NC TRANSITIONS TO COMMUNITY LIVING

ANNUAL REPORT

State Fiscal Year 2024

(July 2023-June 2024)

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

May 2025

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1. ACKNOWLEDGEMENTS

In 2012, the North Carolina Department of Health and Human Services (NCDHHS) entered into a Settlement Agreement with the United States Department of Justice (USDOJ) to develop a framework for community-based housing and services for people with serious and persistent mental illness (SPMI). This agreement aimed to give individuals with SPMI, who are in or at risk of placement in adult care homes, an opportunity to choose to live in their communities. The Transitions to Community Living (TCL) program has helped more than 5,800 people move out of, or avoid entering, adult care homes.

Together with our valued partners and guided by our Olmstead Principles, we will continue to champion a system that supports everyone to live their best lives in their chosen communities.

I would like to thank those who contributed to the TCL program accomplishments and progress listed in the TCL State Fiscal Year 2024 (SFY24) annual report[1]:

- NCDHHS Cross-Division Olmstead/TCL Staff
- NCDHHS Division of Aging
- NCDHHS Division of Health Benefits
- NCDHHS Division of Mental Health, Developmental Disabilities, and Substance Use Services
- NCDHHS Division of Social Services
- NCDHHS Division of State Operated Healthcare Facilities
- NCDHHS Division of Employment and Independence for People with Disabilities
- NC Housing Finance Agency
- NC Money Follows the Person (MFP)
- Mathematica
- Temple University
- The Local Management Entities/Managed Care Organizations (LME/MCOs)[2]
- The Technical Assistance Collaborative (TAC)
- University of North Carolina Institute of Best Practices (UNC-IBP)
- U.S. Department of Housing and Urban Development (HUD) and the network of Public Housing Authorities (PHAs) in North Carolina
- Yale University

Respectfully submitted,

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[1] The state fiscal year runs from July 1 to June 30. In this report, the fiscal year from July 1, 2023, to June 30, 2024, is referred to as SFY24, while the fiscal year from July 1, 2022, to June 30, 2023, is called SFY23. Previous TCL annual reports referred to the State Fiscal Year 2023 as SFY 22-23.

[2] The TCL population is served by Local Management Entities/Managed Care Organizations (LME/MCOs) under contracts with NCDHHS. The services are provided through the Prepaid Inpatient Health Plan (PIHP) contract, which allows LME/MCOs to manage Medicaid funds for mental health, developmental disabilities, and substance use services, and the Tailored Plan (TP) contract, which integrates both physical and behavioral health services to address the complex needs of individuals with mental illnesses. Following the dissolution of Sandhills Center, and Eastpointe and Trillium Health Resources consolidation, the counties that were previously within its catchment area have been reassigned to the four remaining LME/MCOs. Throughout this report, the term "LME/MCO" will be used to refer to both PIHPs and TPs.

2. EXECUTIVE SUMMARY

2.1. PURPOSE

The Transitions to Community Living (TCL) program strives to give individuals with severe and persistent mental illness in North Carolina the opportunity to live in the least restrictive settings of their choice, integrated within their communities, when clinically appropriate. This program stems from the 2012 Settlement Agreement (SA) between the State of North Carolina and the United States Department of Justice (USDOJ)[3]. The Settlement Agreement is intended to ensure the State complies with the Americans with Disabilities Act (ADA) and the U.S. Supreme Court's *Olmstead* decision[4]. The Olmstead decision established that, under the ADA, individuals with disabilities have a right to live in their chosen community settings rather than institutions, when clinically appropriate and when the individuals' needs can be reasonably accommodated.

The TCL Annual Report provides an overview of the program's progress, challenges, and achievements over the past year. It highlights the efforts made to transition individuals from institutional settings to community living, ensuring they receive the necessary support and services to thrive.

The TCL program works closely with the US Department of Justice (USDOJ) and the Independent Reviewer (IR) as part of the TCL Settlement Agreement and shares progress through monthly meetings. The IR conducts in-person and desktop reviews annually across the state to monitor the program's progress and compliance. The IR published the SFY24 IR annual report[5] and shared valuable recommendations to enhance the program's effectiveness.

In December 2024, the sixth modification[6] to the Settlement Agreement was signed and entered by the court, outlining substantial compliance in several provisions and extending the agreement until July 1, 2027.

2.2. OVERVIEW

The Settlement Agreement between the State of North Carolina and the USDOJ is structured around six key pillars to support transitions to community living. This year's report follows the same structure, with one section dedicated to each pillar.

1) **Community-Based Housing**: Ensuring individuals have access to affordable and stable housing options within their communities.
2) **Community-Based Mental Health Services**: Providing comprehensive mental health services to support individuals in their transition and ongoing community living.
3) **Supported Employment (SE) Individual Placement Supports (IPS)**: Offering employment support services to help individuals find and maintain meaningful employment.

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[3] For more information on the North Carolina Settlement Agreement, please visit the North Carolina Department of Health and Human Services website: https://www.ncdhhs.gov/nc-settlement-olmstead/open

[4] For more information on the Americans with Disabilities Act (ADA) and the Olmstead decision, please visit the US Department of Justice (USDOJ) Civil Rights Division website, dedicated to ADA : https://www.ada.gov/resources/olmstead-mandate-statement/

[5] The SFY 2024 Independent Reviewer TCL Report was published on December 10, 2024. It is available on the NCDHHS website: https://www.ncdhhs.gov/fy-2024-independent-reviewer-tcl-report/open

[6] Details about the sixth modification to the Settlement Agreement can also be found on the North Carolina Department of Health and Human Services website: https://www.ncdhhs.gov/20241211-6th-modification-settlement-agreement/open

4) **Discharge and Transition Process**: Developing personalized transition plans that address the specific needs and preferences of each individual.
5) **Preadmission Screening and Diversion**: Implementing processes to screen and divert individuals from unnecessary institutionalization.
6) **Quality Assurance & Performance Improvement (QAPI)**: Implementing measures to monitor the quality of services and supports provided to individuals transitioning and living in the community.

Each section is divided into three subsections:

7) **Progress during SFY24**: This subsection details the progress made toward meeting the SA and requirements still to be met. It also outlines the requirements already met according to previous SA modifications.
8) **SFY24 Supporting Data**: This subsection provides data supporting the progress and activities undertaken during SFY24.
9) **Key Focus Areas and Priorities for SFY25**: This subsection outlines key focus areas and priorities for the upcoming fiscal year, SFY25.

2.3. PROGRESS DURING SFY24

1) Community-Based Housing

- At the end of SFY24, there were 3,645 individuals living in NC with a housing slot.
- 903 new individuals received housing slots.
- The net number of individuals from Adult Care Homes (ACH) in housing increased by 27, from 968 in SFY23 to 995 in SFY24. In total, 203 individuals moved from an ACH to community living with a housing slot.

2) Community-Based Mental Health Services

- The TCL Capacity Report template was finalized, marking a key milestone in standardizing LME/MCO reporting.
- The UNC Institute for Best Practices (UNC-IBP) provided ongoing Technical Assistance (TA) and training to support Assertive Community Treatment (ACT), Community Support Team (CST), and Transition Management Services (TMS) providers in achieving improved fidelity and to provide more effective services.
- NCDHHS developed and launched an on-demand training series focused on tenancy supports and person-centered planning for the Behavioral Health Springboard (BHS) platform.
- NCDHHS supported three peer-led Community Inclusion (CI) organizations across 27 counties to offer support to TCL recipients.

3) Supported Employment

- The North Carolina Collaborative for Ongoing Recovery through Employment (NC CORE) model for Individual Placement Supports (IPS) went live, developed in collaboration with the LME/MCOs, IPS Providers, and UNC.
- IPS Milestone payment rates were increased to improve provider sustainability in providing supported employment services.
- The Division of Employment and Inclusion for People with Disabilities (EIPD) began revising their milestones to improve the quality and funding stream for job development and retention functions in the IPS service.
- The state secured a contract for the development of the Online Benefits Counseling tool, DB101.

4) Discharge and Transition Process

- NCDHHS established two new TCL field-staff positions October 2024 to monitor discharges/transitions and provide technical assistance to plan staff.
- NCDHHS moved from quarterly to monthly monitoring reviews of reassessments for individuals in ACHs resulting in a decrease in overdue reassessments (892 in SFY24Q3 vs. 531 in SFY24Q4).
- Peers conducted more face-to-face in-reach contacts for more effective informed consent, service and support description, and transition decision potential.
- NCDHHS implemented the Informed Decision-Making Tool to ensure individuals are fully informed of the alternatives to living in a licensed facility.

5) Pre-Admission Screening and Diversion

- For SFY24, all LME/MCOs completed screenings and determined TCL eligibility within 30 days of the submission date.
- During SFY24, only 32 individuals were not diverted from entering ACHs, and the number of individuals diverted who remained in the community was 430.
- During SFY24, monthly quality reviews were conducted for all TCL individuals who were not diverted and entered an ACH to monitor the initiation of in-reach.

6) Quality Assurance & Performance Improvement

- NCDHHS developed the TCL Quality Assurance and Performance Improvement (QAPI) Plan.
- NCDHHS added new contract requirements to strengthen LME/MCO TCL QAPI systems.
- Refinements to monthly TOC meetings included increased emphasis on determining action items to mitigate identified risks and barriers.
- New Barriers and Solutions Committees (BASC) were implemented in SFY24 in each of the three state psychiatric hospitals (SPH).
- Barriers tracking and resolution process improvements included migration of the barriers log to the Medicaid Help Center (MHC) platform, which offers enhanced tracking-to-resolution and analytic capabilities.
- Quarterly TCL Dashboard releases included new measures and enhancements to support member outcomes monitoring.

2.4. KEY FOCUS AREAS AND STRATEGIES FOR SFY25

During SFY25, the Transitions to Community Living (TCL) program will focus on the following:

1) Community-Based Housing

- **Expand Housing Pilot Program**: Expand pilot program collaboration with the Targeting/Key program from two to all four LME/MCOs to improve access to housing for TCL individuals, with milestones including training, system access, and regular check-ins.
- **Engage with Public Housing Authorities**: Continue engagement with NC's PHAs to address housing needs, provide training, and enhance financial sustainability through federal vouchers.
- **Increase Access to Bridge Options**: Expand hotel bridge and enhanced bridge programs statewide, updating guidelines and ensuring compliance with housing requirements to support transitions to permanent supportive housing.

2) Community-Based Mental Health Services

- **Enhance the Quality of Person-Centered Plans**: Focus on improving the quality and effectiveness of Person-Centered Planning (PCP) processes, including ongoing training, collaborative learning, and monitoring efforts to support community integration and build a culture of person-centeredness.

- **Strengthen Community-Based Providers**: Enhance the capacity and effectiveness of community-based mental health providers through coaching, technical assistance, targeted training, and support for various programs and initiatives, ensuring high-quality service delivery and recovery-oriented services.
- **Strengthen Community Integration and Peer Support**: Strengthen community integration and peer support by developing Community Inclusion projects, providing ongoing training and technical assistance, and expanding peer support services and resources.

3) IPS/Supported Employment

- **Improve 1915(i), Tailored Care Management (TCM), and IPS Processes**: Collaborate with LME/MCOs to address wait times for 1915(i) assessments, provide education on IPS services, and reduce eligibility wait times to enhance service engagement and sustainability.
- **Implement IPS Landing Page**: Develop a centralized IPS Landing Page for training, guidance, and information to streamline IPS services and support TCM onboarding and referrals.
- **Add North Carolina to DB101**: Integrate North Carolina into the DB101 platform to help individuals with disabilities understand the impact of employment on benefits, providing quick access to accurate benefits counseling resources.
- **Integrate Behavioral Health and Supported Employment Services**: Connect high-performing Integrated Behavioral Health and Supported Employment providers by proposing grant startup funds to develop integrated teams and improve service quality and community placement success.

4) Discharge and Transition Process

- **Strengthen Discharge Planning**: Improve person-centered transition planning by providing training and technical assistance to transition teams on incorporating In-Reach/TCL Tool information into Person-Centered Plans (PCPs)
- **Streamline Discharge Process**: Update policies, resolve state and LME/MCO organizational barriers and give guidance to behavioral health providers and natural supports to complete transitions within the 90-day period.
- **Increase Face-to-Face Engagement**: Enhance the frequency of in-person contacts and reassessments during in-reach to better educate and support TCL individuals.

5) Preadmission Screening and Diversion

- **Monitor and Sustain Success:** Continuously assess RSVP tool to improve functionality, conduct reviews to monitor timely eligibility determination, service linkage, and compliance with Settlement Agreement.

6) Quality Assurance & Performance Improvement (QAPI)

- **Provide QAPI Support to Improve TCL Community-Based Mental Health Services**: Provide targeted support for performance measure development, data tracking, process improvements, and technical assistance to improve service quality and TCL member outcomes.
- **Improve LME/MCO TCL QAPI Planning**: Provide technical assistance for LME/MCOs to meet Medicaid contract requirements and enhance QAPI planning by identifying and addressing QAPI system gaps and improving processes, interventions, and documentation.
- Expand Scope of the External Quality Review Organization (EQRO) to cover TCL Reviews: Collaborate with the Division of Health Benefits (DHB) and Health Services Advisory Group (HSAG) to include TCL review activities.

3. COMMUNITY-BASED HOUSING

Community-Based Housing focuses on providing safe, decent, and affordable housing options for individuals in TCL so they can live in the communities of their choice, with access to the necessary services and support to maintain their well-being.

Housing slots are provided through various means, including vouchers and partnerships with the North Carolina Housing Finance Agency (NCHFA). These partnerships help secure funding and resources to support the housing needs of individuals transitioning from institutional settings to community-based living. The types of housing targeted include scattered-site housing, where no more than 20% of the units in any development are occupied by individuals with disabilities known to the State. This approach promotes community integration and prevents the segregation of individuals with disabilities. The choice of housing is driven by the individual's preferences, allowing them to live in settings that best suit their needs and desires.

Another key aspect of this pillar is preventing separations from the community. Tenancy support services are provided to help individuals attain and maintain integrated, affordable housing. These services are flexible and available as needed but are not mandated as a condition of tenancy. This approach fully supports TCL individuals' access to community activities and interaction with others.

3.1. PROGRESS DURING SFY24

The SA outlines nine substantive requirements related to Community-Based Housing for North Carolina[7]. Table 1 lists key progress made during SFY24 in meeting the three outstanding requirements.

Table 1. Key Progress Made to Meet Outstanding Housing Requirements

Outstanding TCL Compliance Requirements	Key Progress
III(B)(1). The State will develop and implement measures to provide individuals outlined in Section III(B)(2)(a)-(e) access to community-based supported housing. Nothing in this Agreement will require the State to forgo federal funding or federal program participation, for housing that meets all the criteria in Section III(B)(7), to provide community placements for individuals pursuant to this Agreement.	• NCHFA continues to provide access to Low-Income Housing Tax Credit (LIHTC) properties and gave multiple awards to increase the housing stock and access in NC. NC also launched the NC Strategic Housing plan[8]. One of the main workgroups from this plan will focus on non-development/access-related issues in NC.
III(B)(5). As of January 1, 2024, the State shall provide Housing Slots to 1,449 of the individuals described in Sections III(B)(2)(a), (b), and (c) of this Agreement. The State shall provide Housing Slots to 2,000 such individuals by July 1, 2025. While achieving these totals, the State shall take all reasonable steps so that any individuals described in Section III(B)(2) of the Agreement who are eligible for the State's Transitions to	• The state increased the number of TCL housed individuals from population 1-3 by net 27 (from 968 to 995) during SFY24.

[7] Previous reviews confirmed the State has achieved compliance with six of the nine requirements of section III(B) Community-Based Housing Slots. The Fourth modification entered by the Court on March 29, 2021, discharged the obligations in sections III(B)(3), III(B)(4) and III(B)(6). And during SFY25, the sixth modification entered by the Court on December 11, 2024, established the State has achieved the substantive obligations of sections III(B)(2), III(B)(8), and III(B)(9).

[8] For more details on the NC Strategic Housing plan, refer to the NCDHHS webpage dedicated to that topic: https://www.ncdhhs.gov/about/priority-goals/health-equity-portfolio/nc-strategic-housing-plan

Outstanding TCL Compliance Requirements	Key Progress
Community Living program and who have Housing Slots as of March 1, 2023 continue to retain their Housing Slots as long as they do not oppose supported housing and supported housing remains appropriate for them.	
III(B)(7). Housing Slots will be provided for individuals to live in settings that meet the specified criteria	• TCL continues to provide permanent supportive housing tenancies where individuals have full tenancy rights. Services are available for all individuals if they choose to accept them per the Housing First model. Housing is scattered site, and individuals have access to community inclusion services to assist with integrating into their chosen community.

During SFY24, the department continued to monitor its compliance with the six community-based housing slots requirements that were met[9], as shown in Table 2.

Table 2. Progress Made Towards Housing Requirements Already Met

TCL Requirements that Have Been Met and Discharged	Key Progress
III(B)(2). Priority for the receipt of Housing Slots will be given to identified individuals: (a) Individuals with Serious Mental Illness (SMI) who reside in an adult care home determined by the State to be an Institution for Mental Disease ("IMD"); (b) Individuals with 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; (c) 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; (d) Individuals with SPMI who are or will be discharged from a State psychiatric hospital and who are homeless or have unstable housing; and (e) Individuals diverted from entry into adult care homes pursuant to the pre-admission screening and diversion provisions of Section III(F) of this Agreement.	• 903 individuals from one of these priority poulations received new housing slots during SFY24.
III(B)(3). The State will provide access to 3,000 Housing Slots (…) (h) By July 1, 2021, the State	• At the end of SFY24, there were 3,645 individuals living in NC with a housing slot, including 2,032 from population 5, 618 from population 4, and 995 from populations 1-3[10]. As

[9] Previous reviews confirmed the State has achieved compliance with six of the nine requirements of section III(B) Community-Based Housing Slots. The Fourth modification entered by the Court on March 29, 2021, discharged the obligations in sections III(B)(3), III(B)(4) and III(B)(6). And during SFY25, the sixth modification entered by the Court on December 11, 2024, established the State has achieved the substantive obligations of sections III(B)(2), III(B)(8), and III(B)(9).

[10] Population categories are defined in the Settlement Agreement section III(B)(2), and tracked by the TCL teams as follows:

- Population 1: Individuals with SMI who reside in an adult care home.

TCL Requirements that Have Been Met and Discharged	Key Progress
will provide Housing Slots to at least 3,000 individuals.	of the end of SFY24, the TCL program housed 6,502 individuals. This includes 3,003 from population 5, 1,152 from population 4, and 2,347 from populations 1-3.
III(B)(4). The State shall develop rules to establish processes and procedures for determining eligibility for the Housing Slots consistent with this Agreement. Until such time, Housing Slots will be allocated on a first come, first served basis based on geographic housing availability and individual preference in accordance with the priorities set forth in III(B)(2), above. Housing Slots will only be offered to individuals who are Medicaid eligible, Special Assistance eligible in an adult care home, would be Special Assistance eligible in an adult care home though no longer residing in an adult care home, or have a gross income equal to or less than 100% of the Federal Poverty Guidelines for a single individual. The State may elect to revise the criteria in this Paragraph subject to the approval of the Independent Reviewer.	• TCL eligibility is determined by the LME/MCOs and takes place during RSVP screening. A member receives a housing slot after they have been determined eligible for TCL and have indicated they are interested/ready to transition. The LME/MCOs assign each individual a unique housing slot number.
III(B)(6). The State currently has ongoing programs for housing assistance that will continue in effect. The State may utilize those programs to fulfill its obligations under this Agreement to provide Housing Slots to individuals, so long as the Housing Slots provided using those ongoing programs meet all the criteria in III(B)(7)(a)-(g).	• The Targeting/Key program partners with the NCHFA to assist individuals with accessing low-income housing. This program prioritizes TCL for preference. The Public Housing Authorities (PHAs) partner with the State to administer the Mainstream Vouchers, of which individuals at risk for institutionalization have the highest priority. NC was selected to participate in a Housing Services Partnership Accelerator sponsored by U.S. Department of Housing and Urban Development (HUD), with one of key areas of work to inventory available housing and tenancy support programs in NC.
III(B)(8). Housing Slots made available under this Agreement cannot be used in adult care homes, family care homes, group homes, nursing facilities, boarding homes, assisted living residences, supervised living settings, or any setting required to be licensed.	• Housing slots and vouchers can only be used on residencies that comply with permanent supportive housing principles, which exclude congregant and licensed settings.

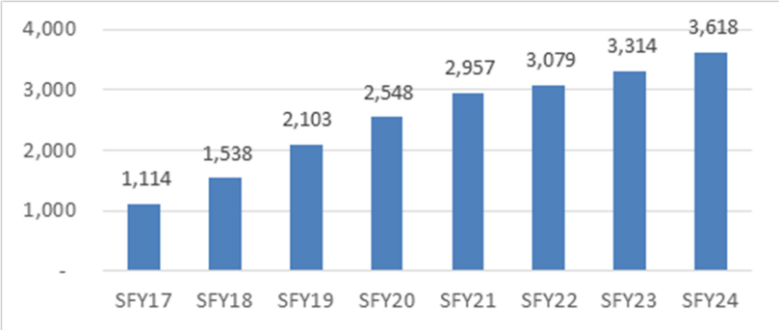
- Population 2: Individuals with SPMI who are residing in adult care homes licensed for at least 50 beds and in which 25% or more of the resident population has a mental illness.
- Population 3: Individuals with SPMI who are residing in adult care homes licensed for between 20 and 49 beds and in which 40% or more of the resident population has a mental illness.
- Population 4: Individuals with SPMI who are or will be discharged from a State psychiatric hospital and who are homeless or have unstable housing; and
- Population 5: Individuals diverted from entry into adult care homes pursuant to the preadmission screening and diversion provisions of Section III(F) of this Agreement.

TCL Requirements that Have Been Met and Discharged	Key Progress
III(B)(9). Individuals will be free to choose other appropriate and available housing options, after being fully informed of all options available. Being fully informed means that an individual has been provided information about the option of transitioning to supported housing, its benefits, and the array of services and supports available as set out in this Agreement. However, housing that does not meet the criteria set forth in Section III(B)(7) will not be considered a Housing Slot for purposes of this Agreement. If an individual chooses a housing option that does not meet the criteria of Section III(B)(7) because a Housing Slot is not available, that individual will receive the in-reach services and discharge planning services described in Section III(E) and will remain eligible to receive a Housing Slot as soon as one is available.	• NCDHHS has implemented the Informed Decision-Making Tool. It is administered by LME/MCO Certified Peer Support Specialists (CPSS) and documents that members are allowed a concrete choice for housing and fully informed of housing and service options available both in their current setting and the community. These tools require the in-reach specialist to develop rapport with the individual before informing them of the options available through TCL.

3.2. SFY24 SUPPORTING DATA

Figure 1 and Figure 2 below show a steady increase in the utilization of housing slots throughout the life of the TCL program. By the end of SFY24, 3,618 TCL individuals were housed in the community and utilized the slot. Looking at each population category separately, since the launch of the program, and the success of the diversion of members at risk of entering an ACH, the number of individuals housed from category 5 has increased sharply to exceed 2,000 in SFY24. This shows how well the pre-admission diversion process and support for finding housing works by keeping people out of ACHs, preventing institutionalization and helping individuals live in the community.

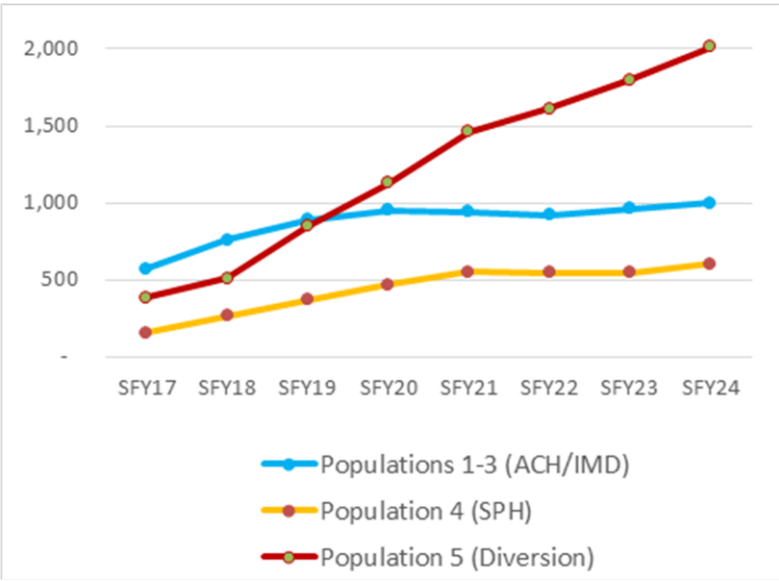
Figure 1. Number of individuals living in the community with a housing slot (at end of state fiscal year)



Source: TCL Dashboard. Data were extracted on 3/18/2025.

SFY	Count
SFY17	1,114
SFY18	1,538
SFY19	2,103
SFY20	2,548
SFY21	2,957
SFY22	3,079
SFY23	3,314
SFY24	3,618

Figure 2. Count of individuals housed with a TCL slot by population category (at end of state fiscal year)

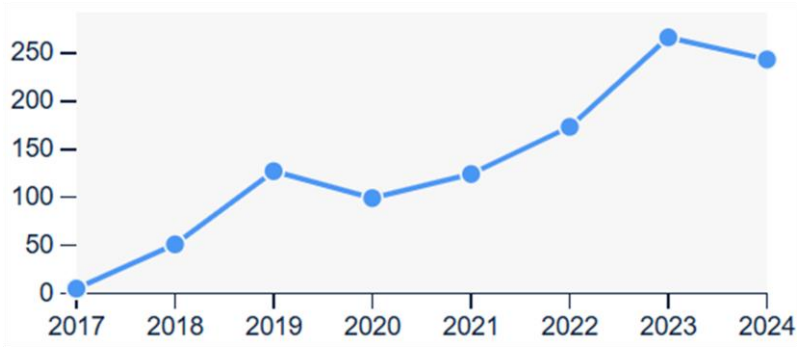


Source: TCL Dashboard. Data were extracted on 3/18/2025.

SFY	Pop 1-3	Pop 4	Pop 5
SFY17	571	156	387
SFY18	761	267	510
SFY19	888	368	846
SFY20	950	467	1,130
SFY21	944	553	1,460
SFY22	919	548	1,612
SFY23	965	548	1,801
SFY24	997	606	2,015

Figure 3 below shows that LME/MCOs are actively working with individuals to assist them with regaining housing after separation. The trend over the years correlates with additional funding provided for rehousing efforts, and these numbers confirm this effort has been effective.

Figure 3. Count of Individuals rehoused after a separation[11] (by state fiscal year)

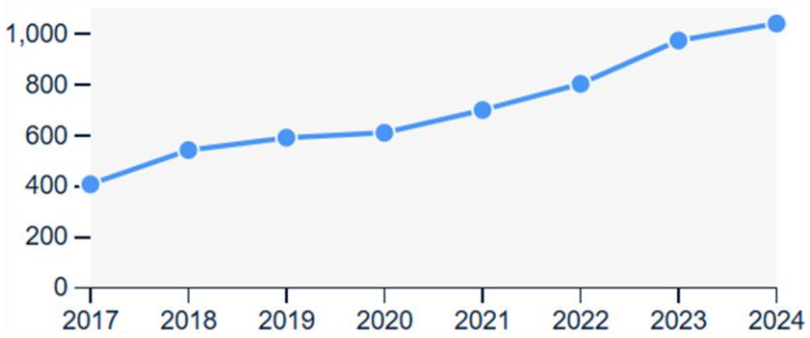


Source: TCL Dashboard. Data were extracted on 3/18/2025.

SFY	Count	Cumulative
SFY17	5	5
SFY18	51	56
SFY19	127	183
SFY20	99	282
SFY21	124	406
SFY22	173	579
SFY23	266	845
SFY24	243	1,088

Figure 4 below shows TCL member utilization of targeting/key units. The consistent growth in targeting/key utilization is important because every unit utilized with targeting/key rather than TCL Vouchers (TCLV) represents cost savings for the program. The rent for targeting/key units is typically lower than private landlord units, and this cost savings allows more individuals to be served .

Figure 4. Count of targeting/key housing unit utilization (as of the last day of each state fiscal year)



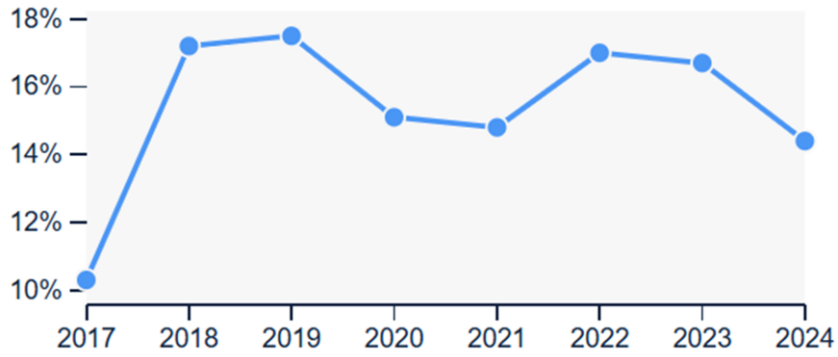
Source: TCL Dashboard. Data were extracted on 3/18/2025.

SFY	Count
SFY17	408
SFY18	543
SFY19	592
SFY20	611
SFY21	701
SFY22	804
SFY23	975
SFY24	1,042

Figure 5 shows that the percentage of people who got housing with a slot and then lost it within the year was lower during SFY20 and SFY21, when there was a national eviction ban. This percentage rose in SFY22 and SFY23 but dropped again in SFY24, getting closer to the state goal of less than 4% per quarter (around 16% per year), thanks to the work of LME/MCOs and providers in preventing these separations and efforts in rehousing.

[11] The count could include a small amount of duplication across individuals separated and rehoused more than once.

Figure 5. Percentage of annual separations (by state fiscal year)



Source: TCL Dashboard. Data were extracted on 4/4/2025.

SFY	Percentage
SFY17	10.3%
SFY18	17.2%
SFY19	17.5%
SFY20	15.1%
SFY21	14.8%
SFY22	17%
SFY23	16.7%
SFY24	14.4%

Additional member outcomes that highlight data trends and successes in housing are reported in section 8. Quality Assurance & Performance Improvement, Figures 15 through 20 and Tables 11 and 12. In general, the data indicate strong housing stability for most members[12], with separation rates remaining low and on a downward trend. However, notable variations in separation rates and ACH admissions or readmissions occur across population categories[13]. Specifically, Population 1-3 experiences higher separation rates, while members who entered the TCL program through the Population 5 Diversion category show a greater likelihood of ACH admission following separation. NCDHHS and LME/MCO TCL teams are analyzing these data trends to identify risks and refine strategies to better support members in maintaining stable housing.

[12] See Figure 17. Years Since Initial Transition, Members Housed at End of SFY24, and Figure 18. Annual Statewide Numbers of Members Transitioned, Separated, and in TCL Housing at End of Reporting Period, SFY20-SFY24.

[13] See Table 11. Life of Program Housing Separations by Population Category at Transition, and **Error! Reference source not found.**.

3.3. KEY FOCUS AREAS AND STRATEGIES FOR SFY25

EXPANSION OF THE HOUSING PILOT PROGRAM

A key strategy for SFY25 is the expansion of the TCL housing pilot to all LME/MCOs:

- In fiscal year SFY24, Vaya and Alliance LME/MCOs agreed to pilot a different approach to housing access. The goal was to make LME/MCOs the primary contact with property managers for targeting/key properties, fostering rapport and collaboration. Vaya and Alliance met weekly with NCHFA and NCDHHS staff to discuss properties and units available, referrals, appeals and support needed. They were also granted access to the V&R system[14], which facilitates collaboration and information sharing on available tenancies. This pilot program significantly increased the number of referrals for vacant units, with many of these units allocated to TCL members.
- Due to the success of the pilot, Partners and Trillium will join the program in SFY25. The program will also review lessons learned from the first year and implement changes to the collaborative process among TCL members, property managers, LME/MCOs, targeting/key staff, NCHFA staff, NCDHHS staff, and Technical Assistance Collaborative (TAC) staff. This strategy aims to directly impact III(B)(1) by ensuring TCL individuals have access to targeting/key properties and addresses III(B)(7)(b) by providing tenancy supports, with LME/MCOs being the first point of contact for any issues.

Several key milestones must be achieved in SFY25 for this project:

1) Give Partners and Trillium access to V&R.
2) Deliver tenancy and housing training to Partners and Trillium TCL staff to match the housing expertise gained by Alliance and Vaya during SFY24 and allow Alliance and Vaya to continue their training to meet the goals set for SFY25.
3) Establish a pipeline of properties for direct collaboration with the four LME/MCOs for CY 2024 and CY 2025.
4) Set up and maintain regular check-ins and technical assistance opportunities with LME/MCOs and other partners in the pilot (targeting/key staff, NCHFA staff, NCDHHS staff, and TAC staff).
5) Develop a clear roadmap for interest to tenancy for all pilot participants and ensure this resource is available to all staff involved.

ENGAGEMENT WITH NC PUBLIC HOUSING AUTHORITIES

A second key strategy will be to continue to engage with NC's Public Housing Authorities (PHAs). This work began in 2023 with the NCDHHS team presenting at the North Carolina Housing Authority Directors Association (NCHADA) and continued throughout 2024. The state team engaged with LME/MCOs regarding different housing authorities in their catchment areas and identified additional support or technical assistance needed to address any outstanding gaps or needs. With the support of TAC, NCDHHS also held office hours for LME/MCOs for training and support on housing-related topics identified either at the LME/MCO or the state level. This strategy is important because every federal voucher utilized instead of the TCL voucher will allow for greater financial sustainability for the program in NC. The actions/milestones for this are to continue the work that was started in 2024, continue to provide one-on-one assistance for LME/MCOs as needed, and continue to partner with the HUD Greensboro Field office.

[14] The Vacancy and Referral (V&R) system facilitates the communication of vacancy and referral information between NCDHHS and property management companies, streamlining the process of connecting eligible applicants with available NCHFA-monitored housing units.

INCREASE ACCESS TO BRIDGE OPTIONS

A final key strategy will be to increase access to hotel bridges and enhanced bridge programs[15], as well as to review the program to identify methods to continue to expand access across NC. Historical data shows individuals who enter bridge housing have a greater than 75% likelihood of continuing to Permanent Supportive Housing. Key milestones to support this goal will be to provide updated guidance and expectations for provider LME/MCO level support for individuals in bridge housing. The State will explore additional ways to expand bridges. In addition to updating the guidelines to better address expectations during bridge housing, the guidelines will also reflect NCDHHS's position to not support discharge from facilities to Multi-Unit Assisted Housing (MUAH) as they are not compliant with III(B)(1) provisions.

[15] In the context of the North Carolina TCL housing program, the hotel bridge and enhanced bridge programs serve different purposes and target different needs:

- Hotel Bridge Programs provide temporary housing solutions for individuals transitioning from institutional care to community-based living environments. Hotel bridge housing is often used as a short-term option to help individuals move from institutions to community living.
- Enhanced Bridge Programs are designed for high-needs individuals transitioning from Adult Care Homes (ACHs) and State Psychiatric Hospitals. Enhanced bridge programs focus on improving physical health management and functional skill development, which leads to better housing retention. They involve more intensive support and monitoring to ensure individuals can successfully transition and maintain their housing.

4. COMMUNITY-BASED MENTAL HEALTH SERVICES

The Community-Based Mental Health Services pillar provides a comprehensive array of recovery-based mental health services and supports enabling individuals who are eligible for TCL to thrive in their communities.

4.1. PROGRESS DURING SFY24

In 2023, the General Assembly invested $835 million in behavioral health to improve access and quality of care and strengthen the state's crisis response system. Additional system-level activities are included in DMH/DD/SUS Strategic Plan published in September 2024. Specific activities include the expansion of the 988 Peer Warmline, Certified Community Behavioral Health Clinics (CCBHC), Peer Respite and Living Rooms, building workforce, and promoting early detection and recovery services.

The Settlement Agreement outlines 10 substantive requirements related to Community-Based Mental Health Services for North Carolina. Table 3 lists some of the key progress made during SFY24 in meeting these requirements.

