	***3,623***	**8**	**1.1**	**356**	**1.5**	**28**	**1.3**	**382**	**1.5**

Figure 26 shows the percentage of each LME/MCO population of members in TCL housing with each type of inpatient admission, as well as unduplicated percentages with any inpatient admissions.

FIGURE 26: SFY 21-22 INPATIENT ADMISSION RATES FROM TCL SUPPORTIVE HOUSING



Not shown, of the 382 individuals with inpatient admissions, 28.3 percent (3.1% of housed) had more than one; 70 individuals (1.9% of housed) had two admissions, 20 (0.6% of housed) had three, and 22 (0.6% of housed) had four or more. The remaining 270 (7.5% of housed, 70.7% of all housed with any admissions) had a single inpatient admission during the year.

Of 3,623 individuals in supportive housing during SFY 21-22, 435 (12% of housed) had inpatient facility

[53] Counts across facility types are unduplicated and may include individuals with admissions to more than one facility type.

admissions in the previous state fiscal year.[54] Of those individuals, 156 (36%, 4.3% of housed) had repeat admissions in SFY 21-22. For the remaining 64 percent with SFY 20-21 inpatient admissions, SFY 21-22 admissions were reduced to zero.

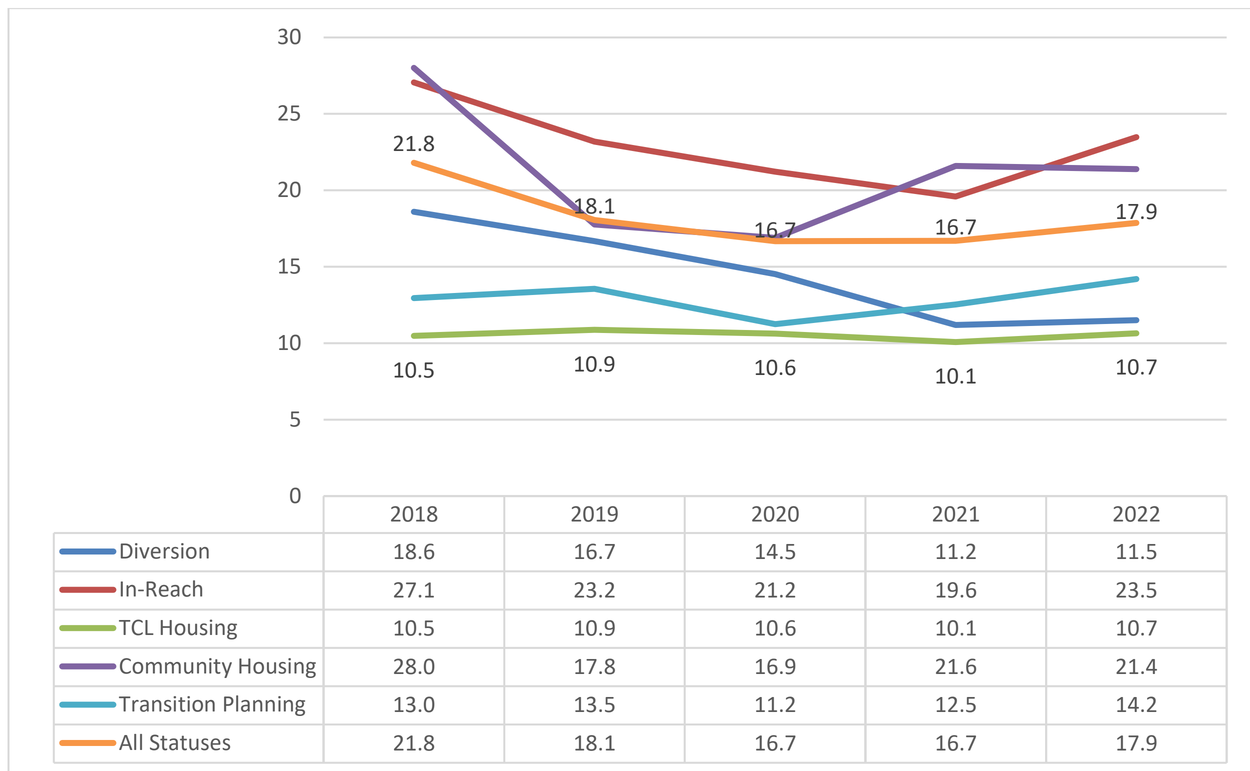
A downward annual trend also was noted in analysis of inpatient length of stay. Not shown, this trend was especially pronounced for state psychiatric hospital settings. Between SFYs 18-19 and 21-22, average SPH length of stay across all TCL statuses decreased by 41 percent, from 209.5 days to 123.5 days. Between SFYs 17-18 and 21-22, average length of stay in community hospitals and inpatient psychiatric units decreased somewhat less dramatically, by 18 percent, from 21.8 to 17.9 days on average across all TCL statuses.

As shown in Table 16 and Figure 26, above, community hospital or psychiatric inpatient admissions account for the vast majority of inpatient admissions for members in TCL supportive housing. This pattern also holds true for the larger TCL population. Over the five-year period from SFY 17-18 to SFY 21-22, across all TCL member statuses and settings, 87 percent of inpatient admissions were to community hospital or inpatient psychiatric unit settings.

Figure 27 and Figure 28 below illustrate annual trends in community hospital or psychiatric inpatient unit average length of stay by TCL status and LME/MCO. Figure 27 demonstrates that members in TCL supportive housing, transition planning, and, to lesser extent, diversion status, experience the shortest stays on average, while members in in-reach and those housed in the community without TCL slots experience longer stays. Figure 28 also shows some variation across LME/MCO in average community hospital or inpatient psychiatric unit length of stay.

[54] The total number of individuals in housing in SFY 21-22 with previous year admissions includes individuals who had not yet transitioned to supportive housing.

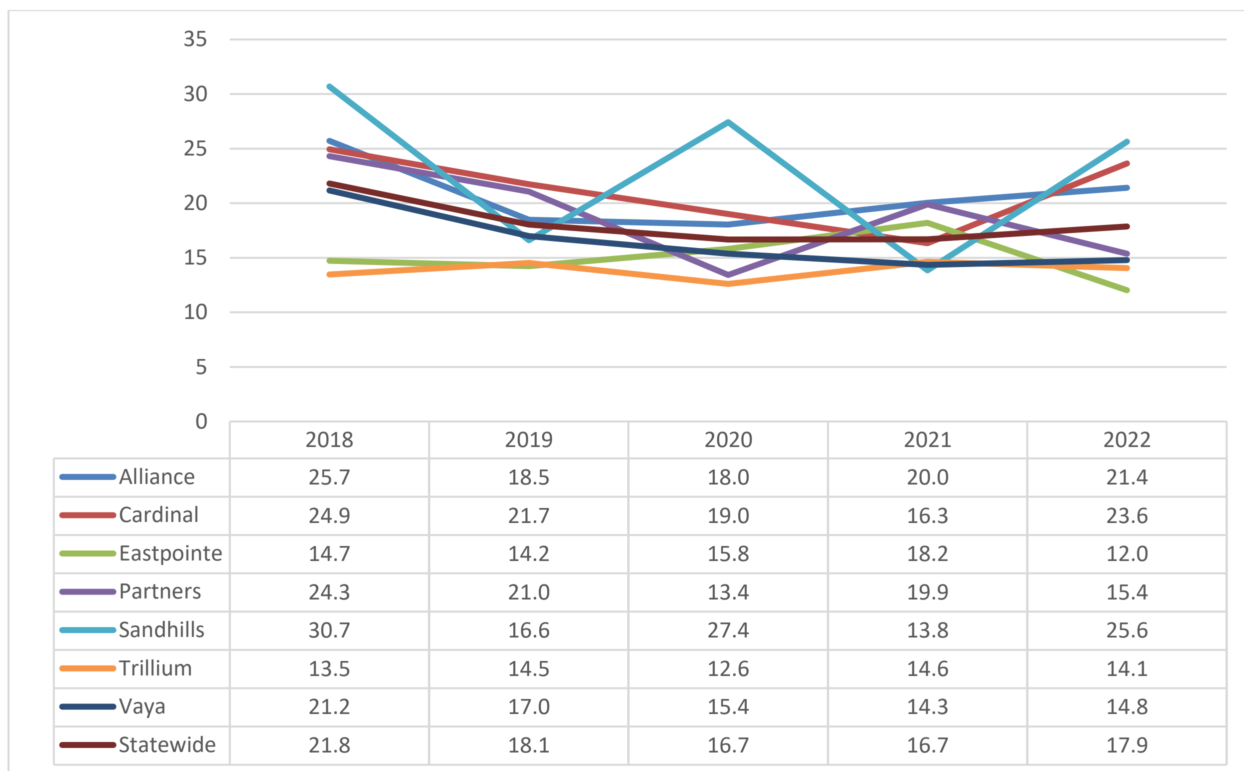
FIGURE 27: COMMUNITY HOSPITAL OR PSYCHIATRIC INPATIENT UNIT AVERAGE LENGTH OF STAY (DAYS) BY TCL STATUS[55]



	2018	2019	2020	2021	2022
Diversion	18.6	16.7	14.5	11.2	11.5
In-Reach	27.1	23.2	21.2	19.6	23.5
TCL Housing	10.5	10.9	10.6	10.1	10.7
Community Housing	28.0	17.8	16.9	21.6	21.4
Transition Planning	13.0	13.5	11.2	12.5	14.2
All Statuses	21.8	18.1	16.7	16.7	17.9

[55] Averages shown are for TCL participants in all settings and statuses, and for individuals in TCL supportive housing; Transition Planning status includes individuals planning for either initial transition or rehousing.

FIGURE 28: COMMUNITY HOSPITAL OR INPATIENT PSYCHIATRIC UNIT AVERAGE LENGTH OF STAY (DAYS) BY LME/MCO, ALL TCL STATUSES



	2018	2019	2020	2021	2022
Alliance	25.7	18.5	18.0	20.0	21.4
Cardinal	24.9	21.7	19.0	16.3	23.6
Eastpointe	14.7	14.2	15.8	18.2	12.0
Partners	24.3	21.0	13.4	19.9	15.4
Sandhills	30.7	16.6	27.4	13.8	25.6
Trillium	13.5	14.5	12.6	14.6	14.1
Vaya	21.2	17.0	15.4	14.3	14.8
Statewide	21.8	18.1	16.7	16.7	17.9

In SFY 21-22 average lengths of stay for members in TCL supportive housing were 10.9 days in Alcohol and Drug Abuse Treatment Centers, 10.7 days in community hospital or inpatient psychiatric units, and 86.7 days in State Psychiatric Hospitals. Figure 29 show minimal variation across LME/MCO in the average number of days in community hospitals and inpatient psychiatric units, which account for the largest number of inpatient admissions, for members admitted from TCL housing.

FIGURE 29: SFY 21-22 AVERAGE LENGTH OF STAY IN COMMUNITY HOSPITALS AND INPATIENT PSYCHIATRIC UNITS, TCL MEMBERS IN SUPPORTIVE HOUSING

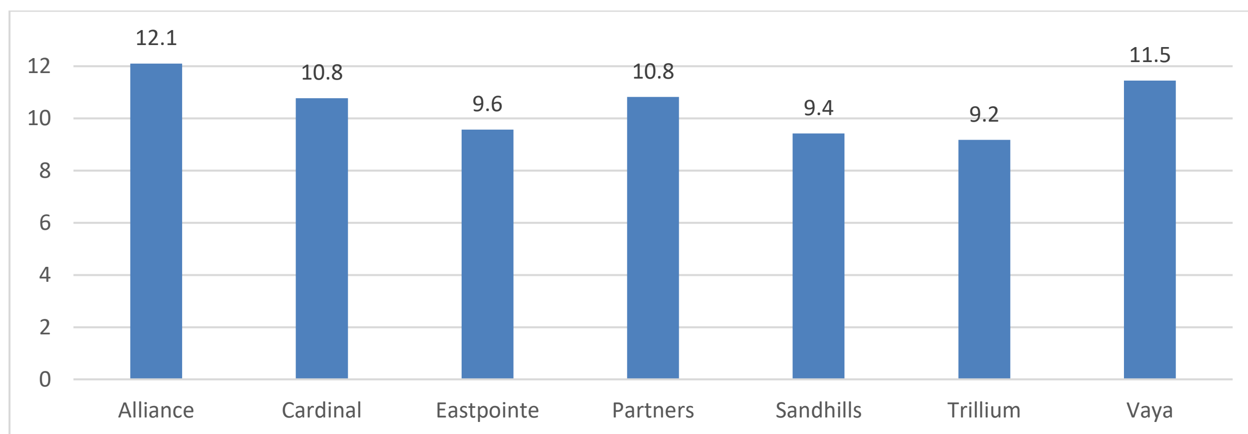


Table 17 shows statewide quarterly counts and percentages of individuals with inpatient admissions from TCL supportive housing. In SFY 21-22, an average of 4 percent of individuals in TCL supportive housing experienced inpatient admissions each quarter. Compared to the annual admission rate of 10.4 percent,

this indicates that approximately 38 percent of individuals with any admissions during SFY 21-22 had an admission during any given quarter. This is consistent with the previously reported finding that 28 percent of individuals with admissions from TCL housing had more than one during the year. SFY 22-23 quarterly admission rates are similar to the previous year.[56]

TABLE 17: STATEWIDE QUARTERLY COUNTS AND PERCENTAGES OF HOUSED INDIVIDUALS WITH INPATIENT ADMISSIONS

	Q1 SFY 21-22		Q2 SFY 21-22		Q3 SFY 21-22		Q4 SFY 21-22		Q1 SFY 22-23		Q2 SFY 22-23	
	N	%	N	%	N	%	N	%	N	%	N	%
ADATC	0	0.0%	4	0.1%	4	0.1%	1	0.0%	0	0.0%	1	0.0%
CH/IPU	138	4.4%	102	3.2%	116	3.6%	115	3.6%	111	3.4%	106	3.1%
SPH	8	0.3%	9	0.3%	9	0.3%	6	0.2%	11	0.3%	7	0.2%
All	145	4.6%	113	3.6%	128	4.0%	120	3.7%	119	3.6%	113	3.3%
Housed Total	**3,149**		**3,167**		**3,191**		**3,227**		**3,279**		**3,401**	

10.4.4. EMERGENCY DEPARTMENT VISITS AND REPEAT VISITS

Table 18 shows statewide annual numbers of individuals in TCL supportive housing who had Emergency Department visits.[57,58]

TABLE 18: ANNUAL COUNTS AND PERCENTAGES OF INDIVIDUALS IN TCL SUPPORTIVE HOUSING WITH ED VISITS AND REPEAT VISITS, SFY 16-17 TO SFY 21-22

	SFY 16-17	SFY 17-18	SFY 18-19	SFY 19-20	SFY 20-21	SFY 21-22
One or more ED visit	137	262	282	320	315	299
Percent of housed	*11.4%*	*14.5%*	*11.4%*	*10.9%*	*9.2%*	*8.3%*
Visit was repeat from previous 12 months	60	129	143	160	148	133
Percent of individuals with visits	*43.8%*	*49.2%*	*50.7%*	*50.0%*	*47.0%*	*44.5%*
Percent of housed	*5.0%*	*7.1%*	*5.8%*	*5.4%*	*4.3%*	*3.7%*
Average number of visits per person with visits	1.9	1.9	1.8	1.8	1.9	1.7
Total in TCL Housing During Period	**1,228**	**1,825**	**2,476**	**2,947**	**3,413**	**3,623**

The percentage of individuals in TCL housing with ED visits in SFY 21-22 was slightly lower compared to previous years. Nearly half (44.5%, 3.7% of housed) with SFY 21-22 visits had one or more previous visits within the prior year. On average, individuals with any visits during the SFY had more than one, with an

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

[57] 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.