Table 3. Key Progress Made to Meet Outstanding Services Requirements

Outstanding TCL Compliance Requirements	Key Progress
III(C)(1). The State shall provide access to the array and intensity of services and supports necessary to enable individuals with SMI in or at risk of entry in adult care homes to successfully transition to and live in community-based settings. The State shall provide each individual receiving a Housing Slot under this Agreement with access to services for which that individual is eligible that are covered under the North Carolina State Plan for Medical Assistance, the Centers for Medicare and Medicaid Services ("CMS") approved Medicaid 1915(b)/(c) waiver, or the State-funded service array.	• NCDHHS developed the TCL Capacity Report template, marking a significant step in standardizing LME/MCOs reporting (*also responsive to III(C)(3), (7), (10)*). The first TCL Capacity Report was submitted by LME/MCOs in July 2024. • Integrated quarterly service measures into the TCL dashboard (*also responsive to III(C)(4)*), enabling comparisons between LME/MCOs' performance and establishing thresholds for ACT, TMS, CST, and Peer Support. • For LME/MCOs not meeting the set thresholds, 1:1 meetings are being held to discuss performance, and recommendations are provided to increase service intensity and frequency.

Outstanding TCL Compliance Requirements	Key Progress
III(C)(2). The State shall also provide individuals with SMI in or at risk of entry to adult care homes who do not receive a Housing Slot under this Agreement with access to services for which that individual is eligible that are covered under the North Carolina State Plan for Medical Assistance, the CMS-approved Medicaid 1915(b)/(c) waiver, or the State funded service array. Services provided with State funds to non-Medicaid eligible individuals who do not receive a Housing Slot shall be subject to availability of funds and in accordance with State laws and regulations regarding access to those services.	• NCDHHS met regularly with LME/MCOs to review the results and progress of Constellation Reviews[16] to identify barriers and provide recommendations for improving performance *(also applicable to III(C)(3), (6)*). Those eight key service areas are: o Community Services o Evidence-Based Services o Recovery Orientation o Flexible Services with no Barriers o Individualized Services o Natural Support Networks o Crisis Management/Planning o Tenancy Support o PCP-related issues • The State collaborated with LME/MCOs to initiate discussions on the PCP monitoring process and how results will be reviewed; as an outcome of these discussions, the State developed a PCP monitoring tool and process, and established a feedback loop with LME/MCOs .
III(C)(3). The services and supports referenced in Sections III(C)(1) and (2), above, shall: be evidence-based, recovery-focused and community-based; be flexible and individualized to meet the needs of each individual; help individuals to increase their ability to recognize and deal with situations that may otherwise result in crises; and increase and strengthen individuals' networks of community and natural supports, as well as their use of these supports for crisis prevention and intervention.	• At the direction of NCDHHS, UNC Institute of Best Practices (IBP) delivered 79 training sessions focused on behavioral health services and covering a wide range of topics including Motivational Interviewing (MI), Recovery-Oriented Cognitive Therapy, Community Inclusion, and Co-Occurring Disorder Treatment *(also responsive to III(C)(5)*). o Over 2,900 individuals participated in these training sessions, receiving both training and technical assistance. o A 96% satisfaction rate was reported for IBP training, reflecting strong positive feedback from attendees. o 35 participants completed the Permanent Supportive Housing (PSH) Refresher training on UNC Behavioral Health Springboard. o Alliance, Partners and Vaya LME/MCOs offered PSH 15-hour training every other month, with Trillium in development for similar training, supported by DMH. • Since the inception of Community Inclusion in 2019, three of the four LME/MCOs (Partners, Trillium, Alliance) now have a Community Inclusion Centers for Independent Living (CIL) serving TCL members. Community Inclusion initiatives support TCL members with serious mental illness (SMI/SPMI) and co-occurring diagnoses, connecting them to resources that help them integrate into their communities and maintain independent housing *(also responsive to III(C)(5)*). • ADANC continued to provide Community Inclusion support, including coaching Solutions for Independence (SFI) to prepare them to become a CIL. As a result, SFI partnered with Trillium in August of 2023, and now supports members through peer-driven, consumer-controlled services.

[16] The NCDHHS TCL team has contracted with Constellation Quality Health, a nonprofit health care quality consulting organization, to conduct desk reviews and perform face-to-face reviews, similar to the reviews conducted by the Independent Reviewer (IR). Constellation Quality Health sends their own reviewers into Adult Care Homes (ACHs), State Psychiatric Hospitals (SPHs), bridge settings, and permanent housing. They collaborate with LME/MCOs and report quarterly on scores and quality assessments. Initiated in SFY24, these reviews aim to evaluate and score living conditions and services to confirm they meet the standards outlined in the Settlement Agreement.

Outstanding TCL Compliance Requirements	Key Progress

	• During SFY24, Community Inclusion staff provided 4,796 community supports visits, enhancing community engagement and strengthening natural support networks for TCL members.
	• At the direction of NCDHHS, Dr. Mark Salzer and Dr. Bryan McCormick **completed** the following activities during SFY24:
	  ○ Developed the "Transitions to Community Living – Community Inclusion (TCL-CI) Program Supports Guide" following approximately 15 hours of meetings with ADA and SIL TCL providers.
	  ○ Completed an evaluation of the impacts of the Freedom Fund initiative in 2023.
	  ○ Provided intensive technical assistance and training to National Alliance on Mental Illness (NAMI-NC) on their Community Inclusion initiatives.
	  ○ Delivered 19 training courses across various LME/MCOs statewide, totaling 33.25 hours of training for 1,572 participants.
	  ○ Held monthly meetings with TCL providers and their respective LME/MCOs.
	  ○ Participated in additional ad hoc meetings with TCL providers.
	  ○ Analyzed Temple University Community Participation Measure (TUCP) data for ADA and created a report on the results.
	  ○ Launched Connections App, a free digital tool that provides peer support and care management tools for individuals during treatment and recovery.

III(C)(4). The State will rely on the following community mental health services to satisfy the requirements of this Agreement: Assertive Community Treatment ("ACT") teams, Community Support Teams ("CST"), case management services, peer support services, psychosocial rehabilitation services (PSR), and any other services as set forth in Sections III(C)(1) and (2) of this Agreement.	• As directed by NCDHHS, TAC completed the following:
	  ○ Developed a four-pronged coaching approach targeting:
	  ▪ CST Team-Led Coaching
	  ▪ Agency Leadership Support
	  ▪ Tailored Plan Accountability & Oversight
	  ▪ Cross Training & Community Collaboration
	  ○ Seventeen CST Teams (across 14 providers) engaged in coaching at the individual team level.
	  ○ Eight provider agencies participated in leadership coaching.
	  ○ All 4 LME/MCOs engaged in the technical assistance process.
	  ○ Total engagements:
	  ▪ 329 with CST teams
	  ▪ 35 with agency leadership
	  ▪ seven with LME/MCOs
	  ○ Developed CST Toolkits, including:
	  ▪ Housing Tenancy Support for CSTs
	  ▪ Leading CSTs: A Toolkit
	  ○ Conducted two quarterly Permanent Supportive Housing (PSH) Learning Collaboratives, covering:
	  ▪ Assessing for Level of Care
	  ▪ Root Cause Analysis
	  ○ Developed seven tenancy support training courses, including:
	  ▪ Supporting tenants with substance use
	  ▪ Navigating challenging tenancy situations
	  ▪ Crisis planning and prevention
	  ▪ Effective policies and procedures
	  ▪ Evaluation 101

Outstanding TCL Compliance Requirements	Key Progress
	○ Created the "Demystifying" podcast series covering key topics like: ▪ Crisis ▪ Diagnostic labels ▪ Personality disorders ▪ Hearing voices ○ Coaching successes include: ▪ Policy creation for outreach, referral/discharge, and staff orientation ○ Improved PCP quality upon reassessment ○ Enhanced agency leadership oversight and monitoring ○ Increased knowledge of TCL and IPS referrals ○ Improved tenancy support • During SFY24, UNC-IBP provided: ○ Seven CST-specific Technical Assistance sessions (90 attendees) ○ CST Collaborative with 18 attendees ○ Twelve mixed ACT, CST, TMS, and IPS Technical Assistance sessions (41 attendees)
III(C)(5). All ACT teams shall operate to fidelity to either, at the State's determination, the Dartmouth Assertive Community Treatment ("DACT") model or the Tool for Measurement of Assertive Community Treatment ("TMACT"). All providers of community mental health services shall adhere to requirements of the applicable service definition.	• Nine new ACT Teams started: Southlight (Cumberland), October Road (Teams 4, 5, 6), Anuvia, Helping You Heal, SPARC, Pathways to Life, A Caring Alternative (Crossroads). • As directed by NCDHHS, UNC IBP completed the following: ○ Provided ongoing technical assistance (TA) and training to guide ACT providers toward improved fidelity to the model. ○ Completed 19 Tools for Measurement of Assertive Community Treatment (TMACTs) Fidelity Reviews, with 59 TCL charts reviewed. ○ Held ACT and IPS Annual Conference with 130 attendees. ○ Provided 55 ACT Coaching Sessions across 57 teams, covering topics such as scheduling, treatment planning, and evidence-based practices. ○ Held six in-person ACT Coalition meetings. ○ Facilitated seven virtual Specialist Meetings covering areas such as: Program Assistant, Housing, Peer, Nursing, Co-Occurring Disorders, Employment/Education, Therapy. ○ During SFY2024, UNC-IBP also provided: ▪ Introduction to Motivational Interviewing (three sessions) ▪ Motivational Interviewing (three sessions) ▪ Motivational Interviewing for Housing ▪ Motivational Interviewing and Co-Occurring Disorders ▪ Recovery-Oriented Cognitive Therapy (two sessions) ▪ Recovery-Oriented Cognitive Therapy Practice Circle (two sessions)
III(C)(6). A person-centered service plan shall be developed for each individual, which will be implemented by a qualified professional who is clinically responsible for ensuring that all elements and components of the plan are arranged for the recipient in a coordinated manner.	• As directed by NCDHHS, Dr. Janis Tondora and Yale University completed the following: ○ Partnered with the Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) PCP Initiative to provide NC providers with tools to implement PCP, emphasizing self-determination and choice for individuals with disabilities and health conditions.

Outstanding TCL Compliance Requirements	Key Progress
Individualized service plans will include psychiatric advance directives and/or crisis plans so that such measures can be incorporated into the response to any behavioral health crisis.	○ Provided Technical Assistance (TA) for the new PCP and Crisis Plan templates, recommended for all provider agencies requiring PCP for service provision. ○ Created a PCP Guidance Document and made it available for all NC cross-disability provider agencies. ○ Facilitated PCP webinar series that addressed specific topic areas and common areas of confusion. ○ Developed a comprehensive online PCP toolkit aligned with Year 1 survey feedback, including sample PCPs, goal-setting tools, crisis planning advice, and systems design for leaders. ○ Engaged key stakeholders through ongoing listening sessions with providers, LME/MCOs, state leadership, and individuals/families with lived experience. • Dr. Janis Tondora and Yale University were also responsible for: ○ 6,769 individuals completing the "From Theory to Practice: Person-Centered Planning in NC" training, totaling 9,184 hours of training. ○ 89 LME/MCO attendees participating in PCP training for Utilization Management (UM) departments, focusing on system regulations, medical necessity, and billing. ○ 44 attendees completed the "Amplifying Voice and Choice in Service Planning" in-person training for individuals and family peer supporters. ○ Developing the curriculum for PCP training on "The Importance of Partnering: What Does a Good PCP Meeting Look Like?" and "Enhanced Crisis Prevention and Intervention Plan," including training, evaluations, flyers, and surveys.
III(C)(7). The State is in the process of implementing capitated prepaid inpatient health plans ("PIHPs") as defined in 42 C.F.R. Part 438 for Medicaid-reimbursable mental health, developmental disabilities and substance abuse services pursuant to a 1915(b)/(c) waiver under the Social Security Act. These plans are currently operated by LMEs. The State will monitor services and service gaps and, through contracts with PIHP and/or LME/MCOs, will ensure that the number and quality of community mental health service providers is sufficient to allow for successful transition of individuals with SMI, who are in or at risk of entry to an adult care homes, to supported housing, and for their long-term stability and success as tenants in supported housing. The State will hold the PIHP and/or LMEs accountable for providing	• Assertive Engagement (AE) was successfully established, with a state-funded standardized definition (*also responsive to III(C)(1)*). TP/PIHP amendments now mandate the provision of AE for TCL and TCL-eligible individuals to facilitate comprehensive service delivery. • A new TP/PIHP amendment added in June 2024 established provider contract requirements that hold the TP/PIHP accountable for providing access to the necessary services and support to help TCL members successfully transition to and thrive in the community. ○ The new TP/PIHP amendment now mandates coaching and technical assistance (TA) for ACT and IPS teams. Teams with scores between 3.0-3.4 (ACT) or IPS teams scoring 100 or below will be required to undergo a minimum of six months of coaching and TA from UNC IBP, with special focus on coaching items related to TCL. • The IPS State Steering Committee facilitated valuable, solution-focused discussions on key IPS/SE issues, including NC CORE milestone standardization, transition to 1915(i) Medicaid eligibility, EIPD processes, and IPS rate setting. ○ The committee met bimonthly and was chaired by NCDHHS. ○ Membership included representatives from DMH/DD/SUS, DHB, EIPD, LME/MCOs, NCAPSE, IPS providers, and UNC IBP.

Outstanding TCL Compliance Requirements	Key Progress
access to community-based mental health services in accordance with 42 C.F.R. Part 438, but the State remains ultimately responsible for fulfilling its obligations under the Agreement.	
III(C)(8). Each PIHP and/or LME will provide publicity, materials and training about the crisis hotline, services, and the availability of information for individuals with limited English proficiency, to every beneficiary consistent with federal requirements at 42 C.F.R. § 438.10 as well as to all behavioral health providers, including hospitals and community providers, police departments, homeless shelters, and department of corrections facilities. Peer supports, enhanced ACT, including employment support from employment specialists on ACT teams for individuals with SMI, Transition Year Stability Resources, Limited English Proficiency requirements, crisis hotlines and treatment planning will be implemented in coordination with the current PIHP implementation schedule. Finally, each PIHP and/or LME will comply with federal requirements related to the accessibility of services provided under the Medicaid State Plan that they are contractually required to provide. The State will remain accountable for implementing and fulfilling the terms of this Agreement.	• Federal requirements for 42 C.F.R. § 438.10 require services and crisis hotline materials and information for individuals with limited English proficiency be available at LME/MCOs websites, as well as all behavioral health providers, including hospitals and community providers, police departments, homeless shelters, and department of corrections facilities. • DMH/DD/SUS is currently updating their State-Funded Services website to support 508 compliance. • The DMH/DD/SUS Traumatic Brain Injury (TBI) section received a grant to develop an accessibility menu widget for the Brain Injury Association of North Carolina. • DMH developed a Crisis Services webpage, which is also available in Spanish. • The NCDHHS website is now accessible in 16 different languages.
III(C)(9). Assertive Community Treatment (ACT) Team Services: the State will increase the number of individuals served by ACT teams to 43 teams serving 4,307 individuals at any one time, using the DACT or TMACT model.	• Amendments to the TP and PIHP contracts between NCDHHS and LME/MCOs now mandate LME/MCOs to monitor their provider network to confirm TCL members receiving ACT and opting for supported employment are provided services by the vocational specialist on the ACT team. • 90 ACT teams (during SFY24) served a monthly average of 5,038 ACT participants, with 1,218 individuals receiving ACT In-Reach or Transition Supports each month.
III(C)(10). Crisis Services: The State shall require that each PIHP and/or	• The initial Capacity Report completed by all LME/MCOs supports NCDHHS in identifying gaps and needs.

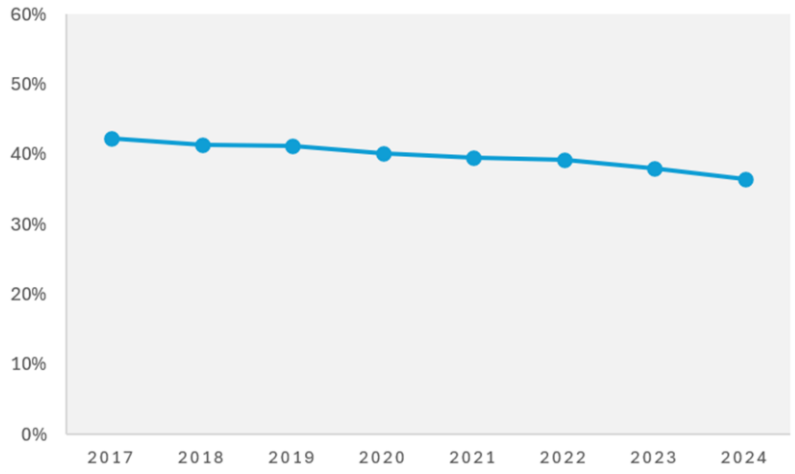
Outstanding TCL Compliance Requirements	Key Progress

LME develops a crisis service system that includes crisis services sufficient to offer timely and accessible services and supports to individuals with SMI experiencing a behavioral health crisis. The services will include mobile crisis teams, walk-in crisis clinics, community hospital beds, and 24-hour-per-day/7day-per-week crisis telephone lines; The State will monitor crisis services and identify service gaps. The State will develop and implement effective measures to address any gaps or weaknesses identified; Crisis services shall be provided in the least restrictive setting (including at the individual's residence whenever practicable), consistent with an already developed individual community-based crisis plan or in a manner that develops such a plan as a result of a crisis situation, and in a manner that prevents unnecessary hospitalization, incarceration or institutionalization.	• DHHS created and distributed the Person-Centered Planning (PCP) Guidance Document and PCP & Crisis Plan templates to all NC providers and disability groups.
	• Launched the 988 Performance Dashboard (link to view the dashboard)
	• In February 2024, DMH/DD/SUS partnered with Promise Resource Network to start the Statewide Peer Warmline that started receiving 7,000 calls a month.
	• DMH/DD/SUS was appropriated $131 million to invest in the Crisis System
	  ○ $15 Million for development of nine new Behavioral Health Urgent Cares
	  ○ $20 million for the development of a Non-Law Enforcement Transportation Program – RFP released 12/20/2024 - Rockingham and Alamance Centers had ribbon cuttings in Spring 2024
	  ○ Over $2 million for Mobile Outreach Response Engagement and Stabilization (MORES) and co-responder services expansion and pilots
	  ○ $20 million identified for technology enhancements with the Behavioral Health Statewide Central Availability Navigator (BH SCAN) - Over 3,100 beds reporting in BH SCAN including Community Hospitals (CH), FBC's State Hospitals, ADATC's and PRTF's
	  ○ Over $25 million identified for new Community Crisis Centers (Facility Based Crisis) and a Peer Respite in Wake County - Rockingham and Alamance Centers had ribbon cuttings in Spring 2024

4.2. SFY24 SUPPORTING DATA

Figure 6 below illustrates a slight downward trend in the percentage of TCL housed individuals receiving ACT. Monitoring statewide and LME/MCO patterns of ACT provision has been an ongoing focus of the NCDHHS Services Team.

Figure 6. Percentage of housed TCL members receiving ACT services (by state fiscal year)



Source: TCL Dashboard. Data were extracted on 3/18/2025.

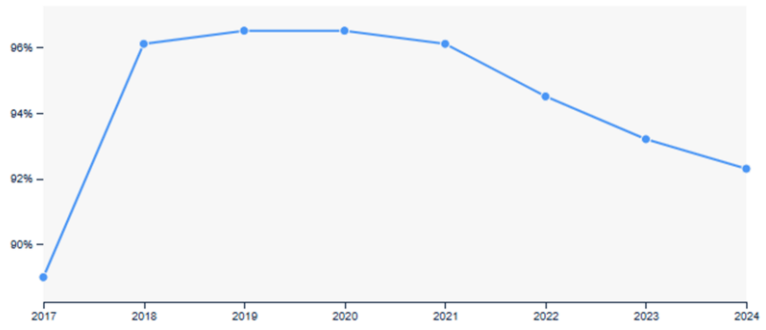
SFY	Percentage
SFY17	42.3%
SFY18	41.4%
SFY19	41.2%
SFY20	40.1%
SFY21	39.6%
SFY22	39.3%
SFY23	38%
SFY24	36.5%

Figure 7 illustrates the percentage of TCL individuals housed in the community receiving ACT, TMS, CST or Peer services. These four services are of special relevance for housed TCL members because they include tenancy support components and interventions. While the State is required to offer tenancy support services to people living in TCL supportive housing, tenancy supports are not mandated as a condition of tenancy, and the percentage of individuals receiving these services has decreased slightly over the past two fiscal years.

Statewide trends and LME/MCO variations in the provision of ACT and other services with tenancy supports to members in TCL housing[17] were a subject of ongoing discussion with LME/MCOs in quarterly or more frequent 1:1 meetings during SFY24. The NCDHHS Services and Quality teams shared supporting data showing the LME/MCO with the lowest service provision rates of ACT had slightly higher incidences of adverse outcomes, such as inpatient admission and housing separation to members in TCL housing. Subsequent discussions focused on expectations around service provision and utilization management practices and processes to confirm members receive services of appropriate intensity. From SFY23 to SFY24, the TCL-housed member annual ACT service rate in this catchment area increased from 30 percent (eight percent below SFY23 average) to 35 percent (one percent below SFY24 average). Percentage increases were observed in each quarter, along with associated decreases in rates of lower intensity TMS and peer support services. The NCDHHS Services team continues to actively monitor these service patterns to identify additional interventions if needed.

[17] LME/MCO variations in TCL housed member service rates are illustrated in Section 10.2. Reporting on Service Patterns See Figure 44. Participants in TCL Supportive Housing, Figure 52 for SFY23, and Figure 60 for SFY24.

Figure 7. Percentage of housed TCL members receiving any of ACT, TMS, CST, or Peer services (by state fiscal year)



Source: TCL Dashboard. Data were extracted on 3/18/2025

SFY	Percentage
SFY17	89%
SFY18	96.1%
SFY19	96.5%
SFY20	96.5%
SFY21	96.1%
SFY22	94.5%
SFY23	93.2%
SFY24	92.3%

Appendix "10.2. Reporting on Service Patterns" provides summaries of a range of behavioral health services provided to members in the various TCL status and settings, as well as a summary of observed service trends. Additional member outcomes that highlight positive trends related to TCL Community-Based Mental Health services are presented under section "8.2. Quality Assurance and Performance Improvement SFY24 data."

- Most housed members who received TCL services and responded to provider outcomes assessments in SFY24[18] reported their services were "very helpful" for achieving positive outcomes related to housing status (68%) and quality of life (64%).
- Just over half (53%) reported their services were very helpful for increasing their hope about the future, while fewer than half reported services were very helpful for decreasing their symptoms (49%) or increasing life control (43%).
- Members were least likely to report a high level of service helpfulness for improving employment status (11%) or educational status (9%).
- Notably, only one percent reported barriers to treatment[19] related to service access or treatment that didn't meet their needs.

4.3. KEY FOCUS AREAS AND PRIORITIES FOR SFY25

ENHANCING THE QUALITY OF PERSON-CENTERED PLANS AND FOSTERING A CULTURE OF PERSON-CENTEREDNESS ACROSS MENTAL HEALTH SERVICES

The strategy aims to elevate the quality and effectiveness of Person-Centered Planning (PCP) processes. Well-executed PCPs empower individuals to lead lives aligned with their unique goals and aspirations, ultimately improving their integration and success within the community. The key actions to achieve this include the PCP Collaborative and monthly PCP training sessions led by Dr. Janis Tondora to give all providers the tools and knowledge needed to deliver high-quality, individualized, recovery-based support. Additionally, the team will further enhance the PCP monitoring effort to confirm consistency and

[18] See Figure 37. NC-TOPPS Participants Who Reported a High Level of Program Services Helpfulness (Very Helpful) for Achieving Positive Outcomes, SFY20-SFY24.

[19] See Figure 38. NC-TOPPS Participants Who Reported Barriers to Treatment at the Most Recent Assessment, SFY20-SFY24

compliance, identifying opportunities for improvement in the process and building a culture of person-centeredness.

STRENGTHENING THE CAPACITY AND EFFECTIVENESS OF COMMUNITY-BASED MENTAL HEALTH SERVICE PROVIDERS

The strategy focuses on enhancing the quality and effectiveness of service providers within the community mental health system. This is a critical priority as individuals transitioning to community living need a strong, supportive network of providers to maintain stability and thrive in their new environments. The desired impact of this strategy is to elevate the overall quality of services, with a specific focus on improving provider performance and service outcomes, as measured through benchmarks and feedback. Key actions for SFY25 include continued coaching and technical assistance for Assertive Community Treatment (ACT) and Individual Placement and Support (IPS) teams, as well as ongoing support through TMS collaboratives, coaching, and the ACT Coalition. The UNC IBP team will provide targeted training sessions and work closely with LME/MCOs to enhance contract monitoring efforts. The introduction of a pilot for the CST Monitoring Tool and the use of the Quarterly Measures Report (QMR) through QAPI will help identify areas for improvement and support effective change. Internal efforts in clearly defining goals and targets will also play a key role in tracking progress and ensuring high-quality service delivery.

These additional activities will strengthen community-based mental health services in North Carolina:

- Launching an accessible communication campaign
- Providing support to five Certified Community Behavioral Health Clinics (CCBHC)
- Expanding NAMI on-campus groups
- Implementing scholarships for direct support professionals (DSP) to attain an advanced DSP micro credential through the NC Community College System
- Providing coaching for low fidelity ACT and IPS providers
- Expanding Peer Respite, Living Room, and Recovery Centers
- Investing in Behavioral Health Urgent Care (BHUC), Facility-Based Crisis (FBC), and Mobile Crisis Management (MCM)
- Modernizing Clubhouses to help people with mental health challenges build skills, connect with others, and work toward recovery in a supportive community setting

STRENGTHENING COMMUNITY INTEGRATION AND PEER SUPPORT

A key focus area and strategy for SFY25 will be strengthening Community Integration and Peer Support through continued development of three Community Inclusion (CI) projects. The state remains committed to providing ongoing training and technical assistance to each project. Monthly meetings will be conducted with the CI team and associated LME/MCOs to review data trackers, address CI barriers, and share success stories. Technical assistance will cover a wide range of topics, including guidance on using the data tracker, strategies to increase IPS referrals and face-to-face community visits, and methods to enhance the administration of TUCP Assessment tool. Additional support will focus on solving staffing and transportation barriers, setting staff targets, addressing stigma and discrimination among individuals living with SMI/SPMI, and improving connections to community and natural supports to help individuals stay integrated in their communities. Success stories from Community Inclusion will also be shared to promote continued progress.

In SFY25, significant strides are being made toward achieving key goals, including establishing a statewide Community of Practice for Community Inclusion in North Carolina, adding a new Community Inclusion provider to Alliance Health, bringing on another Tailored Plan to offer Community Inclusion support, and ensuring each Community Inclusion site undergoes program evaluation. In the first quarter of SFY25,

SouthLight became a Community Inclusion provider in partnership with Alliance. Additionally, the Community of Practice for Community Inclusion held its kickoff meeting in October 2024, and Solutions for Independence completed the first Community Inclusion Program Evaluation. Plans are also in place to bring Vaya on board as a CI provider in SFY25.

Additional activities planned for SFY25 to further reinforce community integration and peer support in North Carolina include:

- Implementing a Peer Support Specialist training program – examples include specialty training in traumatic brain injury (TBI), intellectual/developmental disabilities, etc.
- Expanding Peer Respite services
- Investing in Peer Line Expansion

5. SUPPORTED EMPLOYMENT

The Supported Employment pillar is dedicated to helping individuals with SMI and SPMI gain and maintain employment. Providing personalized assistance and ongoing support helps individuals build meaningful careers, improve their quality of life, and achieve greater independence. The focus on competitive, integrated employment confirms individuals are fully included in their communities, contributing to their overall well-being and long-term stability.

A key component of this pillar is the growing network of Individual Placement and Support (IPS) providers. IPS is an evidence-based model of supported employment that helps individuals find and keep competitive jobs in integrated work settings. The network of IPS providers is continuously expanding, ensuring more individuals have access to these vital services.

The milestone-based payment model is another important aspect of this pillar. It involves setting and achieving specific goals and benchmarks to track progress and confirm the effectiveness of supported employment services. This system monitors the number of individuals in IPS and in competitive employment, providing a structured approach to measure success and make necessary adjustments.

The SFY24 progress has focused on financially stabilizing the network so IPS providers can expand their capacity and provide service members interested in employment, and progress on referrals to the IPS service.

5.1. PROGRESS DURING SFY24

The Settlement Agreement outlines three substantive requirements related to Supported Employment for North Carolina[20]. Table 4 lists some of the key progress made during SFY24 in meeting the two outstanding requirements.

Table 4. Key Progress Made to Meet Outstanding Supported Employment Requirements

Outstanding TCL Compliance Requirements	Key Progress
III(D)(1). The State will develop and implement measures to provide Supported Employment Services to individuals with SMI, who are in or at risk of entry to an adult care home, that meet their individualized needs. Supported Employment Services are defined as services that will assist individuals in preparing for, identifying, and maintaining	• The SE pillar team developed an implementation plan[21] to direct the priorities for the State to meet substantial compliance with the Settlement Agreement that included the following key priority areas: standardizing NC CORE, adjusting provider reimbursement rates, increasing access to IPS, increasing behavioral health integration and executive leadership participation. • IPS reimbursement rates were significantly increased across Medicaid, State funds, and EIPD and went live in November 2023. All LME/MCOs agreed to waive prior authorization for IPS to allow for ease of access and payment for initial engagement efforts by the IPS team.

[20] Previous reviews confirmed the State achieved compliance with one of the three requirements of section III (D) Supported Employment. The Sixth modification entered by Court on December 11, 2024, discharged the obligation in section III(D)(3).

[21] The **TCL Implementation Plan** outlines the priority goals and objectives required to achieve substantial compliance under the fifth modification of The United States of America v. State of North Carolina TCL Settlement Agreement. The plan details how the NCDHHS will meet the remaining components of the TCL Settlement Agreement provisions. The initial version of that plan was published on the NCDHHS website, and NCDHHS continues to work dynamically and revisit strategies to drive the priority goals and objectives. See: https://www.ncdhhs.gov/tcl-implementation-plan/

Outstanding TCL Compliance Requirements	Key Progress
integrated, paid, competitive employment. Services offered may include job coaching, transportation, assistive technology assistance, specialized job training, and individually tailored supervision.	• NCDHHS developed an NC CORE workgroup that included representatives from DMH/DD/SUS, DHB, EIPD, UNC IBP, each Tailored Plan, and IPS providers. This group successfully standardized the IPS NC CORE payment model to follow the same procedures, milestone structures, and rates across all LME/MCOs. Standardized NC CORE went live in April 2023. • Each LME/MCO submitted a strategic plan to NCDHHS by May 2024 detailing their planned efforts for addressing and improving each key priority area. The SE pillar team facilitated bimonthly progress report sessions to receive updates and evaluate effectiveness of identified strategies. • NCDHHS developed a Money Follows the Person proposal for funding a behavioral health integration incentive program to encourage behavioral health providers to partner with, regularly meet with, and refer TCL recipients to IPS providers. • NCDHHS provided funding for Supported Employment Specialists (SES) at each LME/MCO to prioritize increasing employment outcomes for TCL members. • NCDHHS established a targeted employment engagement campaign to increase TCL referrals and enrollments for TCL housed and transitioning members. The campaign provided education on employment as recovery and the IPS/supported employment service and initiated referrals for those interested. LME/MCOs provided employment engagement training to their behavioral health provider networks and TCL staff. • Targeted engagement for TCL members residing in supported housing for less than six months led to 46 IPS referrals across the LME/MCOs. SESs at the LME/MCOs were instrumental in this effort. • NCDHHS established a data collection process for LME/MCOs to track and evaluate TCL IPS referrals and enrollments and connection to ACT vocational specialists. • Each LME/MCO hosted collaborative meetings for ACT, CST and TMS providers where they encouraged TCL referrals to support employment services and shared information on employment engagement and resources. • DHB and DMH/DD/SUS collaborated to develop a Medicaid IPS clinical coverage policy and revise the state-funded IPS service definition. The policies added eligible individuals with a serious emotional disturbance diagnosis and individuals with a severe substance use disorder (SUD). The policies also replaced the requirement for a Person-Centered Plan with the Career Profile to function as the assessment and service plan. • DMH/DD/SUS collaborated with UNC IBP on revisions to the IPS Career Profile that resulted in a more accessible and person-focused document. It serves as a comprehensive assessment of an individual's desires, preferences, strengths and needs and a planning and support plan for searching, finding, and keeping employment. There is a greater inclusion of feedback and participation from natural support, behavioral health providers, and EIPD counselors. • The EIPD Program Specialist for Behavioral Health continues to provide technical assistance and training to EIPD counselors and staff, IPS and ACT providers, and LME/MCOs. Technical assistance is on various programmatic topics with the goal of improving access to EIPD services and to improve collaboration with various external partners.

Outstanding TCL Compliance Requirements	Key Progress
	• EIPD evaluated and revised their three IPS milestones and expanded from three to eight milestones. Revisions included input from IPS providers, cross divisional staff, and our UNC Center of Excellence IPS Trainers. The goal is to address barriers that impacted financial viability communicated by IPS providers and to drive the quality of the service. Barriers included capturing individuals who drop out of the service, providers' ability to earn milestones for individuals who require a longer time frame to secure employment and aligning EIPD milestones with IPS fidelity to drive the quality of service. The milestone's revision went live November 1st, 2024, during SFY25. • As of June 2024, self-reported IPS provider data showed a 17% increase in shared EIPD cases to 41% and a 6% increase to 50% in the competitive, integrated employment rate . • The contract for development of the online benefits counseling tool, DB101, was awarded on May 9, 2024. The vendor kicks off meeting was held May 29, 2024. DB101 is a platform to help individuals with disabilities understand their eligibility and benefits and the impact of employment on their disability benefits. This solution offers quick and efficient access to up-to-date, accurate benefits counseling resources and information for people with disabilities in North Carolina. This will positively impact the TCL population as individuals will have current information on how to simultaneously work and protect their benefits. Phase 2 of DB101 Go-Live is scheduled for May 2025. • Access to benefits counseling has increased with the inclusion of benefits counselors on IPS teams. It is also available for TCL recipients who receive community inclusion services with ADANC. • Over the life of program, a total of 8,520 individuals have received IPS services as captured by our In or At-Risk reporting. • The TCL Settlement requirement to provide IPS to 2,500 individuals in or at risk of adult care home entry was met in SFY22; by the end of SFY24, the State exceeded the required number by 12 percent, with a total of 2,796 individuals receiving IPS as of June 2024. • Over the life of the program, 605 TCL individuals received IPS services from fidelity teams. • Self-reported IPS provider data from the IPS Data summary report for June 2024, showed a 43% average competitive, integrated employment rate for TCL members and those In or At Risk of ACH placement.
III(D)(2). Supported Employment Services will be provided with fidelity to an evidence-based supported employment model for supporting people in their pursuit and maintenance of integrated, paid, competitive work opportunities. Supported Employment Services will be assessed by an established fidelity scale such as the scale included in the Substance Abuse and Mental Health Services	• UNC IBP completed 14 IPS fidelity evaluations in SFY24. At the end of SFY24, all IPS teams had participated in a fidelity evaluation since evaluations resumed in SFY23. • In January 2024, UNC IBP developed an IPS fidelity trends report (inclusive of "pre- and post-pandemic" fidelity reports) and presented to the LME/MCOs and Independent Reviewer. A biannual report cadence was established for continuous monitoring. • DMH/DD/SUS developed a policy requiring technical assistance for IPS teams who rate fair fidelity for evaluations conducted after July 1, 2024. Targeted technical assistance will be reported out to DMH/DD/SUS and LME/MCOs for monitoring fidelity improvements.

Outstanding TCL Compliance Requirements	Key Progress
Administration supported employment toolkit.	• UNC IBP provided valuable supported employment training and technical assistance to IPS, ACT, CST and TMS providers, with over 1,900 (duplicated) attendees. • 30 IPS Fidelity teams were active during the year.

During SFY24, the department continued to monitor its compliance towards one Supported Employment requirement that was met[22], as shown in Table 5.

Table 5. Key Progress Made Towards Supported Employment Requirements Already Met

TCL Requirements that have been Met and Discharged	Key Progress
III(D)(3). By July 1, 2013, the State will provide Supported Employment Services to a total of 100 individuals; by July 2, 2014, the State will provide Supported Employment Services to a total of 250 individuals; by July 1, 2015, the State will provide Supported Employment Services to a total of 708 individuals; by July 1, 2016 , the State will provide Supported Employment Services to a total of 1,166 individuals; by July 1, 2017, the State will provide Supported Employment Services to a total of 1,624 individuals; by July 1, 2018, the State will provide Supported Employment Services to a total of 2,082 individuals; and by July 1, 2019, the State will provide Supported Employment Services to a total of 2,500 individuals.	• There were 2,796 "in or at risk of ACH placement" individuals reported to have received IPS-SE services by June 30, 2024. This is an increase from the 2,711 individuals reported to have received IPS-SE services in SFY23.

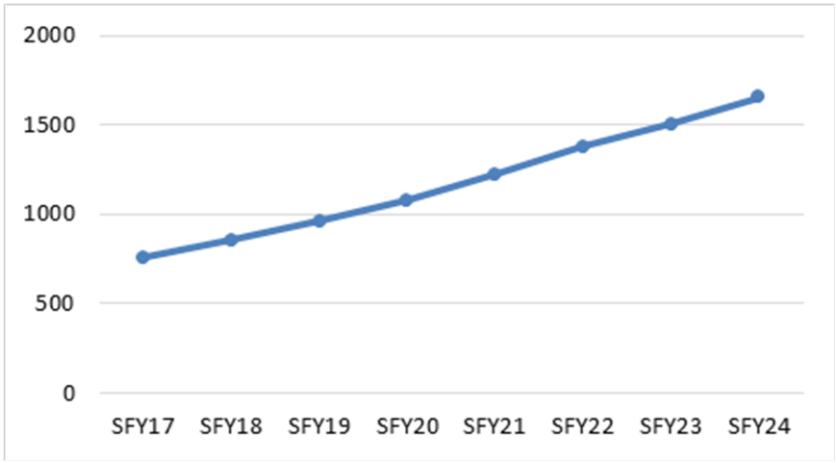
5.2. SFY24 SUPPORTING DATA

Figure 8 below shows continued growth in the SFY24 cumulative count of members in or at risk of entry to an adult care home who have received any stage of standalone IPS. Year-over-year growth of individuals who received IPS in SFY24 was 110 members and included individuals in pre-TCL housing settings as well as

[22] Previous reviews confirmed that the State has achieved compliance with one of the three requirements of section III (D) Supported Employment. During SFY25, the Sixth modification entered by Court on December 11, 2024, discharged the obligation in section III(D)(3).

in TCL supportive housing.[23]

Figure 8. Cumulative number of individuals in or at risk of ACH entry who received any stage of standalone IPS services (by state fiscal year)



SFY	Cumulative
Pre-SFY17	667
SFY17	759
SFY18	855
SFY19	964
SFY20	1,081
SFY21	1,225
SFY22	1,379
SFY23	1,504
SFY24	1,656

Source: Data were reported by each LME/MCO to the NCDHHS team at the end of August 2024.

Employment-related outcomes for housed TCL members are reported in Section 8 of this annual report. Figure 40 shows approximately eight percent of members in TCL housing with provider outcomes assessments in SFY24 were employed at their most recent assessment. Of the 182 individuals employed at time of assessment, 76 percent were paid above minimum wage, and 24 percent received employee benefits such as insurance or paid time off.

As the NC CORE Model for IPS drives people towards employment, this effort in combination with targeted engagement and ensuring IPS service is financially viable has contributed towards sustained or increased pay rate above minimum wage and employee benefits. Through this service, members are supported in advocating for themselves in the workplace.

5.3. KEY FOCUS AREAS AND PRIORITIES FOR SFY25

1915(I), TCM, AND IPS PROCESSES

This strategy will offer opportunities to IPS providers to voice concerns and questions to the State and to LME/MCOs, collaborate with LME/MCOs to better understand the lengthy wait-times for 1915(i) assessments that are delaying the IPS service and identify actionable solutions. This will also provide education to community and Tailored Plan TCM on the IPS service and practice principles, the importance of employment as recovery, and on engagement strategies for talking about employment and supported employment.

Reducing waiting times for eligibility will confirm people seeking services can rapidly engage and begin the job search. It will also allow IPS providers to continue to sustain the service and minimize the impact on

[23] IPS-SE service rates by LME/MCO and by TCL participant status and setting also are presented in the Services Appendix to this report. However, as described in the Appendix, IPS-SE service rates derived from NCTracks, and EPS systems are incomplete and do not include services reimbursed by EIPD or members who received IPS-SE services and did not achieve NC CORE milestones during the reporting period.

fidelity.

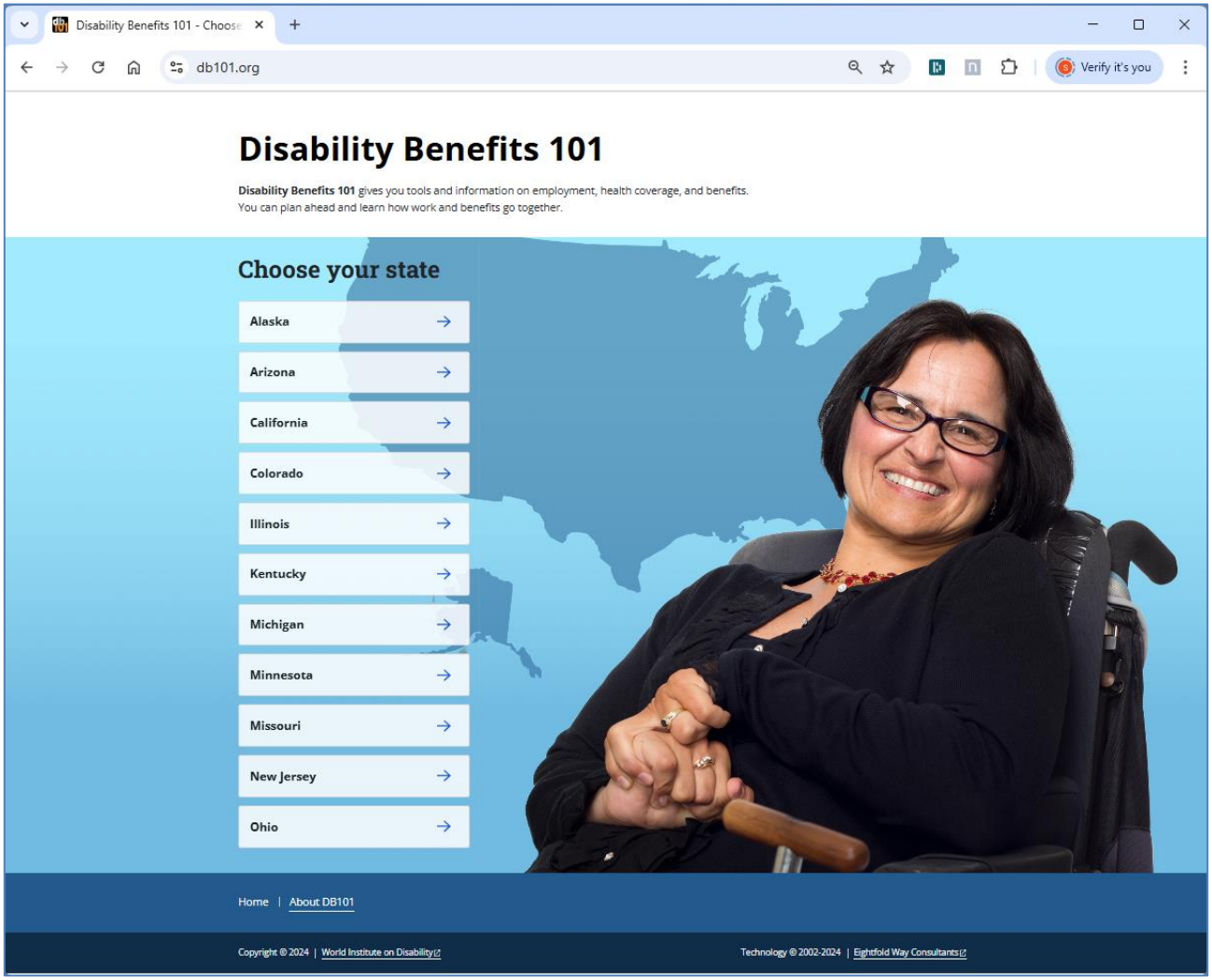
IPS LANDING PAGE

This strategy is to develop an IPS Landing page similar to the Inclusion Connects Landing page to provide a one-stop location for training, guidance and information related to IPS. This is important as IPS is a niche service funded by multiple funding streams. Information related to IPS is housed in multiple areas. The anticipated impact is that the IPS Landing Page will move the IPS service toward a more consistent place, assist with TCM onboarding, and help non-IPS providers with understanding why and how to refer to IPS.

ADD NORTH CAROLINA TO DB101

DB101 (Disability Benefits 101) is a service developed by the World Institute on Disability in partnership with 11 states. It helps individuals with disabilities and service providers better understand the connections and relationship between work and public benefits. The information is available through their dedicated website: https://www.db101.org/

Figure 9. North Carolina is set to become the 12th state featured on DB101.org, showcasing its commitment to providing valuable resources and support for individuals with disabilities seeking guidance.



Making DB101 available will help the people of North Carolina with disabilities better understand their eligibility and benefits and the impact of employment on their disability benefits. This solution offers quick and efficient access to up-to-date, accurate benefits counseling resources and information for people with disabilities in North Carolina.

This is important as the State has heard from individuals with disabilities, their guardians (as applicable) and their providers expressing hesitation to move forward with investigating paid work for fear of losing benefits. This intervention will help more people realize they can work and maintain their benefits.

INTEGRATED BEHAVIORAL HEALTH AND SUPPORTED EMPLOYMENT GRANT

This grant expands the presence and capacity of high-performing Integrated Behavioral Health and Supported Employment service providers by supplying startup funds to develop integrated teams resulting in improved quality of service received and increased success in people maintaining their community placement. This is in line with Medicaid whole person care, creating sustainable support for people with SPMI and SUD.

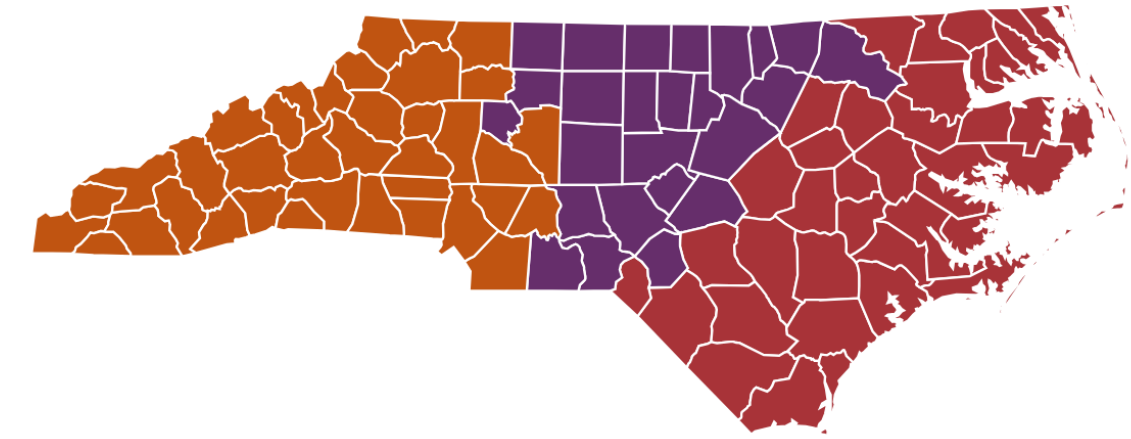
6. DISCHARGE & TRANSITION PROCESS

The **Discharge and Transition** pillar plays a crucial role in facilitating the movement of individuals with SMI or SPMI from institutional settings, such as adult care homes (ACHs) or state psychiatric hospitals (SPHs), to integrated community-based living. This process is essential for ensuring individuals have the necessary support and resources to successfully transition and remain in the community.

LME/MCOs are pivotal in this process. Their in-reach specialists, many of them being Certified Peer Support Specialists (CPSS), meet with individuals, develop rapports, and explain all available TCL services. This includes completing the In-Reach/TCL tool, which outlines the person's choices, goals, and preferences for transition planning. If an individual chooses not to transition, the in-reach specialist assists with completing the Informed Decision-Making (IDM) tool. The informed choice process is a key component, ensuring individuals are fully aware of their options and can make decisions that best suit their needs and preferences. LME/MCOs provide comprehensive information and support throughout the transition.

Strong collaboration with State Psychiatric Hospitals (SPHs) and ACHs is essential to confirm that everyone is given the option to move to community-based living. Three SPHs—Broughton Hospital in Morganton (Burke County), Cherry Hospital in Goldsboro (Wayne County), and Central Regional Hospital in Butner (Granville County)—provide comprehensive inpatient psychiatric services to individuals with severe mental health conditions in North Carolina. TCL works closely with these institutions to identify individuals who are eligible for TCL and facilitate their transition.

Figure 10. Map of North Carolina showing the service areas covered by the three SPHs.



Bridge housing is provided as a temporary solution for individuals who are transitioning from an institutional setting to permanent, supported housing. This helps individuals find a safe and stable place to stay while their permanent housing arrangements are finalized.

Discharge planning is another critical aspect, involving the coordination of numerous services and support to ensure a smooth transition. LME/MCO Qualified Professionals (QP) or licensed staff convene and task transition teams to acquire clinical assessments, care plans, behavioral and physical health services, housing selection, vouchers, and leases. They also coordinate RN and OT assessments, houseware/furniture funding and selection, connection to supported employment, and community activities.

By focusing on these elements, the Discharge and Transition pillar aims to create a supportive and inclusive environment where individuals with SMI or SPMI can thrive and live their best lives in the communities of their choice.

In SFY24, discharge and transition focused on the monitoring and technical assistance improvement of in-reach and transition coordination, specifically, the monitoring and improvement of transition teams. NCDHHS staff participated in several key in-reach visits and transition team meetings. Settlement Agreement transition requirements were woven into technical assistance, training, and monitoring tools. All Plans were given rapid feedback to utilize in their staff training, and patterns of exemplary work and growth areas were recorded to develop future monitoring and technical assistance for SFY25. There were also great strides in the recording, solutions, and analytics of barriers to in-reach and transition when the State utilized their existing Medicaid Help Center to quickly resolve, improve, or elevate TCL barriers.

6.1. PROGRESS DURING SFY24

The Settlement Agreement outlines 14 substantive requirements related to Community-Based Housing for North Carolina[24]. Table 6 lists some of the key progress made during SFY24 in meeting the 12 outstanding requirements.

Table 6. Key Progress Made by NCDHHS Staff to Meet Outstanding Discharge & Transition Requirements

Outstanding TCL Compliance Requirements	Key Progress
III(E)(1) The State will implement procedures for ensuring that individuals with SMI in, or later admitted to, an adult care home or State psychiatric hospital will be accurately and fully informed about all community-based options, including the option of transitioning to supported housing, its benefits, the array of services and supports available to those in supported housing, and the rental subsidy and other assistance they will receive while in supported housing.	• During SFY24 Q1, NCDHHS staff conducted six onsite role-play sessions for LME/MCOs that offered the opportunity for mock scenarios and technical assistance (TA) to improve engagement with TCL individuals and guardians, if applicable. Mock scenarios were utilized to assess potential barriers during in-reach and informed decision-making (IDM) discussions. A total of 85 attendees participated. • During SFY24 Q2, NCDHHS staff conducted two virtual training sessions for State Psychiatric Hospital (SPH) staff that consisted of an overview of in-reach functions and purpose of the informed decision-making (IDM) tool for individuals with SPMI who are institutionalized. This cross-departmental collaboration streamlined the IDM process, reduced redundancies, and helped TCL individuals (and guardians, if applicable) be fully informed about permanent supportive housing (PSH) before discharging from the facility. A total of 105 attendees participated. • During SFY24Q3 conducted virtual one-to-one TA meetings with LME/MCOs TCL leadership to review the TCL informed choice process, documentation procedures in TCLD, and expectations for continued frequency of engagement with individuals after informed choice. The TA sessions provided transparency and developed a standardized method to track individuals who made an informed choice.

[24] Previous reviews confirmed the State has achieved compliance with two of the 14 requirements of section III (E) Discharge and Transition Process and partially achieved compliance with one other requirement. The Fourth modification entered by the Court on March 29, 2021, discharged the obligations in sections III(E)(13)(a)(b)(d). During SFY25, the sixth modification entered by the court on December 11, 2024, established the State has met substantive obligations of section III(E)(9), and III(E)(14).

Outstanding TCL Compliance Requirements	Key Progress
	• During SFY24Q4, the new informed choice tracking method for individuals with SMI/SPMI in SPHs and Adult Care Homes (ACHs) went live on May 6. Improved data accessibility produced real-time monitoring. • Conducted two virtual informed choice trainings for LME/MCOs TCL staff that outlined documentation requirements and tracking in TCLD. Easy access to informed choice data allowed TCL peers to focus on higher-priority work, ultimately improving overall productivity and efficiency. There was a total of 75 attendees. On June 25, 2024, 123 individuals made an informed choice not to transition into the community.
III(E)(2) In-Reach: The State will provide or arrange for frequent education efforts targeted to individuals in adult care homes and State psychiatric hospitals. The State will initially target in-reach to adult care homes that are determined to be IMDs. The State may temporarily suspend in-reach efforts during any time period when the interest list for Housing Slots exceeds twice the number of Housing Slots required to be filled in the current and subsequent fiscal year. The in-reach will include providing information about the benefits of supported housing; facilitating visits in such settings; and offering opportunities to meet with other individuals with disabilities who are living, working and receiving services in integrated settings, with their families, and with community providers. The in-reach will be provided by individuals who are knowledgeable about community services and supports, including supported housing, and will not be provided by operators of adult care homes. The State will provide in-reach to adult care home residents on a regular basis, but not less than quarterly.	• During SFY24Q1, NCDHHS Staff facilitated four virtual peer-to-peer training sessions for TCL peers. The training focused on engaging with TCL individuals and best practices for documenting individuals' needs, preferences, and what's important to and for them so they feel supported as they participate in the discharge and transition process. There were 74 participants. • During SFY24Q4, co-planned and implemented with the LME/MCOs the fourth annual In-Reach Professional Development Collaborative Conference on Apil 9-10, 2024. The theme of the conference was "Supporting Growth Through In-Reach: **R**ecovery, **E**mpowerment, & **A**cceptance to **C**hange Through **H**ealing'" The topics during the two-day conference included trauma informed care and rapport, re-entry/substance use, recovery focused support, NC Peer Voice, PSS and Peer Justice Initiative, and ethics training for PSS. The conference provides an effective platform for certified peers to network and enhance their knowledge about permanent supportive housing. There were 95 attendees. • Since Joint Communication Bulletin (JCB) 415-Clarification of TCL In-Reach Function was issued on May 13, 2022, face-to-face In contacts rose to 62.4% in SFY24Q4. At baseline in SFY22Q3, 16% of in-reach was conducted face-to-face. In SFY23Q3, it was 46%, and two years later in SFY24Q3 it was 58% showing a consistent increase in frequent engagement. • Changing quality reviews to monitor timely reassessments for individuals in ACHs from quarterly to monthly resulted in a decrease in overdue reassessments. In SFY24Q3 there were 892 delayed reassessments, and that decreased to 531 in SFY24Q4.
III(E)(3) The State will provide each individual with SMI in, or later admitted to, an adult care home, or State psychiatric hospital operated by the Department of Health and Human Services, with effective discharge planning and a written discharge plan. The goal of discharge planning is to assist the individual in developing a plan to achieve outcomes that promote the individual's growth, wellbeing and	• In State psychiatric hospitals and ACHs, progress was made through continued NCDHHS monitoring of transition teams and discharge and subsequent transition written feedback given to LME/MCO SPH TCL leadership using an informal transition team checklist. The checklist was refined in SFY25. There are now 10 items tracking the presence of Settlement Agreement requirements in a transition team: Onsite or two-way conferencing participation, behavioral health Assertive Engagement provider involvement, natural supports sought or attending, member leading team, LME/MCO staff facilitating,

Outstanding TCL Compliance Requirements	Key Progress
independence, based on the individual's strengths, needs, goals and preferences, in the most integrated setting appropriate in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare and relationships).	In-Reach/TCL Tool informing written discharge/transition plan, meaningful activities planned, discharge/transition barriers discussed and addressed, all post-transition services arranged, and a pre-transition community visit scheduled. These elements are expected by NCDHHS to regularly appear both in the individual's written State psychiatric hospital discharge plan known as the Continuing Care Plan and the post-discharge community provider Person Centered Plan.
III(E)(4) Discharge planning conducted by transition teams that include: persons knowledgeable about resources, supports, services and opportunities available in the community, including community mental health service providers; professionals with subject matter expertise about accessing needed community mental health care, and for those with complex health care needs, accessing additional needed community health care, therapeutic services and other necessary services and supports to ensure a safe and successful transition to community living; persons who have the linguistic and cultural competence to serve the individual; peer specialists when available; and with the consent of the individual, persons whose involvement is relevant to identifying the strengths, needs, preferences, capabilities, and interests of the individual and to devising ways to meet them in an integrated community setting.	• In terms of State psychiatric hospital discharges into TCL transitions, Improvements were made with the increase of the assertive engagement service (AES) provision to both inform the individual of post-transition services but also perform pre-transition tasks in the person's chosen community. Additionally, NCDHHS funded, monitors, and technically assists four Community Inclusion providers such that peer support services can be added to any level of community behavioral health service in key catchment counties. • During SFY24, random quality reviews revealed an increase in transitions from ACHs but a gap in monitoring transition planning by the transition teams to help individuals to remain in the community successfully. • With approximately 1200 ACHs in NC and limited NCDHHS TCL staff to monitor the discharge and transition process, two new positions were funded for field staff. Both staff were added to the NCDHHS TCL team on Oct. 21, 2024. The Discharge and Transition Specialists provide support to the LME/MCO Transition Coordinators by attending and monitoring the facilitation of member's transition team meetings, primarily individuals in ACHs.
III(E)(5) For individuals in State psychiatric facilities, the PIHP and/or LME transition coordinator will work in concert with the facility team. The PIHP and/or LME transition coordinator will serve as the lead contact with the individual leading up to transition from an adult care home or State psychiatric hospital, including during the transition team meetings and while administering the required transition process.	• Through NCDHHS onsite participation in bi-annual DOJ Reviews, ad hoc technical assistance call presentation, written guidance to LME/MCOs and SPHs, and three semi-monthly State psychiatric hospital Barrier and Solutions Committee meetings, LME/MCO staff roles were repeatedly clarified. SPH-embedded TCL staff know how to lead transition planning, service and meaningful support acquisition, and the coaching of individuals to lead during their transition team planning meetings. In SFY25, NCDHHS will use the transition team checklist data to improve transition team adherence to Settlement Agreement requirements by providing technical assistance to each LME/MCO TCL staff working on transitions in the State psychiatric hospitals. • In SFY25, NCDHHS will conduct random quality reviews, utilize the transition team checklist, and provide bi-weekly feedback to LME/MCO to improve transition team adherence to Settlement Agreement requirements by providing technical assistance to each LME/MCO TCL staff working on transitions in the ACHs.
III(E)(6) Each individual shall be given the opportunity to participate as fully as	• Through State psychiatric hospital transition team monitoring and subsequent NCDHHS feedback, LME/MCO TCL staff are

Outstanding TCL Compliance Requirements	Key Progress
possible in his or her treatment and discharge planning.	expected to coach individuals in leading their transition team and to use the person's choices written in their In-Reach/TCL Tool to structure the transition plan. • During SFY24, peer-to-peer trainings and role play sessions provided reeducation for TCL peers and guidance on how to advocate for inclusion of the information captured on the In-Reach/Transition TCL tool in the development of the person-centered plan. • During SFY24, the NCDHHS TCL IDM Review team utilized the IDM review process approved in SFY23 when reviewing IDM tools submitted monthly. Implementing a standardized tool provided a streamlined process that has improved monitoring to confirm that all TCL individuals are afforded the opportunity to participate in discussions about their lives, even those with an appointed guardian. The review process and tool are utilized for all five DOJ populations.
III(E)(7) Discharge planning begins at admission; is based on the principle that with sufficient services and supports, people with SMI or SPMI can live in an integrated community setting; assists the individual in developing an effective written plan to enable the individual to live independently in an integrated community setting; is developed and implemented through a person-centered planning process in which the individual has a primary role and is based on the principle of self-determination.	• Through NCDHHS monitoring in State psychiatric hospitals and ACHs, the referral and in-reach process within seven days of admission remains the standard and common occurrence. Improvements have been made in the request for a housing slot, assignment of a transition coordinator, and convening the initial transition team.
III(E)(8) The discharge planning process will result in a written discharge plan that: identifies the individual's strengths, preferences, needs, and desired outcomes; identifies the specific supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes, regardless of whether those services and supports are currently available; includes a list of specific providers that can provide the identified supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes; documents any barriers preventing the individual from transitioning to a more integrated setting and sets forth a plan for addressing those barriers (Such barriers shall not include the individual's disability or the severity of the disability, For individuals with a history of re-admission or	• In State psychiatric hospitals and ACHs, progress was made through the continued NCDHHS monitoring of transition teams and discharge and subsequent transition written feedback given to LME/MCO SPH TCL leadership using an informal transition team checklist. The checklist was refined SFY25. There are now 10 items tracking the presence of Settlement Agreement requirements in a transition team: Onsite or two-way conferencing participation, behavioral health Assertive Engagement provider involvement, natural supports sought or attending, member leading team, LME/MCO staff facilitating, In-Reach/TCL Tool informing written discharge/transition plan, meaningful activities planned, discharge/transition barriers discussed and addressed, all post-transition services arranged, and a pre-transition community visit scheduled. These elements are expected by NCDHHS to regularly appear in both in the individual's written State psychiatric hospital discharge plan known as the Continuing Care Plan and the post-discharge community provider Person Centered Plan.

Outstanding TCL Compliance Requirements	Key Progress
crises, the factors that led to re-admission or crises shall be identified and addressed); sets forth the date that transition can occur, as well as the timeframes for completion of all needed steps to effect the transition; and prompts the development and implementation of needed actions to occur before, during, and after the transition.	
III(E)(10) The NCDHHS transition team will ensure that transition teams (both State hospital facility staff and leadership and PIHP and/or LME Transition Coordinators) are adequately trained. It will oversee the transition teams to ensure that they effectively inform individuals of community opportunities. The training will include training on person-centered planning. The NCDHHS transition team will assist local transition teams in addressing identified barriers to discharge for individuals whose teams recommend that an individual remain in a State hospital or adult care home or recommend discharge to a less integrated setting (e.g., congregate care setting, family care home, group home, or nursing facility). The NCDHHS transition team will also assist local transition teams in addressing identified barriers to discharge for individuals whose teams cannot agree on a plan, are having difficulty implementing a plan, or need assistance in developing a plan to meet an individual's needs.	• In terms of State psychiatric hospitals, in SFY25 NCDHHS will analyze the SPH transition team checklist information from the previous year and devise onsite transition team improvement technical assistance for each LME/MCO. • In terms of State psychiatric hospitals, monthly Division of State Operated Healthcare Facilities (DSOHF) data of individuals transitioning to adult care homes or less integrated settings is analyzed with feedback to the LME/MCO and state psychiatric hospital to improve diversion and elevate contributing systemic barriers to the State. In addition, in SFY24, NCDHHS added additional standing agenda item detail to the semi-monthly SPH Barriers and Solutions Committee meetings where impending discharges to non-integrated settings can be diverted. In SFY25, NCDHHS will utilize the existing Barriers Intervention Team process with SPH and LME/MCO leadership to better divert SPH discharges to non-integrated settings. • In terms of local transition team or Local Barriers Committees (LBCs) improvement, in SFY24, NCDHHS funded specific LME/MCO training and barriers staff, and attended all four LME/MCO LBCs. NCDHHS improved barriers tracking by utilizing an automated barriers recording, LME/MCO engagement, and resolution tracking platform.
III(E)(11) If the individual chooses to remain in an adult care home or State psychiatric hospital, the transition team shall identify barriers to placement in a more integrated setting, describe steps to address the barriers and attempt to address the barriers (including housing). The State shall document the steps taken to ensure that the decision is an informed one and will regularly educate the individual about the various community options open to the individual, utilizing methods and timetables described in Section III(E)(2).	• In terms of State psychiatric hospitals, in SFY24, NCDHHS clarified through technical assistance and direct LME/MCO discussions to continue the regular use and submission of Informed Decision-Making Tools for TCL individuals to the TCL IDM Review team. • During SFY24, the NCDHHS TCL IDM Review team increased their participation in onsite transition team meetings and tracked transition barriers in real-time. They also clarified guidance for documenting barriers in TCLD and on the IDM tool to confirm individuals who remain in ACHs and SPHs did so after being "fully informed' and receiving that decision in writing. There is evidence the composition of transition teams is expanding to address barriers to housing and employment.
III(E)(12) The State will re-assess individuals with SPMI who remain in adult care homes or State psychiatric hospitals for discharge to an integrated community setting on a quarterly basis, or more frequently upon	• Changing quality reviews to monitor timely reassessments for individuals in ACHs from quarterly to monthly resulted in a decrease in overdue reassessments. The number of delayed

Outstanding TCL Compliance Requirements	Key Progress
request; the State will update the written discharge plans as needed based on new information and/or developments.	reassessments decreased from 892 in SFY24Q3 to 531 in SFY24Q4.
III(E)(13)(c) Implementation of the In-Reach, Discharge and Transition Process: Transition and discharge planning for an individual will be completed within 90 days of assignment to a transition team. Discharge of an individual will occur within 90 days of assignment to a transition team provided that a Housing Slot, as described in Sections II(A) and III(B), is then available. If a Housing Slot is not available for an individual within 90 days of assignment to the transition team, the transition team will maintain contact and work with the individual on an ongoing basis until the individual transitions to community-based housing as described in Section III(B)(7).	• QAPI team meets quarterly to review performance trends for the LME/MCOs- average number of days to complete the transition process. In SFY24, the Discharge & Transition pillar leads and TCL Housing Director met monthly with LME-MCOs- to identify gaps in the transition process. Technical assistance was provided to address delays in identifying barriers to housing and when to escalate concerns to their local barriers committee or the state barriers committee. An overlap of TCL functions for in-reach and transition planning started so administrative barriers are addressed sooner, shortening the transition process.

During SFY24, the department continued to monitor its compliance with three Discharge and Transition Process requirements that were met[25], as shown in Table 7.

Table 7. Key Progress Made Towards Discharge & Transition Requirements Already Met

TCL Requirements that Have Been Met and Discharged	Key Progress
III(E)(9) The North Carolina Department of Health and Human Services ("NCDHHS") will create a transition team at the State level to assist local transition teams in addressing and overcoming identified barriers preventing individuals from transitioning to an integrated setting. The members of the NCDHHS transition team will include individuals with experience and expertise in how to successfully resolve problems that arise during discharge planning and implementation of discharge plans.	• In SFY24, NCDHHS convened monthly State Barriers Committees, attended all LME/MCO Local Barriers Committees (LBCs) to receive local barrier elevations, created and facilitated semi-monthly virtual Barriers and Solutions Committee (BASC) meetings at each State Psychiatric Hospital, elevated systemic barriers to the Transition Oversight Committee (TOC), and in subsequent meetings, conveyed updates and solutions back to the LBCs. Barriers elevated to NCDHHS were newly and more efficiently tracked by logging cases in the existing Medicaid Help Center (MHC), a ServiceNow-run ticketing portal. Barrier tracking and resolution efficiency improved because MHC is mutually shared with the LME/MCOs.
III(E)(13)(a)(b)(d) a. Within 90 days of signing this Agreement, the State will work with PIHP and/or LMEs to develop	• In SFY24, there were no new notifications of IMDs in North Carolina.

[25] Previous reviews confirmed the State has achieved compliance with two of the 14 requirements of section III (E) Discharge and Transition Process and partially achieved compliance with one other requirement. The Fourth modification entered by the Court on March 29, 2021, discharged the obligations in sections III(E)(13)(a)(b)(d). And during SFY25, the sixth modification entered by the court on December 11, 2024, established the State has met substantive obligations of section III(E)(9), and III(E)(14).

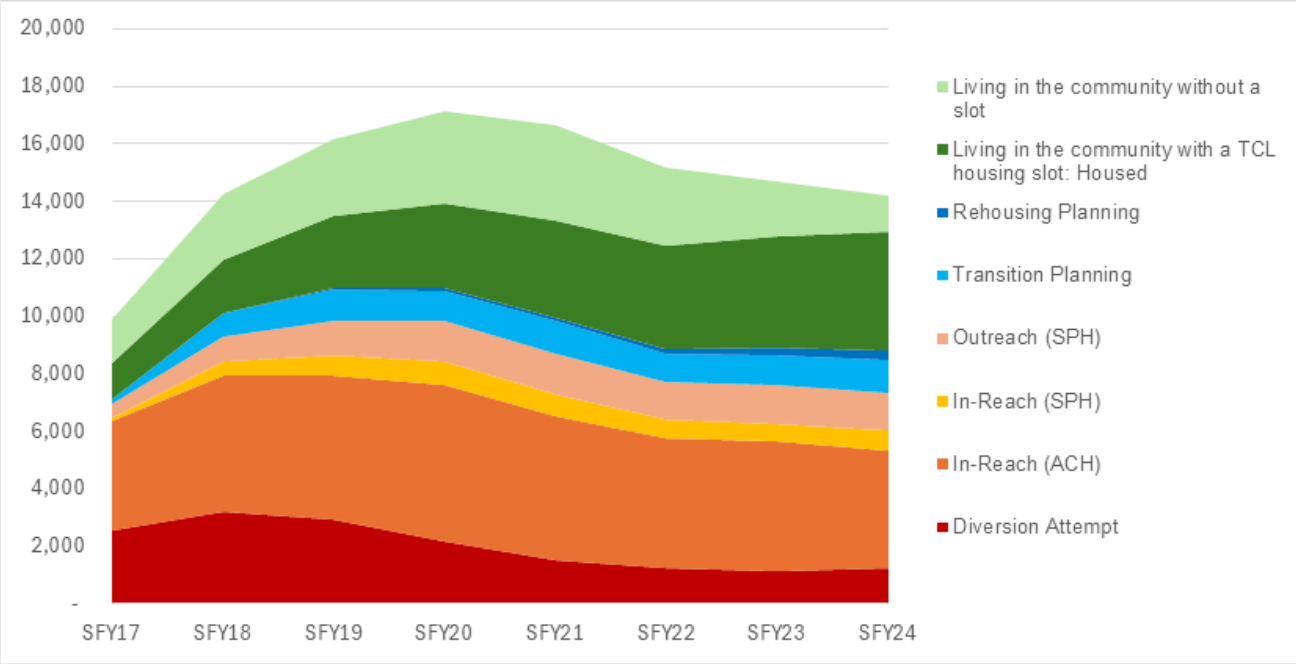
TCL Requirements that Have Been Met and Discharged	Key Progress
requirements and materials for in-reach and transition coordinators and teams. b. Within 180 days after the Agreement is signed, PIHP and/or LMEs will begin to conduct ongoing in-reach to residents in adult care homes and State psychiatric hospitals, and residents will be assigned to a transition team, consistent with Section III(E)(2). d. The State will undertake the following procedures with respect to individuals with SMI in an adult care home that has received a notice that it is at risk of a determination that it is an IMD, in addition to any other applicable requirements under this Agreement: Within one business day after any adult care home is notified by the State that it is at risk of being determined to be an IMD, the State will also notify the Independent Reviewer, Disability Rights North Carolina, and the applicable LME or PIHP and county Departments of Social Services of the at-risk determination; The LME and/or PIHP will connect individuals with SMI who wish to transition from the at-risk adult care home to another appropriate living situation. The LME and/or PIHP will also link individuals with SMI to appropriate mental health services. For individuals with SMI who are enrolled in a PIHP, the PIHP will implement care coordination activities to address the needs of individuals who wish to transition from the at-risk adult care home to another appropriate living situation; The State will use best efforts to track the location of individuals who move out of an adult care home on or after the date of the at-risk notice. If the adult care home initiates a discharge and the destination is unknown or inappropriate as set forth in N.C. Session Law 2011-272, a discharge team will be convened; Upon implementation of this Agreement, any individual identified by the efforts described in Section III(E)(13)(d)(iii) who has moved from an adult care home determined to be at risk of an IMD determination shall be offered in-reach, person-centered planning, discharge and transition planning, community-based services, and housing in accordance with this Agreement. Such individuals shall be considered part of the priority group established by Section III(B)(2)(a).	
III(E)(14) The State and/or the LME and/or the PIHP shall monitor adult care homes for compliance with the Adult Care Home Residents' Bill of Rights requirements contained in Chapter 131D of the North Carolina General Statutes and 42 C.F.R. § 438.100, including the right to be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy; to associate and communicate privately and without restriction with people and groups of his or her own choice; to be encouraged to exercise his or her rights as a resident and a citizen; to be permitted to make complaints and suggestions without fear of coercion or retaliation; to maximum flexibility to exercise choices; to receive information on available treatment options and alternatives; and to participate in decisions	• Potential violations to Residents' Bill of Rights decreased during SFY24. This was the result of peers conducting more face-to-face in-reach contacts to engage with TCL individuals and educate them about their rights. Increased peer presence in ACHs meant peers were able to observe potential violations more often, report potential violations they observed, and support residents who chose to submit their own DHSR reports. • Educating ACH residents improved statewide after NCDHHS developed a one-page document for all peer specialists to utilize during in-reach visits. The document included a list of the

TCL Requirements that Have Been Met and Discharged	Key Progress
regarding his or her health care. In accordance with 42 C.F.R. § 438.100, the State will ensure that each individual is free to exercise his or her rights, and that the exercise of rights does not adversely affect the way the PIHP, LME, providers, or State agencies treat the enrollee.	Residents' Bill of Rights, how to file DHSR complaints, list of local Ombudsman in NC, and strategies to address access barriers for ACHs that prevented or limited engagement with individuals in ACHs.