[58] 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.

average of 1.7 visits per person with visits.

In total, 30 percent of individuals with any visits during the year (2.5% of housed) had more than one; 52 individuals (17% of individuals with any visits, 1.4% of all housed) had two visits, 19 (6%, 0.5% of housed) had three, and 20 (7%, 0.6% of housed) had four or more. The remaining 208 (70%, 5.7% of housed) had a single ED visit during the year. This pattern indicates that ED visits experienced by members in TCL housing are largely accounted for by a small number of individuals with multiple visits, and that repeat visits from the previous 12 months are more likely than multiple visits within the same SFY.

Of the 3,623 individuals in housing during SFY 21-22, 364 (10.0%) had ED visits in the previous state fiscal year. Of those individuals, 103 (28%, 2.8% of housed) had repeat visits in SFY 21-22. For the remaining 72 percent with previous visits, SFY 21-22 visits were reduced to zero.

As shown in Table 19, ED visits varied considerably by LME/MCO, as did each of the three measures of repeat visits.

TABLE 19: INDIVIDUALS IN TCL SUPPORTIVE HOUSING WITH ED VISITS AND REPEAT VISITS, SFY 21-22

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 SFY	*Percent of Housed*	Avg Number ED Visits
Alliance	*1,104*	67	*6.1%*	24	*2.2%*	16	*1.4%*	1.4
Cardinal	*908*	43	*4.7%*	25	*2.8%*	9	*1.0%*	1.5
Eastpointe	*307*	31	*10.1%*	14	*4.6%*	10	*3.3%*	2.0
Partners	*545*	32	*5.9%*	10	*1.8%*	6	*1.1%*	1.2
Sandhills	*427*	48	*11.2%*	24	*5.6%*	18	*4.2%*	2.2
Trillium	*546*	54	*9.9%*	29	*5.3%*	19	*3.5%*	1.7
Vaya	*635*	35	*5.5%*	16	*2.5%*	11	*1.7%*	1.6
Statewide	***4,472***	**310**	***6.9%***	**142**	***3.2%***	**89**	***2.0%***	**1.6**

Although some variation was observed across LME/MCO in ED visit and repeat visit rates, repeat visit patterns were similar. Across LME/MCO, a relatively large proportion of individuals with ED visits during the year were experienced by individuals with previous visits, and somewhat smaller proportions of individuals with any ED visits experienced two or more during the SFY.

FIGURE 30: SFY 21-22 ED VISIT AND REPEAT VISIT RATES FROM TCL SUPPORTIVE HOUSING, PERCENTAGES OF INDIVIDUALS WITH ANY VISITS, REPEAT VISITS FROM PAST 12 MONTHS, AND REPEAT VISITS

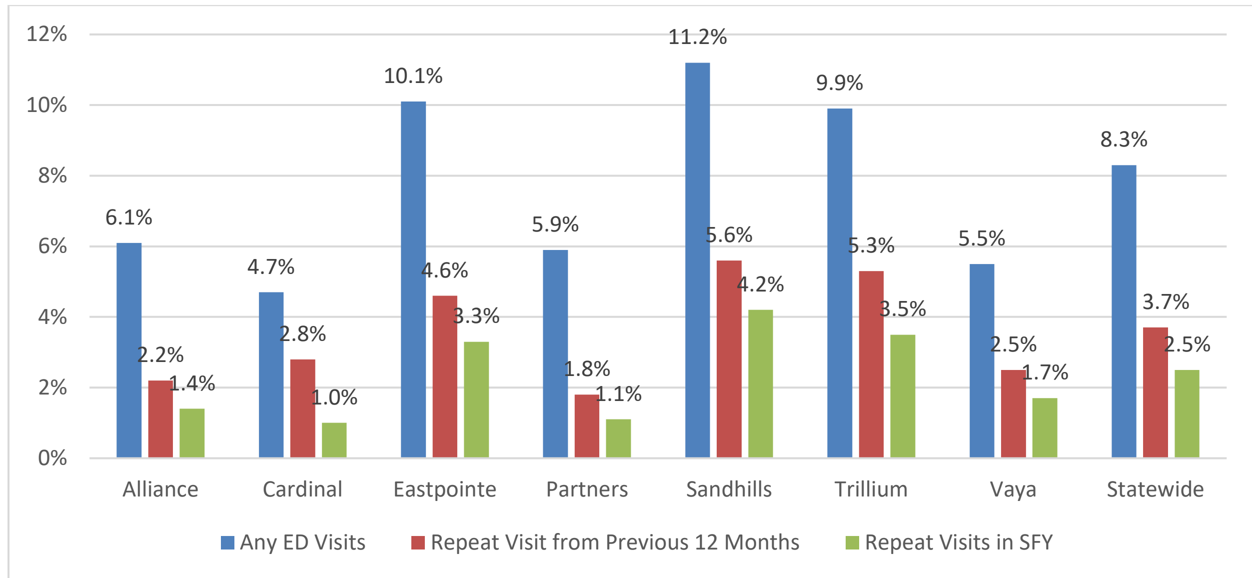


Table 20 shows statewide quarterly counts and percentages of housed individuals with ED visits during SFY 21-22 and the first two quarters of SFY 22-23. On average per quarter, 3.1 percent of housed members had an ED visit. That the quarterly rate is more than one-third (37%) the annual rate reflects the fact that nearly one-third of individuals with ED visits had more than one visit. SFY 21-22 quarterly ED visit rates are similar to previous year quarterly rates.[59]

TABLE 20: STATEWIDE QUARTERLY COUNTS AND PERCENTAGES OF INDIVIDUALS WITH ED VISITS, SFY 21-22 Q1 TO SFY 22-23 Q2

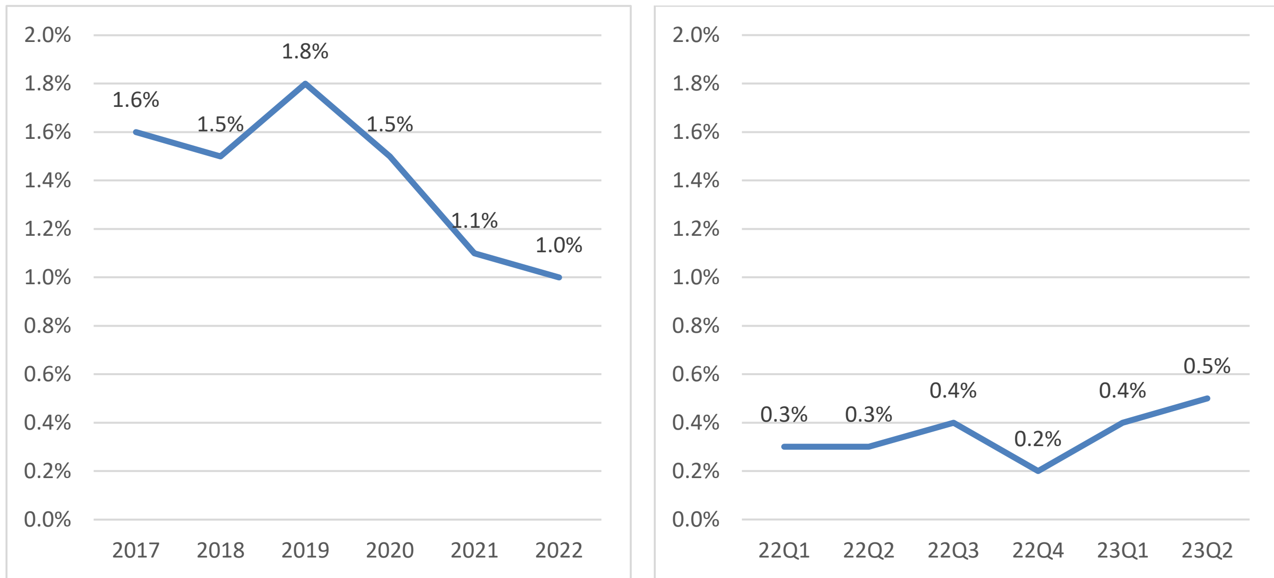
	Q1 SFY21-22		Q2 SFY21-22		Q3 SFY21-22		Q4 SFY21-22		Q1 SFY22-23		Q2 SFY22-23	
	N	%	N	%	N	%	N	%	N	%	N	%
	103	3.3%	98	3.1%	76	2.4%	105	3.3%	108	3.3%	104	3.1%
Housed Total		**3,149**		**3,167**		**3,191**		**3,227**		**3,279**		**3,401**

10.4.5. FACILITY CRISIS BED USE

As reported in Section 3 of this annual report, 35 individuals in supportive housing received Facility Based Crisis services during SFY 21-22. As shown in Figure 9, annual rates of housed individuals receiving Facility Based Crisis services show a downward trend, with minor variation across quarters.

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

FIGURE 31: ANNUAL AND QUARTERLY TRENDS IN HOUSED MEMBER USE OF FACILITY BASED CRISIS BEDS



10.4.6. QUALITY OF LIFE AND COMMUNITY INTEGRATION

Transitions to Community Living (TCL) participant quality of life is assessed in part 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), participants surveyed in follow-up interviews after 11 and 24 months in supportive housing have reported small improvements in quality of life, and significantly greater satisfaction with home and community compared to 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 and have been reported in detail in an optional Appendix to the State's previous annual TCL reports.

Aggregate Quality of Life scores (QOL) are based on 28 distinct survey questions related to participant Meaningful Day, Choice and Control, Natural Supports, Safety, Health and Wellness, Services and Staff Support, Service Planning, and Service Sufficiency. Satisfaction index scores (SAT) reflect ratings of 10 aspects of housing and community resources: Shopping, Transportation, Church/Place of worship, Parks/Open space, Leisure/Entertainment, Healthcare, Home's location, Home's maintenance, Neighbors, and Landlord.[60]

Table 21, Figure 32 and Figure 33 below illustrate results of response patterns from the SFY 22-23 survey year.[61,62] Statewide Quality of Life index scores at each time point were within +/- 1.5 points of SFY 21-22

[60] Aggregate index scores are converted to a scale that may range from zero to 100. 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 individual survey questions.

[61] In September 2022, NCDHHS SurveyMax web-based survey application through which LME/MCOs submitted TCL member survey responses was disabled due to a security issue. NCDHHS identified and implemented a replacement application, and TCL Quality of Life survey submission resumed in May 2023. LME/MCOs continued to administer surveys in the interim and began upon implementation of the new survey application to submit the backlog of surveys administered over the previous eight months. Survey response data for this annual report were downloaded after September 30, 2023, to allow sufficient time for data cleaning and analysis. At the time of download, approximately 60 percent of expected surveys based on member housing and separation dates had been submitted via the new application. Survey data analysis for this annual report thus may reflect incomplete data.

[62] Utilization of the same provider-facilitated Quality of Life survey over the life of the TCL program has allowed for direct year-to-year comparisons and trending of member responses. As has been noted by the Independent Reviewer, however, while the State has continued to meet the

index scores. Satisfaction scores were within +/-3 points of SFY 21-22. Quality of Life at 24month follow-up was 1.5 points lower in SFY 22-23. All other index scores were higher in SFY 22-23 compared to SFY 21-22.

As in previous survey years, respondents reported significantly higher Satisfaction than Quality of Life pre-transition, and the largest post-transition statistical gain was in reported satisfaction. Follow-up satisfaction at both 11 and 24 months was significantly higher than pre-transition satisfaction, and follow-up quality of life was significantly higher at 11 but not 24 months. Also as in previous years, and as indicated by the larger standard deviations (SD), reported satisfaction was considerably more variable across respondents, particularly at the pre-transition survey, than was reported quality of life.[63]

TABLE 21: SFY 22-23 TCL PARTICIPANT QUALITY OF LIFE AND SATISFACTION INDEX SCORE MEANS

	Pre-Transition	11-Month Follow-Up	24-Month Follow-Up
Quality of Life	82.3 (N=423, SD=14.5)	84.5 (N=282, SD=14.1)	83.3 (N=301, SD=13.9)
Satisfaction	74.6 (N=410, SD=27.6)	85.3 (N=281, SD=20.9)	84.5 (N=298, SD=21.3)

Figure 32 and Figure 33 illustrate that the nature of differences between pre-transition and post-transition survey index scores varied by LME/MCO. The largest pre-to-post gains were observed for Eastpointe and Vaya members, for whom pre-transition QOL and SAT were the lowest. Alliance and Trillium members tended to report higher pre-transition QOL and SAT and smaller post-transition gains. Partners pre-transition respondents reported relatively high levels of QOL, and lower SAT. Sandhills respondent post-transition reports were among the highest, particularly for SAT.[64]

requirement for conducting Quality of Life surveys since implementing them in 2013, alternative administration methods such as per to peer interviews or third-party or independent administration may be more useful. As part of its QAPI work with Mathematica in SFY 23-24, the State is researching alternative models and tools in an effort to identify a replacement Quality of Life survey.

[63] SD = standard deviation, an indicator of variability that expresses the average number of points individual respondents' scores differed from the overall average.

[64] Partners Pre-Transition and Sandhills Supportive Housing population scores are suppressed due to small numbers of respondent surveys (< 30) submitted by the time of response data download.