SFY24 Supporting Data

Figure 11 shows how counts of TCL members in various participant statuses and settings, from in-reach/outreach to TCL housing, have changed. Decreases in members in statuses such as ACH In-Reach reflect intensive LME/MCO data cleanup efforts as well as improved targeting of face-to-face in-reach and transition efforts. Other significant trends in SFY24 include increases in the number of members living in, and planning for rehousing or initial transition to, TCL supportive housing.

Figure 11. Count of TCL members by status and setting (total participants per state fiscal year)[26]



Count of TCL Individuals	SFY17	SFY18	SFY19	SFY20	SFY21	SFY22	SFY23	SFY24
Diversion Attempt	2,560	3,212	2,930	2,180	1,543	1,236	1,138	1,245
In-Reach in ACH	3,797	4,700	5,010	5,447	4,992	4,552	4,520	4,090
In-Reach in SPH	134	508	711	801	769	626	570	672
Outreach (SPH only)	457	858	1,208	1,390	1,391	1,325	1,393	1,322
Transition Planning	188	823	1,091	1,081	1,128	937	1,023	1,131
Rehousing Planning		26	55	65	111	165	288	331
Living in the community with housing slot	1,228	1,825	2,476	2,948	3,417	3,626	3,858	4,135
Living in the community without a slot	1,556	2,307	2,663	3,244	3,306	2,723	1,892	1,295
TOTAL TCL POPULATION	**9,635**	**11,595**	**13,047**	**13,769**	**13,636**	**12,758**	**12,013**	**11,373**

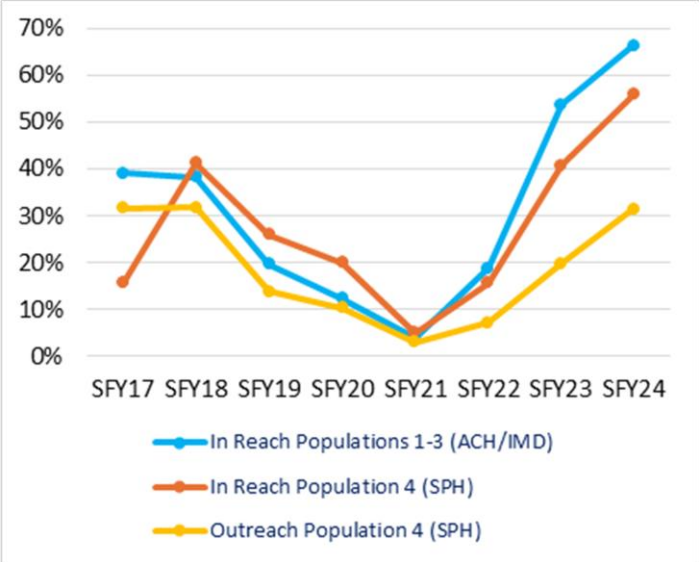
Source: TCL Dashboard. Data were extracted on 3/28/2025.

[26] Total TCL Population values are unduplicated counts per state fiscal year. Summing across TCL statuses and settings will result in larger totals that include duplication of members counted in more than one category, reflecting changes in status within the state fiscal year.

Figure 12 shows the average quarterly percentage of ACH and SPH in-reach and SPH outreach eligible individuals who had face-to-face contact within the previous 90 days. Frequent in-reach and outreach is important to ensure individuals are informed of options for housing and services and to facilitate member transitions into the community. Concerted NCDHHS efforts including written guidance, technical assistance, and ongoing monitoring of the LME/MCOs have yielded substantial percentage increases of face-to-face in-reach visits in recent state fiscal years. LME/MCOs also adopted team-based in-reach and transition models, and more efficiently deployed their In-Reach Specialists across newly consolidated catchments.

Figure 12 also demonstrates targeted efforts to improve accuracy of in-reach member lists and frequency of face-to-face contacts have been most successful in ACH settings. While Population 4 face-to-face visits also have improved over both previous two state fiscal years, they remain lower overall in SPH in-reach and outreach settings compared to ACH in-reach. These trends are attributable in part to challenges associated with locating some members in SPH outreach, especially those who lack stable housing, and to a need to slow or pause in-reach efforts for members with a legal "Incapable to Proceed" to trial (ITP) status[27].

Figure 12. Average quarterly percentages of in-reach and outreach eligible individuals who had at least one face-to-face contact within the previous 90 days (by state fiscal year)



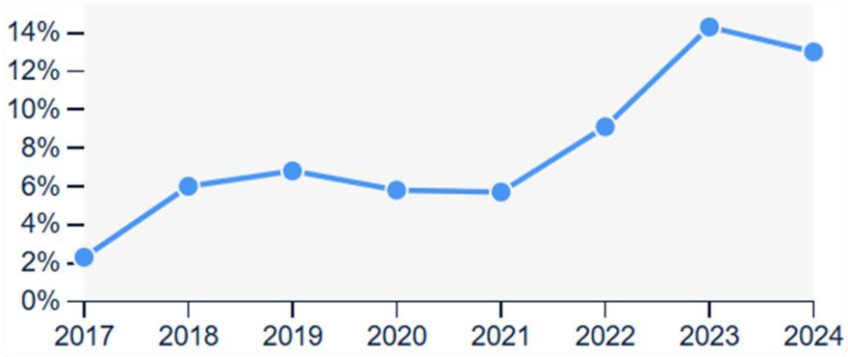
Source: TCL Dashboard. Data were extracted on 3/18/2025.

SFY	In-Reach Populations 1-3 (ACH)	In-Reach Population 4 (SPH)	Outreach Population 4 (SPH)
SFY17	39%	16%	32%
SFY18	38%	41%	32%
SFY19	20%	26%	14%
SFY20	12%	20%	10%
SFY21	4%	5%	3%
SFY22	19%	16%	7%
SFY23	54%	41%	20%
SFY24	66%	56%	31%

[27] During SFY25, NCDHHS provided guidance in response to USDOJ Reviews documenting wide variation in the number of months members remained under an ITP court order. This guidance allows for reduced frequency of in-reach for TCL recipients in ITP status for more than six months.

Figure 13 illustrates the percentage of individuals in ACH in-reach who began receiving ACT each state fiscal year and transitioned to TCL housing within 180 days of service initiation. While ACT service definitions do not prohibit the provision of ACT in ACH settings, and members in those settings may meet medical necessity for ACT service intensity, tracking of this measure is related to NCDHHS efforts to monitor and refocus ACT engagement on transition for TCL members residing in ACHs. The overall upward trend suggests a positive impact of NCDHHS monitoring and guidance shared with LME/MCOs and in provider collaboratives of this departmental priority. Further supporting the interpretation ACT services can successfully be leveraged to support members transitioning out of ACHs, related program data show 39 percent of Population 1-3 members transitioned or rehoused during SFY23 and SFY24 had received ACT services in the previous 180 days.[28]

Figure 13. Percentage of individuals who began receiving ACT during ACH in-reach who transitioned to TCL housing within 180 days (by state fiscal year of ACT service initiation)



Source: TCL Dashboard. Data were extracted on 3/18/2025.

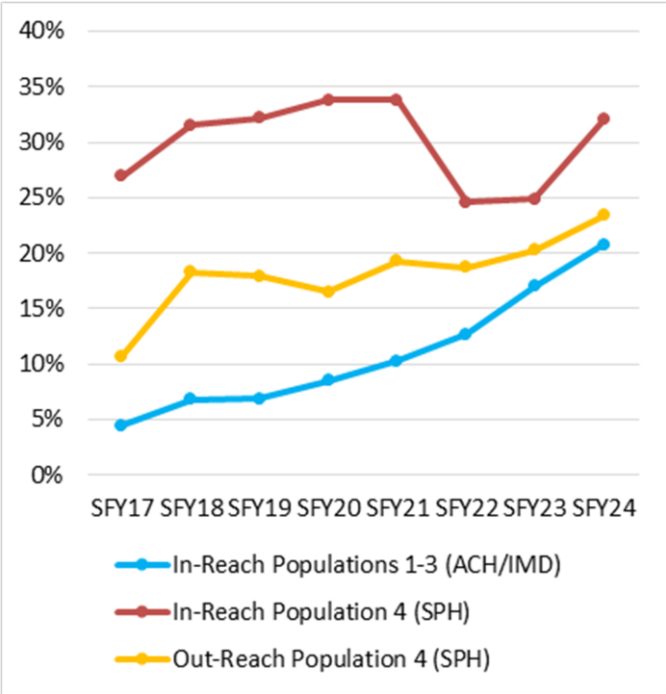
SFY	Percent
SFY17	2.3%
SFY18	6%
SFY19	6.8%
SFY20	5.8%
SFY21	5.7%
SFY22	9.1%
SFY23	14.3%
SFY24	13%

[28] Ad hoc data analysis of 481 Population 1-3 members who started TCL housing leases, including initial transitions as well as rehousing, showed that 101 (42%) of 243 in SFY23, 88 (37%) of 238 in SFY24, and 39 percent overall, had received ACT in the previous 180 days.

Figure 14 below shows a steady increase in the percentage of members in ACH and SPH in-reach and SPH outreach who decided to transition into the community. This pattern generally holds for members in all three settings, and SFY24 percentages for each were at or near their highest levels over the period shown. The SFY24 combined percentage for all three groups was 23.3 percent, only slightly higher than for members in ACH in-reach, who represent approximately two-thirds of the combined population.

Differences in rates of yes decisions between groups also have remained relatively stable, with the highest percentage of yes decisions among members in SPH in-reach and the lowest among members in ACH in-reach. The observed upward trend in yes decisions overall may reflect in part ongoing quality improvement activities as well as a larger number of peers employed statewide to conduct in-reach.

Figure 14. Percentage of members in ACH in-reach, SPH in-reach, and SPH outreach who made a yes decision to transition (by state fiscal year)



Source: TCL Dashboard. Data were extracted on 3/18/2025.

SFY	In-Reach Populations 1-3 (ACH)	In-Reach Population 4 (SPH)	Outreach Population 4 (SPH)
SFY17	4.5%	26.9%	10.7%
SFY18	6.8%	31.5%	18.3%
SFY19	6.9%	32.2%	17.9%
SFY20	8.5%	33.8%	16.5%
SFY21	10.3%	33.8%	19.3%
SFY22	12.7%	24.6%	18.7%
SFY23	17%	24.9%	20.3%
SFY24	20.8%	32%	23.4%

6.2. KEY FOCUS AREAS AND PRIORITIES FOR SFY25

For State Fiscal Year 2025, the NCDHHS TCL Team in charge of discharge and transition will focus on three key areas. Firstly, the team aims to strengthen the discharge planning process to confirm it illustrates a person-centered approach. Secondly, efforts will be made to streamline discharge planning to facilitate individuals' transitions within the 90-day transition period. Lastly, the team plans to increase the rate of face-to-face engagement during in-reach, thereby improving the frequency of in-reach reassessments.

STRENGTHEN THE DISCHARGE PLANNING PROCESS, TO BETTER REFLECT A PERSON-CENTERED APPROACH.

The 1st strategy for SFY25 is the improvement in Transition Teams' person-centered transition planning across both community and in State Psychiatric Hospitals (SPHs). All TCL members complete the required In-Reach/TCL Tool. Though some of the LME/MCOs have some requirements that In-Reach/TCL tool preferences, choices, interests, and goals make it into the member's Person-Centered Plan (PCP), there is no consistent policy or procedure. The inclusion of that rich person-centered information would not only help meet the Settlement Agreement person-centered transition planning requirements in III(E)(3), (4)(e), (7)(c), (8) (a), and (10), but would lessen completion time and only ask members once about their transition choices. Actualizing In-Reach/TCL Tool information into PCP goals better supports behavioral treatment goals and leads to meaningful life outcomes. In SFY25, NCDHHS will perform multiple technical assistance and trainings to utilize In-Reach/TCL Tool information to structure the transition team planning process, greatly inform the member's PCP, and as a post-transition monitoring of progress toward those person-centered goals. Within SFY25, this training to TCL transition coordination staff serving both in the community and in the three SPHs. Transition team monitoring tools will be used thereafter to record progress and communicate continued quality improvement information on this to the Plans.

STREAMLINE DISCHARGE PLANNING SO INDIVIDUALS TRANSITION WITHIN 90 DAYS.

The 2nd strategy for SFY25 is to reduce the transition time through the removal of unnecessary policies, procedures, practices, and/or barriers to housing, services, or community inclusion. As described in Section 8.2, the average time from slot acquisition to housing acquisition substantially exceeds the 90-day period required by the Settlement Agreement provision III(E)(13)(c). The average number of days from housing slot approval to the transition to supportive housing in SFY24 was 184 days, and fewer than half of transitions to supportive housing were completed within 90 days.

Increasing the speed of transition will help secure permanent supportive housing and the speed of its availability and more quickly capitalize on the transitional hopes of the individual before internal and external barriers dampen those hopes. In SFY25, NCDHHS will provide written and technical assistance guidance on simultaneous transition engagement of behavioral health providers and natural supports to augment the work of Plan staff. Secondly, NCDHHS will individually meet with each Plan's TCL leadership to map out each Plan's transition process out of ACHs, SPHs, and in Diversion. Improvement actions will be identified regardless of the impediment being within the Plan, State, or outside entity. Post transition process improvements will be measured utilizing the current transition time data.

INCREASE THE RATE OF FACE-TO-FACE ENGAGEMENT AND FREQUENCY OF REASSESSMENTS DURING IN-REACH.

The 3rd strategy for SFY25 is intended to increase the quantity of face-to-face contacts performed by CPPS when TCL individuals reside in ACHs and are admitted into SPHs. More in-person contacts support peers in fully educating individuals (guardians when applicable) about the benefits of permanent supportive housing and identifying those who want to transition into the community. The decision to transition to the

community belongs to individual TCL participants. Frequent engagement and performing timely reassessments allow peers to establish a rapport with TCL individuals, affording them the opportunity to decide if they want to transition to the community and their preference of location. Key actions to achieve this include ongoing reduction of the ACH in-reach list to identify individuals who are ineligible for TCL and collaboration between NCDHHS and the LME/MCOs to offer an annual In-Reach Professional Development Conference so CPPS and peer extenders remain knowledgeable about community services and supports, including supported housing. In addition, NCDHHS created a peer led community of practice (CoP) that enables collective learning, fosters interaction and encourages a willingness to share ideas. TCL peers have the opportunity to build a shared repertoire of resources and ideas . The CoP meets monthly to discuss in-reach topics, offer peer support to new peers, and give more experienced peers a forum to share their experiences and knowledge to solve problems. This helps fuel continuous improvement with the discharge and transition process by allowing peers to contribute to the larger goal of frequent engagement during in-reach. These efforts are intended to decrease peer caseload ratios so they have time to perform targeted in-reach to address barriers to transition. Increasing the rate of face-to-face engagement and frequency of reassessments help TCL individuals say YES to transition sooner, so peers initiate the “warm hand-off” to transition coordinators who facilitate the transition planning phase. Although these milestones are critical, the team recognizes adjustments may be needed, and new focus areas may emerge during the year.

7. PRE-ADMISSION SCREENING & DIVERSION

The **Pre-admission screening and Diversion** process is essential for preventing unnecessary institutionalization and ensuring individuals receive appropriate care in the least restrictive setting possible. Pre-admission screening and diversion is supervised by the Discharge and Transition NCDHHS TCL pillar team.

This process is primarily conducted by LME/MCOs. Pre-admission screening is carried out using Referral, Screening, and Verification Process (RSVP). This involves engaging with individuals who are referred to the TCL program before they enter adult care homes (ACHs) or state psychiatric hospitals (SPHs). LME/MCO licensed staff, Qualified Professionals (QP), and CPSS assess the individual's eligibility for TCL and fully inform them of their options to divert from institutional admission. The department oversees and supports the LME/MCOs in implementing these processes, providing guidance, resources, and training for more effective and consistent screenings.

Before transitioning to community-based housing, diverted TCL individuals may stay in temporary or transitional housing options that are not institutional in nature. These temporary accommodations provide necessary support while they prepare for a more permanent community-based living situation:

- **Bridge Housing**: This temporary housing solution provides a safe and supportive environment while individuals prepare for permanent housing. This preferably involves living arrangements where individuals receive ongoing support to maintain their housing, as well as help with case management, life skills training, and support in finding permanent housing.
- **Transitional Housing**: These short-term housing options offer stability and support. They are designed to help individuals develop the skills and resources needed for independent living. Services may include mental health support, substance use treatment, and employment assistance.
- **Community-Based Services**: While in temporary housing, individuals have access to a range of community-based services such as Assertive Community Treatment (ACT) and Community Support Teams (CST), which provide intensive, personalized support to help them transition successfully.

These temporary housing options are crucial in ensuring individuals are not placed in institutional settings and can smoothly transition to permanent, community-based housing with the necessary support systems in place.

7.1. PROGRESS DURING SFY24

The Settlement Agreement outlines three substantive requirements related to Pre-Admission Screening and Diversion for North Carolina[29]. During SFY24, the department continued to monitor its compliance towards these three requirements that are met, as shown in Table 8.

[29] Previous reviews confirmed the State has achieved compliance with all three requirements of section III (F) Pre-Admission Screening and Diversion. The Fourth modification entered by the Court on March 29, 2021, discharged the obligations in sections III(F)(1) and (2). During SFY25, the sixth modification entered by the Court on December 11, 2024, discharged the obligations in section III(F)(3).

Table 8. Key Progress Made Towards Pre-Admission Screening & Diversion Requirements Already Met

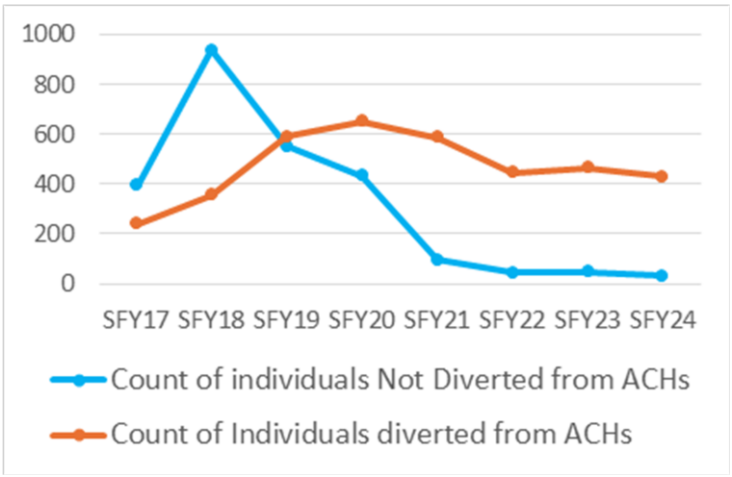
TCL Requirements that Have Been Met and Discharged	Key Progress
III(F)(1) Beginning January 1, 2013, the State will refine and implement tools and training to ensure that when any individual is being considered for admission to an adult care home, the State shall arrange for a determination, by an independent screener, of whether the individual has SMI. The State shall connect any individual with SMI to the appropriate PIHP and/or LME for a prompt determination of eligibility for mental health services.	• RSVP was implemented Nov. 1, 2018, as the new pre-admission screening tool replacing Pre-admission Screening Resident Review (PASRR) used previously to divert individuals with SMI being considered for admission to an ACH. Since implementation, we have successfully diverted 5,894 individuals from ACHs, and 2,683 are still actively housed in the community and participating with TCL. • During SFY24, NCDHHS conducted quarterly quality reviews of a 10% sample of individuals referred to as diversion to evaluate the screening tool and identify risks that could potentially jeopardize diversions from ACHs. To mitigate risks and a reduction in the statewide 90% diversion rate, one minor modification was implemented for the referral tool in SFY24 Q4 to create a distinction between SPH in-reach and diversion referrals. This addressed potential gaps with diverting individuals with SMI/SPMI from institutions and ACH settings. • During SFY24, NCDHHS conducted monthly quality reviews to monitor the number of diversion referrals not completed within 30 days of submission to confirm LME/MCOs- (independent screeners) were promptly linking individuals to mental health services upon completion of the screening. For SFY24, All LME/MCO-TP's completed screenings and determined TCL eligibility within 30 days of submission.
III(F)(2) Once an individual is determined to be eligible for mental health services, the State and/or the PIHP and/or LME will work with the individual to develop and implement a community integration plan. The individual shall be given the opportunity to participate as fully as possible in this process. The development and implementation of the community integration plan shall be consistent with the discharge planning provisions in Section III(E) of this Agreement.	• During SFY24, semi-annual quality reviews were conducted to assess the effectiveness of LME/MCOs-community planning procedures and process workflows. • During SFY24, monthly quality reviews were conducted on all individuals determined as TCL eligible and being diverted from ACHs. Reviews aligned with the ADA and *Olmstead* and confirmed if individuals had the opportunity to participate in discharge planning using a person-centered approach. Reviews focused on individuals who did not receive prompt determination, were not provided with the opportunity to participate in the development of their community integration plan, nor provided a choice between an ACH or community living with housing and support. • During SFY24, only 32 individuals were not diverted and entered ACHs, and 430 were diverted from ACHs, which is a 95% diversion rate. That's to compare to SFY17, during which 394 individuals were not diverted, and 240 were diverted (38% of diversion).
III(F)(3) 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	• During SFY24, monthly quality reviews were conducted on 100% of TCL individuals who were not diverted and entered an ACH. Reviews were conducted by NCDHHS TCL IDM Review team that determined whether TCL individuals were fully informed of all housing alternatives before entering an adult care home and that the decision was an informed choice. Steps to document informed choice included addressing all concerns that hinder individuals from remaining in community settings and person-centered strategies implemented to overcome barriers. Informed choice was captured on the IDM tool utilized by all five TCL DOJ populations. IDM discussions were person-centered and led by individuals who were later provided with a copy of the IDM tool. All individuals who entered ACHs were assigned a CPPS to conduct a reassessment at least quarterly, which acknowledged individuals

TCL Requirements that Have Been Met and Discharged	Key Progress
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.	must be provided with the opportunity to change their decision. Reviews conducted showed a significant increase in individuals who were fully informed of all housing alternatives before entering an ACH and that their decision to enter was an informed choice.

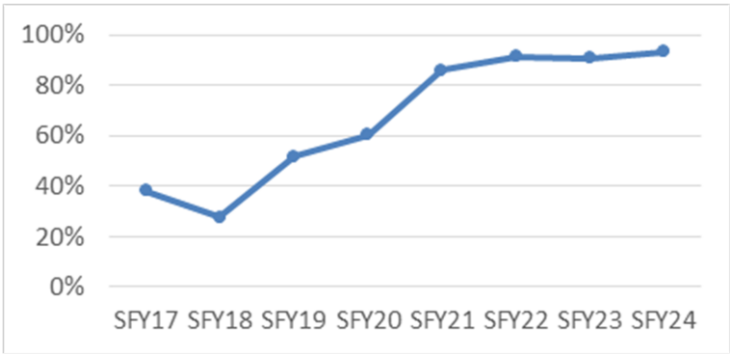
7.2. SFY24 SUPPORTING DATA

Figure 15 shows a dramatic decrease beginning in SFY18 in the annual number of individuals not diverted from ACHs, and a corresponding increase in the percentage successfully diverted. These trends continued even through the COVID pandemic and are recognized as successful outcomes of the state's SFY18 implementation of a new pre-admission referral and screening process (RSVP), of ongoing quality assurance (QA) and improvement activities, and education of stakeholder and pre-admission screening and diversion staff. Observed improvement continued through SFY24, during which an all-time low number, 32 individuals, were not diverted, and the state achieved an all-time high percentage of 95 percent successfully diverted.

Figure 15. Count and percentage of members not diverted, and members diverted from ACH admission (by state fiscal year)



Percentage of Individuals Diverted from ACH Admission



Source: TCL Dashboard. Data were extracted on 3/18/2025.

SFY	Not Diverted Count	Diverted Count	Diverted Percentage
SFY17	394	240	37.9%
SFY18	937	354	27.4%
SFY19	553	591	51.7%
SFY20	433	651	60.1%
SFY21	96	588	86.0%
SFY22	42	444	91.4%
SFY23	47	464	90.8%
SFY24	32	430	93.1%

7.3. KEY FOCUS AREAS AND PRIORITIES FOR SFY25

MONITORING AND SUSTAINING SUCCESS

Assessment of the current tool (RSVP) will continue to monitor for any needed changes to improve functionality and data collection. Monthly monitoring and quality reviews will continue to support prompt determination of eligibility and linkage to services. Additionally, annual quality reviews of community integration planning and LME/MCO workflows will continue to ensure compliance with Settlement Agreement requirements. Monthly monitoring and quality reviews will also continue to ensure individuals are educated and informed of all alternatives to adult care home admission and that strategies are implemented to address concerns and objections. This monitoring will also continue to confirm the informed choice is documented in RSVP, TCLD or on the recommended IDMT for Category 5 individuals.

8. QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

The TCL **Quality Assurance & Performance Improvement (QAPI)** system is designed to support development, implementation, and oversight of high quality, community-based, recovery-oriented services that effectively meet individuals' needs and safeguard their health, safety, and welfare. Data-driven, proactive, and a routine part of TCL operations, the QAPI system leverages data to identify problems and generate and carry out quality and performance improvement actions and interventions.

Implementation of the TCL QAPI system is overseen by the NCDHHS Olmstead-TCL Director and QAPI staff. The QAPI team carries out and supports ongoing functioning of core system processes, provides support for state level TCL subject matter expert (SME) activity planning, implementation, and evaluation, oversees and delivers technical assistance related to LME/MCO planning and activities. As part of daily operations, TCL SMEs interface with the broader TCL QAPI system processes and conduct quality assurance, monitoring, and performance improvement activities focused on discrete identified issues within their subject areas, both independently and with QAPI team support, often using collaboratively developed methods and tools.

The TCL QAPI system encompasses complementary, repeatable processes that address the spectrum of quality and performance issues, from member level to systemic, and long-term to emergent to urgent. Generalizable QAPI frameworks that may be applied to any TCL component or requirement are described in the NCDHHS TCL QAPI Plan, which serves as a blueprint and internal resource and guide for carrying out QAPI activities. The NCDHHS Olmstead-TCL Director and QAPI team review and update the QAPI Plan annually to meet emerging TCL needs. **Core processes related to the following broad functions are described in detail in the Plan:**

- **Performance measurement, quality monitoring, and improvement cycles:** The NCDHHS Performance Measurement Plan (PMP) promotes ongoing measurement and monitoring of a wide range of TCL participant outcomes, program operations, and Settlement Agreement objectives. The TCL Dashboard contains more than 100 measures related to TCL housing, prescreening and diversion, in-reach, discharge and transition, community mental health and employment services, and member outcomes. These are updated at least quarterly and serve as a critical source for ongoing monitoring, reporting, and ad hoc data investigations. Both the PMP and the dashboard continue to evolve, with new measures added regularly in response to emerging program needs and availability of new data elements and sources.
  As part of a quarterly QAPI cycle, NCDHHS TCL SMEs prioritize and select dashboard performance measures for systematic review and analysis to inform planning and implementation of focused quality improvement activities. Measure results, follow-up actions, and their outcomes are documented in a quarterly Quality Measure Report (QMR) that is disseminated among NCDHHS TCL SMEs and leadership. This quarterly cycle of monitoring, analysis, quality improvement planning and implementation, and reporting promotes transparency and accountability within the state's QAPI system for addressing identified quality issues.

  NCDHHS TCL SMEs also develop and monitor performance measures and data responsive to specific program issues and reporting needs daily, using administrative data, member surveys and assessments, stakeholder surveys and input, routine provider reviews, and other information gathered through specialized data collection tools and focused reviews, as well as standardized TCL dashboard measures. Systematic measure monitoring is a critical step in a feedback loop that promotes continuous improvement. Identified trends over time, areas of low state performance, and regional and population

variations help shape state-level quality initiatives, policy and program operations, contractual requirements, communications, and technical assistance.

- **Data aggregation, analysis, and evaluation:** The State's use of data extends beyond monitoring and trending of discrete measure values to include analysis of relationships among variables, and evaluation of progress toward achieving key TCL program objectives and outcomes. Advanced data analytic projects carried out to further refine and target quality improvement initiatives are overseen by the State's TCL QAPI leads and generally are conducted with the support of the State's TCL QAPI contractor, Mathematica. These projects aim to address questions that are less effectively answered by monitoring distinct performance measures and focus more broadly on defining the degree and direction of association between and among program variables.

  Examples of subjects explored through previous or current advanced analytic projects include the relationship of service intensity and duration to member outcomes such as housing separation and institutional admission, whether time to transition is correlated with post-transition housing stability, and which quality of life indicators are most predictive of positive and adverse member outcomes. Because program outcomes are real world data that are not collected in carefully controlled experiments, and member outcomes may be determined by a multitude of factors, not all of which are or can be measured, the definitive determination of causal relationships typically is not possible. However, correlational analysis can help to isolate variables with stronger associations to outcome measures and help point to directions and opportunities for interventions, the impacts of which can be assessed.

  Members of the interdivisional NCDHHS TCL Quality Assurance Committee (QAC) also carry out functions related to the use of data, both individually and collectively, including aggregation, analysis, and assessment of progress toward TCL objectives in their respective areas of expertise. QAC is chaired by the NCDHHS TCL QAPI leads, who provide regular updates on its activities to leadership through the TCL Transition Oversight Committee (TOC). QAC operates both as a working group that carries out use of data functions, and as a resource to support activities including design of data collection tools; data summary and analysis; training and technical assistance; development, implementation, and evaluation of QAPI interventions; and dialogue around persistent program challenges. This collaborative discussion may give rise to ideas for future analytic projects.

- **Identification and resolution of barriers**: The State's barriers identification and resolution process provides a mechanism for all TCL partners and participants to improve TCL through broad-based, "no wrong door" reporting of obstacles to successful transitions and community integration. State barriers may be reported by any person. All barriers are routed to the NCDHHS State Barriers Lead, who assigns a priority level based on scale and severity of potential impact. The priority level determines the timeframe for response.

  This process also supports tracking of all barriers to resolution or to escalation to an entity with its own tracking and resolution processes. The State's Medicaid Help Center (MHC) platform serves as the primary barrier tracking tool and repository of all barriers reported to NCDHHS. This platform includes tracking features, such as alerts to LME/MCO contacts, as well as analytic capabilities related to barrier and resolution patterns.

  Barriers initially reported or escalated to the State level are resolved through defined pathways that may include State Barriers Committee (SBC) planning, involvement of State SMEs, the creation of intervention teams, or further escalation. LME/MCOs and State Psychiatric Hospitals also have defined processes to escalate barriers to local committees charged with addressing and further escalating barriers as needed.

  With oversight of the NCDHHS TCL Director, the State Barriers Lead chairs the SBC, which includes

representation by NCDHHS divisions, Area Agency on Aging ombudspersons, and LME/MCOs. SBC provides regular updates on progress toward Settlement Agreement compliance to the NCDHHS TCL Transition Oversight Committee (TOC), as well as guidance on addressing and resolving barriers and on the need for further escalation, particularly of systemic barriers, to TOC. TOC may respond to escalated barriers with guidance or creation of a dedicated subcommittee charged with resolution of a specific barrier.

- **Oversight of state operations and progress:** Responsibility for monitoring TCL program implementation lies with the NCDHHS Deputy Secretary and Chief Health Equity Officer, Olmstead-TCL Director, and TCL Transition Oversight Committee (TOC), which broadly monitors progress related to referrals, discharge and transition, and housing, as well as barriers and associated risks. The ongoing work of the TOC is focused on identification of action items to address systemic transition barriers that are unable to be resolved through SBC. TOC also addresses state budget impacts on the work and implementation of TCL and collaborates with NCDHHS budget officials to address challenges or needs for realignment of allocations to accomplish Settlement Agreement goals.

  TOC progress monitoring employs a combination of State and LME/MCO data and reporting, including but not limited to measures related to discharge and transition. Risks to TCL implementation and compliance may be reported to TOC through TCL leadership and staff as well as NCDHHS General Counsel. To address barriers, TOC can form ad hoc, cross-division intervention teams to work through necessary changes to policies or business practices and disseminate guidance via the State Barriers lead back to LME/MCOs, providers, and other TCL stakeholders. Barriers not addressable by any other committee are escalated to TOC. Risks requiring further action are reviewed by the Deputy Secretary and may be escalated to the Secretary.

- **Monitoring of contracted LME/MCO functions and services:** Cross-divisional LME/MCO contract monitoring is carried out to identify and address performance and compliance issues related to the accessibility, adequacy, and quality of services and supports and other contracted TCL functions. Primary data sources include contract quality and performance measures, member services data, provider review reports, network access and adequacy data, LME/MCO QAPI Plans and reports, and database submissions. External Quality Reviews (EQR), which entail extensive data and documentation to review to assess compliance with contractual service delivery and quality requirements, also include focused review of contracted TCL functions.

  TCL contract monitoring carried out by NCDHHS personnel chiefly involves review and evaluation of relevant data against contract requirements to assess compliance. These activities contribute to the development, implementation, and ongoing evaluation of corrective actions and responses when compliance and performance deficits are identified. Reviews may result in actions ranging from issuance of guidance and technical assistance to engagement of leadership and appropriate stakeholders to develop and implement remediation strategies.

The TCL QAPI system ideally empowers subject matter experts to design and embed effective QAPI processes within routine operations and to lead and drive decision making in their areas of expertise. Aspirational goals of the system include fostering and maintaining a culture of learning and continuous quality improvement (CQI) that permeates throughout TCL program elements and across operational levels, including state leadership and oversight, NCDHHS TCL program administration and activities, local TP/PIHP performance and execution of contracted TCL functions, and the provision of TCL services.

8.1. PROGRESS DURING SFY24

The Settlement Agreement outlines eight substantive requirements related to Quality Assurance and

Performance Improvement for North Carolina[30]. During SFY24, the department continued to monitor its compliance towards these requirements, as shown in Table 9.

Table 9. Key Progress Made Towards Quality Assurance & Performance Improvement Requirements Already Met

TCL Requirements that Have Been Met and Discharged	Key Progress
III(G)(1) The State will develop and implement a quality assurance and performance improvement monitoring system to ensure that community-based placements and services are developed in accordance with this Agreement, and that the individuals who receive services or Housing Slots pursuant to this Agreement are provided with the services and supports they need for their health, safety, and welfare. The goal of the State's system will be that all mental health and other services and supports funded by the State are of good quality and are sufficient to help individuals achieve increased independence, gain greater integration into the community, obtain and maintain stable housing, avoid harms, and decrease the incidence of hospital contacts and institutionalization.	• The State completed a full narrative draft of the NCDHHS TCL QAPI Plan that was developed in outline version of the previous SFY. The QAPI Plan, which was finalized with a date of September 30, 2024 (SFY25), broadly describes the TCL QAPI system and five core operating processes that interact to promote QAPI system efficiency and effectiveness and support a cycle of continuous quality improvement. The five core QAPI processes have all been implemented and include a quarterly measure monitoring and QAPI cycle, operations of the TCL Quality Assurance Committee, barriers identification and resolution processes, Transition Oversight Committee functions, and PIHP/TP contract monitoring. • The State team strengthened requirements and monitoring of Plan-level TCL quality assurance and performance improvement systems and related activities through PIHP and TP Medicaid contract amendments with new requirements related to TCL QAPI functions. Effective in SFY24, Plans are required, as part of overall QAPI planning, to incorporate and report on activities to improve the quality of core TCL program components related to services and supports, program operations, member outcomes, and data and reporting. With ongoing technical assistance and support, all Plans submitted initial iterations of TCL QAPI Plans in May 2024 and quarterly thereafter for State review and feedback.
III(G)(2) A Transition Oversight Committee will be created at NCDHHS to monitor monthly progress of implementation of this Agreement and will be chaired by the NCDHHS Designee (Deputy Secretary). The Division of Medical Assistance, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Division of State Operated Healthcare Facilities, State Hospital Team Lead, State Hospital Chief Executive Officers, Money Follows the Person Program, and PIHPs and/or LMEs will be responsible for reporting on the progress being made. PIHPs and/or LMEs will be responsible for reporting on discharge-related measures, including, but not limited	• The TCL Transition Oversight Committee (TOC) met monthly in SFY24, with a meeting distribution list that included all required entities and NCDHHS Divisions. Each meeting included agenda items focused on program updates, implementation progress, and barriers. • The monthly TOC meeting agenda was updated in Q3 with greater emphasis on determining action items to mitigate identified risks and barriers. The updated agenda also includes standing items dedicated to discharge and transition barriers and related data and measures, LME/MCO progress reporting, and key status updates and risks. • Examples of discharge and transition related data and measures presented for LME/MCO analysis and reporting in SFY24 included numbers of ACH population members in TCL supportive housing, planning for transition, and transitioned in previous measurement periods; housing separations overall,

[30] Previous reviews confirmed the State has achieved compliance with all eight requirements of section III (G) Quality Assurance and Performance Improvement. During SFY25, the sixth modification entered by the Court on December 11, 2024, established the State met all substantive obligations of sections III(G)(1) through (8).

TCL Requirements that Have Been Met and Discharged	Key Progress
to housing vacancies; discharge planning and transition process; referral process and subsequent admissions; time between application for services to discharge destination; and actual admission date to community-based settings.	separations due to unit abandonment and eviction, and separations by priority population; and housing stability and tenure by priority population. • Where administrative measure data are maintained by the State, NCDHHS presented summaries of measure data to promote a standard approach to operationalization and calculation. LME/MCO reporting centered on root causes of identified trends, planned strategies to address obstacles, impacts of implemented solutions and interventions, projections for future measurement periods, and challenges and anticipated support needed.
III(G)(3) NCDHHS agrees to take the following steps related to Quality Assurance and Performance Improvement: Develop and phase in protocols, data collection instruments and database enhancements for on-going monitoring and evaluation; Develop and implement uniform application for institutional census tracking; Develop and implement standard report to monitor institutional patients length of stay, readmissions and community tenure; Develop and implement dashboard for daily decision support; Develop and implement centralized housing data system to inform discharge planning; Develop and utilize template for published, annual progress reports; Develop and utilize monitoring and evaluation protocols and data collection regarding personal outcomes measures, which include the following: (i. number of incidents of harm, ii. number of repeat admissions to State hospitals, adult care homes, or inpatient psychiatric facility, iii. use of crisis beds and community hospital admissions, iv. repeat emergency room visits, v. time spent in congregate day programming, vi. number of people employed, attending school, or engaged in community life, and vii. maintenance of a chosen living arrangement)	• Quarterly NCDHHS TCL Dashboard releases in SFY24 included significant refinements and enhancements to support member outcomes monitoring. For example, multiple new dashboard measures were developed and implemented to support monitoring of the following: o housing transitions of TCL members receiving ACT services during ACH In-Reach o PSR average service hours and duration o community integration and quality of life o employment and education related outcomes o member reported impact of TCL services o barriers to treatment • The QAPI team and TCL subject matter leads continued to conduct quarterly priority performance measure review and QAPI cycles and to produce related quarterly Quality Measure Reports, both previously implemented in SFY23. The quarterly cycle and reports follow a standard protocol for measure monitoring and evaluation, performance improvement planning, and reporting on key TCL outcomes and State QAPI activities and results. Measures prioritized for SFY24 cycles are related to ACH priority population member transitions to supportive housing, transition times to TCL housing, housing separations, frequency and outcomes of in-reach, and provision of ACT and other services with tenancy supports components.
III(G)(4) Quality Assurance System: The State will regularly collect, aggregate and analyze data related to in-reach and person-centered discharge and community placement efforts, including but not limited to information related to both successful and unsuccessful placements, as well as the problems or barriers to placing and/or keeping individuals in the most integrated setting. The State will	Tracking and addressing barriers and their resolutions significantly improved in SFY24. • The State Barriers Log spanning many years of the Settlement Agreement was migrated into the existing MHC, which has tracking-to-resolution and analytic capability. This transition resulted in improved timeliness in alerts to LME/MCO points of contact and greater efficiency in the analysis of patterns of barriers and resolutions. The migration to MHC coincided with codifying the barriers process, tying together the barriers

TCL Requirements that Have Been Met and Discharged	Key Progress
review this information on a semi-annual basis and develop and implement measures to overcome the problems and barriers identified.	continuum from local, State Psychiatric Hospital, State, and Transition Oversight Committee. • All LME/MCOs completed internal staff and external stakeholder barriers identification and reporting training and made it part of their onboarding process. • New Barriers and Solutions Committees (BASC) were implemented in SFY24 within each of the three State Psychiatric Hospitals (SPH). BASC membership includes SPH social work directors and managers, DSOHF, and LME/MCO TCL SPH leadership, with committee meetings hosted by NCDHHS. Analogous to Local Barriers Committee operations, BASCs elevate barriers requiring higher level resolution authority to the State. • Accenture project management staff are now embedded in the barriers processes in SBC and each BASC for the three state psychiatric hospitals and four Plans, resulting in improvements in the tracking of barriers to completion. • Additional follow-up on identified barriers occurred in monthly one-on-one meetings between NCDHHS and each LME/MCO. • Ongoing participation of NCDHHS in each of the four Plans' local barriers committees also provided support for immediate problem-solving, quicker elevation of barriers to the State, and improvements in state barrier resolution.
III(G)(5) Quality of Life Surveys: The State will implement three quality of life surveys to be completed by individuals with SMI who are transitioning out of an adult care home or State psychiatric hospital. The surveys will be implemented (1) prior to transitioning out of the facility; (2) eleven months after transitioning out of the facility; and (3) twenty-four months after transitioning out of the facility. Participation in the survey is completely voluntary and does not impact the participant's ability to transition.	• Work that started in SFY24 to explore alternative approaches to quality of life (QoL) assessment included interviews with key subject matter experts, including the Independent Reviewer and team as well as NCDHHS and other State SMEs and stakeholders, and an environmental scan of existing QoL models, tools, and assessment approaches. Guiding objectives of this ongoing work include reducing survey administration and response burden, improving the relevance of survey content to members, reducing redundancy, and increasing data accessibility, usability, and value for quality assurance and performance improvement.
III(G)(6) External Quality Review ("EQR") Program: As part of the quality assurance system, the State shall complete an annual PIHP and/or LME EQR process by which an EQR Organization, through a specific agreement with the State, will review PIHP and/or LME policies and processes for the State's mental health service system. EQR will include extensive review of PIHP and/or LME documentation and interviews with PIHP and/or LME staff. Interviews with	• Since the previous EQR conducted by the Carolinas Center for Medical Excellence (CCME) in SFY22, DHB has contracted with a new EQRO, the Health Services Advisory Group (HSAG). • The NC Medicaid Annual Technical Report published in March 2024[31] includes a comprehensive summary of EQR activities, program findings and conclusions, and quality strategy recommendations for the five NC Medicaid Standard Plans reviewed in SFY23 and illustrates the partial scope of EQR activities applicable to LME/MCOs in SFY25. • Planning with HSAG in SFY24 also included a significant focus on EQR process improvements to increase the following:

[31] See the SFY23 NC Medicaid Annual Technical Report published at https://medicaid.ncdhhs.gov/documents/reports/annual-reports/2022-2023-eqr-technical-report/download?attachment

TCL Requirements that Have Been Met and Discharged	Key Progress
stakeholders and confirmation of data will also be initiated. The reviews will focus on monitoring services, reviewing grievances and appeals received, reviewing medical charts as needed, and any individual provider follow up. EQR will provide monitoring information related to: (Marketing, Program integrity, Information to beneficiaries, Grievances, Timely access to services, Primary care provider/specialist capacity, Coordination/continuity of care, Coverage/authorization, Provider selection, Quality of care).	○ Engagement with Plans to enhance QI efforts ○ Transparency of quality outcomes to inform QI design ○ Insight into equity across health outcomes and perceptions of care • Supplementing the program during an EQRO transition year, NCDHHS contracted with Constellation Quality Health to conduct quarterly reviews beginning in SFY24 Q3. These reviews focus on programmatic and technical components of TCL and assist with monitoring and maintaining compliance with Settlement Agreement requirements. Review components include clinical document reviews and interviews with TCL program participants, guardians, and provider/plan staff, as well as trending and analysis of barriers to community living. Each quarterly review centers on eight randomly selected TCL participants per LME/MCO and includes evaluation of extensive case documentation submitted by the LME/MCO prior to face-to-face interviews with each individual. Review standards and scoring mirror those used by the Independent Reviewer and correspond to discharge and transition processes, supportive housing access and tenancy review, and community services/supported employment. Constellation also provides an annual review of LME/MCO program materials pertaining to TCL policies, procedures, and quality improvement initiatives.
III(G)(7) Use of Data: Each year the State will aggregate and analyze the data collected by the State, PIHPs and/or LMEs, and the EQR Organization on the outcomes of this Agreement. If data collected shows that the Agreement's intended outcomes of increased integration, stable integrated housing, and decreased hospitalization and institutionalization are not occurring, the State will evaluate why the goals are not being met and assess whether action is needed to better meet these goals.	• Functions of the interdivisional TCL Quality Assurance Committee (QAC) evolved in SFY24 with an enhanced focus and role in carrying out requirements related to analysis and use of TCL program data. Committee meetings in SFY24 included analysis results, presentations, and presenter and committee assessment of program data on TCL member institutional contacts, in-reach, diversion, and housing as they relate to TCL goals of increasing integration and decreasing institutionalization. • The quarterly measure monitoring and QAPI cycle described above under III(G)(1) entails additional outcomes analysis in support of focused quality improvement planning and action.
III(G)(8) Reporting: The State will publish, on the NCDHHS website, an annual report identifying the number of people served in each type of setting and service described in this Agreement. In the annual report, the State will detail the quality of services and supports provided by the State and its community providers using data collected through the quality assurance and performance improvement system, the contracting process, the EQRs, and the outcome data described above.	• The State continues to meet this annual requirement, refining the report template each year and incorporating additional relevant contextual details and pertinent data collected through the growing QAPI system. Reporting enhancements in this SFY24 annual report include the following: ○ Progress summaries related to each substantive Settlement Agreement obligation in the areas of housing, services, supported employment, discharge and transition, pre-screening and diversion, and quality assurance and performance improvement ○ Focused reporting on supporting data in each area ○ Identification of key focus areas and priorities in the next SFY

8.2. SFY24 SUPPORTING DATA

Supporting data related to Quality Assurance and Performance Improvement include measures of member outcomes referenced in Section III(G) of the Settlement Agreement with USDOJ. Data on time in TCL status and setting, housing tenure, and separations address requirements for reporting on member maintenance of chosen living arrangement and community tenure.

Institutional use outcomes include hospital admissions and readmissions and length of stay, emergency department visits and repeat visits, facility-based crisis bed use, and adult care home admissions and readmissions. Time spent in congregate day programming is detailed in this section and summarized in Appendix 10.2 service summaries. [32]

This section also includes required and related measures corresponding to member community integration, including incidents of harm, employment and school attendance, and other indicators of engagement in community life. Also included are measures of quality of life and linked concepts such as member reported program helpfulness for achieving positive outcomes and barriers to treatment.

The key member outcomes reported in this section reflect fundamental TCL objectives related to housing stability; reduced hospital contacts, institutionalization, and incidents of harm; and increased independence, community integration, and quality of life. Other data related to the quality of TCL member services and supports in distinct program areas are presented in Sections 3 through 7 of this report.

8.2.1. COMMUNITY TENURE AND TIME IN TCL STATUS AND SETTING

Figure 16 shows annual trends in TCL participant tenure in various settings and statuses.[33] Not shown, the average number of days from housing slot approval to the transition to supportive housing in SFY24 was 184 days, and 39 percent of individuals who transitioned did so by the 90th day.[34]

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 for a first Transition Planning meeting within an additional 10 days. Average time to transition from the first Transition Plan meeting thus may have been shorter than six months, and a slightly higher percentage of individuals, 43 percent, had transitioned by the 100th versus 90th day.

Some individuals also experience more than one attempt before transitioning to TCL housing. The number of days from the most recent transition attempt start date to the date members transitioned to supportive housing in SFY24 was 113 days. This is nearly 40 percent lower than the length of time from initial housing slot approval, and approximately 14 percent lower than the comparable figure for SFY23, although still nearly 25 percent longer than the target length of 90 days to transition.

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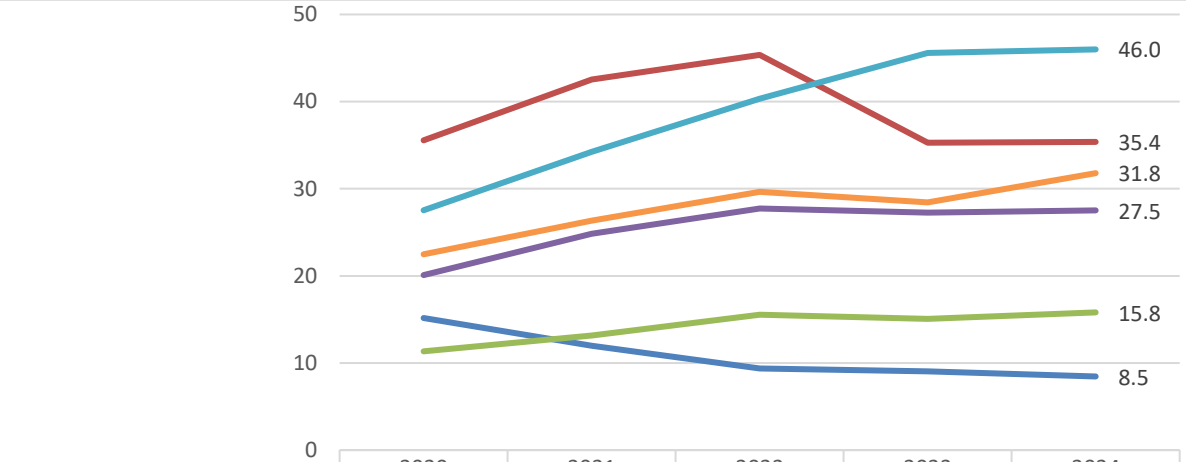
[32] Service providers have up to 365 days from the first date of service on a claim to submit Medicaid claims for processing and payment, except for inpatient and nursing facility claims, which may be submitted up to 365 days from the last date of service on the claim, https://medicaid.ncdhhs.gov/providers/claims-and-billing. Institutional and service based personal outcomes measures in this report section reflect claims adjudicated through September 2024. Timely filing limits may affect data completeness, especially for services provided in SFY24.

[33] These measures include individuals in the various TCL statuses and settings at any time during each state fiscal year. The average number of months for members in TCL housing is calculated from the initial transition date, whether members were continuously housed or previously separated and rehoused.

[34] 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.

Figure 16. Average Months in TCL Status, SFY20-SFY24



	2020	2021	2022	2023	2024
Diversion Attempt	15.2	12.0	9.4	9.0	8.5
ACH In-Reach	35.5	42.5	45.4	35.3	35.4
SPH In-Reach	11.3	13.2	15.5	15.1	15.8
SPH Outreach	20.1	24.8	27.7	27.3	27.5
Community w/out TCL Slot	27.5	34.3	40.3	45.6	46.0
TCL Supportive Housing	22.5	26.3	29.6	28.4	31.8

At the end of SFY24, 56 percent of individuals transitioned over the life of the program were in TCL supportive housing. For this subset of the SFY24 population of members in TCL housing, the average time from the initial transition date was 3.9 years, with a median of 3.7 years.[35]

Table 10 shows percentages of members transitioned since SFY17 who were in TCL supportive housing at milestones ranging from three months to two years or longer after the initial transition.

Table 10. Individuals in TCL Supportive Housing at Post-Transition Milestones[36]

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	5,324	5,491	97%
6 months or longer	4,935	5,335	93%
1 year or longer	4,142	4,999	83%
1.5 years or longer	3,530	4,695	75%
2 years or longer	2,998	4,396	69%

Figure 17 shows the numbers and percentages of members in housing relative to the number of years since their initial transitions to supportive housing. Members in housing at the end of SFY24 included

[35] As shown in the previous figure, average time from transition for the larger population of members in housing at any time during SFY24, including those who separated during the year as well as those in housing at year end, was 31.8 months (2.7 years).

[36] 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 who had initially transitioned to TCL supportive housing three months or more before the end of SFY24.

approximately equal numbers of individuals housed in the prior two years (31%), two to five years earlier (35%), and more than five years earlier (34%).

Figure 17. Years Since Initial Transition, Members Housed at End of SFY24[37][38]

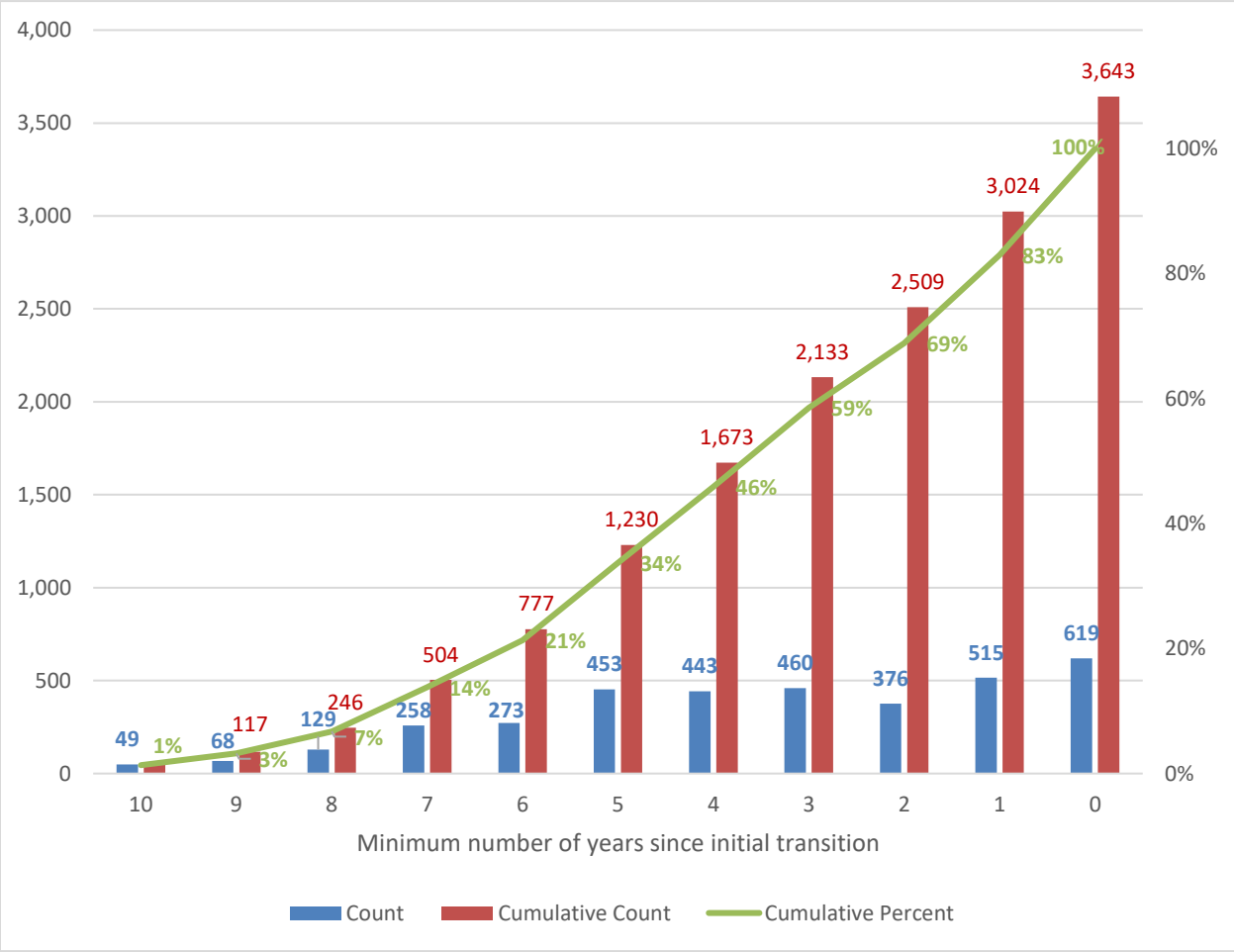


Figure 18 shows annual trends in numbers of individuals in TCL supportive housing at state fiscal year end, members housed for the first time or rehoused during the year, and members separated during the year. Gradual increases over time in the number of members in housing are associated with higher numbers of transitions compared to separations.

[37] The cumulative percent line shows the proportion of individuals in housing at the end of the reporting period who first transitioned at least the corresponding number of years earlier; for example, 21 percent transitioned six or more years earlier.

[38] Values in this figure are derived solely from the NCHFA Community Living Verification (CLIVe) centralized housing subsidy reimbursement and data system, which showed 3,643 TCL members with active leases and null move out dates at the end of SFY24. This estimate is slightly higher than the comparable TCL Dashboard measure value of 3,618 members in housing at the end of SFY24. The TCL Dashboard measure incorporates additional administrative data such as the member status documented in TCLD to assign individuals to TCL status groups, resulting in a slight difference, less than one percent, in these measure values.

Figure 18. Annual Statewide Numbers of Members Transitioned, Separated, and in TCL Housing at End of Reporting Period, SFY20-SFY24

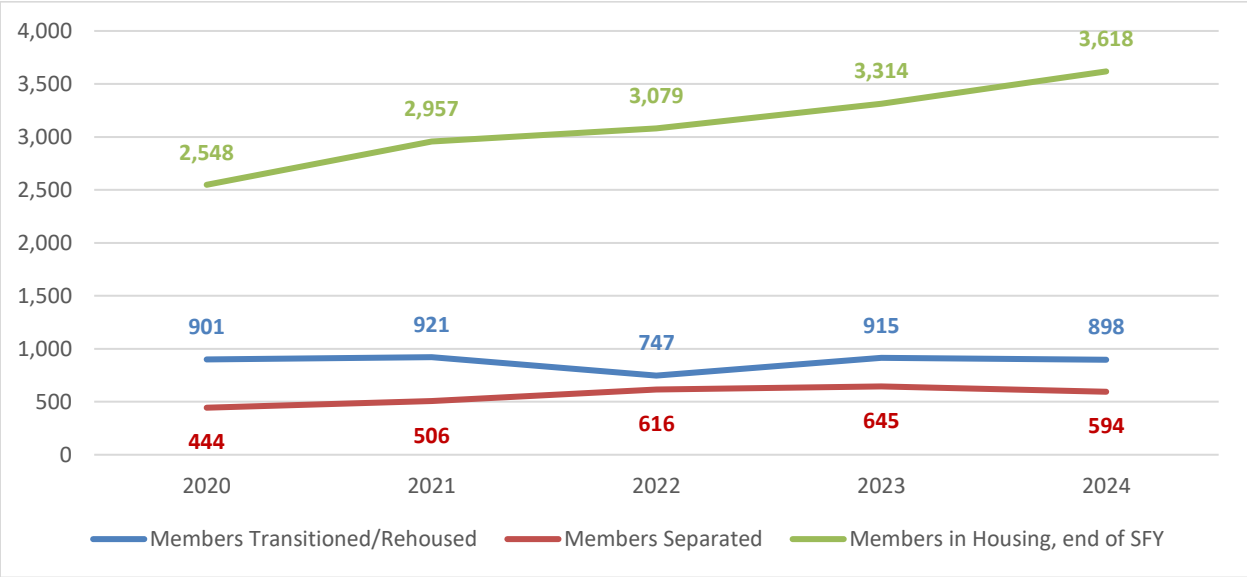


Figure 19 illustrates statewide annual and average quarterly housing separation rates. Over the five-year period from SFY20 to SFY24, average annual and quarterly separation rates were 15.6 and 4.5 percent, respectively, with noticeably lower rates in the most recent state fiscal year.

Figure 19. Statewide Annual and Average Quarterly Housing Separation Rates, SFY20-SFY24

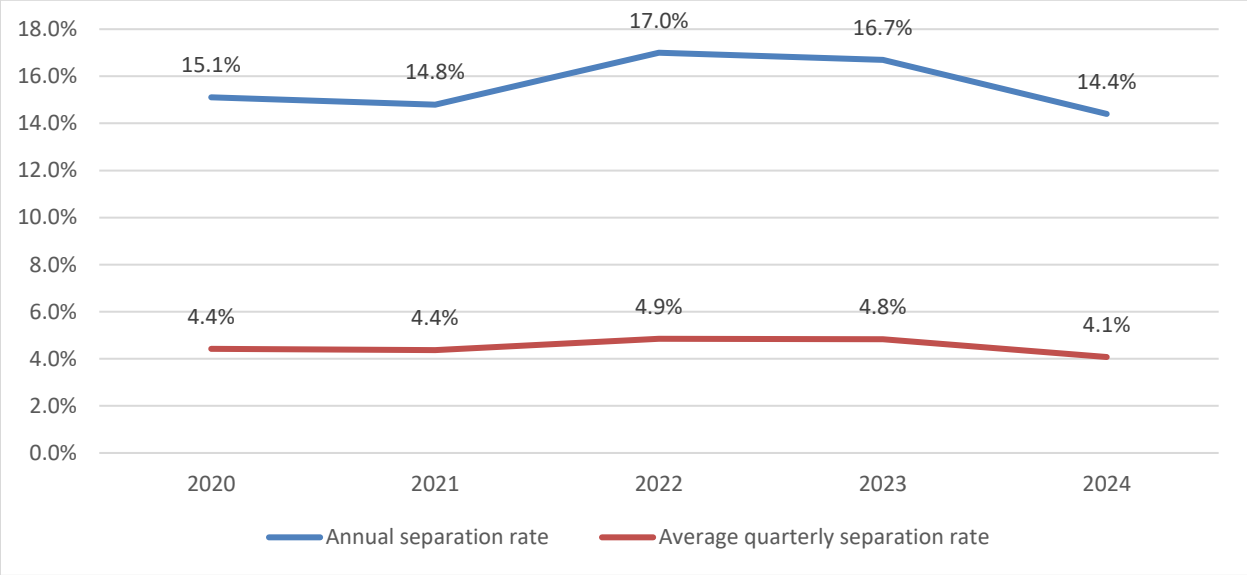


Figure 20 shows LME/MCO annual and average quarterly separation rates.[39] All LME/MCOs experienced decreases in the most recent state fiscal year.

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

Figure 20. Annual and Average Quarterly Housing Separation Rates by LME/MCO, SFY23 and SFY24

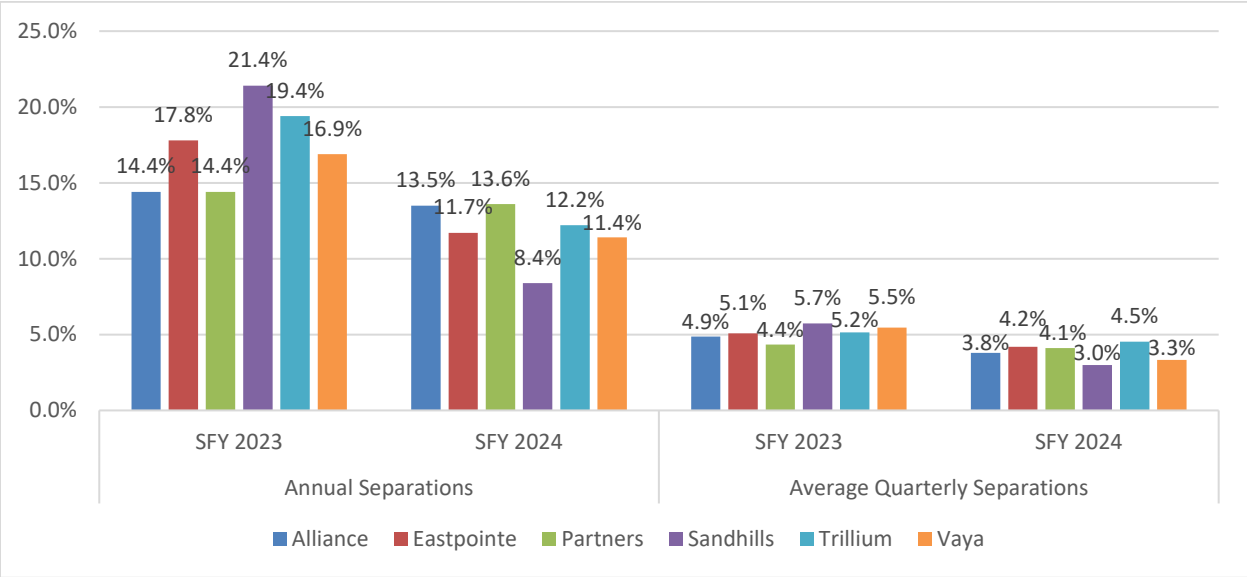


Figure 21 illustrates variability both within and across LME/MCOs in SFY23 and SFY24 quarterly LME/MCO separation rates. This figure also demonstrates greater variability at the LME/MCO level compared to statewide, as well as somewhat greater variability for LME/MCOs with smaller populations of members in TCL housing. [40]

Figure 21. Quarterly Housing Separation Rates by LME/MCO, SFY23 and SFY24

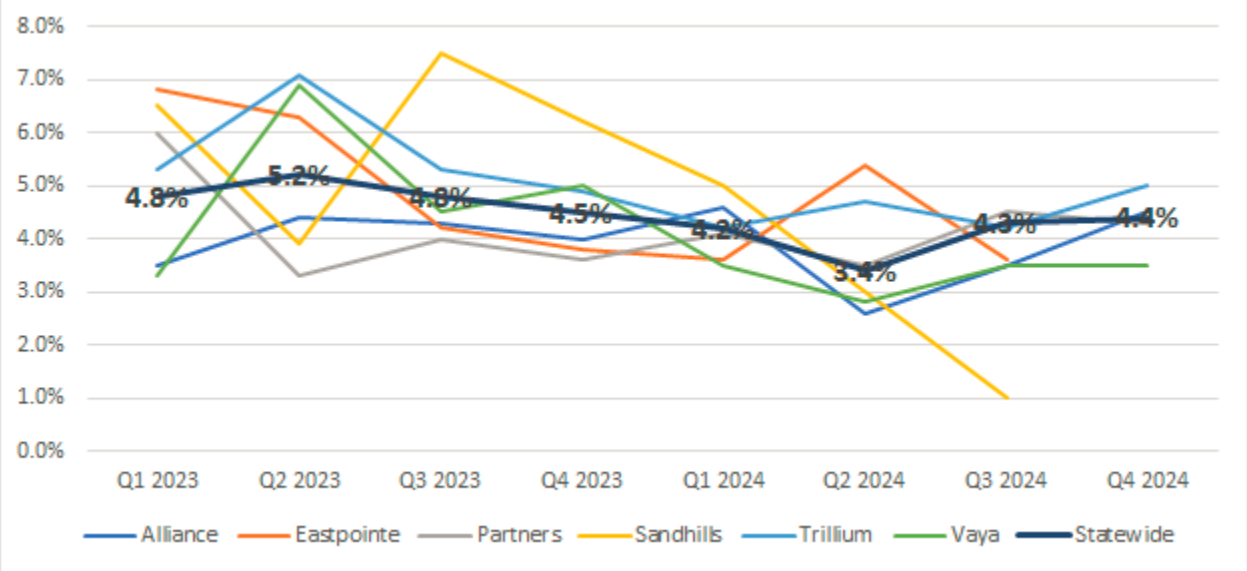


Table 11 shows the life of program housing and separation rates by priority population category. SPH population percentages in housing have remained relatively stable over time, representing 18 percent of

[40]Greater separation rate variability within smaller housed populations such as Eastpointe and Sandhills, and in LME/MCO quarterly separation rates compared to statewide annual, statewide quarterly, and LME/MCO annual separation rates, is in part a statistical function of smaller measure denominators, such that relatively small increases or decreases in numbers of members separated across quarters produce larger relative changes in resulting percentages.

members ever housed, 17 percent in housing at SFY24 year-end, and 19 percent of all separations. In contrast, the ACH population represents 36 percent of members ever housed, 28 percent in housing at year end, and 47 percent of all separations. The Diversion population shows a reverse pattern compared to the ACH population, representing 46 percent of members ever housed, 56 percent of members housed at year end, and 34 percent of separations.

The shift over time in the population makeup of members in TCL housing is accounted for largely by the 58 percent ACH population separation rate, which is 1.75 times higher than the Diversion population separation rate. While 78 percent of many ACH compared to Diversion population members have ever transitioned to TCL supportive housing, just under half as many ACH as Diversion population members remained in housing at SFY24 year-end.

Table 11. Life of Program Housing Separations by Population Category at Transition[41]

Priority Population Category	Ever housed, end of SFY24	Percent of ever housed	Housed at end of SFY24	Percent of housed at end of SFY24	Life of program separations	Percent of all program separations	Population group separation rate
Pop 1-3 ACH	2,347	36.1%	996	27.5%	1,351	46.8%	57.6%
Pop 4 SPH	1,152	17.7%	607	16.8%	545	18.9%	47.3%
Pop 5 Diversion	3,003	46.2%	2,015	55.7%	988	34.3%	32.9%
All Populations	**6,502**	**100%**	**3618**	**100%**	**2884**	**100%**	**44.4%**

Error! Reference source not found. shows estimates of individuals admitted to adult care homes after separation from TCL housing. These are individuals for whom NCTracks eligibility data, at any time after a member's most recent housing separation, showed a living arrangement code indicating the person resided in an adult care home.

Over the life of the TCL program, 710 individuals had an adult care home living arrangement code after a TCL supportive housing separation that was not succeeded by subsequent TCL rehousing.

Table 12. Individuals with ACH Admission after TCL Housing Separation, by Year of Housing Separation[42]

SFY13	SFY14	SFY15	SFY16	SFY17	SFY18	SFY19	SFY20	SFY21	SFY22	SFY23	SFY24	Total
1	11	17	29	44	102	114	85	72	84	85	66	710

Additional program data show that a private living arrangement is by far the most common living arrangement *first* documented in NCDHHS claims and eligibility systems after a TCL housing separation.[43] Approximately 63 percent of members with a most recent TCL housing separation over the life of the program through the end of SFY24 had a first subsequent NCTracks living arrangement code that indicated a private living arrangement. This percentage varied by member population group at the time of separation to include 49, 68, and 76 percent, respectively, of ACH, Diversion, and SPH population members with

[41] Values in this table are sourced from June 2024 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.

[42] **Error! Reference source not found.** counts are derived from an ad hoc report that is based on data extracts used to produce TCL Dashboard measures. Individuals are counted as having been admitted to an ACH 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.

[43] Summary data on first post-separation living arrangements are based on ad hoc analysis of subsequent NCTracks eligibility data for members who separated from TCL housing.

separations.[44]

While Table 12 shows a total of 710 (approximately 25%) of separated members had an ACH living arrangement code *any time* after separation, approximately half that number, 373 (approximately 14%) separated members, had a *first* post-separation ACH living arrangement code after separation. First subsequent ACH living arrangement codes were more common for members in the ACH population group at the time of separation (24%) compared to Diversion (11%) and SPH (5%) population members. Subsequent Skilled Nursing Facility (SNF) living arrangements also were more likely for members in the ACH population at the time of separation (10%) compared to Diversion (3%) and SPH (2%) population members.

The percentage of members without an eligibility segment and corresponding living arrangement code with a begin date after a TCL housing separation was approximately 15% overall and varied little across ACH (15%), Diversion (16%), and SPH (13%) populations. The absence of subsequent eligibility segments would apply to deceased members or those who lost eligibility for other reasons, such as moving out of state.

These patterns overall are consistent with program data that members in ACHs are older with more chronic health conditions compared to other TCL subpopulations, presenting unique challenges for this population related to housing stability and tenure. At the end of SFY24, for example, approximately five percent of SPH population members receiving outreach in the community were 65 years and older, compared to less than ten percent of members in non-TCL housed Diversion status, and more than one-third of members receiving in-reach, 86 percent of whom resided in ACHs. Whether TCL members with experience living in ACHs first entered the program through the diversion process or as residents of ACHs; after separating from TCL housing, they may be more likely to require skilled nursing care or to be readmitted to an ACH.