FIGURE 32: QUALITY OF LIFE INDEX BY LME/MCO, SFY 22-23

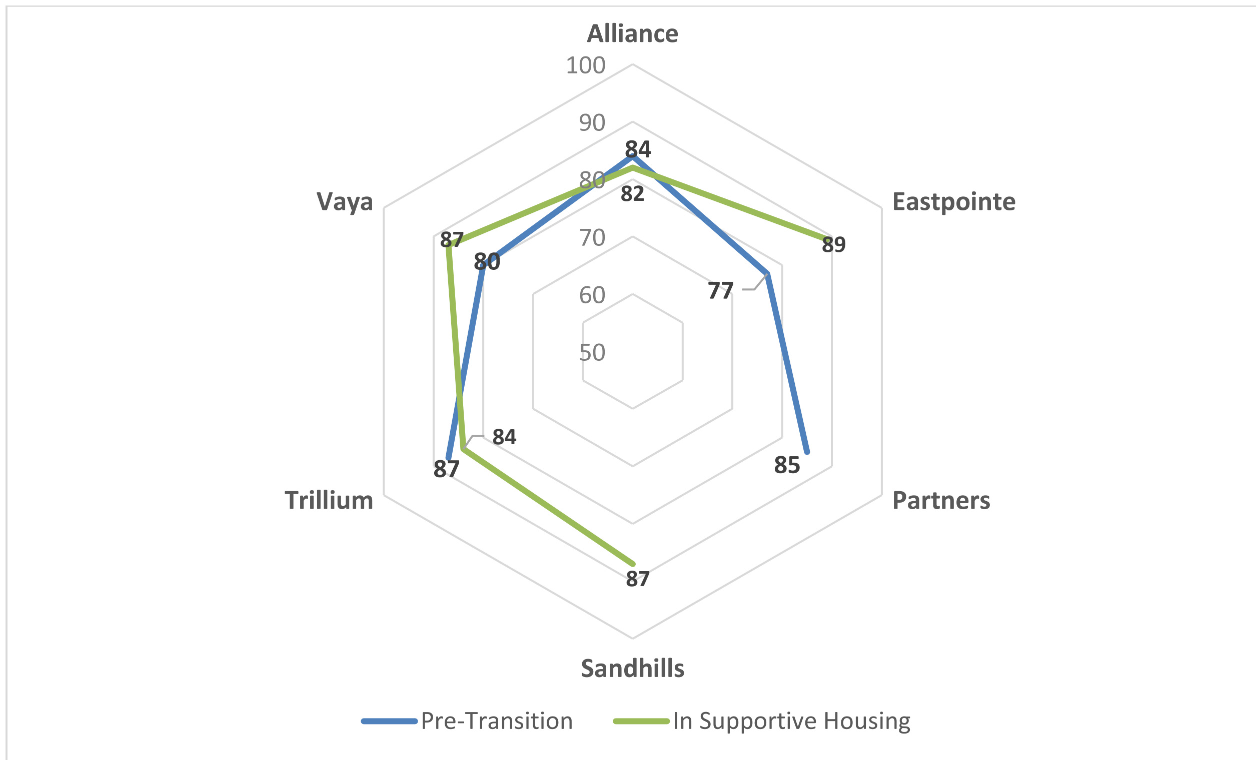
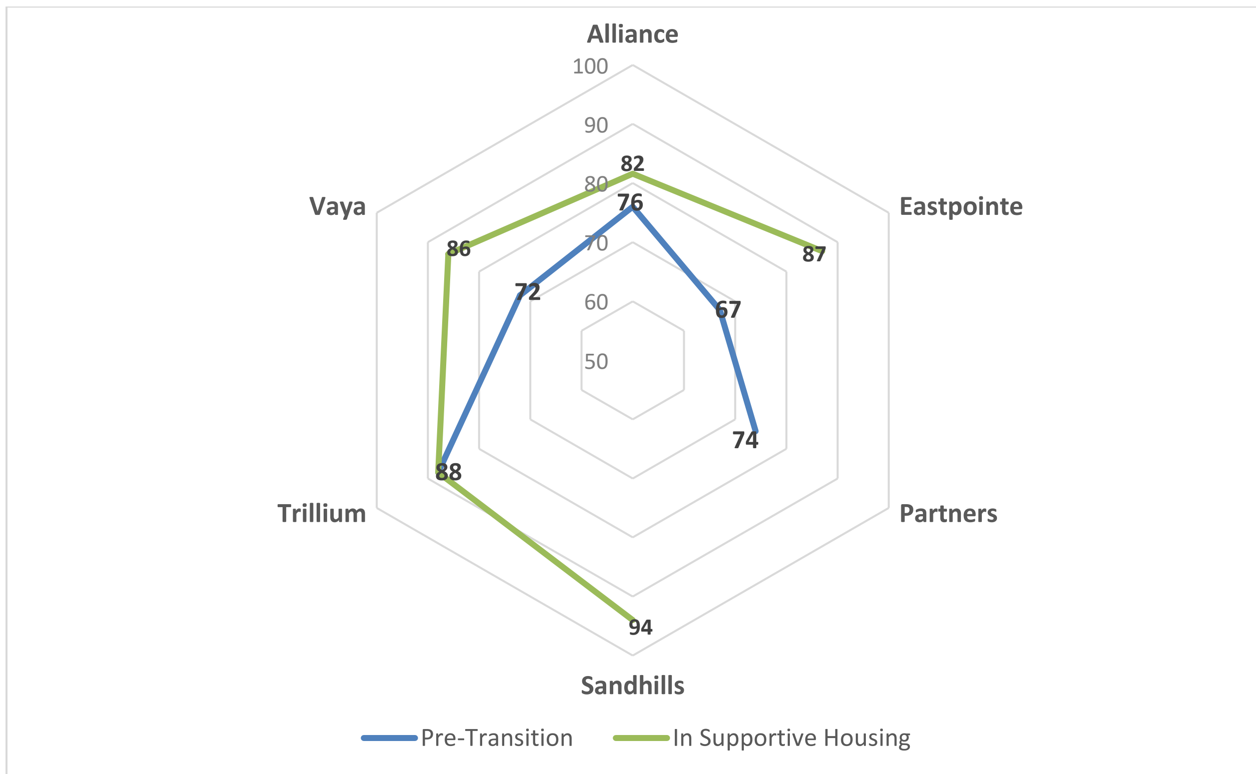


FIGURE 33: SATISFACTION INDEX BY LME/MCO, SFY 22-23



Additional member outcome measures related to Quality of Life, community integration, employment and

education, perceptions of service helpfulness, and barriers to treatments were implemented in SFY 22-23 through the TCL Performance Data Dashboard. These measures are based on NC Treatment Outcomes and Program Performance System (NC-TOPPS), a web-based assessment program that gathers outcome and performance data on behalf of mental health and substance use service clients.[65] To support annual outcomes trending, retrospective TCL Dashboard NC-TOPPS measures were calculated using housed TCL member assessments dating back to SFY 16-17.[66]

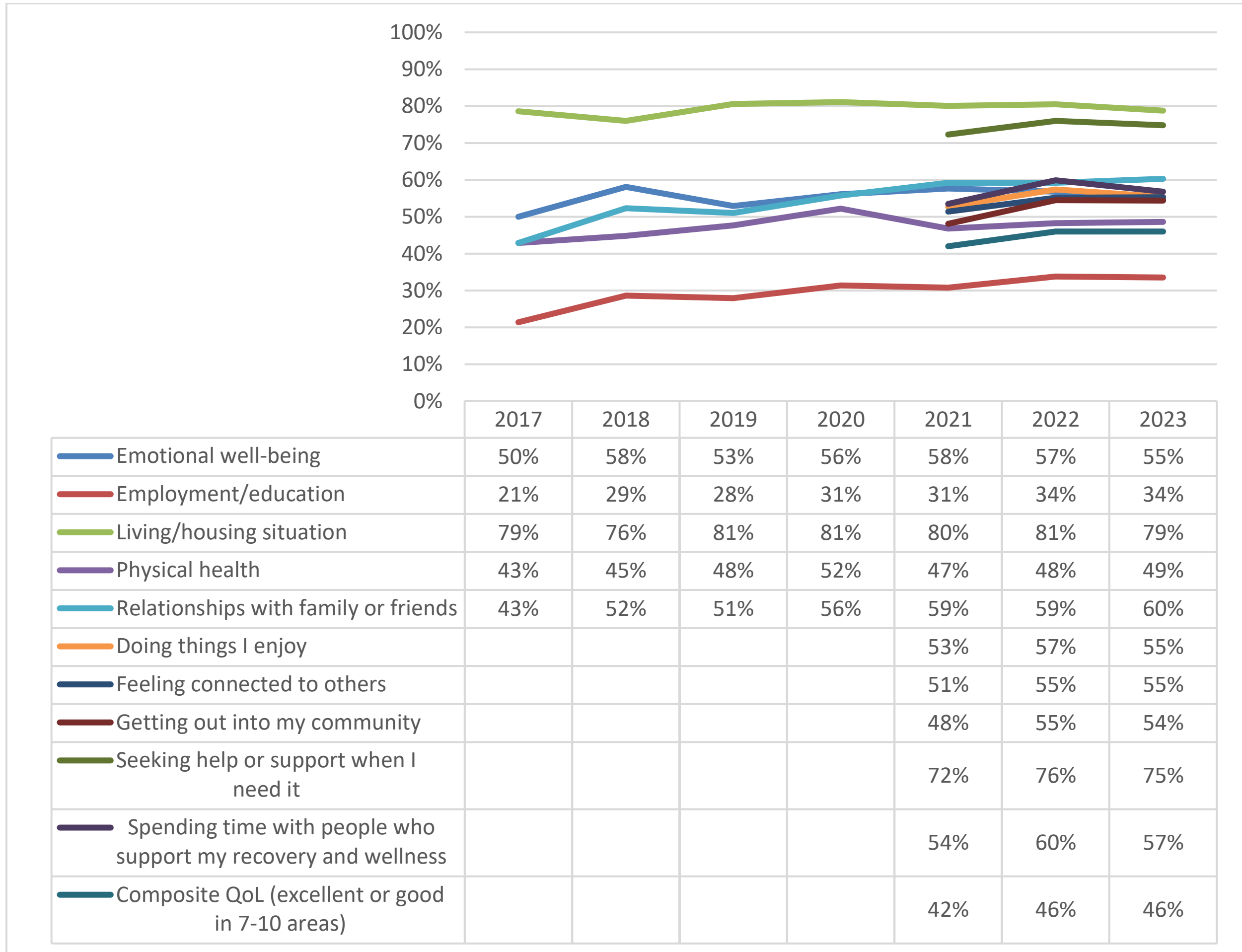
NC-TOPPS assessments are facilitated by service providers and administered upon service admission, at regular intervals (3, 6, and 12 months, and every 6 months thereafter), and again upon treatment discharge. These assessments are required for members receiving substance use services and enhanced community-based mental health services such as Assertive Community Treatment Team (ACT), Community Support Team (CST), and Individual Placement and Support (IPS) Supported Employment, as well as Transition Management Services (TMS). NC-TOPPS assessment data therefore are available for most individuals in TCL supportive housing, although not every member in housing during a particular reporting period will have an assessment during the period.

[65] https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/reports/nc-topps-reports/nc-treatment-outcomes-and-program-performance-system-nc-topps

[66] A subset of measures is only available from SFY 20-21, when additional assessment items were added to NC-TOPPS interviews to support TCL monitoring of aspects of member community integration.

Figure 34 illustrates annual assessment results for an alternate Quality of Life measure that is based on SFY 22-23 NC-TOPPS interviews with members in housing. A composite NC-TOPPS QOL measure is derived from assessment items that correspond to the 10 distinct areas of life shown. For each component, percentages shown reflect the proportion of individuals assessed who reported doing “excellent” or “good” versus “fair” or “poor” in that particular area of their life over the past three months. The composite measure reflects the percentage of members assessed to reported doing “excellent” or “good” in seven or more of the 10 areas assessed.

FIGURE 34: NC-TOPPS QUALITY OF LIFE COMPOSITE AND COMPONENT MEASURES: PARTICIPANTS WHO REPORTED HIGH QUALITY OF LIFE (DOING “EXCELLENT” OR “GOOD”) IN PAST THREE MONTHS[67][68]



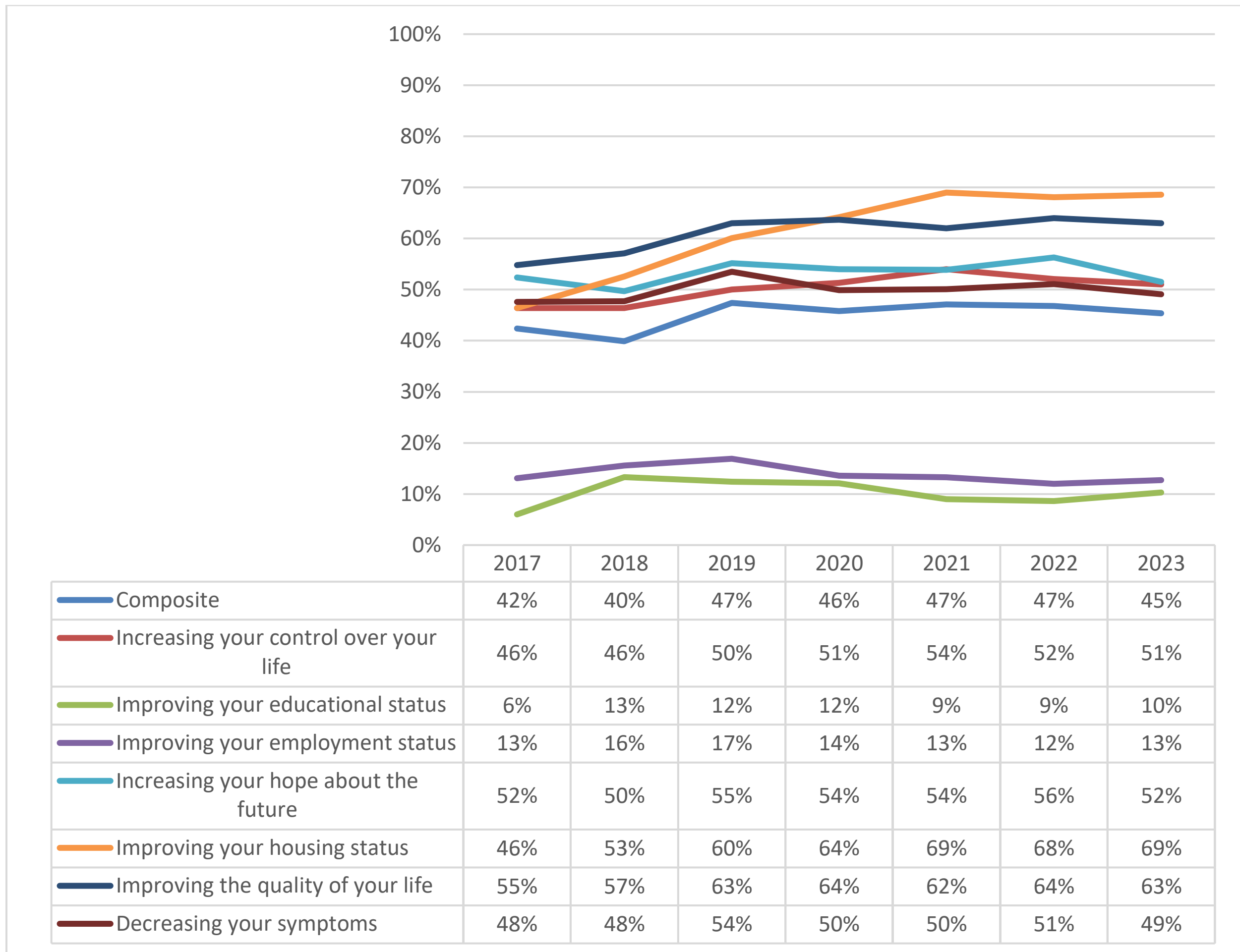
	2017	2018	2019	2020	2021	2022	2023
Emotional well-being	50%	58%	53%	56%	58%	57%	55%
Employment/education	21%	29%	28%	31%	31%	34%	34%
Living/housing situation	79%	76%	81%	81%	80%	81%	79%
Physical health	43%	45%	48%	52%	47%	48%	49%
Relationships with family or friends	43%	52%	51%	56%	59%	59%	60%
Doing things I enjoy					53%	57%	55%
Feeling connected to others					51%	55%	55%
Getting out into my community					48%	55%	54%
Seeking help or support when I need it					72%	76%	75%
Spending time with people who support my recovery and wellness					54%	60%	57%
Composite QoL (excellent or good in 7-10 areas)					42%	46%	46%

[67] Five of the 10 component items were added to the NC-TOPPS assessment in SFY 20-21 to support TCL monitoring and reporting. Values for those five items and the composite QOL measure are not available prior to SFY 20-21.

[68] SFY 22-23 values are based on NC-TOPPS interviews with 1,244 members in TCL Housing.

Figure 35 shows percentages of housed members who reported at the most recent NC-TOPPS assessment during the year that their services had been "very helpful" versus "somewhat helpful" or "not helpful" with each of seven outcomes. The composite Service Helpfulness measure is the calculated percentage of participants who indicated that services had been "very helpful" with 70 percent or more of the number of outcomes they rated.

FIGURE 35: NC-TOPPS PARTICIPANTS WHO REPORTED A HIGH LEVEL OF PROGRAM SERVICES HELPFULNESS ("VERY HELPFUL") FOR ACHIEVING POSITIVE OUTCOMES[69,70]



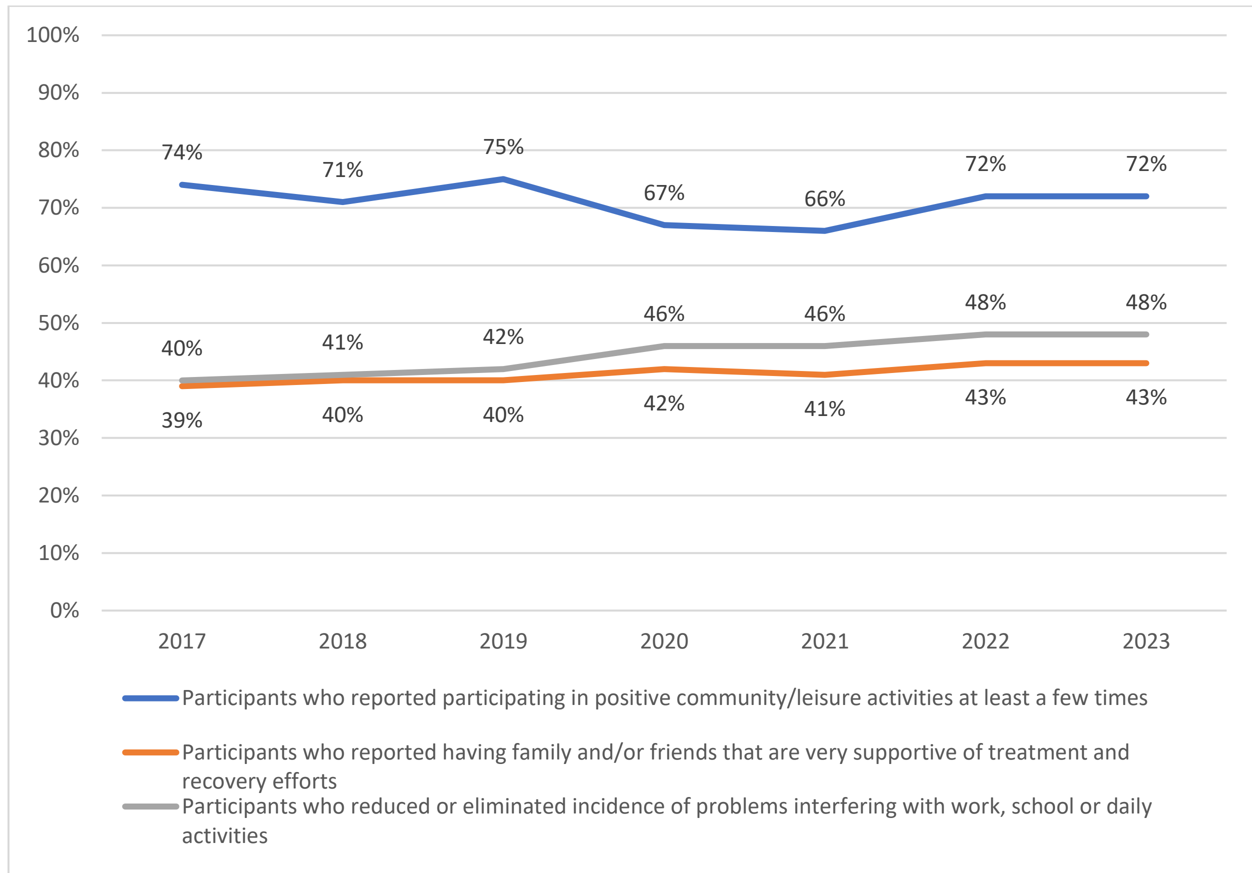
	2017	2018	2019	2020	2021	2022	2023
Composite	42%	40%	47%	46%	47%	47%	45%
Increasing your control over your life	46%	46%	50%	51%	54%	52%	51%
Improving your educational status	6%	13%	12%	12%	9%	9%	10%
Improving your employment status	13%	16%	17%	14%	13%	12%	13%
Increasing your hope about the future	52%	50%	55%	54%	54%	56%	52%
Improving your housing status	46%	53%	60%	64%	69%	68%	69%
Improving the quality of your life	55%	57%	63%	64%	62%	64%	63%
Decreasing your symptoms	48%	48%	54%	50%	50%	51%	49%

[69] Five of the 10 component items were added to the NC-TOPPS assessment in SFY 20-21 to support TCL monitoring and reporting. Values for those five items and the composite QOL measure are not available prior to SFY 20-21.

[70] SFY 22-23 values are based on NC-TOPPS interviews with 1,237 members in TCL Housing.

Figure 36 shows annual trend data for members in TCL housing, based on their most recent NC-TOPPS assessments, of participating in positive activities and having natural supports who are supportive of their treatment and recovery. Individuals who reduced or eliminated problems include those who reported problems had "never" interfered with work, school, or daily activities, as well as those who reported "a few times" at most recent assessment after having answered "more than a few times" in a previous assessment.

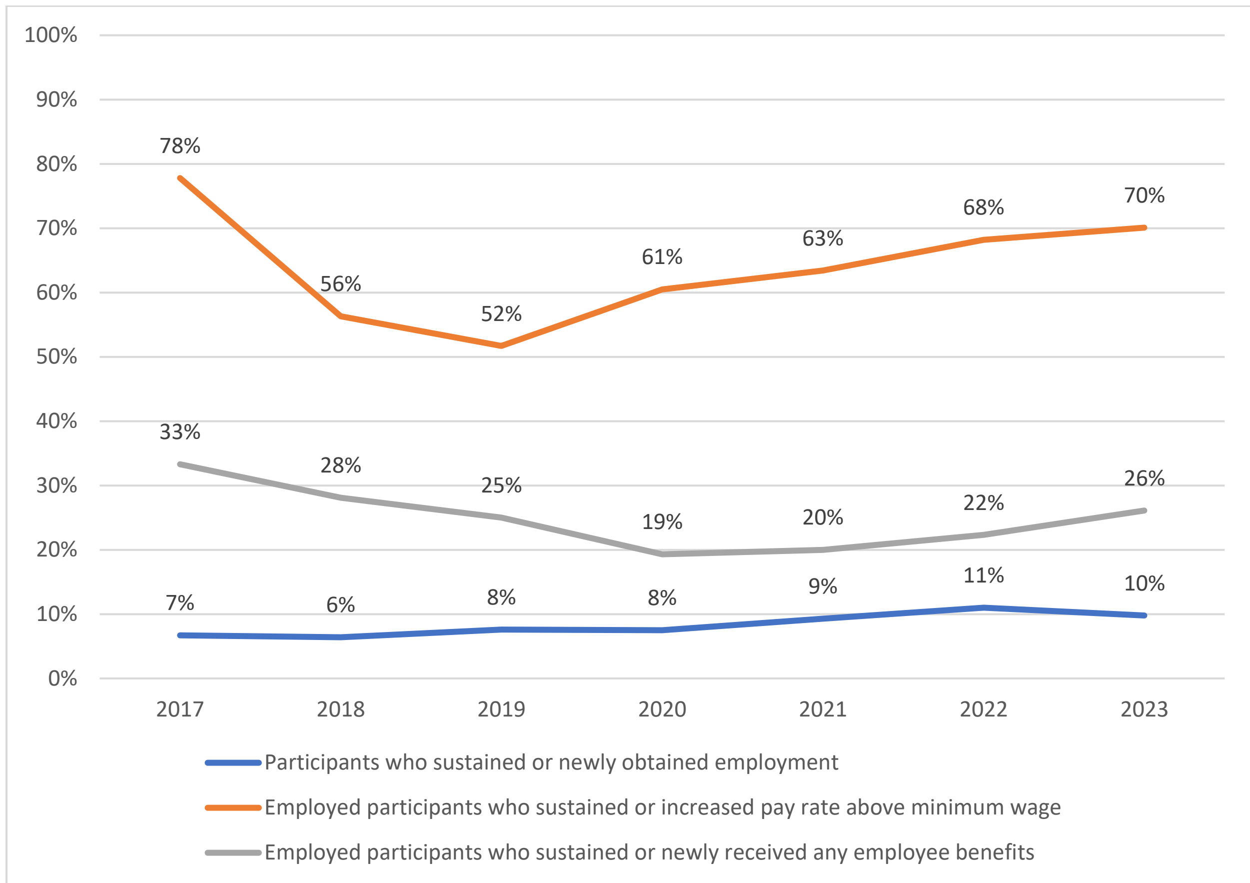
FIGURE 36: NC-TOPPS PARTICIPANTS WHO REPORTED POSITIVE COMMUNITY INTEGRATION OUTCOMES AT MOST RECENT ASSESSMENT[71]



[71] SFY 22-23 values for "problems interfering" and "community activities" measures are based on NC-TOPPS interviews with 2,145 members in TCL Housing; "supportive of recovery" measure is based on interviews with 1,244 members.

Figure 37 shows the percentage of NC-TOPPS participants who maintained or had become newly employed at the most recent assessment. Percentages shown of those who maintained or gained above minimum wage pay rates and employee benefits are subsets of those employed. Not shown, fewer than 2% each SFY beginning in 2021 reported each of four education related outcomes at their most recent assessment: college enrollment, high school or GED enrollment, vocational school, or certificate program enrollment, or taking adult education or recreational classes.

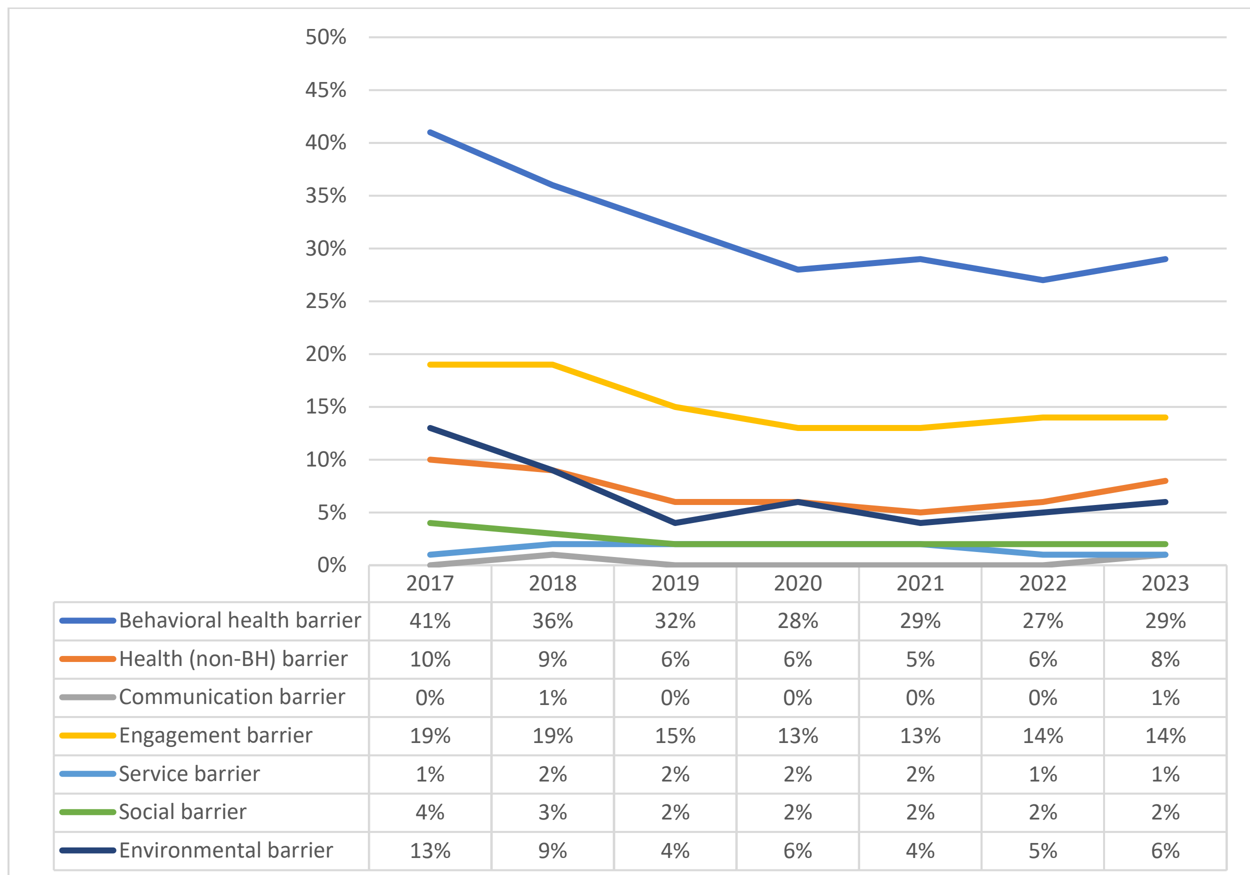
FIGURE 37: NC-TOPPS PARTICIPANTS WHO REPORTED POSITIVE EMPLOYMENT OUTCOMES AT MOST RECENT ASSESSMENT[72]



[72] SFY 22-23 values are based on NC-TOPPS interviews with 2,145 members in TCL Housing, 211 of whom sustained or newly obtained employment.

Figure 38 illustrates the percentage of NC-TOPPS participants who reported each of seven different types or categories of barriers to treatment: Physical Health, Communication (being deaf or hard of hearing, language or communication), Environmental (housing instability, transportation or distance to provider), Engagement (member engagement, cost of services, or other financial, legal, or scheduling barriers), Behavioral Health (mental health symptoms, substance use), Social (stigma/discrimination, family or guardian, personal safety), and Treatment (access, treatment didn't meet needs).