8.2.2. TCL MEMBER INSTITUTIONAL CONTACTS

Institutional census tracking and length of stay are monitored through the State Psychiatric Hospital (SPH) Healthcare Enterprise Accounts Receivable Tracking System (HEARTS), the Medicaid Encounter Processing System (EPS), and the NCTracks claims data warehouse.[45] SPH census, admissions, and discharge data are summarized in other sections of this report.

Inpatient admissions and readmissions and Emergency Department (ED) visits and repeat visits are based on EPS 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.[46] 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.

8.2.2.1. Inpatient Admissions and Readmissions

Table 13 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), and State Psychiatric Hospitals (SPH) over a five-year period.

[44] Population category at separation may differ compared to population category at time of TCL eligibility determination or transition. For example, members identified as TCL eligible through the Diversion process and subsequently transition to TCL housing after an ACH admission are transitioned as ACH population members.

[45] EPS is the NCDHHS Encounter Processing System for Medicaid Managed Care service encounter claims. Effective 4/1/2023, EPS is the source of Medicaid institutional and professional services data. NCTracks is the previous multi-payer Medicaid Management Information System for the NC Department of Health and Human Services and the current system for processing state funded services.

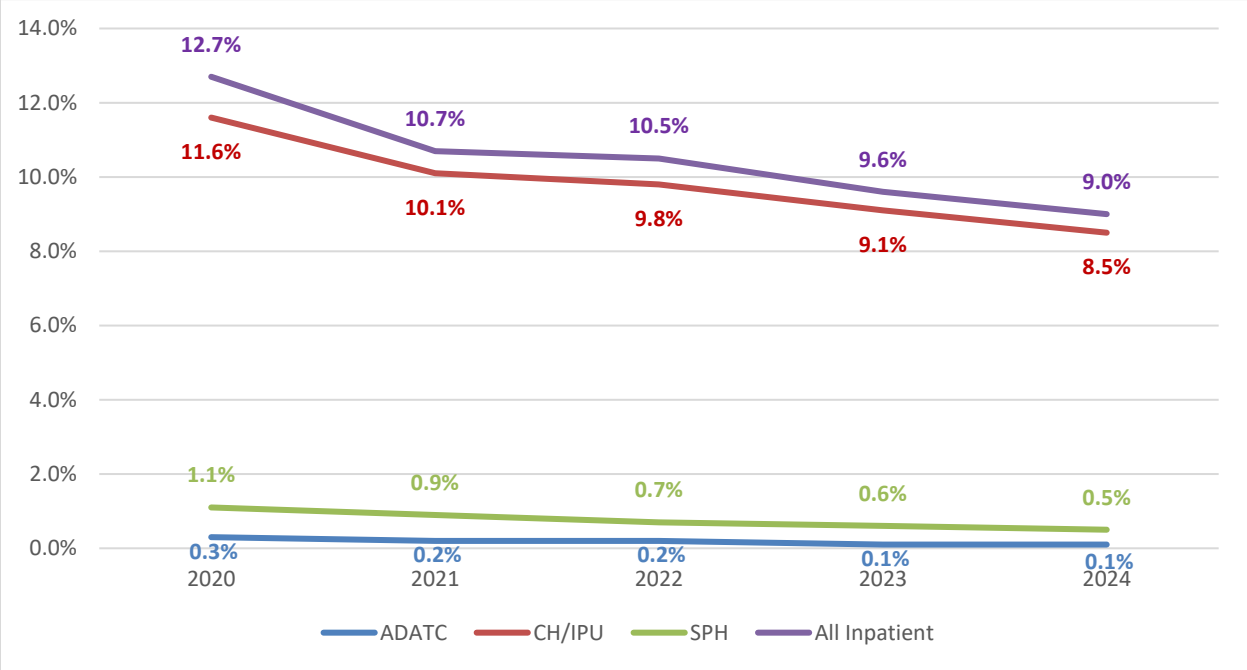
[46] Institutional admission measure values were calculated using standardized TCL Performance Data Dashboard specifications.

Table 13. TCL Housed Individuals with Inpatient Admissions, SFY20-SFY24

Facility Type	SFY20	SFY21	SFY22	SFY23	SFY24
Alcohol and Drug Treatment Center (ADATC)	9	6	8	2	6
Community Hospital/Inpatient Psychological Unit (CH/IPU)	341	345	357	351	351
State Psychiatric Hospital (SPH)	33	32	27	22	21
All Facility Types[47]	373	366	382	369	372
Total in TCL Housing During Period	**2,948**	**3,417**	**3,626**	**3,897**	**4,171**

Figure 22 below shows admissions to each type of facility as a percentage of the total number of members in TCL housing for the same five-year period. State psychiatric hospital and ADATC admission rates remained low over this period, and a steady decrease over time in community hospital and inpatient psychiatric hospital admission rates are observed.

Figure 22. Percentages of TCL Housed Members with Inpatient Admissions, SFY20-SFY24



Over the two-year period including SFY23 and SFY24, approximately 94 percent of housed member inpatient admissions were to community hospitals or inpatient psychiatric units, five percent were to state psychiatric hospitals, and less than one percent were ADATC admissions. A similar pattern is observed across all TCL member statuses and setting for the same two-year period, with approximately 90 percent of TCL member inpatient admissions to community hospitals or inpatient psychiatric units, nine percent to state psychiatric hospitals, and less than one percent to ADATCs.

Of individuals with inpatient admissions of any type, 49 percent in SFY23 and 47 percent in SFY24 also had one or more inpatient admissions within the preceding 12 months. Table 14 shows counts by LME/MCO of individuals with inpatient facility admissions from TCL supportive housing. A second measure of repeat

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

admissions, the average number of admissions per person with admissions during the same state fiscal year, is also shown. Together, these measures demonstrate that the number of TCL housed *individuals* with inpatient admissions is relatively low and nearly 40 percent lower than the total number of admissions from TCL housing.[48]

Table 14. TCL Housed Members with Inpatient Admissions, and Average Admissions per Person with Admissions, SFY23 and SFY24

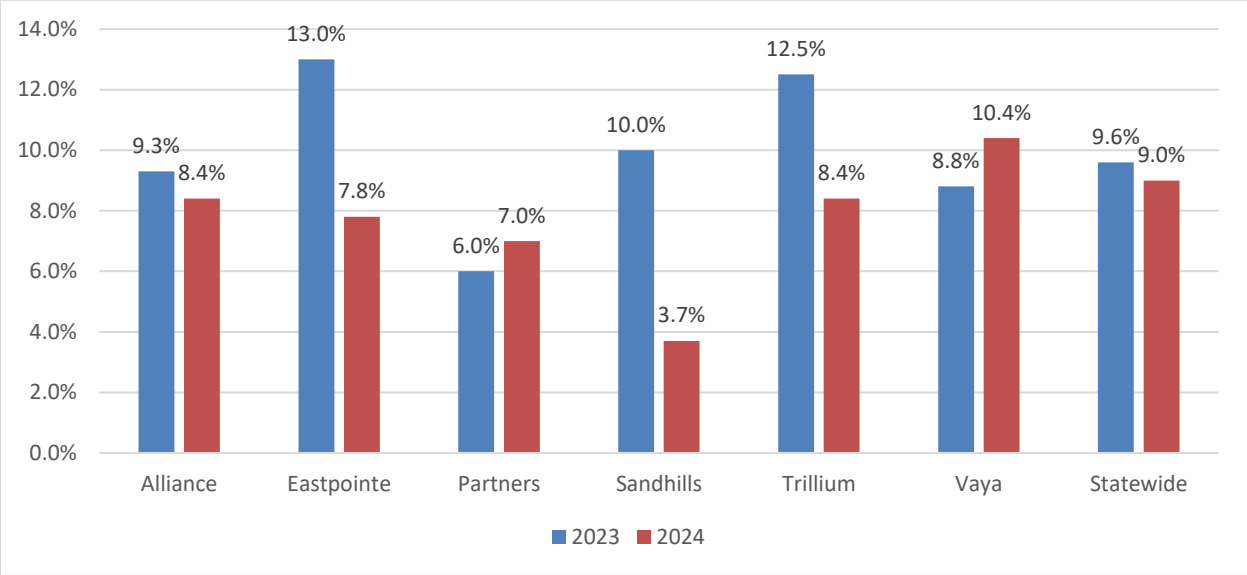
	ADATC		CH/IPU		SPH		All Facility Types[49]	
LME/MCO	Count	Avg	Count	Avg	Count	Avg	Count	Avg
	SFY23							
Alliance	0	0.0	103	1.6	9	1.2	110	1.6
Eastpointe	0	0.0	38	1.2	6	2.2	43	1.3
Partners	0	0.0	36	1.4	2	1.0	37	1.5
Sandhills	0	0.0	45	1.6	2	1.0	46	1.6
Trillium	1	1.0	69	1.6	3	1.3	72	1.6
Vaya	1	1.0	60	1.5	0	0.0	61	1.5
Statewide	**2**	**1.0**	**351**	**1.5**	**22**	**1.5**	**369**	**1.5**
	SFY24							
Alliance	0	0.0	101	1.6	5	2.2	105	1.6
Eastpointe	0	0.0	21	1.5	6	1.2	26	1.5
Partners	0	0.0	52	1.4	2	1.0	54	1.4
Sandhills	0	0.0	15	1.3	1	1.0	16	1.3
Trillium	2	1.0	100	1.4	7	1.1	107	1.4
Vaya	4	1.0	78	1.5	1	1.0	81	1.5
Statewide	**6**	**1.0**	**351**	**1.5**	**21**	**1.4**	**372**	**1.5**

Figure 23 shows the SFY23 and SFY24 inpatient admission rates from TCL housing by LME/MCO and statewide. Some evident variations across LME/MCO and between years, such as lower SFY24 rates for Eastpointe and Sandhills compared to SFY23 and statewide rates, may be attributable to LME/MCO consolidation and the calculation of SFY24 annual rates using partial year data for those that merged.

[48] The total number of admissions is approximately equal to the number of individuals with admissions multiplied by the average number of admissions. For all facility types, there were 567 housed TCL inpatient admissions in SFY23 and 604 in SFY24.

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

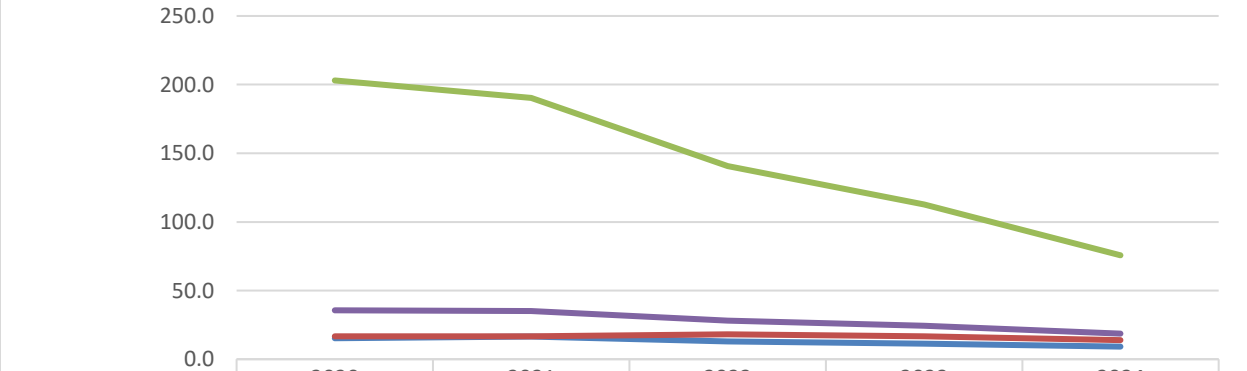
Figure 23. TCL Housed Members with Inpatient Admissions, All Facility Types, SFY23 and SFY24



8.2.2.2. Inpatient Length of Stay

The previously reported downward annual trend in inpatient length of stay (LOS) continued in SFY23 and SFY24, largely accounted for by decreases in state psychiatric hospital LOS. Figure 24 illustrates annual statewide trends in average length of stay by facility type.

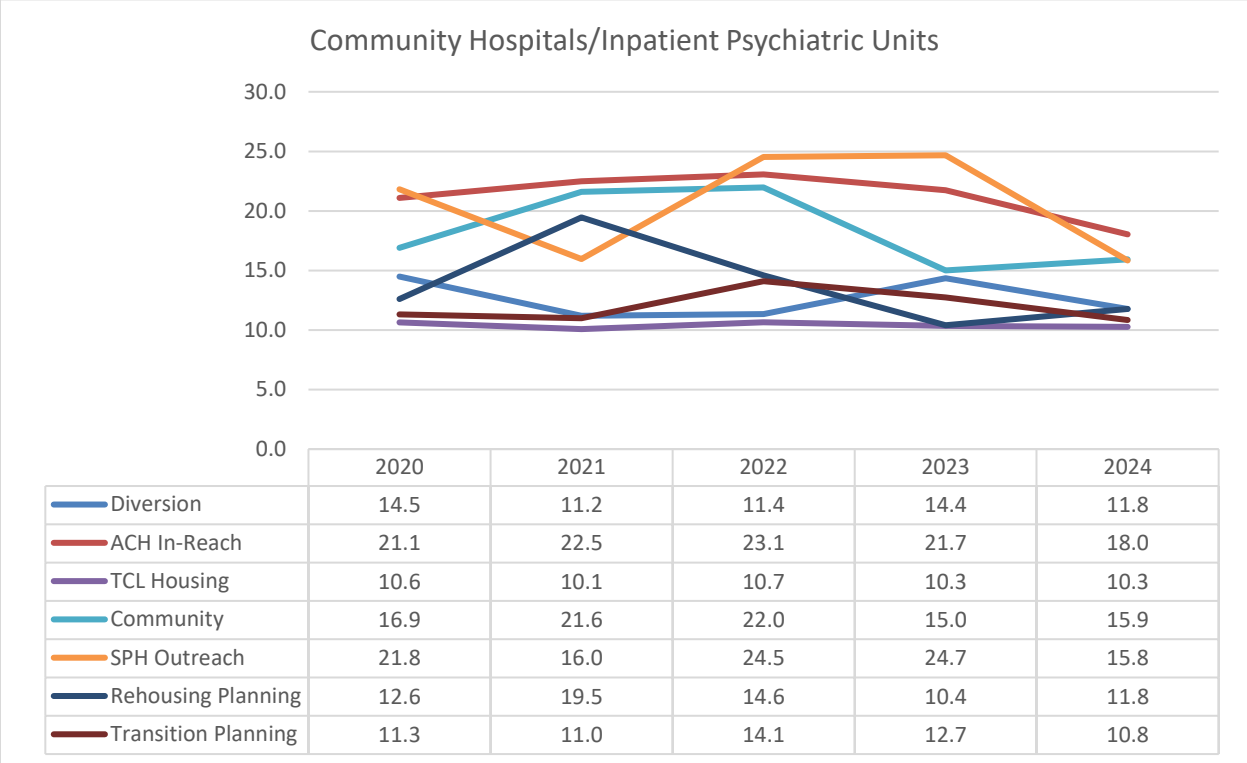
Figure 24. Annual Trends in TCL Member Average Inpatient Length of Stay (days), All TCL Statuses, SFY20-SFY24



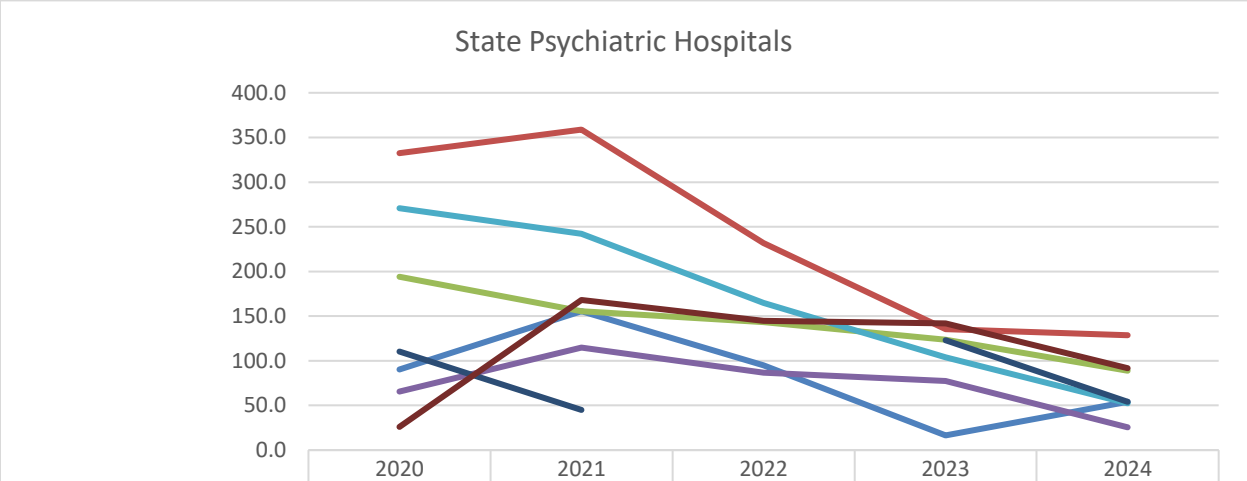
	2020	2021	2022	2023	2024
ADATC	15.4	16.5	13.1	11.3	9.2
CH/iPU	16.7	16.7	18.2	16.8	13.9
SPH	203.0	190.3	140.8	112.8	75.7
All Inpatient	35.6	35.0	28.2	24.4	18.6

Figure 25 demonstrates that members in TCL supportive housing have experienced shorter inpatient stays on average compared to individuals in other statuses and settings.

Figure 25. Annual Trends in Average Inpatient Length of Stay (days) by TCL Status, SFY20-SFY24



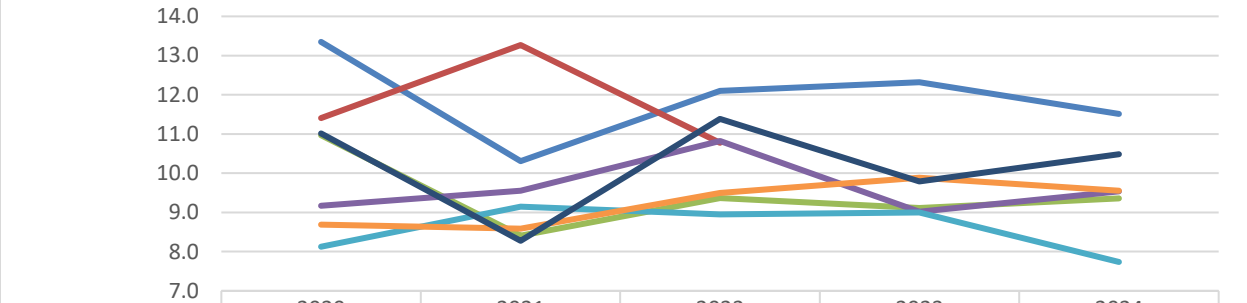
	2020	2021	2022	2023	2024
Diversion	14.5	11.2	11.4	14.4	11.8
ACH In-Reach	21.1	22.5	23.1	21.7	18.0
TCL Housing	10.6	10.1	10.7	10.3	10.3
Community	16.9	21.6	22.0	15.0	15.9
SPH Outreach	21.8	16.0	24.5	24.7	15.8
Rehousing Planning	12.6	19.5	14.6	10.4	11.8
Transition Planning	11.3	11.0	14.1	12.7	10.8



	2020	2021	2022	2023	2024
Diversion	90.2	155.5	95.0	16.5	54.0
ACH In-Reach	332.4	358.8	231.9	135.6	128.6
SPH In-Reach	194.1	155.6	143.5	123.6	88.9
TCL Housing	65.5	114.8	86.7	77.5	25.5
Community	270.8	242.1	164.8	104.0	52.4
Rehousing Planning	110.5	45.0		123.0	54.0
Transition Planning	26.0	168.1	144.8	141.8	91.7

Figure 26 demonstrates minimal variation by LME/MCO over the previous five-year period in housed member average length of stay in the most common inpatient settings, community hospitals or psychiatric units.[50]

Figure 26. Annual Trends in TCL Housed Member Community Hospital and Inpatient Psychiatric Unit Average Length of Stay by LME/MCO, SFY20-SFY24



	2020	2021	2022	2023	2024
Alliance	13.3	10.3	12.1	12.3	11.5
Cardinal	11.4	13.3	10.8		
Eastpointe	11.0	8.4	9.4	9.1	9.4
Partners	9.2	9.6	10.8	9.0	9.5
Sandhills	8.1	9.1	9.0	9.0	7.7
Trillium	8.7	8.6	9.5	9.9	9.6
Vaya	11.0	8.3	11.4	9.8	10.5

8.2.2.3. Emergency Department Visits and Repeat Visits

Table 15 shows statewide annual numbers of individuals in TCL supportive housing who had standalone Emergency Department visits or repeat visits.[51,52] Both the percentage of housed members with any ED visits and the percentage with more than one show a downward trend over a five-year period.[53] Most individuals with ED visits during each state fiscal year had a single visit, and just over 30 percent had more than one.

Table 15. TCL Housed Members with ED Visits and Repeat Visits, Statewide, SFY20-SFY24

	SFY20	SFY21	SFY22	SFY23	SFY24
Members with one or more ED visit in SFY	322	317	300	329	284
Percent of housed	*10.9%*	*9.3%*	*8.3%*	*8.5%*	*6.9%*
Subset with two or more ED visits in SFY	102	108	91	102	88

[50] State psychiatric hospital length of stay by LME/MCO is not shown due to the small number of individuals, less than five members on average per LME/MCO over this five-year period, who experienced SPH admissions from TCL housing.

[51] 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.

[52] 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. Institutional contacts that involved inpatient admission from an ED are reported as inpatient admissions in the previous report section.

[53] Completeness of ED visit claims for the most recent state fiscal year may be affected by timely filing limits.

	SFY20	SFY21	SFY22	SFY23	SFY24
Percent of housed	*3.5%*	*3.2%*	*2.5%*	*2.6%*	*2.1%*
Percent of individuals with any ED visits	31.7%	34.1%	30.3%	31.0%	31.0%
Total in TCL Housing During Period	**2,948**	**3,417**	**3,626**	**3,897**	**4,171**

As shown in Table 16, percentages of housed members with ED visits and repeat visits within the previous two state fiscal years varied somewhat by LME/MCO.

Table 16. TCL Housed Members with ED Visits and Repeat Visits by LME-MCO, SFY23 and SFY24

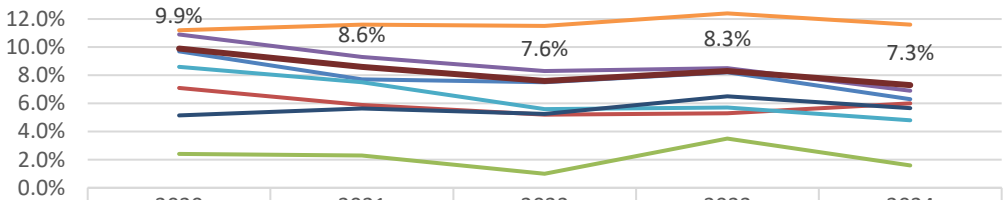
	SFY23					SFY24				
LME/ MCO	**N Housed**	**N with ED Visits**	***Percent of Housed***	**N with More than one ED Visit**	***Percent of Housed***	**N Housed**	**N with ED Visits**	***Percent of Housed***	**N with More than one ED Visit**	***Percent of Housed***
Alliance	1,202	118	9.9%	39	3.3%	1,258	106	8.5%	38	3.0%
Eastpointe	340	41	12.3%	12	3.6%	340	20	6.0%	7	2.1%
Partners	626	29	4.7%	7	1.1%	778	18	2.3%	5	0.6%
Sandhills	461	52	11.4%	19	4.1%	430	19	4.4%	4	0.9%
Trillium	581	47	8.2%	15	2.6%	1291	79	6.2%	17	1.3%
Vaya	693	42	6.1%	10	1.4%	781	51	6.6%	15	1.9%

As shown in Figure 27, TCL members most likely to experience ED visits were individuals previously discharged from state psychiatric hospitals and receiving outreach in the community. Individuals residing in 24-hour facilities were less likely to have ED visits, as were members planning to transition to supportive housing. As the average length of diversion attempts has decreased (see Figure 16), the percentage of members in Diversion experiencing ED visits has also trended downward. The percentage of members living in the community without TCL housing slots who had ED visits has also decreased.

In previous years, members in TCL housing were slightly more likely to have ED visits compared to the percentage for the TCL population overall. Consistent with the overall downward trend in ED visits for this population, in the most recent state fiscal year, TCL housed members were slightly less likely to have ED visits compared to the full TCL population.[54]

[54] The downward trend in the ED visit rate for the total TCL population increasingly mirrors the percentage of members in TCL housing with ED visits. The number of TCL housed members grew steadily from approximately 21 percent of the total TCL population in SFY20 to 36 percent in SFY24. During the same period, the percentage of members in transition or rehousing planning also increased slightly as a proportion of the total TCL population, while percentages of members in all other statuses and settings decreased or remained stable.

Figure 27. Annual Trends in ED Visit Rates by TCL Status, Members with One or More ED Visit, SFY20-SFY24

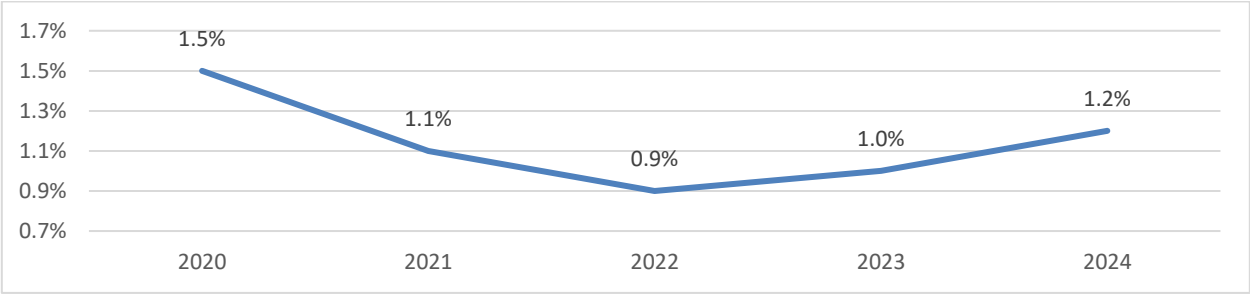


	2020	2021	2022	2023	2024
Diversion Attempt	9.7%	7.7%	7.5%	8.2%	6.3%
ACH In-Reach	7.1%	5.9%	5.2%	5.3%	6.0%
SPH In-Reach	2.4%	2.3%	1.0%	3.5%	1.6%
TCL Housing	10.9%	9.3%	8.3%	8.5%	6.9%
Community	8.6%	7.5%	5.6%	5.7%	4.8%
SPH Outreach	11.2%	11.6%	11.5%	12.4%	11.6%
Transition Planning	5.1%	5.6%	5.3%	6.5%	5.7%
All TCL Settings	9.9%	8.6%	7.6%	8.3%	7.3%

8.2.2.4. Other Crisis Bed Use

As shown in Appendix 10.2, approximately one percent of individuals in supportive housing received Facility Based Crisis services, including 40 individuals during SFY23, and 52 in SFY24. Figure 28 shows the five-year trend in annual rates of housed individuals receiving Facility Based Crisis services, with a minor variation across quarters.

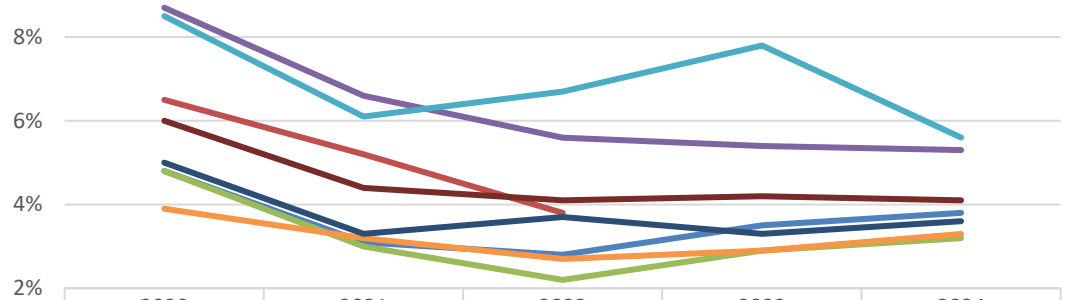
Figure 28. Annual Trends in Housed TCL Member Use of Facility Based Crisis Beds, SFY20-SFY24



8.2.3. TIME SPENT IN CONGREGATE DAY PROGRAMMING

Psychosocial Rehabilitation (PSR) service rates are shown in Appendix. Figure 29 demonstrates the state total percentage of individuals in TCL supportive housing receiving services in congregate day programming settings has remained low after declining steadily prior to SFY21, and this pattern generally applies across LMEs/MCOs.

Figure 29. Annual Trends in TCL Housed Member Psychosocial Rehabilitation Service Rates, SFY20-SFY24



	2020	2021	2022	2023	2024
Alliance	4.8%	3.1%	2.8%	3.5%	3.8%
Cardinal	6.5%	5.2%	3.8%		
Eastpointe	4.8%	3.0%	2.2%	2.9%	3.2%
Partners	8.7%	6.6%	5.6%	5.4%	5.3%
Sandhills	8.5%	6.1%	6.7%	7.8%	5.6%
Trillium	3.9%	3.2%	2.7%	2.9%	3.3%
Vaya	5.0%	3.3%	3.7%	3.3%	3.6%
State Total	6.0%	4.4%	4.1%	4.2%	4.1%

Results of additional Psychosocial Rehabilitation Service claims analysis for individuals in TCL housing are shown in Table 17. TCL Housed Member Time Spent on Congregate Day Programming (Psychosocial Rehabilitation, PSR), SFY23 and SFY24[,]. These results address the requirement to collect and monitor data on time spent in congregate day programming.

Table 17. TCL Housed Member Time Spent on Congregate Day Programming (Psychosocial Rehabilitation, PSR), SFY23 and SFY24[55,56,57]

	SFY23			SFY24		
LME/MCO	**N with PSR**	**Average Hours/ Week**	**Average Duration (Weeks)**	**N with PSR**	**Average Hours/ Week**	**Average Duration (Weeks)**
Alliance	41	13.6	25.1	48	13.4	22.7
Eastpointe	10	18.1	27.5	11	17.2	21.1
Partners	33	13.1	33.0	40	13.8	30.0
Sandhills	37	13.6	23.0	25	15.0	17.6
Trillium	17	11.6	19.0	42	15.9	17.2
Vaya	22	13.1	27.0	29	14.9	22.3
State Total	**163**	**13.5**	**26.0**	**160**	**14.3**	**25.6**

As shown in Figure 30 and Figure 31, the percentage of TCL participants receiving Psychosocial

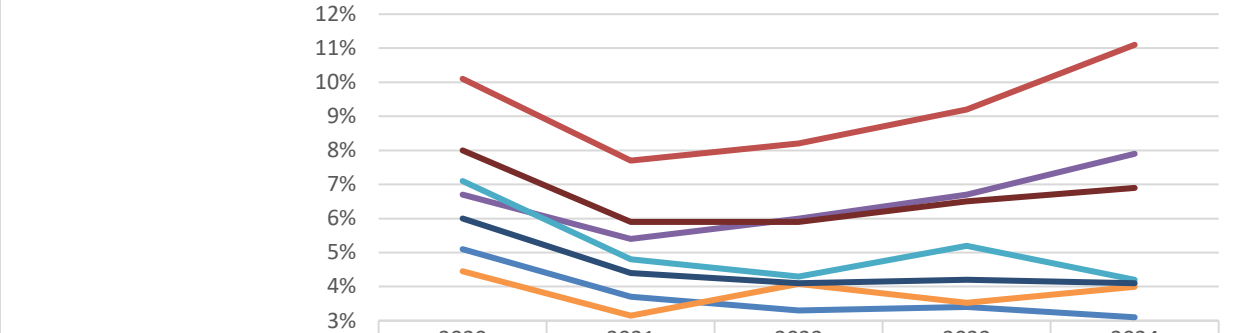
[55] The State Total N is the unduplicated client count.

[56] Duration is calculated as the length of the interval between the earliest and latest PSR service claim dates of service within the calendar year (CY) and during the period the individual was in TCL housing supported by the LME/MCO.

[57] 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.

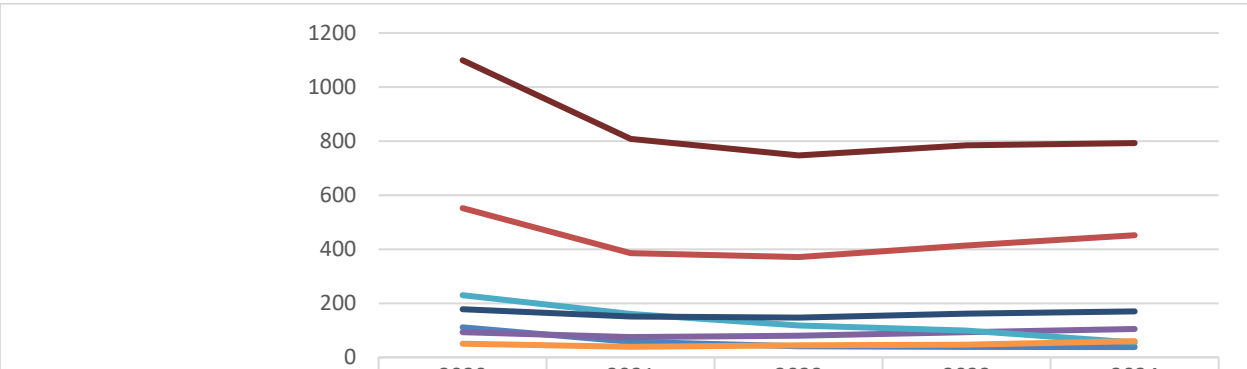
Rehabilitation Services across all statuses has ticked upward slightly after decreasing in SFY20, even though the total number of TCL members remains lower compared to SFY20. The slight upward trend primarily reflects service rates for members residing in ACHs or receiving TCL outreach in the community after SPH discharge. PSR service rates in other TCL statuses and settings have remained stable or decreased.