FIGURE 38: NC-TOPPS PARTICIPANTS WHO REPORTED BARRIERS TO TREATMENT AT MOST RECENT ASSESSMENT[73]



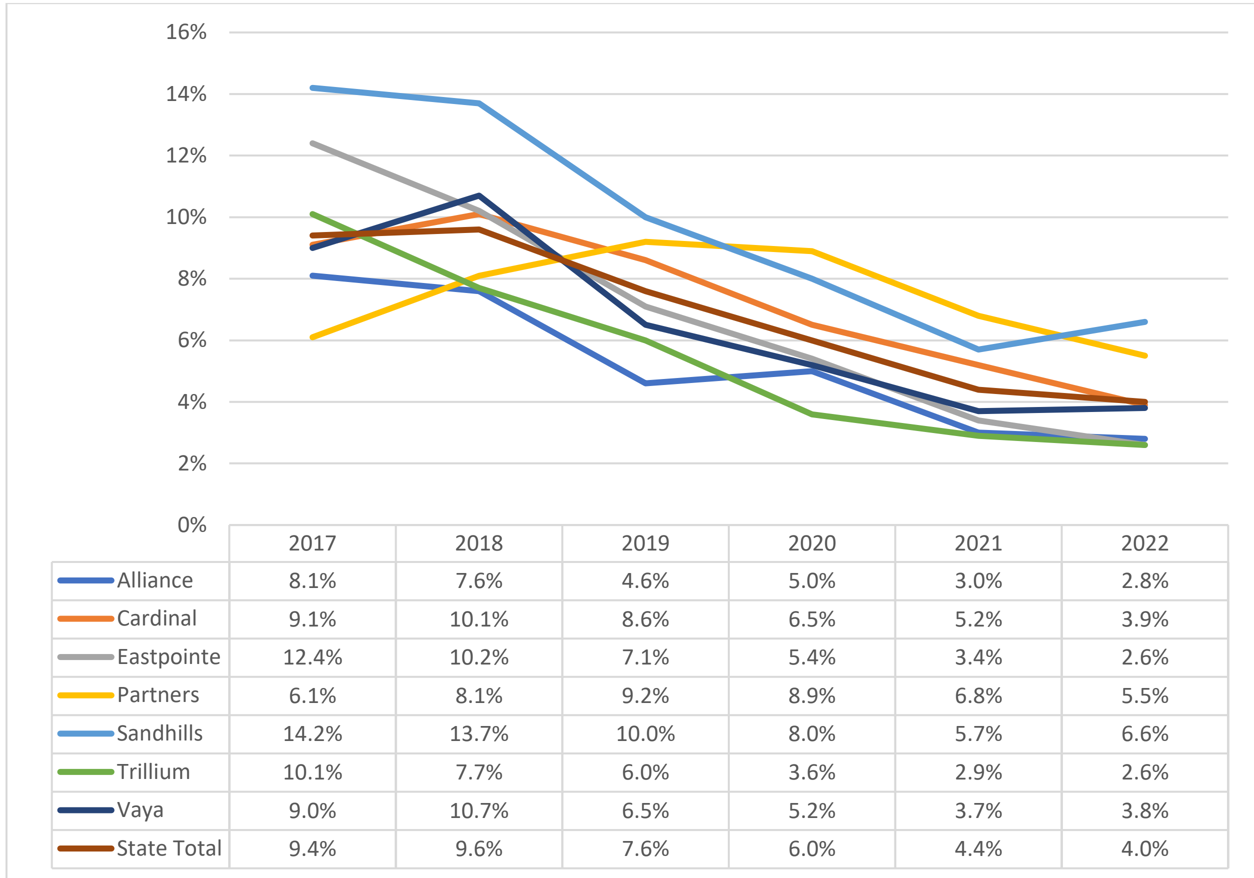
	2017	2018	2019	2020	2021	2022	2023
Behavioral health barrier	41%	36%	32%	28%	29%	27%	29%
Health (non-BH) barrier	10%	9%	6%	6%	5%	6%	8%
Communication barrier	0%	1%	0%	0%	0%	0%	1%
Engagement barrier	19%	19%	15%	13%	13%	14%	14%
Service barrier	1%	2%	2%	2%	2%	1%	1%
Social barrier	4%	3%	2%	2%	2%	2%	2%
Environmental barrier	13%	9%	4%	6%	4%	5%	6%

10.4.7. TIME SPENT IN CONGREGATE DAY PROGRAMMING

Psychosocial Rehabilitation (PSR) service rates are shown in Section 3 of this annual report. Figure 39 demonstrates that the state total percentage of individuals in TCL supportive housing receiving services in congregate day programming settings has declined steadily since 2017, and this general pattern is observed across LME/MCOs.

[73] SFY 22-23 values are based on NC-TOPPS interviews with 2,145 members in TCL Housing.

FIGURE 39: MEMBERS IN TCL SUPPORTIVE HOUSING PSYCHOSOCIAL REHABILITATION SERVICE RATES, ANNUAL TRENDS, SFY 16-17 TO SFY 21-22



	2017	2018	2019	2020	2021	2022
Alliance	8.1%	7.6%	4.6%	5.0%	3.0%	2.8%
Cardinal	9.1%	10.1%	8.6%	6.5%	5.2%	3.9%
Eastpointe	12.4%	10.2%	7.1%	5.4%	3.4%	2.6%
Partners	6.1%	8.1%	9.2%	8.9%	6.8%	5.5%
Sandhills	14.2%	13.7%	10.0%	8.0%	5.7%	6.6%
Trillium	10.1%	7.7%	6.0%	3.6%	2.9%	2.6%
Vaya	9.0%	10.7%	6.5%	5.2%	3.7%	3.8%
State Total	9.4%	9.6%	7.6%	6.0%	4.4%	4.0%

Results of additional analysis of paid NCTracks claims for individuals in TCL housing are shown in Table 22.[74] These results address the requirement in III.G.3.g.v. of the settlement agreement with US DOJ for the State to collect and monitor data on time spent in congregate day programming.

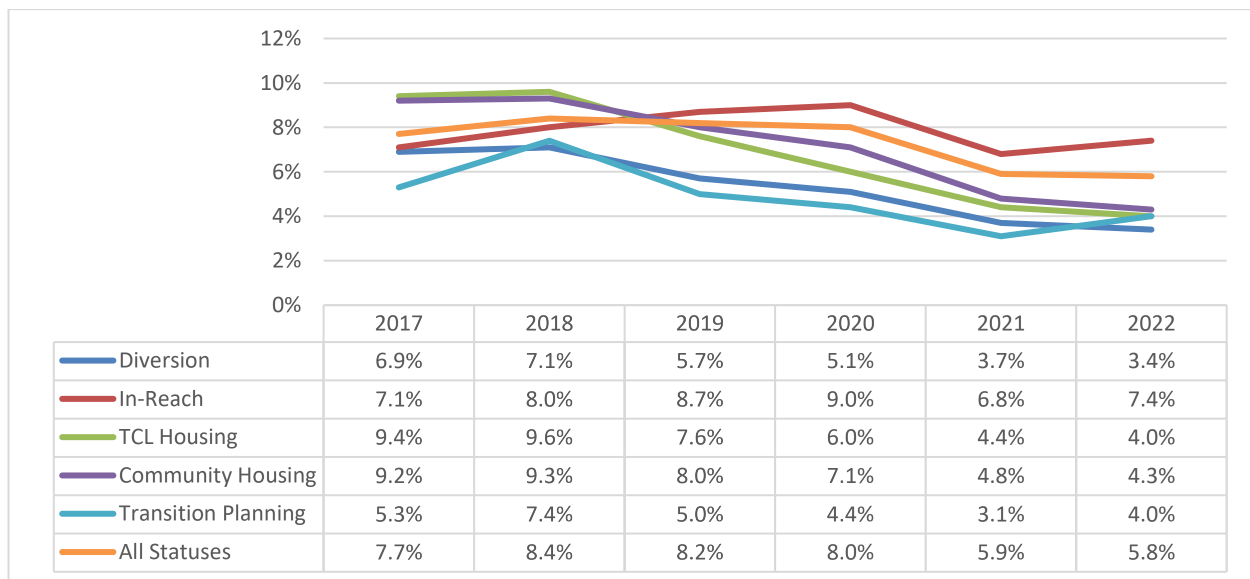
[74]Psychosocial Rehabilitation service claim details including minimum and maximum service dates and total numbers of 15-minute service units per member were retrieved directly from the NCTracks claims data warehouse in July 2022 with a six-month lag to allow for adjudication of Calendar Year 2021 professional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

TABLE 22: SFY 21-22 TIME SPENT IN CONGREGATE DAY PROGRAMMING (PSYCHOSOCIAL REHABILITATION, PSR), INDIVIDUALS IN TCL SUPPORTIVE HOUSING

LME/MCO	N with PSR[75]	% of Housed	Average Duration[76] (Weeks)	Average Hours/ Week[77]
Alliance	31	2.8%	23.3	7.6
Cardinal	35	3.9%	29.1	14.1
Eastpointe	8	2.6%	37.5	18.2
Partners	30	5.5%	31.9	8.5
Sandhills	28	6.6%	30.9	15.4
Trillium	14	2.6%	31.1	12.4
Vaya	24	3.8%	33.8	14.4
State Total	**146**	**4.0%**	**35.2**	**14.3**

Although the trend is less pronounced for individuals receiving In-Reach services, percentages of participants in all settings and TCL statuses receiving Psychosocial Rehabilitation services in congregate day program settings have declined over time, as shown in Figure 40 through Figure 43.[78]

FIGURE 40: ANNUAL TRENDS IN TCL MEMBER PSYCHOSOCIAL REHABILITATION SERVICE RATES BY STATUS



	2017	2018	2019	2020	2021	2022
Diversion	6.9%	7.1%	5.7%	5.1%	3.7%	3.4%
In-Reach	7.1%	8.0%	8.7%	9.0%	6.8%	7.4%
TCL Housing	9.4%	9.6%	7.6%	6.0%	4.4%	4.0%
Community Housing	9.2%	9.3%	8.0%	7.1%	4.8%	4.3%
Transition Planning	5.3%	7.4%	5.0%	4.4%	3.1%	4.0%
All Statuses	7.7%	8.4%	8.2%	8.0%	5.9%	5.8%

Figure 41, Figure 42, and Figure 43 show historical trends by TCL status in numbers of individuals receiving PSR, and average weeks and hours per week of PSR.

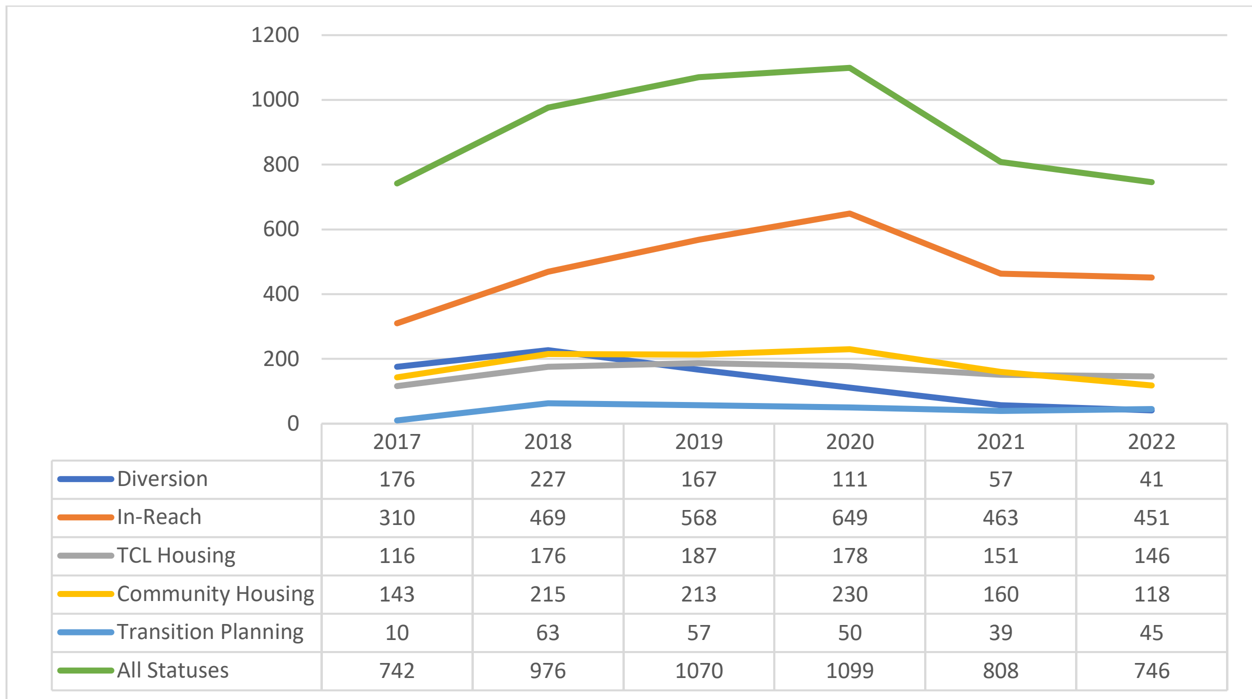
[75] The State Total is the unduplicated client count.

[76] 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.

[77] 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.

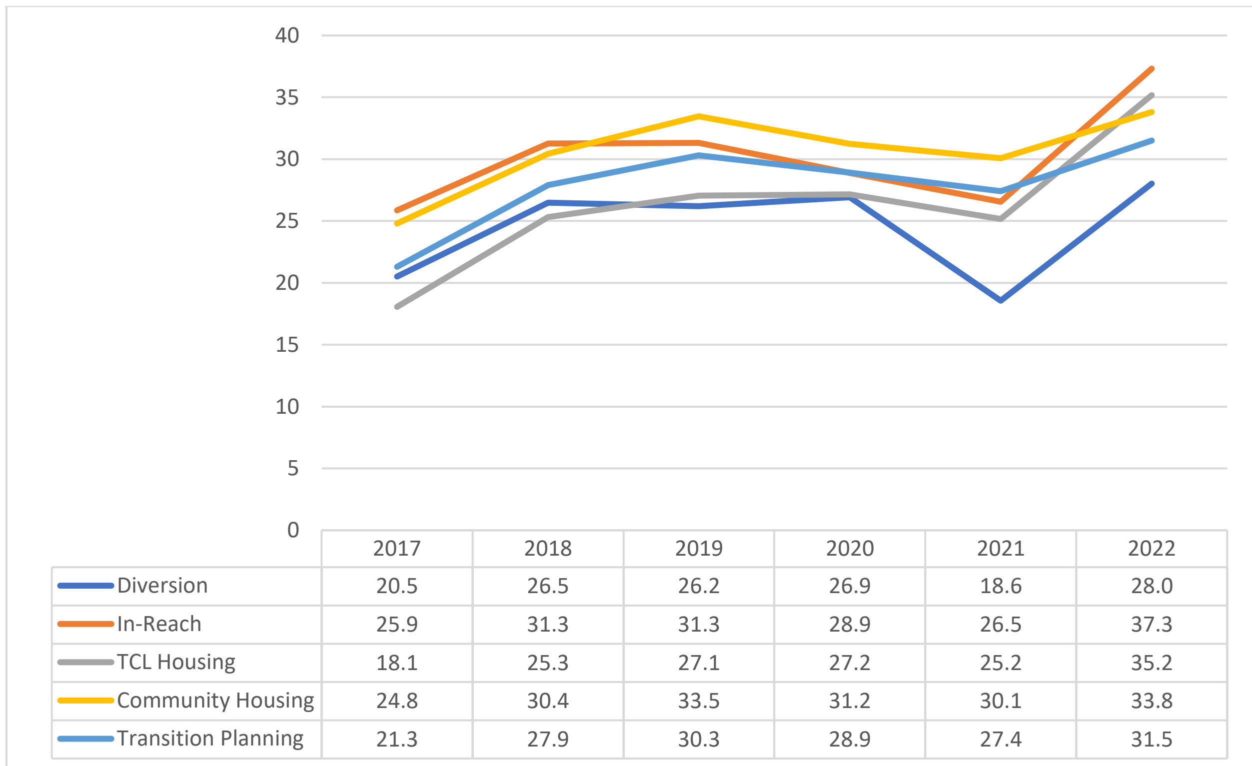
[78] In Figures 40 through 43, Transition Planning status includes members planning for either initial transition or rehousing.

FIGURE 41: ANNUAL TRENDS IN NUMBERS OF TCL MEMBERS RECEIVING PSR



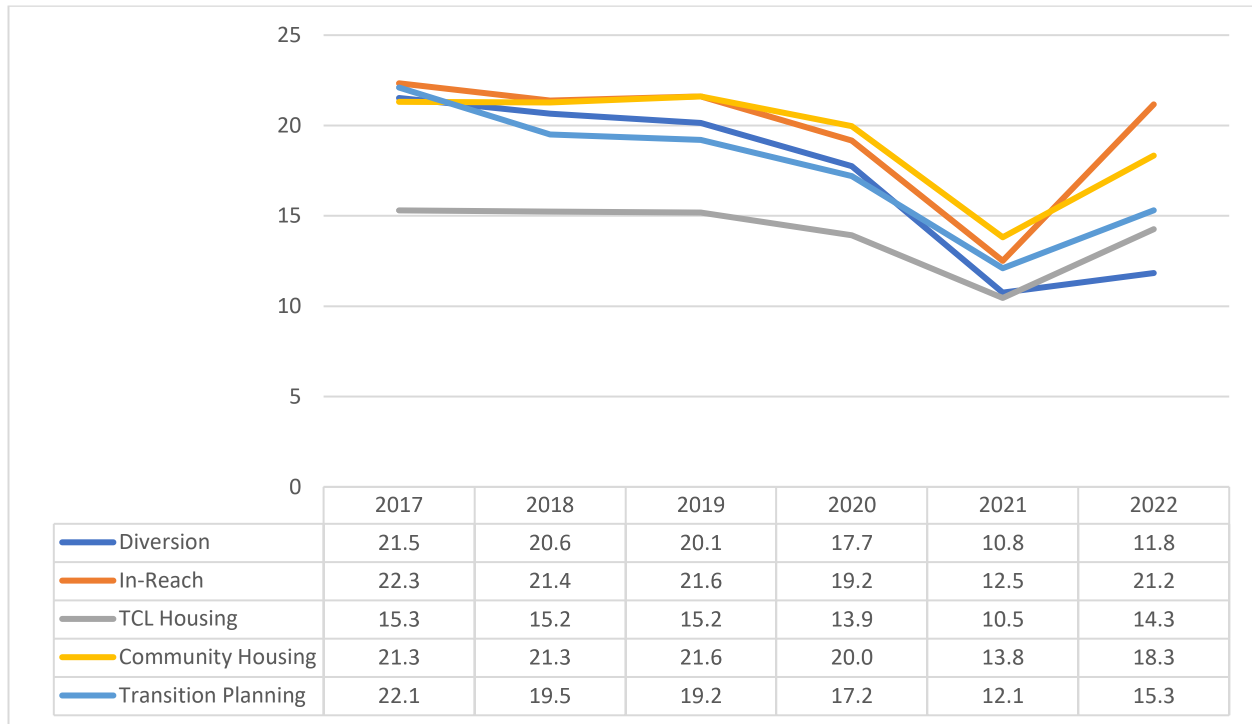
	2017	2018	2019	2020	2021	2022
Diversion	176	227	167	111	57	41
In-Reach	310	469	568	649	463	451
TCL Housing	116	176	187	178	151	146
Community Housing	143	215	213	230	160	118
Transition Planning	10	63	57	50	39	45
All Statuses	742	976	1070	1099	808	746

FIGURE 42: ANNUAL TRENDS IN AVERAGE WEEKS OF PSR BY STATUS



	2017	2018	2019	2020	2021	2022
Diversion	20.5	26.5	26.2	26.9	18.6	28.0
In-Reach	25.9	31.3	31.3	28.9	26.5	37.3
TCL Housing	18.1	25.3	27.1	27.2	25.2	35.2
Community Housing	24.8	30.4	33.5	31.2	30.1	33.8
Transition Planning	21.3	27.9	30.3	28.9	27.4	31.5

FIGURE 43: ANNUAL TRENDS IN AVERAGE HOURS PER WEEK OF PSR BY STATUS



	2017	2018	2019	2020	2021	2022
Diversion	21.5	20.6	20.1	17.7	10.8	11.8
In-Reach	22.3	21.4	21.6	19.2	12.5	21.2
TCL Housing	15.3	15.2	15.2	13.9	10.5	14.3
Community Housing	21.3	21.3	21.6	20.0	13.8	18.3
Transition Planning	22.1	19.5	19.2	17.2	12.1	15.3

10.4.8. COMMUNITY TENURE AND SEPARATIONS

At the end of SFY 22-23, 58 percent of individuals transitioned over the life of the program were in TCL supportive housing, with an average of 28.5 months since the initial transition date. Table 23 shows life of program percentages ever transitioned who were in TCL supportive housing at milestones ranging from three months to two years or longer after the initial transition.

TABLE 23: LIFE OF PROGRAM INDIVIDUALS IN TCL SUPPORTIVE HOUSING AT POST-TRANSITION MILESTONES[79]

Time from Initial Transition	Total Possible in TCL Housing at Milestone	Number in TCL Housing at Milestone	Percent in TCL Housing at Milestone
3 months or longer	4,924	4,772	97%
6 months or longer	4,743	4,377	92%
1 year or longer	4,391	3,618	82%
1.5 years or longer	4,117	3,083	75%
2 years or longer	3,820	2,630	69%

Figure 44 shows the percentages of individuals in housing at SFY 22-23 year-end relative to the number of years since their initial transitions to supportive housing. Approximately equal numbers of members in housing were housed within and earlier than the past two state fiscal years. More than one-third of housed

[79] Individuals in TCL supportive housing at each milestone include members continuously housed since the time of transition as well as members separated and rehoused between initial transition and milestone. “Total Possible” is the total number of individuals at end of SFY 22-23 who had initially transitioned to TCL supportive housing three months or more before April 2023.

members first transitioned more than three years ago, and more than one-fifth transitioned more than four years ago. More than one-tenth (421 individuals, 12.6% of housed) of individuals in TCL housing at SFY 22-23 year-end initially transitioned more than five years and up to 10 years earlier.

FIGURE 44: FULL OR PARTIAL YEARS SINCE TRANSITION, MEMBERS HOUSED AT END OF SFY 22-23[80]

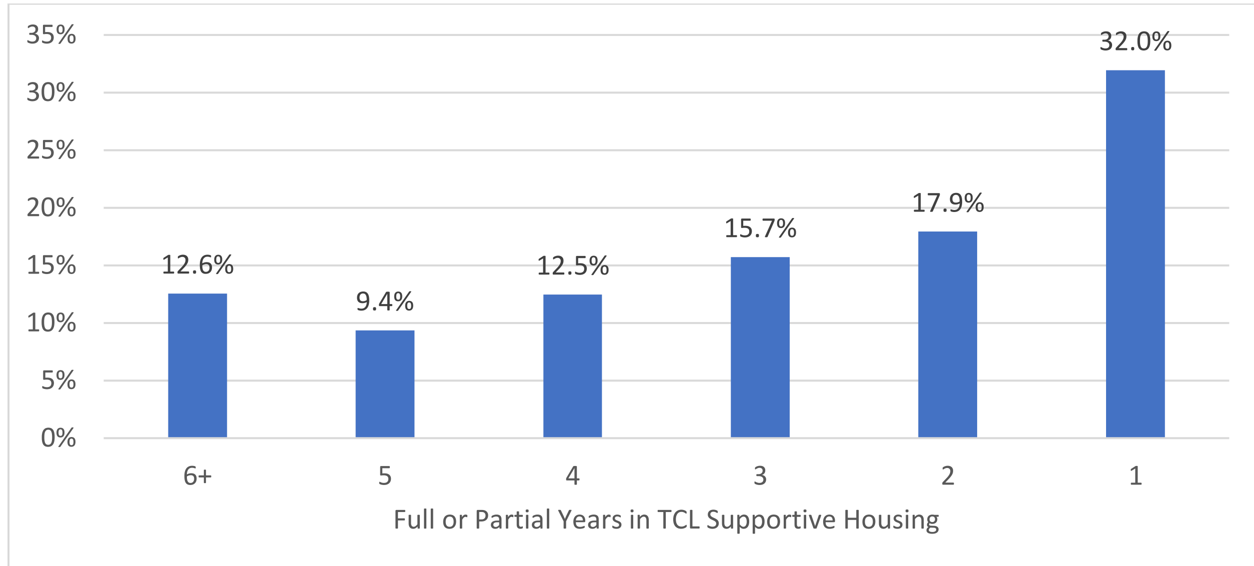
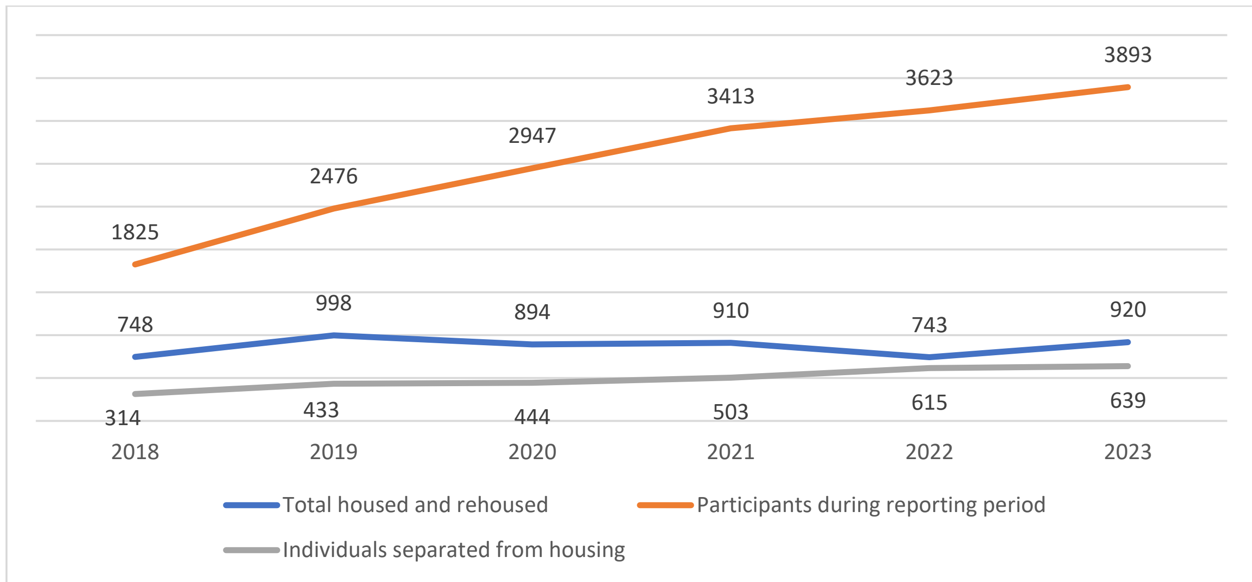


Figure 45 shows annual trends and relationships between total numbers of individuals in TCL supportive housing, numbers housed for the first time and rehoused, and numbers separated each SFY. Beginning with SFY 17-18, a negligible association is observed between the number of separations and the number of individuals housed for the first time or rehoused each SFY (correlation = 0.08), with the number separated ranging between 42 to 83 percent of the number housed in the same SFY. In contrast, annual numbers of separations for the same period are almost perfectly predicted by the total number of individuals in housing during each SFY (correlation = 0.96).[81]

[80] Values in this figure are derived from NCDHHS administrative housing record initial transition dates for members in housing at end of SFY 22-23.

[81] Including earlier SFYs in this analysis, the correlation between total numbers in housing and separated is substantially higher, likely a statistical result of the smaller number of individuals in housing and the larger impact of individuals transitioned or rehoused on the total number in housing. For example, with SFY 16-17 (1,228 in housing at any time during SFY, 676 housed or rehoused during the SFY, and 127 separated), the correlation between number housed or rehoused and number separated jumps to 0.52. The resulting correlation between total number in housing and number of separations also increases, to 0.98.

FIGURE 45: TCL HOUSING POPULATION SIZE, HOUSING TRANSITIONS, AND HOUSING SEPARATIONS



The interpretation that separation numbers are a stable function of the size of the population in housing is supported by annual trends in housing separation rates. Figure 46 illustrates remarkable stability in annual and average quarterly housing separation rates, with slight variation apparent in lower SFY 19-20 and SFY 20-21 separation rates, which may be attributable to pandemic conditions during those years. Over the six-year period from SFY 17-18 to SFY 22-23, average annual and quarterly separation rates were 16.3 and 4.9 percent, respectively.