Figure 30. Annual Trends in Member Psychosocial Rehabilitation Service Rates by TCL Status and Setting, SFY20-SFY24



	2020	2021	2022	2023	2024
Diversion	5.1%	3.7%	3.3%	3.4%	3.1%
ACH In-Reach	10.1%	7.7%	8.2%	9.2%	11.1%
SPH Outreach	6.7%	5.4%	6.0%	6.7%	7.9%
Community w/out TCL Slot	7.1%	4.8%	4.3%	5.2%	4.2%
Transition Planning	4.5%	3.1%	4.1%	3.5%	4.0%
TCL Housing	6.0%	4.4%	4.1%	4.2%	4.1%
All Statuses	8.0%	5.9%	5.9%	6.5%	6.9%

Figure 31. Annual Trends in Members Receiving PSR by TCL Status and Setting, SFY20-SFY24

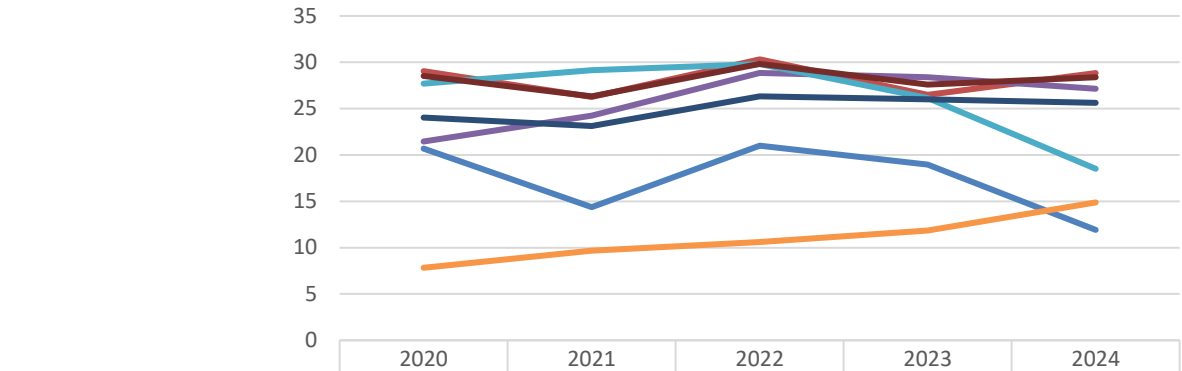


	2020	2021	2022	2023	2024
Diversion	111	57	41	39	38
ACH In-Reach	552	386	371	414	452
SPH Outreach	93	75	80	93	105
Community w/out TCL Slot	230	160	118	99	55
Transition Planning	51	39	45	47	60
TCL Housing	178	151	147	162	170
All Statuses	1099	808	747	785	793

Figure 32 and Figure 33 show, for members who received PSR, the average number of weeks of service per

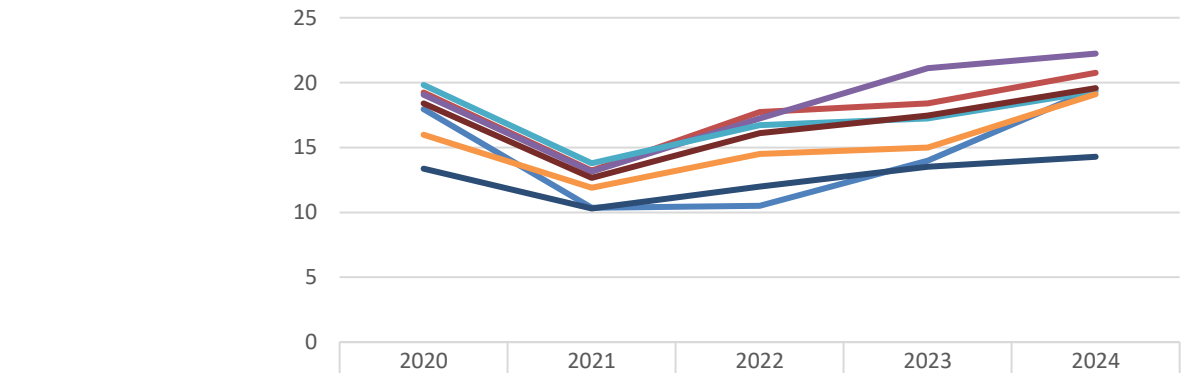
SFY, and the average hours of service per week of service.[58]

Figure 32. Annual Trends in Average Weeks of PSR by TCL Status and setting, SFY20-SFY24



	2020	2021	2022	2023	2024
Diversion	20.7	14.4	21.0	18.9	11.9
ACH In-Reach	29.0	26.3	30.3	26.5	28.8
SPH Outreach	21.5	24.3	28.9	28.4	27.1
Community w/out TCL Slot	27.7	29.1	29.8	26.1	18.5
Transition Planning	7.8	9.7	10.6	11.9	14.9
TCL Housing	24.1	23.1	26.3	26.0	25.6
All Statuses	28.5	26.3	29.8	27.6	28.4

Figure 33. Annual Trends in Average Hours per Week of PSR by TCL Status and Setting, SFY20-SFY24



	2020	2021	2022	2023	2024
Diversion	18.0	10.4	10.5	14.0	19.5
ACH In-Reach	19.2	13.2	17.7	18.4	20.8
SPH Outreach	19.1	13.1	17.2	21.1	22.2
Community w/out TCL Slot	19.8	13.8	16.7	17.3	19.3
Transition Planning	16.0	11.9	14.5	15.0	19.1
TCL Housing	13.4	10.3	12.0	13.5	14.3
All Statuses	18.4	12.7	16.1	17.5	19.6

8.2.4. QUALITY OF LIFE AND COMMUNITY INTEGRATION

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

Table 18 summarizes Pre-Transition, 11-Month, and 24-Month Quality of Life Survey scores for members surveyed during SFY24. Composite Quality of Life (QoL) scores 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. Composite Satisfaction (SAT) scores 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.[59]

State-level results from SFY24 surveys replicate previous year patterns, which have generally shown higher scores among members surveyed in post-transition follow-ups compared to members in pre-transition settings, a nonsignificant difference between 11-month and 24-month scores, and greater gains in satisfaction than in quality of life. Also as in previous years, and as indicated by larger standard deviations (SD), reported satisfaction was considerably more variable across respondents, particularly in the pre-transition survey, than was reported quality of life.[60]

Table 18. Statewide Member Quality of Life and Satisfaction Index Scores before and after Transition to TCL Supportive Housing, members surveyed SFY24

	Pre-Transition	11-Month Follow-Up	24-Month Follow-Up
Quality of Life	83.2 (N=491, SD=13.1)	84.6 (N=333, SD=14.6)	84.5 (N=247, SD=14.4)
Satisfaction	78.7 (N=480, SD=27.1)	89.1 (N=329, SD=18.4)	87.0 (N=246, SD=20.6)

Figure 34 and Figure 35 illustrate the size and direction of differences between pre-transition and post-transition composite survey scores varied by LME/MCO. The largest differences between pre-transition and follow-up QoL and SAT scores were observed for Sandhills members, for whom pre-transition scores also were lowest. Vaya members in TCL housing reported the highest QoL and SAT scores overall.[61]

[59] 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 respondents reported the most positive experience or satisfaction in response to about half of the individual survey questions.

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

[61] All SFY24 surveys submitted by Partners LME/MCO through the State's web-based survey application were submitted as Pre-transition surveys, although 18 percent were submitted documented survey dates later than member projected moving dates. This may account for slightly higher scores for Partners member surveys submitted as Pre-transition surveys.

Figure 34. Quality of Life Index by LME/MCO, SFY24

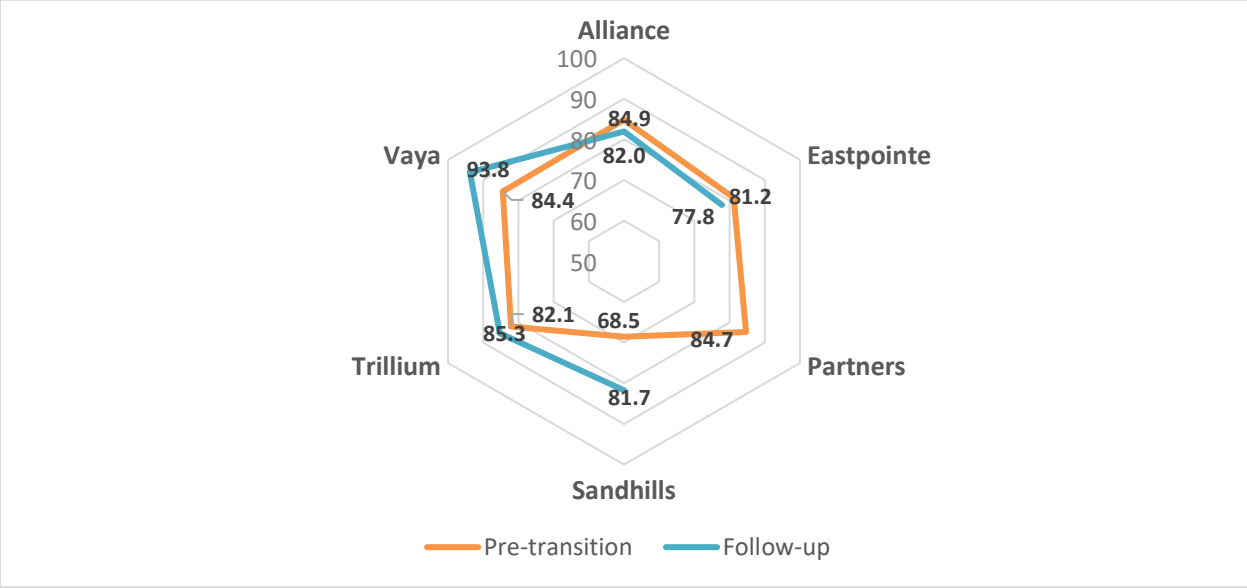
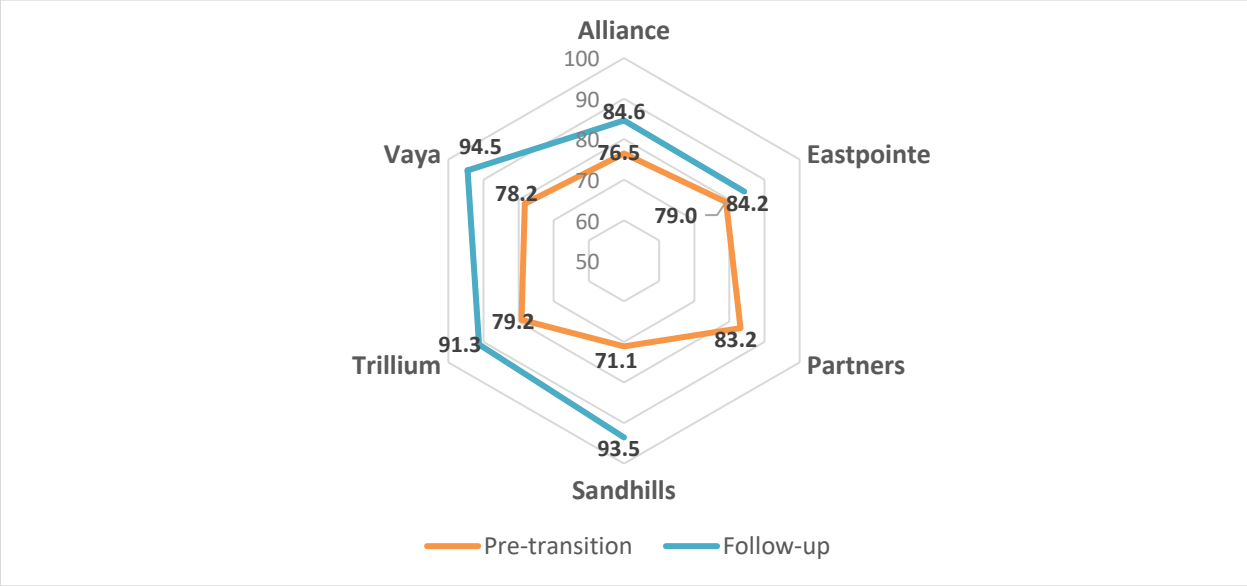


Figure 35. Satisfaction Index by LME/MCO, SFY24



Additional member outcomes measures related to quality of life and community integration 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.[62,63] NC-TOPPS assessments are facilitated by service providers and administered upon service admission, at regular intervals (three months, six months, 12 months, and every six months thereafter), and

[62] NC Treatment Outcomes and Program Performance System (NC-TOPPS) dashboards and methodology are available on this webpage: 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

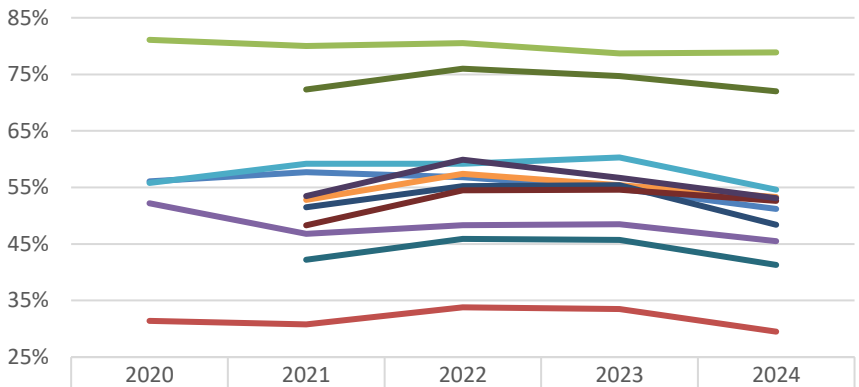
[63] A subset of measures is only available from SFY21, when additional assessment items were added to NC-TOPPS interviews to support TCL monitoring of aspects of member community integration.

again upon treatment discharge.

NC-TOPPS 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). Assessment data therefore are available for most individuals in TCL supportive housing, although not every member of housing during some or all of a particular reporting period will have been assessed during the same reporting period.

Figure 36 illustrates annual assessment results for an alternate Quality of Life measure that is based on NC-TOPPS interviews with members in housing. A composite NC-TOPPS QoL measure is derived from assessment items that correspond to the 10 specific components listed. 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 who reported doing "excellent" or "good" in seven or more of the 10 areas assessed.

Figure 36. Participants Who Reported High Quality of Life (Doing "Excellent" or "Good") Across Quality-of-Life Domains, SFY20-SFY24[64,65]



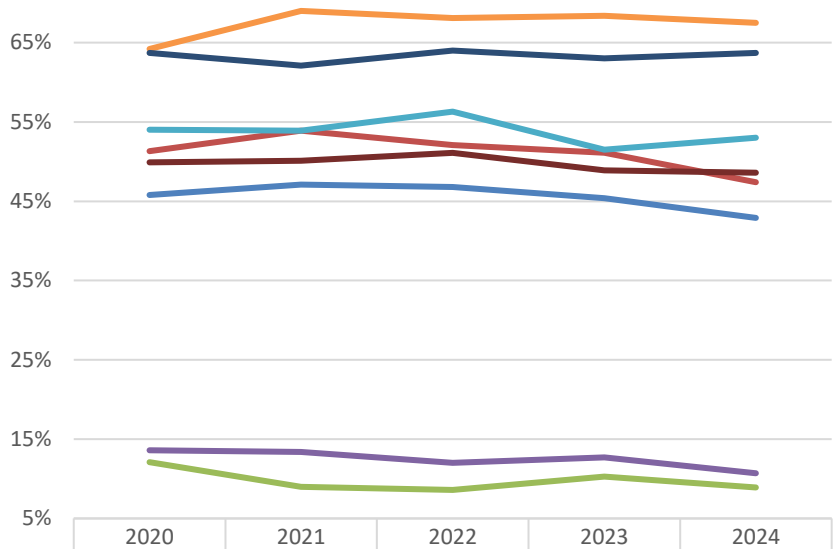
	2020	2021	2022	2023	2024
Emotional well-being	56%	58%	57%	55%	51%
Employment/education	31%	31%	34%	34%	30%
Living/housing situation	81%	80%	81%	79%	79%
Physical health	52%	47%	48%	49%	46%
Relationships with family or friends	56%	59%	59%	60%	55%
Doing things I enjoy		53%	57%	55%	53%
Feeling connected to others		52%	55%	55%	48%
Getting out into my community		48%	55%	55%	53%
Seeking help or support when I need it		72%	76%	75%	72%
Spending time with people who support my recovery and wellness		54%	60%	57%	53%
Composite QoL (excellent or good in 7-10 areas)		42%	46%	46%	41%

[64] Five of the ten component items were added to the NC-TOPPS assessment in SFY21 to support TCL monitoring and reporting. Values for those five items and the composite QoL measure are not available prior to SFY21.

[65] SFY24 values are based on NC-TOPPS interviews with 1,247 members in TCL Housing.

Figure 37 shows percentages of housed members who reported their services had been "very helpful" versus "somewhat helpful" or "not helpful" with each of seven outcomes at the most recent NC-TOPPS assessment during the year. The composite Service Helpfulness measure is the calculated percentage of participants who indicated services had been "very helpful" with 70 percent or more of the number of outcomes they rated.

Figure 37. NC-TOPPS Participants Who Reported a High Level of Program Services Helpfulness (Very Helpful) for Achieving Positive Outcomes, SFY20-SFY24[66]

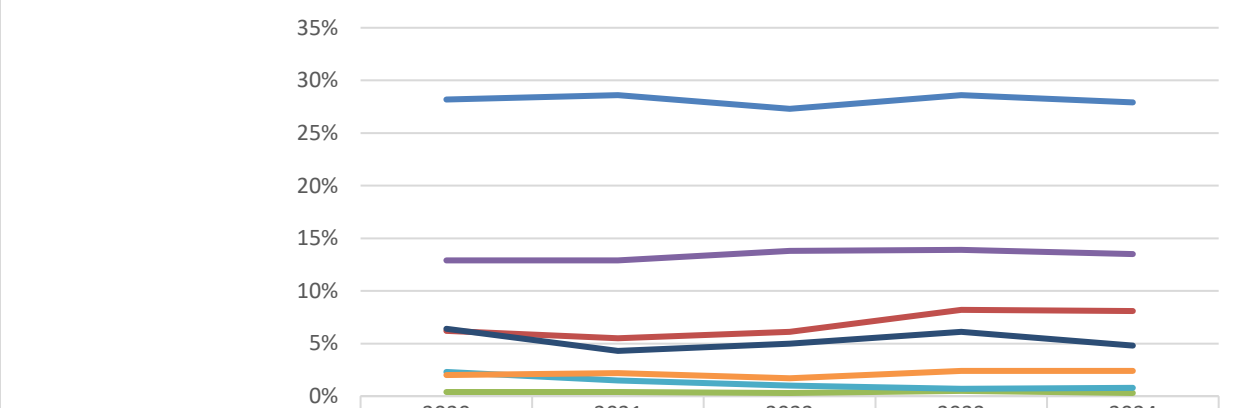


	2020	2021	2022	2023	2024
Composite Service Helpfulness	46%	47%	47%	45%	43%
Increasing your control over your life	51%	54%	52%	51%	47%
Improving your educational status	12%	9%	9%	10%	9%
Improving your employment status	14%	13%	12%	13%	11%
Increasing your hope about the future	54%	54%	56%	52%	53%
Improving your housing status	64%	69%	68%	68%	68%
Improving the quality of your life	64%	62%	64%	63%	64%
Decreasing your symptoms	50%	50%	51%	49%	49%

[66] SFY24 values are based on NC-TOPPS interviews with 1,239 members in TCL Housing.

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 Service related (access, treatment didn't meet needs).

Figure 38. NC-TOPPS Participants Who Reported Barriers to Treatment at the Most Recent Assessment, SFY20-SFY24[67]

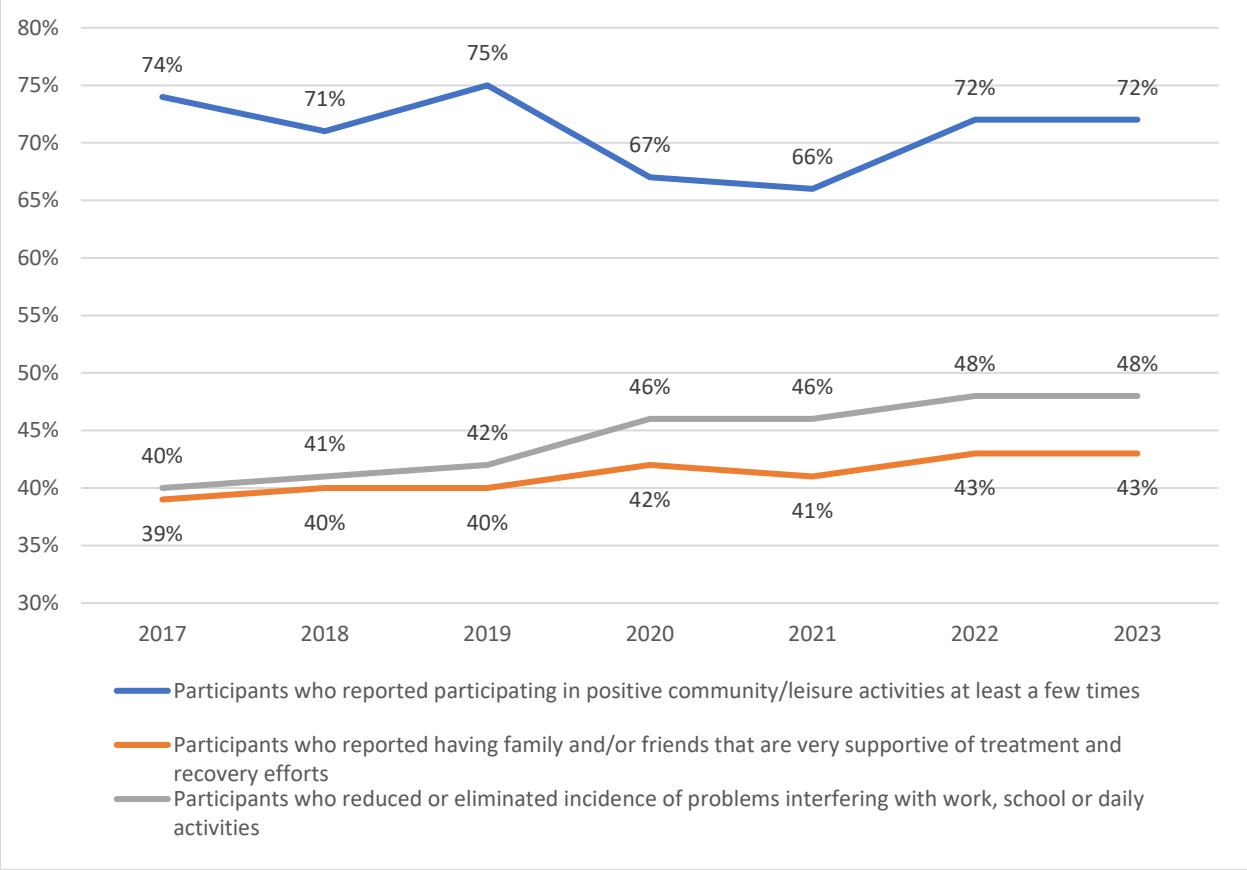


	2020	2021	2022	2023	2024
Behavioral health barrier	28%	29%	27%	29%	28%
Health (non-BH) barrier	6%	6%	6%	8%	8%
Communication barrier	0%	0%	0%	1%	0%
Engagement barrier	13%	13%	14%	14%	14%
Service barrier	2%	2%	1%	1%	1%
Social barrier	2%	2%	2%	2%	2%
Environmental barrier	6%	4%	5%	6%	5%

[67] SFY24 values are based on NC-TOPPS interviews with 2,387 members in TCL Housing.

Figure 39 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 39. NC-TOPPS Participants Who Reported Positive Community Integration Outcomes at Most Recent Assessment, SFY20-SFY24[68]

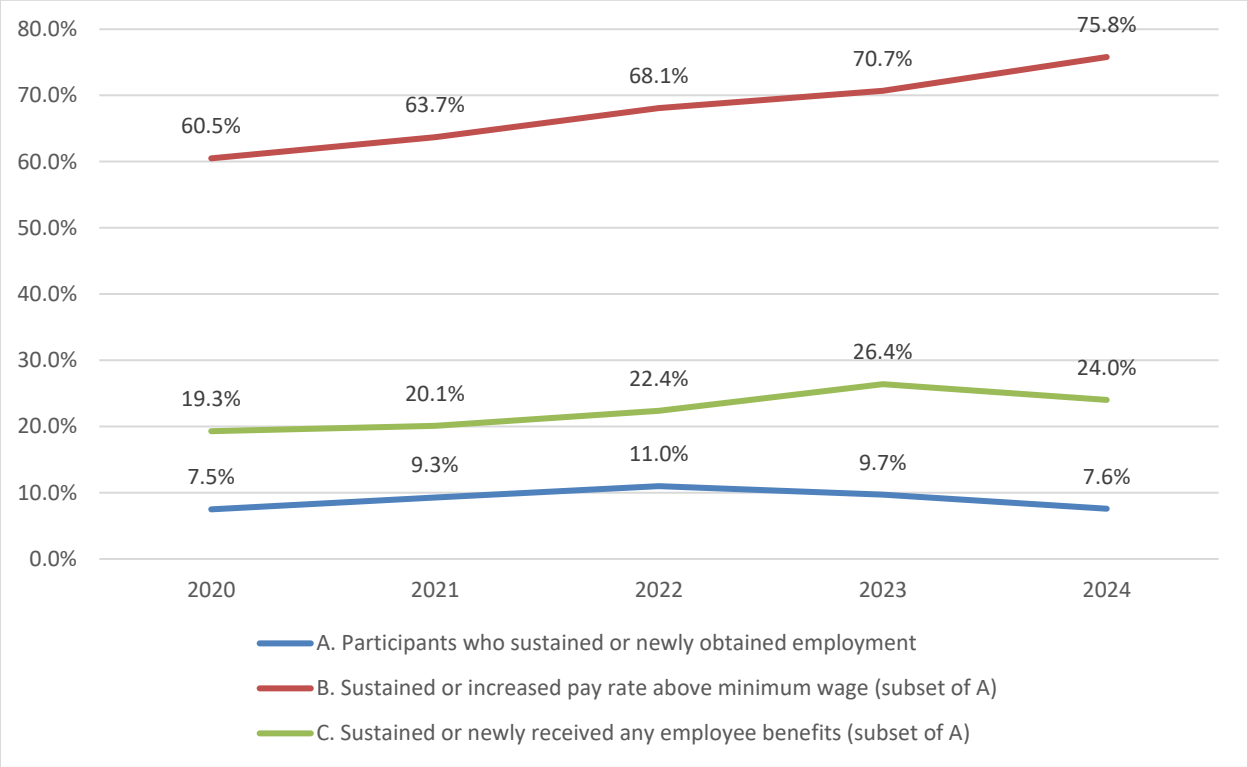


[68] SFY24 values for "problems interfering" and "community activities" measures are based on NC-TOPPS interviews with 2,387 members in TCL Housing; "supportive of recovery" measure is based on interviews with 1,247 members.

Figure 40 shows the percentage of NC-TOPPS participants who maintained or had become newly employed at their most recent assessment. Percentages shown of those who maintained or gained above minimum wage pay rates and employee benefits such as insurance and paid time off are subsets of members employed. Of note, employed members who sustained or gained an above minimum wage pay rate increased by more than 15 absolute percentage points over the five-year period.

Not shown, each SFY beginning in 2021, two percent or less of TCL housed respondents 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 40. NC-TOPPS Participants Who Reported Positive Employment Outcomes at Most Recent Assessment, SFY20-SFY24[69]



[69] SFY24 values are based on NC-TOPPS interviews with 2,387 members in TCL Housing, 182 of whom had sustained or newly obtained employment.

8.2.5. INCIDENTS OF HARM

Adverse incidents involving individuals receiving mental health, developmental disabilities and/ or substance use services are reported through the State's web-based Incident Response and Improvement System (IRIS). 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 that 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, unplanned absence, and inappropriate sexual, aggressive, destructive, or illegal behavior); Suspension/Expulsion from services; and Fire.

Incidents involving TCL participants are retrieved, reviewed, and reported in aggregate monthly using a query that matches reported IRIS incidents to a reference file of unique member Common Name Database Services (CNDS)[70] identifiers for members who were in TCL housing.

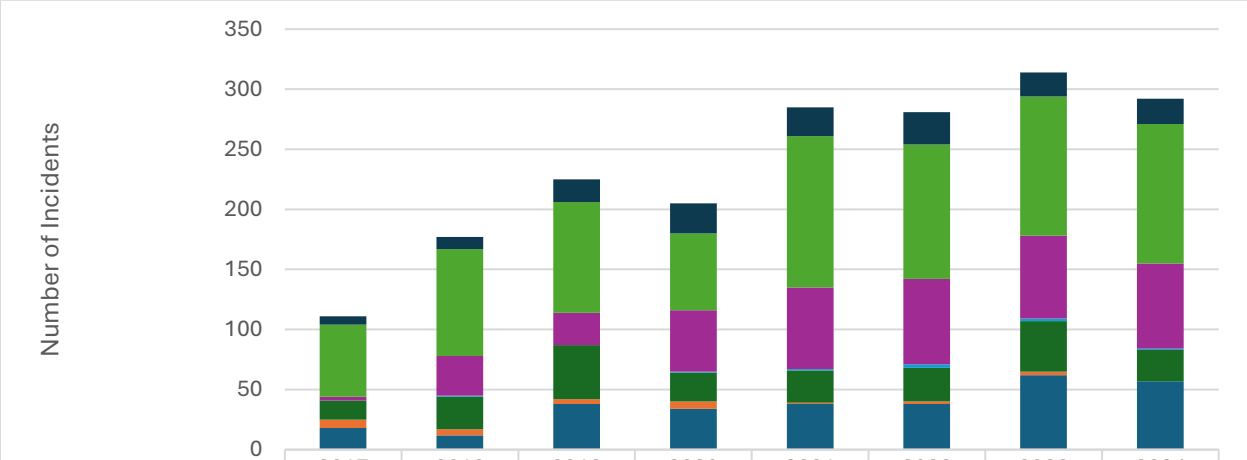
This annual report used a full IRIS database extract for SFY17 through SFY24 to retrospectively identify housed TCL member provider reported incidents based on CNDS matches, as well as incidents that were not captured in previous incident query results and reporting due to missing or incorrect CNDS numbers in submitted reports.[71] Figure 41 shows full results of this analysis from SFY17 through SFY24.

Across the previous eight state fiscal years, and in each of the five years beginning 2020, the most frequently reported incident type related to consumer behavior, followed by member deaths, which constituted 38 percent and 24 percent of reported incidents, respectively, across the most recent five-year period. Not shown, in the two-year period including SFY23 and SFY24, 35 percent of incidents related to consumer behavior, and 14 percent of all incidents, involved incident subtypes of aggressive, destructive, and/or illegal acts. Suicide attempts constituted nine percent of consumer behavior related incidents, and 3.5% of all reported incidents.

[70] For Medicaid beneficiaries, the CNDS number is also the Medicaid ID.

[71] A "fuzzy matching" technique was used to identify identical or close matches between member dates of birth and first and last names documented in incident reports and administrative TCL member data from NCTracks. An algorithm-based match score ranging from zero to one was assigned to assess the level of similarity between data strings from the two sources. For this project, incidents were treated as TCL member incidents if the match score was greater than or equal to 0.75. Selection of the 0.75 threshold was based on qualitative review of the visual similarity of data elements and steep drop-off in true matches below this value.

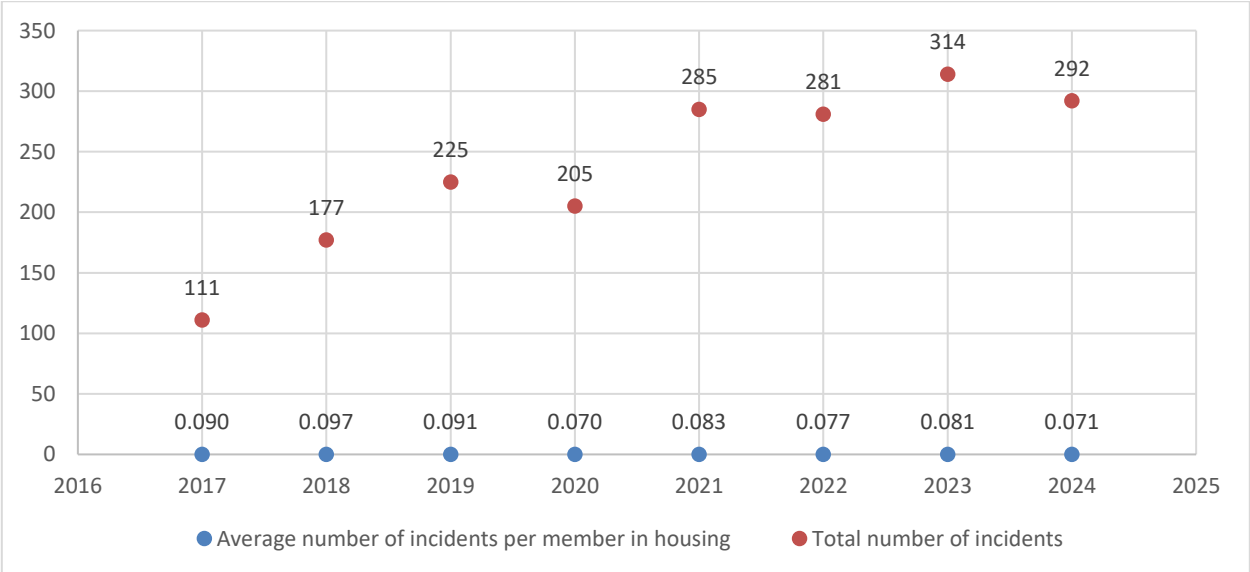
Figure 41. Retrospective Summary of TCL Housed Member Adverse Incidents by Incident Type



	2017	2018	2019	2020	2021	2022	2023	2024
Abuse	7	10	19	25	24	27	20	21
Consumer Behavior	60	89	92	64	126	112	116	116
Death	3	33	27	51	68	71	69	71
Fire		1		1	1	3	2	1
Injury	16	27	45	24	27	28	42	26
Medication Error	7	5	4	6	1	2	3	
Other	18	12	38	34	38	38	62	57

Figure 42 demonstrates that the total raw count of reported incidents among housed TCL members has increased over state fiscal years as the number of members in housing increased, the average number of incidents per member in housing has decreased. Average incidents per member dropped in SFY20 to 0.07, approximately seven incidents for every 100 members in housing during the year, and the average has remained lower compared to the three previous years, representing a relative reduction of approximately 18 percent for the SFY20 to SFY24 period compared to SFY17 to SFY19.

Figure 42. Retrospective Summary of TCL Housed Member Adverse Incident Totals and Average Incidents per Member



8.3. KEY FOCUS AREAS AND PRIORITIES FOR SFY25

The NCDHHS TCL team, dedicated to quality assurance and performance improvement, has identified several key priority strategies for SFY25:

- QAPI support for TCL CMH Services: Provide instrumental support for State team activities including performance measure development, data tracking, and development of processes improvements and interventions, as well as technical assistance to LME/MCOs focused on improving service quality and TCL member outcomes
- Support for LME/MCO TCL QAPI planning and activities: Continue work implemented in SFY24 to support LME/MCOs to meet Medicaid contract requirements related to TCL QAPI, including targeted technical assistance to identify and address QAPI system gaps and improve QAPI processes, interventions, measurement, data use, and documentation
- Expand scope of SFY25 EQR TCL reviews: Collaborate with DHB and HSAG to amend scope to include all TCL review activities included in previous EQRO contract and additional activities related to new PIHP and TP Medicaid contract requirements for TCL around Tailored Care Management (TCM) and QAPI planning

9. CONCLUSION

The North Carolina TCL program has made significant strides in transitioning individuals with serious and persistent mental illness from institutional settings to community living. Progress achieved across the six key pillars—Community-Based Housing, Community-Based Mental Health Services, Supported Employment, Discharge & Transition Process, Pre-Admission Screening & Diversion, and Quality Assurance & Performance Improvement—demonstrates the program's commitment. The collaborative efforts of various key partners, including LME/MCOs, HUD, PHAs, SPHs, NCHFA, USDOJ, and the Independent Reviewer, have been instrumental in achieving the program's goals. The data and analysis provided in this report highlight the positive outcomes and areas for improvement, ensuring the TCL program continues to evolve and meet the needs of individuals with SPMI.

Throughout SFY24, the TCL program showed marked progress in several areas:

- The **increase in individuals utilizing community-based housing slots** has provided more individuals with stable and supportive living environments. Specifically, 3,645 individuals are now living in permanent supportive housing, and 902 new individuals received housing slots in SFY24. Additionally, the Housing Pilot experimentation and engagement with Public Housing Authorities have further strengthened the program's housing initiatives.
- The TCL program made several advancements in community-based mental health services. The **finalization of the TCL Capacity Report** template and the provision of technical assistance and training to providers improved the measure of the quantity of services offered. The UNC IBP provided 79 training sessions attended by 2,900 individuals. The steady percentage of TCL individuals receiving ACT services and the overall high percentage of individuals receiving ACT, TMS, CST, or Peer services reflect the work on improving access to comprehensive mental health support.
- **Supported employment** saw notable improvements, with 2,796 individuals receiving IPS services as of June 2024 and a 43% average competitive, integrated employment rate. The implementation of the standardized NC CORE payment model and the targeted employment engagement campaign successfully connected more individuals with meaningful employment opportunities, contributing to their overall well-being and independence.
- Improved monitoring, technical assistance, and the development and hiring of two new field staff at NCDHHS strengthened the **discharge and transition process**. The decrease in overdue reassessments from 892 in SFY24Q3 to 531 in SFY24Q4 and the increase in face-to-face in-reach contacts to 62.4% in SFY24Q4 demonstrate the program's progress in facilitating smooth and person-centered transitions from institutional settings to community living.
- **Pre-admission screening and diversion efforts** were bolstered by the timely completion of screenings within 30 days and a 27% increase in individuals diverted who remained in the community. Monthly quality reviews helped to confirm non-diverted individuals receive appropriate support and services, further enhancing the program's effectiveness.
- **Quality assurance and performance improvement** advances included completion of a TCL QAPI Plan and ongoing operation of the core processes described therein, encompassing enhancements to TCL data systems for improved outcomes monitoring, systematic aggregation and analysis of data to inform QAPI actions and initiatives, and quality measure monitoring and performance improvement action cycles. The state's QAPI efforts were expanded through new contract requirements for LME/MCO processes and activities focused on TCL services and supports, program functions and operations, member outcomes, and data and reporting. Implementation of new barriers tracking and resolution processes further contributed to the program's continuous improvement.