FIGURE 46: ANNUAL AND AVERAGE QUARTERLY HOUSING SEPARATION RATES

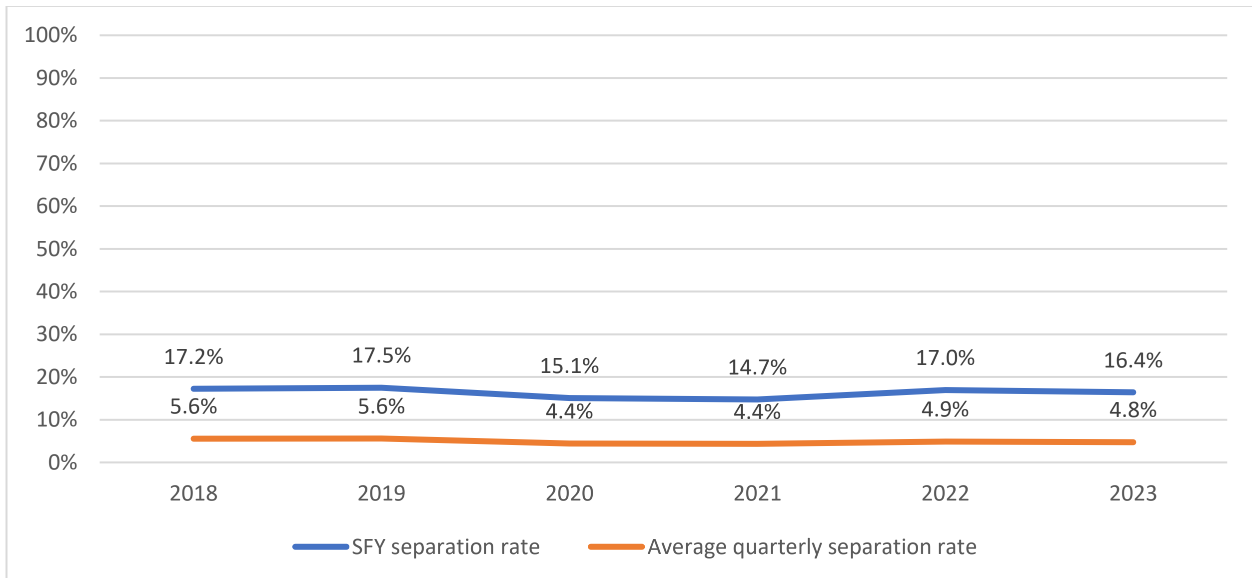
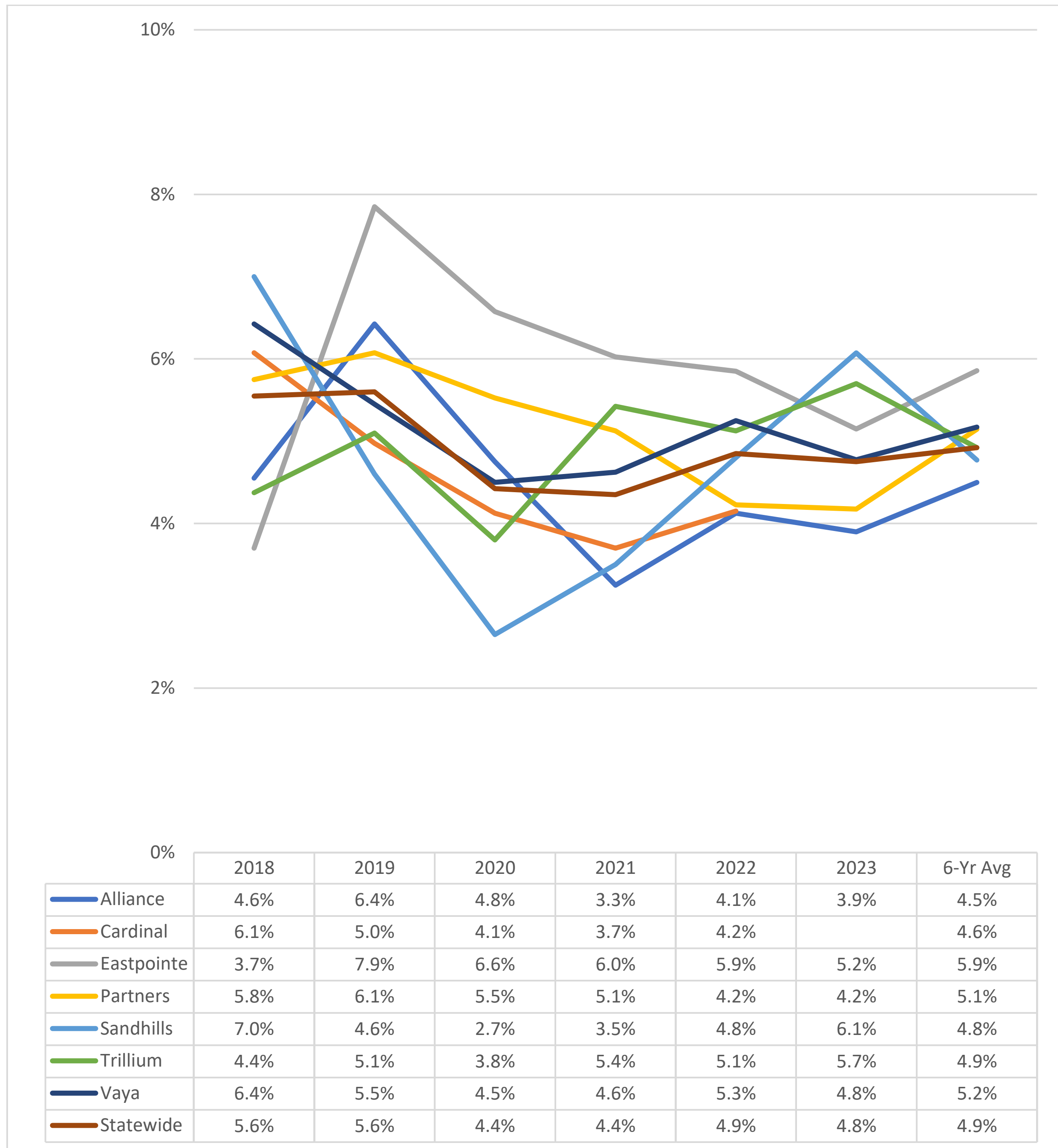


Figure 47 illustrates six-year trends in average quarterly separations by LME/MCO, and Figure 48 illustrates SFY 22-23 quarterly separation rates.[82] Greater variability across LME/MCOs is observed within quarters

[82] TCL Performance Data Dashboard housing separation rates are based on retrospective analysis of member leasing and tenancy data from the NC

than in average quarterly rates or across years, and annual average quarterly rates are more variable than average rates across the six-year span. Greater variability in separation rates over shorter periods of time likely reflects, in part, random statistical fluctuations, such as unique circumstances that may contribute to individual housing separations.

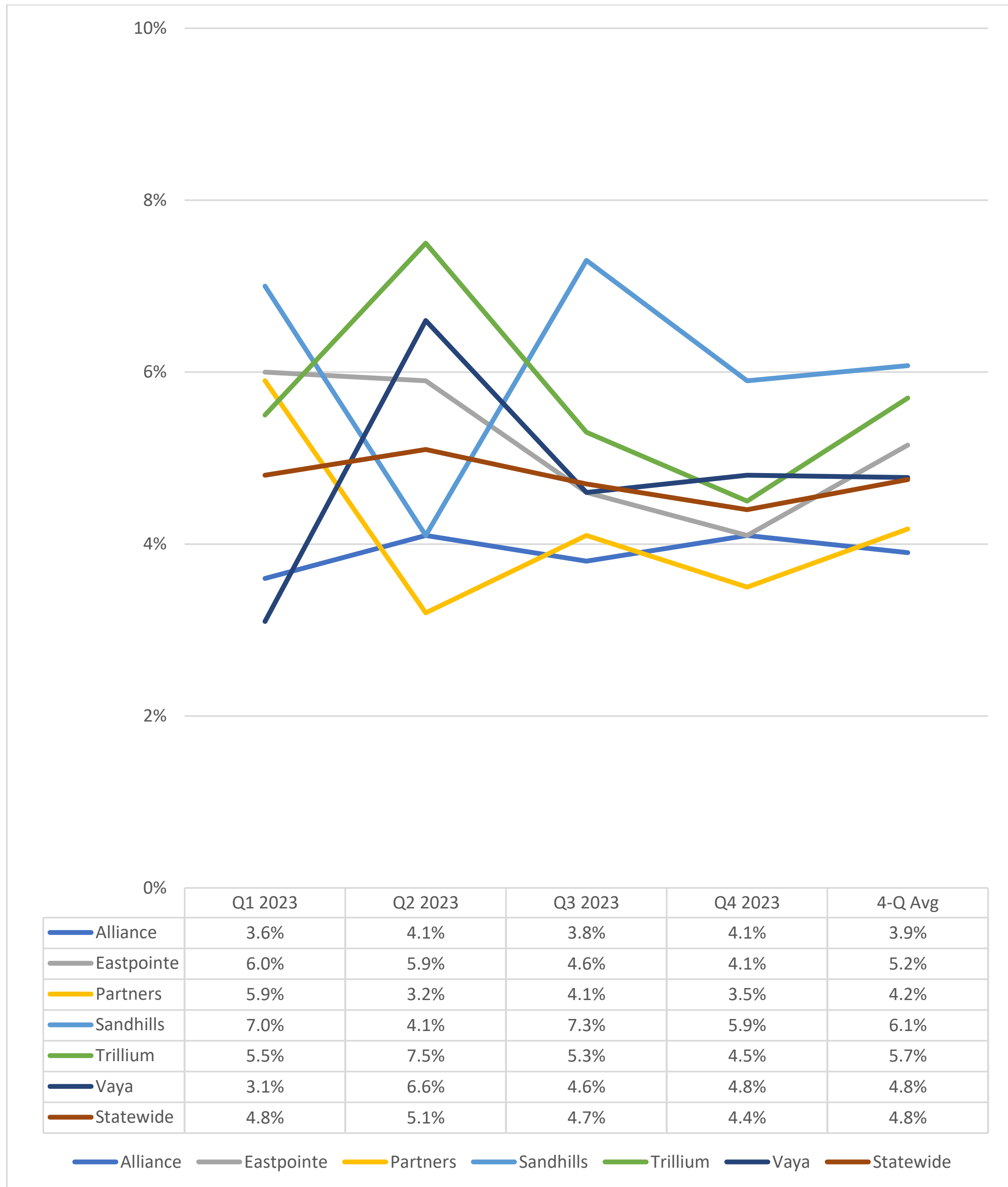
FIGURE 47: SFY AVERAGE QUARTERLY HOUSING SEPARATION RATES BY LME/MCO



	2018	2019	2020	2021	2022	2023	6-Yr Avg
Alliance	4.6%	6.4%	4.8%	3.3%	4.1%	3.9%	4.5%
Cardinal	6.1%	5.0%	4.1%	3.7%	4.2%		4.6%
Eastpointe	3.7%	7.9%	6.6%	6.0%	5.9%	5.2%	5.9%
Partners	5.8%	6.1%	5.5%	5.1%	4.2%	4.2%	5.1%
Sandhills	7.0%	4.6%	2.7%	3.5%	4.8%	6.1%	4.8%
Trillium	4.4%	5.1%	3.8%	5.4%	5.1%	5.7%	4.9%
Vaya	6.4%	5.5%	4.5%	4.6%	5.3%	4.8%	5.2%
Statewide	5.6%	5.6%	4.4%	4.4%	4.9%	4.8%	4.9%

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.

FIGURE 48: QUARTERLY HOUSING SEPARATION RATES BY LME/MCO, SFY 22-23



	Q1 2023	Q2 2023	Q3 2023	Q4 2023	4-Q Avg
Alliance	3.6%	4.1%	3.8%	4.1%	3.9%
Eastpointe	6.0%	5.9%	4.6%	4.1%	5.2%
Partners	5.9%	3.2%	4.1%	3.5%	4.2%
Sandhills	7.0%	4.1%	7.3%	5.9%	6.1%
Trillium	5.5%	7.5%	5.3%	4.5%	5.7%
Vaya	3.1%	6.6%	4.6%	4.8%	4.8%
Statewide	4.8%	5.1%	4.7%	4.4%	4.8%

Table 24 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. The outcomes and destinations shown in Table 24 are reported by LME/MCOs upon member separations from housing.

TABLE 24: LIFE OF PROGRAM HOUSING SEPARATION OUTCOMES AND DESTINATIONS[83]

Outcome or Destination	Number	Percent
Adult Care Home	480	20.5%
Alternative Family Living (Unlicensed)	7	0.3%
Adult Living Facility	33	1.4%
Deceased	556	23.8%
Family/Friends	345	14.7%
Hospice	3	0.1%
Independent	552	23.6%
Jail/ Prison	113	4.8%
Medical Hospital	57	2.4%
Mental Health Group Home	47	2.0%
Skilled Nursing Facility	61	2.6%
State Psychiatric Hospital	42	1.8%
Substance Use Facility	39	1.7%
Unknown	5	0.2%
Out of State	1	0.0%
Total	**2341**	**100.0%**

Table 25 shows life of program housing and separation rates by priority population category. SPH population percentages in housing have remained relatively stable over time, representing 18 percent ever housed and 17 percent in housing at SFY 22-23 year-end. In contrast, the ACH population percentage of members in housing has decreased as a percentage of those ever housed by approximately 22 relative percentage points, from 37 percent ever housed to 29 percent in housing at SFY 22-23 year-end. This decrease is mirrored by a 22-percentage increase in Diversion population members who remained in housing relative to the number ever housed. The shift over time in the population makeup of members in housing is accounted for largely by the 55 percent ACH population separation rate, which is more than 1.75 times higher than the Diversion population separation rate. While 80 percent as many ACH compared to Diversion population members have ever transitioned to TCL supportive housing, only half as many ACH as Diversion population members remained in housing at SFY 22-23 year-end. For every 20 ACH population members ever housed, approximately nine remained in housing, compared to 14 of every 20 Diversion population members ever housed.

TABLE 25: LIFE OF PROGRAM HOUSING SEPARATIONS BY POPULATION CATEGORY[84]

Priority Population Category	Ever housed	Percent of ever housed	Housed at end of SFY 22-23	Percent of housed at end of SFY 22-23	Separations	Percent of Separations	Population Separation Rate
Pop 1-3 ACH	2144	37%	957	29%	1187	48%	55%
Pop 4 SPH	1034	18%	557	17%	477	19%	46%
Pop 5 Diversion	2645	45%	1838	55%	807	33%	31%
All Populations	**5823**	**100%**	**3352**	**100%**	**2471**	**100%**	

[83] Values in this table are sourced from cumulative tallies from LME/MCO exit forms when members separate from TCL housing. The exit forms are point-in-time reports that are not currently integrated with TCL Dashboard data.

[84] Values in this table are sourced from June 2023 NCDHHS TCL monthly report cumulative and point-in-time counts of members ever housed and members in housing at the end of the report period.

Table 26 shows preliminary estimates of numbers of individuals admitted to adult care homes after their most recent separation from TCL housing. These are individuals for whom NCTracks eligibility data, at any time in the future after their most recent housing separation, included a living arrangement code indicating the person resided in an adult care home. Over the life of the TCL program, 695 individuals subsequently had NCTracks eligibility codes indicative of adult care home living arrangements after their most recent separation. ACH readmission may be inferred from TCL priority population category, such that the 253 individuals in Priority Population 1-3 who transitioned to TCL housing from adult care homes and resided in an ACH sometime after housing separation represent ACH readmissions.

TABLE 26: ACH ADMISSIONS ANY TIME AFTER MOST RECENT TCL HOUSING SEPARATION (PRELIMINARY ESTIMATES OF ACH ADMISSIONS AND READMISSIONS)[85]

	SFY of Housing Separation											
Priority Population	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**Total**
ACH	0	4	5	13	17	39	32	29	31	44	39	**253**
SPH	0	2	0	2	3	5	10	10	4	13	4	**53**
Diversion	1	7	13	17	25	65	86	61	41	37	36	**389**
All	**1**	**13**	**18**	**32**	**45**	**109**	**128**	**100**	**76**	**94**	**79**	**695**

10.4.9. 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.

Query of the IRIS system for SFY 22-23 returned Level 2 or 3 incidents for 139 individuals in TCL supportive housing, including 125 members with a single incident, nine members with two, and five with three or

[85] Table 26 counts are derived from an ad hoc report that is based on data extracts used to produce TCL Dashboard measures. This report is currently undergoing refinement to account for the length of the interval from housing separation to a living arrangement code indicative of adult care home residence type. In this iteration of the report, individuals are counted as having been admitted or readmitted regardless of how long after separating from TCL housing NCTracks reflected an ACH living arrangement code. As such, these counts likely overstate the incidence of ACH admission directly or soon after separation from TCL housing. Individuals currently only are included based on their most recent separation from TCL housing, i.e., they are not included if they had an NCTracks ACH living arrangement code after a prior TCL housing separation but before their most recent housing separation, unless they also had an NCTracks ACH living arrangement code after the most recent separation.

more incidents.[86] Table 27 shows the distribution of incidents across report months.

TABLE 27: IRIS LEVEL 2 AND 3 INCIDENTS BY REPORT MONTH, SFY 22-23

Incident Month	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Count of Incidents	11	14	12	16	17	13	14	12	13	11	12	20

Table 28 shows the distribution of Level 2 and 3 Incidents by Incident Type and Subtype.

TABLE 28: IRIS LEVEL 2 AND 3 INCIDENT TYPES AND SUBTYPES, SFY 22-23

Incident Type and Subtype	Level 2 Incident Count	Level 3 Incident Count	Total
Abuse	**6**	**5**	**11**
Exploitation or Neglect	*5*	*0*	*6*
Physical or Sexual Abuse	*1*	*5*	*6*
Consumer Behavior	**62**	**1**	**63**
Aggressive or Destructive Behavior or Illegal Act	*28*	*1*	*29*
Suicide Attempt	*7*	*0*	*7*
Unplanned Absence	*5*	*0*	*5*
Other	*22*	*0*	*22*
Death	**15**	**30**	**45**
Accident	*0*	*8*	*8*
Homicide/Violence	*0*	*2*	*2*
Suicide	*0*	*2*	*2*
Terminal Illness/Natural Cause	*15*	*2*	*17*
Unknown Cause	*0*	*16*	*16*
Injury	**14**	**4**	**18**
Accident	*0*	*1*	*1*
Physical Injury	*14*		*14*
Other	*0*	*3*	*3*
Medication Error	**3**	**0**	**3**
Wrong Patient	*3*	*0*	*3*
Other	**24**	**1**	**25**
Total	**124**	**41**	**165**

[86] Annual report incident counts may differ from previous monthly report values, which reflect the month each incident was reported and not necessarily the month the incident occurred. Annual counts also may differ from monthly report counts due to subsequent housing event date reconciliation.

11. BUDGET

For SFY 22-23, the TCL team completed the following budget activities for ongoing monitoring, optimization, and performance improvements.

- Provided bi-monthly budget reporting for leadership staff and monitoring.
- Held quarterly reviews with LME/MCOs to track forecasting and expenditures for optimization of funds.
- Continued the operations of the TCL Incentive Plan.

In SFY 21-22, the TCL team launched the Incentive Plan to reward LME/MCOs performance and foster continued progress in achieving compliance with the settlement agreement. The TCL incentive plan successfully continued in SFY 22-23, as LME/MCOs achieved an average of 54% of measures/outcomes for the entire year based on quarterly expectations established by the TCL team. Because of its success, the Incentive Plan will continue throughout SFY 23-24.

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 22-23 budget expended reflects the following:

- TCL SFY 21–22 Budget = $63,059,019
- TCL SFY 22–23 Budget = $71,954,019

TABLE 29: Key Expenditures Comparison Table

Cost Category	Expenditures	
	SFY 21-22	SFY 22-23
Rental Assistance	$24,104,385	$33,933,809
DMH LME/MCO	$15,909,008	$17,623,516
Medicaid LME/MCO	$10,550,566	$13,262,558
DHHS Staffing and Admin	$1,412,693	$505,423
Contracts	$1,637,396	$1,032,166
Olmstead Planning	$159,825	$25,930
TCL Incentives	$9,285,250	$5,570,617
Total	**$63,059,019**	**$71,954,019**

12. CONCLUSION

As we conclude SFY 22-23, we recognize this period as a year of reset and foundational work, setting the stage for substantial progress toward compliance with the Transitions to Community Living (TCL) settlement agreement signed with the US DOJ. Despite the ongoing challenges posed by the pandemic and transitions within the managed care environment, we achieved significant milestones and laid the groundwork for future advancements.

Housing Achievements: we successfully provided a housing option to over 3,300 individuals, ensuring stability and support. The development of the Strategic Housing Plan marks a pivotal step in addressing the needs of individuals with disabilities, particularly those who are homeless, residing in congregate settings, or at risk of such placements. Our collaboration with HUD has strengthened fair housing practices, making our tenant selection criteria among the most robust in the nation. The continued implementation of the Transition Incentive Plan underscores our commitment to accelerating transitions.

Expanding our Mental Health and Supported Employment Service capacity has been a critical focus: Three new ACT Teams began serving clients, increasing support in Pembroke, Shallotte, and Durham. Funding was secured for Eastpointe and Vaya to enhance ACT services in rural communities. The ACT and IPS Annual Conference saw strong engagement, owing to our dedication to professional development and service improvement. Partnerships with the Technical Assistance Collaborative (TAC) and the UNC Institute for Best Practices have been crucial in providing coaching, training, and technical assistance to Community Support Teams. Community Inclusion training, led by the Temple University Collaborative and NAMI NC, has fostered a more inclusive environment for individuals with psychiatric disabilities. Members in TCL supportive housing, as well as individuals planning for transition or rehousing, received tenancy support services through Tenancy Management Supports (TMS), Community Support Teams (CST), or Assertive Community Treatment Teams (ACT).

The Person-Centered Planning (PCP) process was reinforced this year, with over 2,600 participants engaging in virtual, 4-hour training sessions offered on seven occasions. These trainees came from 480 unique agencies in 175 towns and cities across all 100 counties in North Carolina, demonstrating our extensive geographic reach and commitment to comprehensive training.

In collaboration with DMH/DD/SUS, DHB, and EIPD, a revised fee-for-service rate of $26.40 per unit to update the NC CORE milestone rates was established. EIPD is revising its IPS policy to align with DHB and DMH/DD/SUS service definitions, clarify team member roles, and emphasize best practices.

Diversion, Pre-screening Admission, Discharge and Transition processes were improved. The reimplementation of the TCL Informed Decision-Making (IDM) Tool has been pivotal in ensuring individuals understand their rights to live and receive services in the community. This tool has been updated to allow guardians and individuals to document their preferences and concerns about community living. In-Reach Specialists use the IDM Tool to address any concerns immediately with tailored strategies. Local Barriers Committees, with participation from Regional Ombudsmen, work to resolve barriers to community living, escalating unresolved issues to the State Barriers Committee and, if necessary, the Transition Oversight Committee. This structured approach has successfully addressed many systemic barriers, maintaining a log for accountability and follow-up. Additionally, our Complex Medical Care Management process ensures thorough transition planning and support, particularly for individuals with complex medical needs, facilitating smoother transitions from Adult Care Homes to community living.

Our accomplishments in Quality Assurance and Performance Improvement (QAPI) this year have built on prior progress, with significant enhancements in TCL data quality, dashboard functionality, and performance measure implementation. The establishment of the TCL Quality Assurance Committee and

refinement of barriers reporting processes has strengthened the ability to address challenges efficiently. Notably, housing stability remains high, with 82% of individuals maintaining supportive housing at their one-year milestone and 69% at their two-year milestone. Housing separation rates have remained low, demonstrating the effectiveness of our support systems.

In summary, state fiscal year 2022-2023 has been a transformative period, characterized by resilience, strategic planning, and foundational work. We look forward to building on these achievements in the coming year, as we continue to enhance the lives of individuals with disabilities across North Carolina. Transitions to Community Living 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.

NCDHHS' commitment to the Olmstead Plan: Transitions to Community Living (TCL), specifically focusing on individuals with Serious Mental Illness (SMI) and Severe and Persistent Mental Illness (SPMI), is a targeted initiative within the larger Olmstead Plan. The Olmstead Plan, however, addresses a much broader population of people with disabilities across North Carolina, ensuring that they have access to appropriate, community-based services as required by the United States Supreme Court in Olmstead v. L.C.

In December of 2021, NCDHHS reinvigorated its commitment to building community capacity to serve people with disabilities by issuing an Olmstead Plan for the State of North Carolina. NCDHHS engaged the Technical Assistance Collaborative (TAC), in partnership with the Human Services Research Institute, and later, Mathematica, to assist in the development and implementation of a comprehensive, effective Olmstead Plan. The State's Olmstead Plan is a blueprint to provide people with disabilities[87] with appropriate, community-based services when they desire or would not oppose these, as required by the United States Supreme Court in *Olmstead v. L.C.*[88] In April of 2021, the TAC issued a report that assessed and analyzed how the systems, funding, services, and housing options offered by NCDHHS and other agencies and organizations within the State functioned to serve people with disabilities in integrated settings.[89] The findings of this report were among many sources of information used in the development of the State's initial Olmstead Plan, covering calendar years (CY) 2022 - 2023. The updated CY 2024 – 2025 Olmstead Plan builds on the earlier plan. NCDHHS released the updated plan on April 1, 2024[90].

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[87] The Americans with Disabilities Act (ADA) defines a person with a disability as someone who:
Has a physical or mental impairment that substantially limits one or more major life activities, or
Has a history or *record* of an impairment (such as cancer that is in remission), or
Is *regarded* as having such an impairment by others even if the individual does not actually have a disability (such as a person who has scars from a severe burn that does not limit any major life activity).
For more information, the definition of disability that applies to the Olmstead Plan, see https://adata.org/factsheet/ada-definitions. Retrieved on 2/9/24.

[88] On June 22, 1999, the United States Supreme Court held in *Olmstead v. L.C.* that the unjustified segregation of persons with disabilities constitutes discrimination in violation of Title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, considering the resources available to the public entity and the needs of others who are receiving disability services from the entity.

[89] Technical Assistance Collaborative, Inc., and Human Services Research Institute (2021). *An assessment of the North Carolina Department of Health and Human Services' system of services and supports for individuals with disabilities* [PDF], Raleigh, NC: North Carolina Department of Health and Human Services, https://bit.ly/3uZFBPB, retrieved on 1/16/24.

[90] See the "North Carolina Olmstead Plan 2024-2025" report, authored by NCDHHS, published on April 1, 2024, on the NCDHHS website at: https://www.ncdhhs.gov/2024-25-olmstead-plan

13. APPENDIX

13.1. BREAKDOWN OF BUDGET BY LME/MCOS -SFY 22-23

TABLE 30: BREAKDOWN OF BUDGET BY LME/MCOS, SFY 22-23

TCL Service	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya
Transition Year Stability Resources (TYSR)	$414,109	$60,000	$200,000	$116,067	$126,199	$295,118
Community Living Assistance (CLA)	$865,791	$196,671	$465,000	$371,640	$440,723	$679,111
Emergency Housing Funds	$33,983	$21,090	$127,000	$21,600	$49,804	$25,285
MCO Transition Coordinators	$180,000	$67,476	$90,000	$90,000	$146,867	$180,000
Bridge Housing	$734,141	$213,044	$397,000	$252,000	$315,000	$322,430
Mental Health Services	$933,660	$312,948	$539,033	$431,291	$674,984	$597,579
Supported Employment	$362,035	$137,068	$249,990	$369,300	$477,292	$197,187
Alliance of Disability Advocates NC Pilot	$29,430		$94,613			
Subsidy Administration	$180,000	$90,000	$90,000	$61,213	$120,962	$180,000
Diversion	$696,000	$261,000	$435,000	$203,000	$406,994	$841,000
Assertive Engagement	$4408		$100	$7,269	$870	$200
TCL Incentive Payments	$1,147,833	$321,175	$1,412,685	$239,000	$580,000	$1,869,924
Totals	**$5,581,390**	**$1,680,472**	**$4,100,421**	**$2,162,380**	**$3,339,695**	**$5,187,834**

13.2. LIST OF ACRONYMS

ACH: Adult Care Home.

ACT: Assertive Community Treatment.

ACTT: Assertive Community Treatment Team.

ADA: Americans with Disabilities Act.

ADANC: Alcohol and Drug Abuse Treatment Center.

AES: Assertive Engagement Service.

AHEC: Area Health Education Centers.

AMH: Adult Mental Health.

AMS: Assessment Management System.

CARES Act: Coronavirus Aid, Relief, and Economic Security Act.

CH: Community Hospital.

CH/PU: Community Hospitals and Psychiatric Units.

CI: Community Inclusion.

CIE: Competitive Integrated Employment.

CIL: Centers for Independent Living.

CIS: Community Integration Specialist.

CLA: Community Living Assistance.

CoC: Continuum of Care.

NC-CORE: North Carolina Community Outreach and Resource Engagement.

CPSS: Certified Peer Support Specialist.

CQI: Continuous Quality Improvement.

CRT: Crisis Response Team.

CST: Community Support Team.

CTI: Critical Time Intervention.

CY: Calendar Year.

DHB: Division of Health Behavior.

DMH: Division of Mental Health.

DMH/DD/SUS: Division of Mental Health, Developmental Disabilities, and Substance Use Services.

DOJ: US Department of Justice.

DSOHF: Division of State Operated Healthcare Facilities.

DVRS: Division of Vocational Rehabilitation Services.

E&M: Evaluation and Management.

EAF: Emergency Assistance Fund.

ED: Emergency Department.

EHB: Enhanced Bridge Housing.

EIPD: Division of Employment and Independence for People with Disabilities (formerly the Division of Vocational Rehabilitation - DVRS).

EQR: External Quality Review.

FBC: Facility-Based Crisis.

FMR: Fair Market Rent.

FTE: Full-Time Equivalent.

GED: General Educational Development.

HAP: Housing Assistance Program.

HFA: Housing Finance Agency.

HUD: Department of Housing and Urban Development.

IDD: Intellectual and Developmental Disabilities.

IDM: Informed Decision-Making.

IPS: Individual Placement and Support.

IPU: Inpatient Psychiatric Unit.

IR: In-Reach.

IRIS: Incident Reporting Information System.

JCB: Joint Communication Bulletin.

KELS: Kohlman Evaluation of Living Skills.

LBC: Local Barriers Committee.

LIHTC: Low-Income Housing Tax Credit.

LME/MCO: Local Management Entity/Managed Care Organization.

LOP: Life Of Program.

MAT: Medication-Assisted Treatment.

MCM: Mobile Crisis Management.

MFP: Money Follows the Person.

MI: Motivational Interviewing.

NAMI: National Alliance on Mental Illness.

NBCC: National Board for Certified Counselors.

NCDHHS: North Carolina Department of Health and Human Services.

NCHFA: North Carolina Housing Finance Agency.

OT: Occupational Therapy.

PCP: Person-Centered Planning.

PIHP: Prepaid Inpatient Health Plan.

PoP: Profile of Participation.

PSH: Permanent Supportive Housing.

PSR Services: Psychosocial Rehabilitation Services.

PSS: Peer Support Specialist.

QA: Quality Assurance.

QAC: Quality Assurance Committee.

QAPI: Quality Assurance and Performance Improvement.

QOL: Quality of Life.

RN/OT: Registered Nurses and Occupational Therapists.

RSVP: Referral Screening Verification Process.

SACOT: Substance Abuse Comprehensive Outpatient Treatment.

SAIOP: Substance Abuse Intensive Outpatient Program.

SAT: SATisfaction index scores.

SBC: State Barriers Committee.

SD: Standard Deviation.

SE: Supported Employment.

SFI: Solutions For Independence.

SFY: State Fiscal Year.

SMI: Serious Mental Illness.

SPH: State Psychiatric Hospital.

SPMI: Severe and Persistent Mental Illness.

SUD: Substance Use Disorder.

T&H: Transition and Housing.

TA: Technical Assistance.

TAC: Technical Assistance Collaborative.

TBI: Traumatic Brain Injury.

TCL: Transitions to Community Living.

TCLD: Transitions to Community Living Database.

TCLI: Transitions to Community Living Initiative.

TCLV: Transitions to Community Living Voucher.

TMACT: Tool for Measurement of Assertive Community Treatment.

TMS: Transition Management Service.

TOC: Transition Oversight Committee.

TOPPS: Treatment Outcomes and Program Performance System.

TP: Tailored Plan.

TST: Tenancy Support Team.

TYSR: Transition Year Stability Resources.

UM: Utilization Management.

UNC: University of North Carolina.

UNC IBP: UNC Institute for Best Practices.

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