As we look ahead to SFY25, the TCL program aims to continue building and sustaining a system where individuals with SMI and SPMI can live their best lives in their chosen communities:

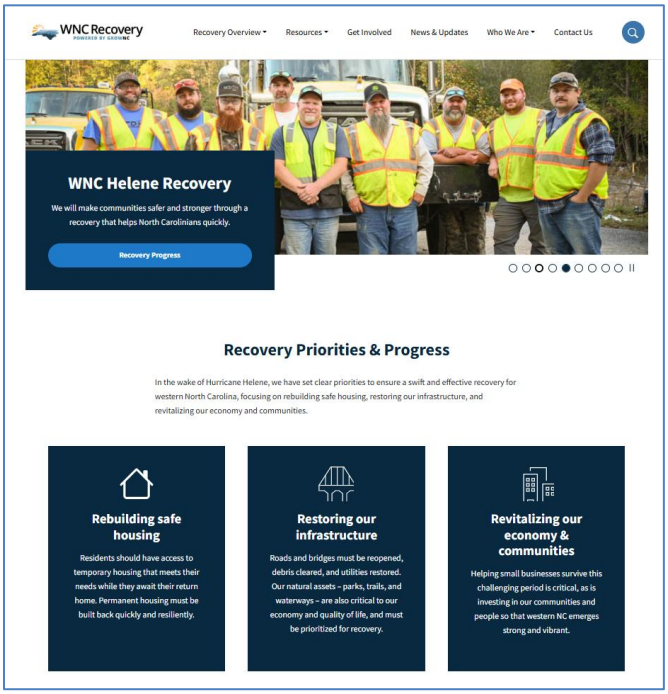
- **Community-Based Housing**: The TCL program will expand the Housing Pilot Program to include Trillium and Partners LME/MCOs. Engagement with NC's Public Housing Authorities will continue to address housing needs and enhance financial sustainability through federal vouchers. Access to bridge options will be increased by working to expand hotel bridge and enhanced bridge programs statewide.
- **Community-Based Mental Health Services**: The TCL program will focus on improving the quality and effectiveness of Person-Centered Planning (PCP) processes. The capacity and effectiveness of community-based mental health service providers will be enhanced through coaching, technical assistance, and targeted training. Community integration and peer support will be enhanced by the development of Community Inclusion projects, expanding training opportunities for peer support specialists, and increasing the number of CPPS.
- **Increasing Face-to-Face Engagement:** The TCL program will increase the quantity of CPSS face-to-face in-reach contacts . Efforts will be made to reduce the ACH in-reach list to identify non-TCL eligible individuals. Collaboration with LME/MCOs will continue to offer annual In-Reach Professional Development Conferences and create a peer-led community of practice (CoP) for collective learning and interaction. The program will also work on decreasing peer caseload ratios to allow targeted in-reach and address barriers to transition.
- **Supported Employment:** The TCL program will collaborate with LME/MCOs to address waiting times for 1915(i) assessments, increase access to IPS, and provide education on IPS services. A centralized IPS Landing Page will be developed for training, guidance, and information. North Carolina will be integrated into the DB101 platform to help individuals with disabilities understand the impact of employment on benefits. The program will also expand high-performing Integrated Behavioral Health and Supported Employment providers by offering startup funds to develop integrated teams.
- **Strengthening Discharge Planning**: The TCL program will enhance person-centered transition planning across community and State Psychiatric Hospitals (SPHs). This includes utilizing In-Reach/TCL Tool information to structure transition team planning and inform Person-Centered Plans (PCPs). Multiple technical assistance and training sessions will be conducted for TCL transition coordination staff to support effective discharge planning. Additionally, the program will focus on reducing transition time by removing barriers, providing written and technical assistance on coordinated tasking and tracking of transition team actions, and mapping out each Plan's transition process to identify efficiencies and best practices. Improvements will be made using current transition time data.
- **Expanding Quality Assurance and Performance Improvement Initiatives**: Finalizing a comprehensive plan describing the state's TCL QAPI system and core operating processes will address the last significant remaining settlement agreement requirement related to QAPI.[72] Expansion of the scope of the External Quality Review (EQR) process to cover TCL reviews will further enhance the program's quality assurance efforts. The state will continue to work with LME/MCOs to strengthen regional TCL QAPI systems through ongoing monitoring and technical assistance and support to meet contract requirements implemented in SFY24. The scope of state level efforts will also be expanded to include enhanced collaboration and instrumental support for state TCL mental health services team activities and QAPI efforts in other program pillars.

[72] The NCDHHS TCL QAPI Plan was finalized in September 2024. The Plan will be reviewed annually and updated as needed to reflect structural changes and process modifications.

The State of North Carolina places a high priority on the TCL program, underscoring its commitment to ensure individuals with SMI and SPMI can live in integrated community settings. This work and dedication have informed other initiatives under the **NCDHHS Olmstead Plan**, including Inclusion Connects, Inclusion Works, Justice Involved, and Psychiatric Residential Treatment Facilities (PRTF) initiatives. Our collective experience in implementing diversion from institutional settings, developing access to housing, generalizing the use of housing vouchers, contracting with LME/MCOs and key partners is now leveraged to fast-track these other important initiatives. The 2024-25 North Carolina Olmstead Plan[73] focuses on several priorities: increasing opportunities for community inclusion through access to Medicaid Waiver Home and Community-Based Services (HCBS), diverting and transitioning individuals from unnecessary institutionalization, addressing gaps in community-based services, promoting Competitive Integrated Employment (CIE), and supporting successful reentry for individuals involved in the criminal justice system.

Finally, the TCL program faced **significant challenges due to Hurricane Helene in October 2024**[74], particularly in regions managed by Vaya and Partners LME/MCOs. Hurricane Helene brought catastrophic damage to North Carolina, affecting millions of residents and impacting on our TCL population living in this area, as well as local providers and partners. The NCDHHS provided behavioral health resources, crisis counseling, and disaster assistance to those impacted. Despite these obstacles, Vaya and Partners exhibited remarkable determination in safeguarding TCL members, and their efforts are deeply appreciated.

Figure 43. Western North Carolina was severely impacted by Hurricane Helene in October 2024, and NCDHHS, along with the state of North Carolina, are still actively working on recovery efforts.



Recovery in this region remains a top concern, and we are committed to ensuring TCL members are supported and receiving the options they need.

[73] For more information on the 2024-25 Olmstead Plan, please visit this website: https://www.ncdhhs.gov/about/administrative-offices/office-secretary/nc-olmstead

[74] For more information on the state's recovery efforts and resources, please visit the North Carolina Recovery website at https://www.wncrecovery.nc.gov/ .

10. APPENDIX

10.1. SFY24 BUDGET

In SFY24, the TCL Team implemented strategic budget management practices to confirm effective allocation, monitoring, and optimization of funds. The team successfully carried out the following key budget activities:

- **Strategic Financial Planning** – Allocated funds based on operational priorities, contractual commitments, and continuous improvement initiatives to enhance program sustainability and effectiveness.
- **Proactive Expenditure Monitoring** – Conducted monthly expenditure assessments to resolve any shortfalls and identify emerging needs, allowing for timely budget reallocations and additional funding for program optimization.
- **Quarterly Financial Reviews** – Collaborated with Managed Care Organizations/ and DMH/DD/SUS to track financial forecasting, evaluate expenditures, and implement necessary budgetary adjustments.
- **TCL Incentive Plan Implementation** – Continued administering performance-based incentives to LME/MCOs, rewarding target achievements in net housing transitions, net Adult Care Home (ACH) transitions, Targeting/Key Utilization, and separation rate improvements.

The TCL budget increased in SFY24 due to rising costs associated with rental assistance, operational needs, and other essential expenditures to sustain program progress and enhance performance outcomes. A comparative analysis of budget expenditure is as follows:

- SFY22 Actual Expenditures: $63,059,019
- SFY23 Actual Expenditures: $71,954,019
- SFY24 Actual Expenditures: $81,365,996

The year-over-year increase reflects the program's commitment to expanding access, improving service delivery, and meeting the evolving needs of individuals transitioning to community living.

Table 19. Key Expenditures Comparison

Cost Category	Total	
	SFY23	SFY24
Rental Assistance	$ 33,933,809	$ 35,626,077
DMH LME/MCO Costs	$ 17,623,516	$ 16,093,251
Medicaid LME/MCO Cost	$ 13,262,558	$ 16,403,147
NCDHHS Staffing and Operational Costs	$ 505,423	$ 732,544
Contracts	$ 1,032,166	$ 6,130,183
Olmstead Planning	$ 25,930	$ 88,907
TCL Incentives	$ 5,570,617	$ 6,291,887
Total	**$ 71,954,019**	**$ 81,365,996**

Table 20. Breakdown of Budget By LME/MCO's for SFY24

TCL Service	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya
Transition Year Stability Resources (TYSR)	$ 510,000	$ 90,000	$ 225,000	$ 180,000	$ 225,000	$ 270,000
Community Living Assistance (CLA)	$ 1,054,000	$ 186,000	$ 465,000	$ 372,000	$ 465,000	$ 558,000
Emergency Housing Funds	$ 119,000	$ 21,000	$ 52,500	$ 42,000	$ 52,500	$ 25,285
MCO Transition Coordinators	$ 180,000	$ 90,000	$ 90,000	$ 90,000	$ 180,000	$ 180,000
Bridge Housing	$ 850,000	$ 150,000	$ 375,000	$ 300,000	$ 375,000	$ 322,430
Mental Health Services	$ 1,273,628	$ 239,986	$ 762,906	$ 432,000	$ 839,991	$ 1,170,796
Supported Employment	$ 575,000	$ 125,000	$ 340,000	$ 170,000	$ 420,000	$ 370,000
In-Reach Collab/Com Inclusion	$ 227,865	$ 0	$ 284,034	$ 0	$ 0	$ 0
Subsidy Administration	$ 180,000	$ 90,000	$ 90,000	$ 90,000	$ 170,000	$ 180,000
Diversion	$ 696,000	$ 226,500	$ 427,500	$ 294,000	$ 456,000	$ 841,000
Assertive Engagement	$ 34,000	$ 0	$ 15,000	$ 23,997	$ 15,000	$ 18,000
TCL Incentive Payments	$ 1,697,000	$ 22,500	$ 1,296,438	$ 45,000	$ 1,656,995	$ 1,573,954
Enhanced Bridge*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 155,316
Totals	**$ 7,396,493**	**$ 1,240,986**	**$ 4,423,378**	**$ 2,038,997**	**$ 4,855,486**	**$ 5,664,781**

*Funding for this Service is provided through the American Recovery and Reinvestment Act (ARPA) for Home and Community-Based Services (HCBS).

10.2. REPORTING ON SERVICE PATTERNS

OVERVIEW

This section addresses the requirement for the State to publish an annual report identifying the number of people served in each TCL setting and service. Annual statewide service summaries are updated to include data for the previous two full state fiscal years; full SFY23 and SFY24 summaries by LME/MCO also are presented.[75]

Service summaries are based on EPS and NCTracks Medicaid and DMH/DD/SUS adjudicated behavioral health service claims for the TCL participant populations described in Table 21 [76,77]

Table 21. SFY23 and SFY24 TCL Participant Populations by Status and Setting[78]

Participant Status and Service Setting	Description	SFY23	SFY24
TCL Supportive Housing	Individuals in TCL supportive housing during the reporting period	3,897	4,171
Transition Planning[79]	Individuals with approved TCL supportive housing slots who had an initial transition attempt in progress	1,028	1,142
Rehousing Planning	Individuals separated from TCL supportive housing who had a subsequent transition attempt in progress	304	361
ACH In-Reach	Individuals residing in an Adult Care Home	4,522	4,081
SPH In-Reach	Individuals residing in a State Psychiatric Hospital	570	674
SPH Outreach	Individuals residing in the community after SPH discharge	1,398	1,331
Diversion	Individuals who had an Adult Care Home Diversion attempt in progress	1,138	1,240
Living in the Community without a TCL Housing Slot	Individuals living in community settings other than TCL supportive housing	1,899	1,300
Unduplicated Total	**Total count of TCL participants, each counted once regardless of transitions across setting and status**	**12,074**	**11,437**

Data tables in the remainder of this section show, by the TCL statuses and settings described in Table 22, statewide annual percentages of individuals who received services, and numbers and percentages by

[75] The SFY23 annual report included full-year service summaries through SFY22 and, because full-year data were not yet available for SFY23, quarterly data for the six quarters through SFY23 Q2. As the SFY24 annual report was produced later in the calendar year (CY) compared to previous annual reports, with greater claims lag after the end of the report year, annual service summaries in this report are updated to include two additional full year summaries, for SFY23 and SFY24, rather than partial year quarterly data for SFY24. Apart from this report, quarterly service summaries also are shared with the Independent Reviewer on an ongoing basis.

[76] EPS is the NCDHHS Encounter Processing System for Medicaid Managed Care service encounter claims. Effective April 1, 2023, EPS is the source of Medicaid institutional and professional services data. NCTracks is the previous multi-payer Medicaid Management Information System for the NCDHHS and the current system for processing state-funded 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.

[77] Reporting for SPH In-Reach and Outreach was combined in previous annual reports.

[78] Population counts for each category include all individuals with the status at any time during the state fiscal year. Individuals with status changes during the year are included in population counts for each one that applied. In service summaries that follow, sums of individual counts per setting may exceed the unduplicated totals.

[79] Where the housing slot was assigned fewer than 90 days before the initial lease start date, the transition planning period for the purpose of this services summary is operationalized as the 90 days before the transition to supportive housing.

LME/MCO of individuals who received services within the date range of status periods.

Table 22. Service Categories

Service Category	Services Included
ACT	• Assertive Community Treatment Team
CST	• Community Support Team
Transition Management and Tenancy Support Services (TMS)	• Tenancy Management Supports (TMS) • Critical Time Intervention (CTI) • b(3) Individual Supports and 1915(i) Individual and Transitional Supports
PSS	• Peer Support Services
Any Core Service	• Any of ACT, CST, TMS, or PSS
AES	• State-Funded Assertive Engagement Service (AES)
IPS-SE	• Individual Placement and Support-Supported Employment (IPS-SE) • b(3) IPS-SE, and 1915(i) IPS-SE
PSR	• Psychosocial Rehabilitation Services
Psychological Diagnostic, Evaluation, and Testing (PsyDx/Texting)	• Neuropsychological Testing and Evaluation • Psychological Testing and Evaluation • Psychiatric Diagnostic Evaluation
Evaluation & Management Office and Outpatient Visits (E&M)	• New and Established Patient Office/Outpatient Visits • Office Consultations • Behavioral Health Counseling • Outpatient Psychiatric Services • Mental Health Partial Hospitalization
Psychotherapy	• Individual Psychotherapy • Group Psychotherapy • Family Psychotherapy • Outpatient Dialectical Behavior Therapy (Group and Individual) • Psychosocial Rehabilitation Services
Substance Use Services and Treatment (SUD)	• Alcohol/Drug Group Counseling, Halfway House, and Residential • Ambulatory, Inpatient, and Social Setting Detox • Counseling for smoking and tobacco use • Medication Assisted Treatment (MAT) • Substance Abuse Comprehensive Outpatient Treatment (SACOT) • Substance Abuse Intensive Outpatient Treatment (SAIOP)
MCM	• Mobile Crisis Management
FBC	• Facility-Based Crisis

DATA INTERPRETATION

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 EPS and NCTracks were processed through the NCDHHS TCL Dashboard. The following notes are provided to assist with data interpretation.

- Annual service rates reflect claims adjudicated through September 2024. Timely filing limits may affect data completeness, especially for services provided late in SFY24.
- Service rates are based on counts of all TCL participants per status documented in TCLD and CLIVe during the reporting period indicated.
- Statewide client counts and service rates may include a small amount of duplication due to client LME/MCO transfers within measurement periods.
- Shifts in LME/MCO client counts over state fiscal years are due in part to the February 2024 County realignments and LME/MCO consolidation.[80]
- Related to the February 2024 LME/MCO consolidation, observable increases and decreases in some LME/MCO service rates across state fiscal years may reflect changes in the composition of their member populations rather than, or in addition to, an underlying change in performance.
- Medicaid and State-funded IPS-SE services provided under the NC CORE value-based payment model are reimbursed only when member service milestones are achieved. IPS-SE services paid by EIPD are not submitted to EPS or NCTracks. As a result of these two factors, client service counts and rates derived from paid claims underestimate numbers of individuals who received IPS-SE services during each measurement period.
- TCL Performance Data Dashboard undergoes continuous quality assurance review 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.

SUMMARY OF SERVICE TRENDS

The following are summaries of noteworthy patterns observed in the most recent analysis of service claims data:

- Statewide, ACT service rates are higher than lower intensity CST, TMS, and peer-support services for members in TCL housing.
- Over a five-year period, CST surpassed ACT as the service most provided for members planning for the initial transition to supportive housing, while TMS rates declined for this group.
- ACT service rates continue to be higher than CST and TMS rates for members planning for rehousing after a separation.
- Use of standalone crisis services such as Facility Based Crisis and Mobile Crisis Management remained low across statuses and settings.[81]
- Housed TCL member FBC and MCM crisis service rates declined over the previous five-year period, even as inpatient admissions and length of stay and ED visit rates decreased for this population (see Section 8.2. SFY24 Supporting Data).
- Apparent downward trends in IPS-SE service rates for members in some TCL statuses and settings in part reflect implementation of the North Carolina Community Outreach and Resource Engagement (NC-CORE) value-based model, in which services are billed only when service milestones are achieved. In contrast, the cumulative number of individuals in or at risk of ACH admission who have received any stage of IPS services has increased (see Section 5.2.).
- Percentages of participants receiving services in congregate day programming through Psychosocial

[80] Eastpointe and Sandhills SFY24 client counts include members served during the first seven months of the year and are generally lower than SFY23 counts. Alliance, Partners, Vaya, and especially Trillium client counts generally increased during SFY24 due to member transfers.

[81] Service claims data do not capture crisis services provided by ACT and CST teams to members receiving those services.

Rehabilitation Services remained low across participant statuses and settings and were highest for members in ACH In-Reach, followed by members in SPH Outreach.

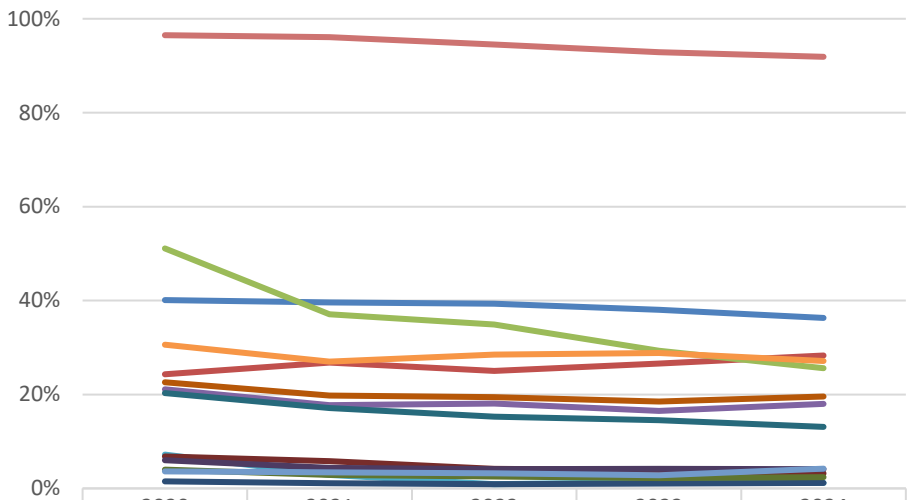
- ACT service rates during ACH In-Reach remained stable over a five-year period.
- Members in In-Reach status remained least likely to receive Substance Use Disorder services.
- Peer Support Service rates were highest for members in TCL supportive housing, followed by members in Diversion status and those planning for rehousing after separation.
- Members previously discharged from SPHs and receiving outreach in the community were more likely to receive core TCL services such as ACT, CST, and Peer Support Services compared to other members living in the community without a TCL housing slot.
- Individuals living in the community without a TCL housing slot received stand-alone services such as Psychological Diagnosis and Testing, Psychotherapy, and Evaluation and Management at lower rates than members in other statuses and settings.

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 22. Service Categories.

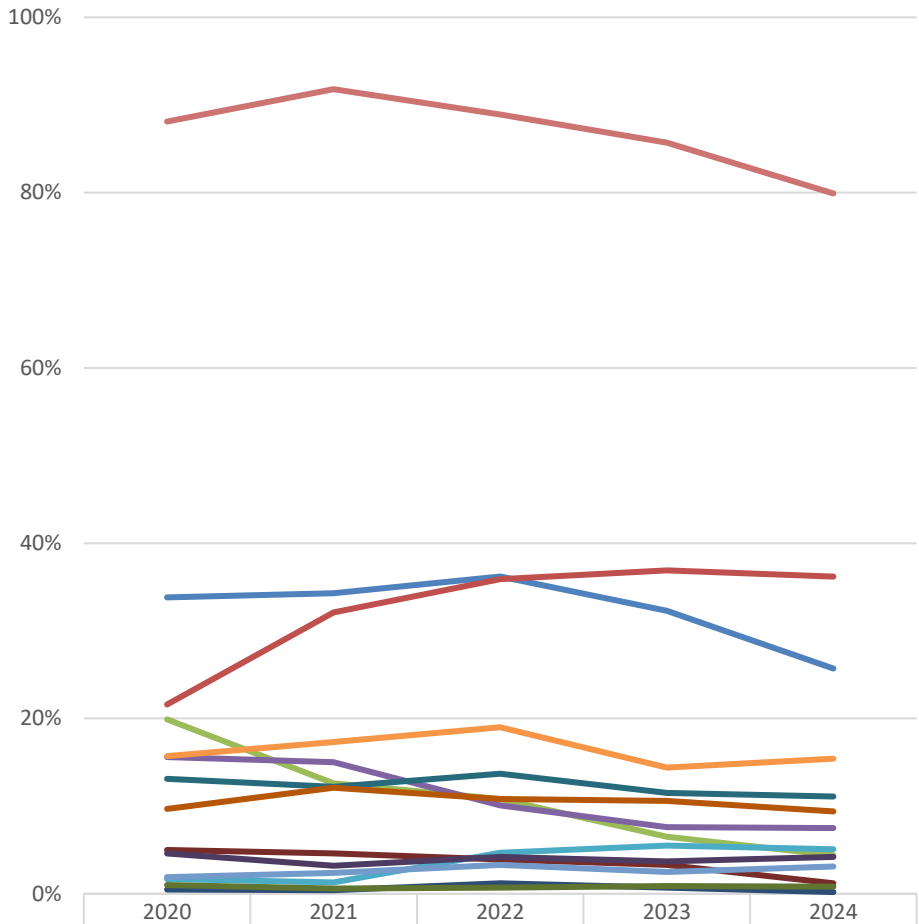
Annual Service Rates, SFY20 to SFY24

Figure 44. Participants in TCL Supportive Housing



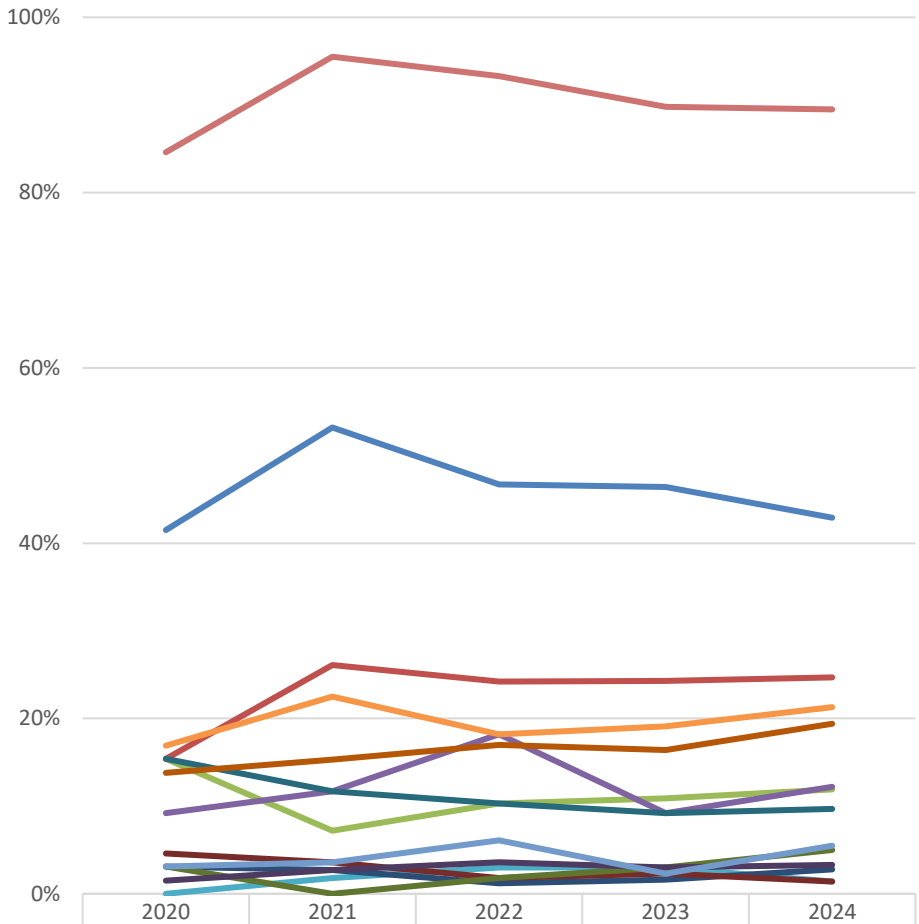
	2020	2021	2022	2023	2024
ACT	40%	40%	39%	38%	36%
CST	24%	27%	25%	27%	28%
TMS	51%	37%	35%	29%	26%
PEER	21%	18%	18%	17%	18%
AES	7%	3%	1%	1%	1%
E&M	31%	27%	29%	29%	27%
FBC	2%	1%	1%	1%	1%
IPS	7%	6%	4%	4%	3%
MCM	4%	3%	3%	2%	2%
PSR	6%	4%	4%	4%	4%
Psychotherapy	20%	17%	15%	15%	13%
PsyDx/Testing	23%	20%	19%	19%	20%
SUD	4%	3%	3%	3%	4%
Any of ACT, CST, TMS, PEER	97%	96%	95%	93%	92%

Figure 45. Participants in Transition Planning



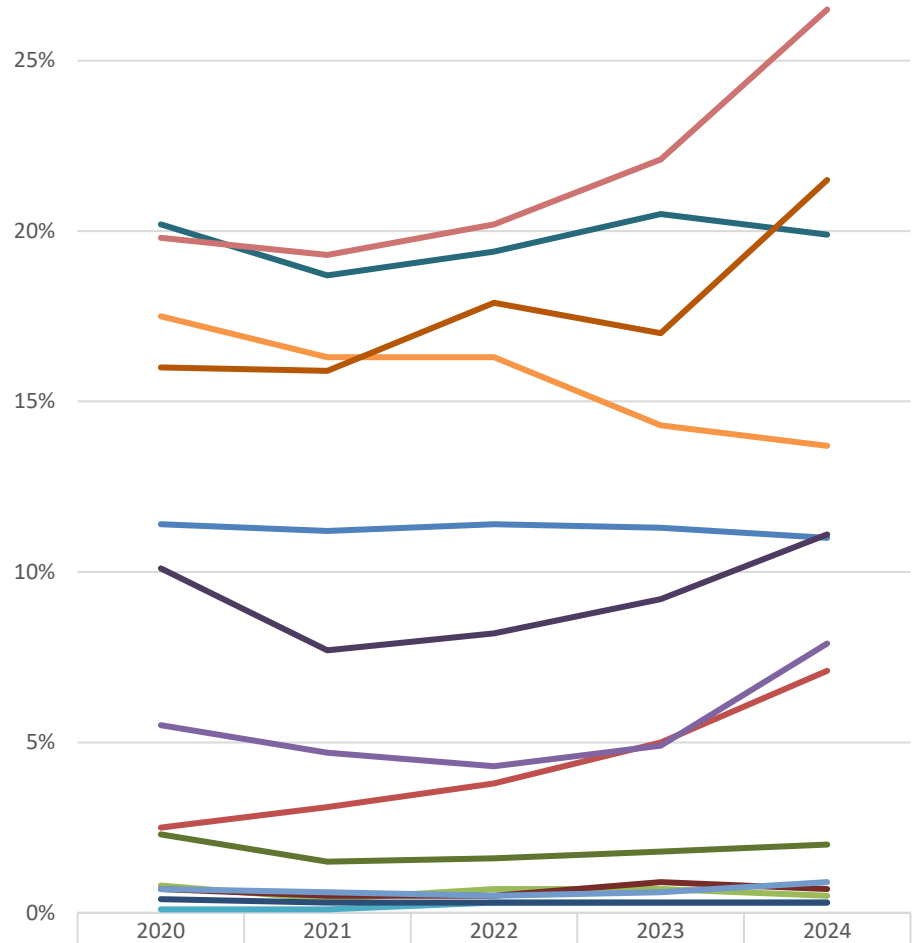
	2020	2021	2022	2023	2024
ACT	34%	34%	36%	32%	26%
CST	22%	32%	36%	37%	36%
TMS	20%	13%	11%	7%	4%
PEER	16%	15%	10%	8%	8%
AES	2%	1%	5%	6%	5%
E&M	16%	17%	19%	14%	15%
FBC	1%	0%	1%	1%	0%
IPS	5%	5%	4%	3%	1%
MCM	1%	1%	1%	1%	1%
PSR	5%	3%	4%	4%	4%
Psychotherapy	13%	12%	14%	12%	11%
PsyDx/Testing	10%	12%	11%	11%	9%
SUD	2%	2%	3%	3%	3%
Any of ACT, CST, TMS, PEER	88%	92%	89%	86%	80%

Figure 46. Participants in Rehousing Planning



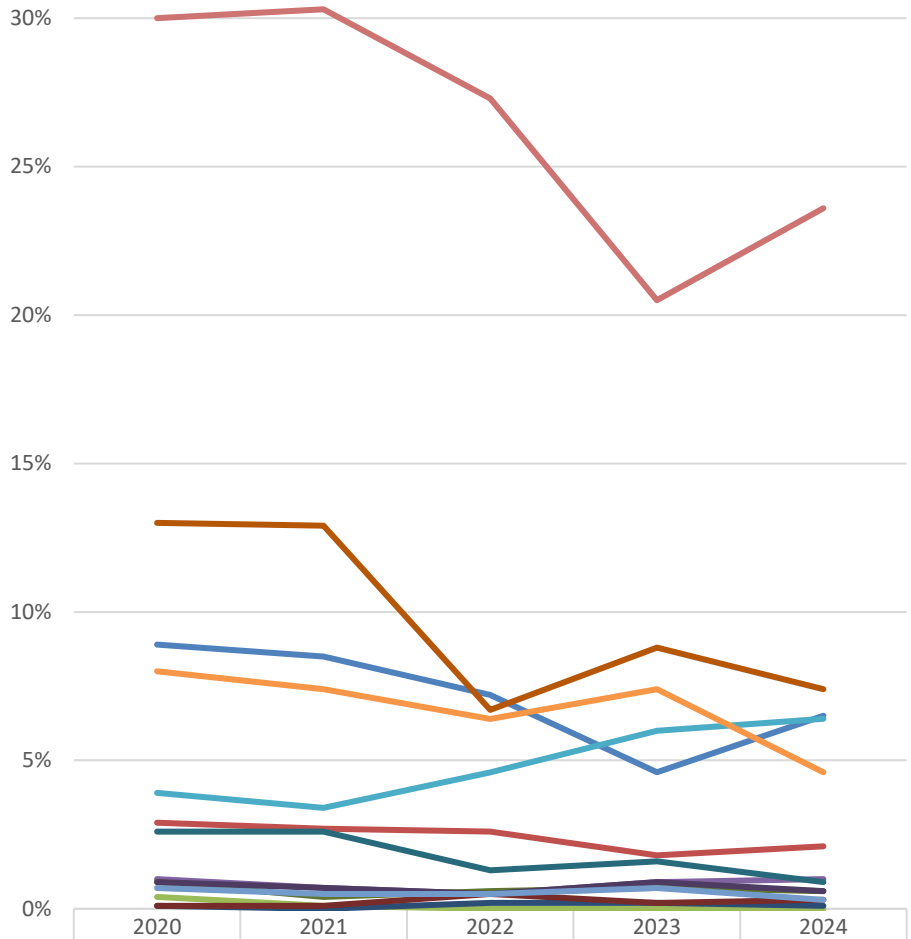
	2020	2021	2022	2023	2024
ACT	42%	53%	47%	46%	43%
CST	15%	26%	24%	24%	25%
TMS	15%	7%	10%	11%	12%
PEER	9%	12%	18%	9%	12%
AES	0%	2%	3%	3%	1%
E&M	17%	23%	18%	19%	21%
FBC	3%	3%	1%	2%	3%
IPS	5%	4%	2%	2%	1%
MCM	3%	0%	2%	3%	5%
PSR	2%	3%	4%	3%	3%
Psychotherapy	15%	12%	10%	9%	10%
PsyDx/Testing	14%	15%	17%	16%	19%
SUD	3%	4%	6%	2%	6%
Any of ACT, CST, TMS, PEER	85%	96%	93%	90%	90%

Figure 47. Participants in ACH In-Reach



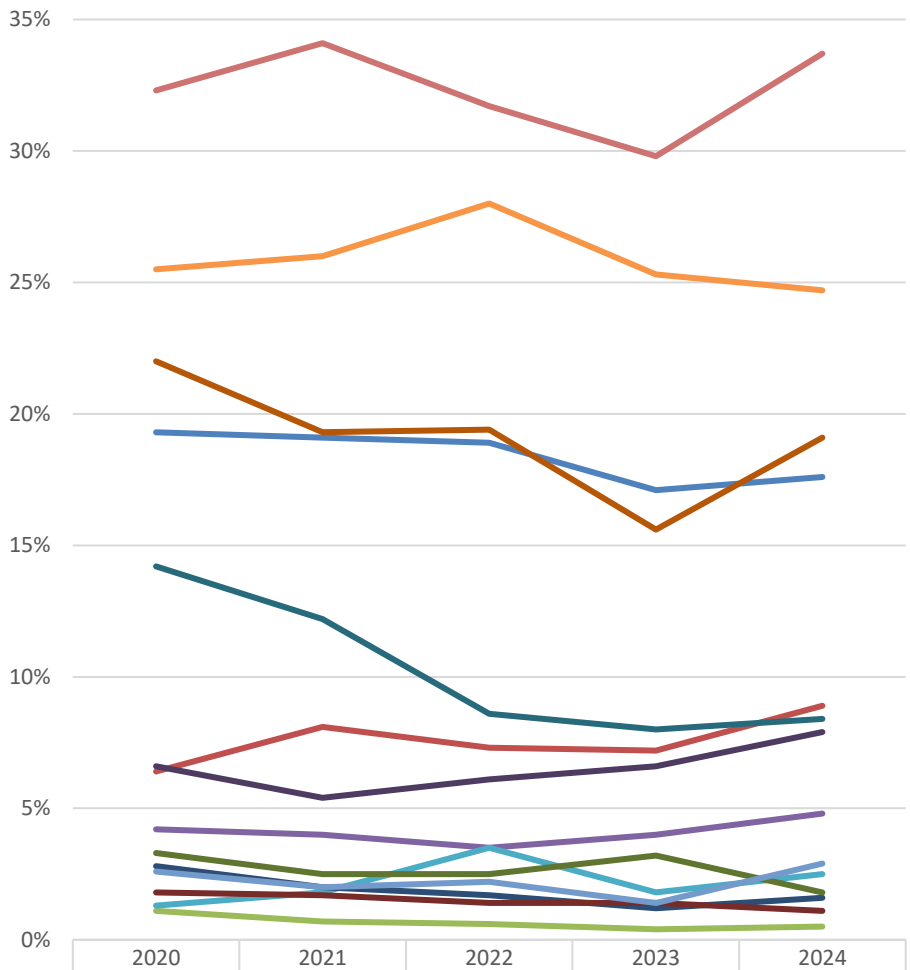
	2020	2021	2022	2023	2024
ACT	11%	11%	11%	11%	11%
CST	3%	3%	4%	5%	7%
TMS	1%	0%	1%	1%	1%
PEER	6%	5%	4%	5%	8%
AES	0%	0%	0%	0%	0%
E&M	18%	16%	16%	14%	14%
FBC	0%	0%	0%	0%	0%
IPS	1%	1%	1%	1%	1%
MCM	2%	2%	2%	2%	2%
PSR	10%	8%	8%	9%	11%
Psychotherapy	20%	19%	19%	21%	20%
PsyDx/Testing	16%	16%	18%	17%	22%
SUD	1%	1%	1%	1%	1%
Any of ACT, CST, TMS, PEER	20%	19%	20%	22%	27%

Figure 48. Participants in SPH In-Reach



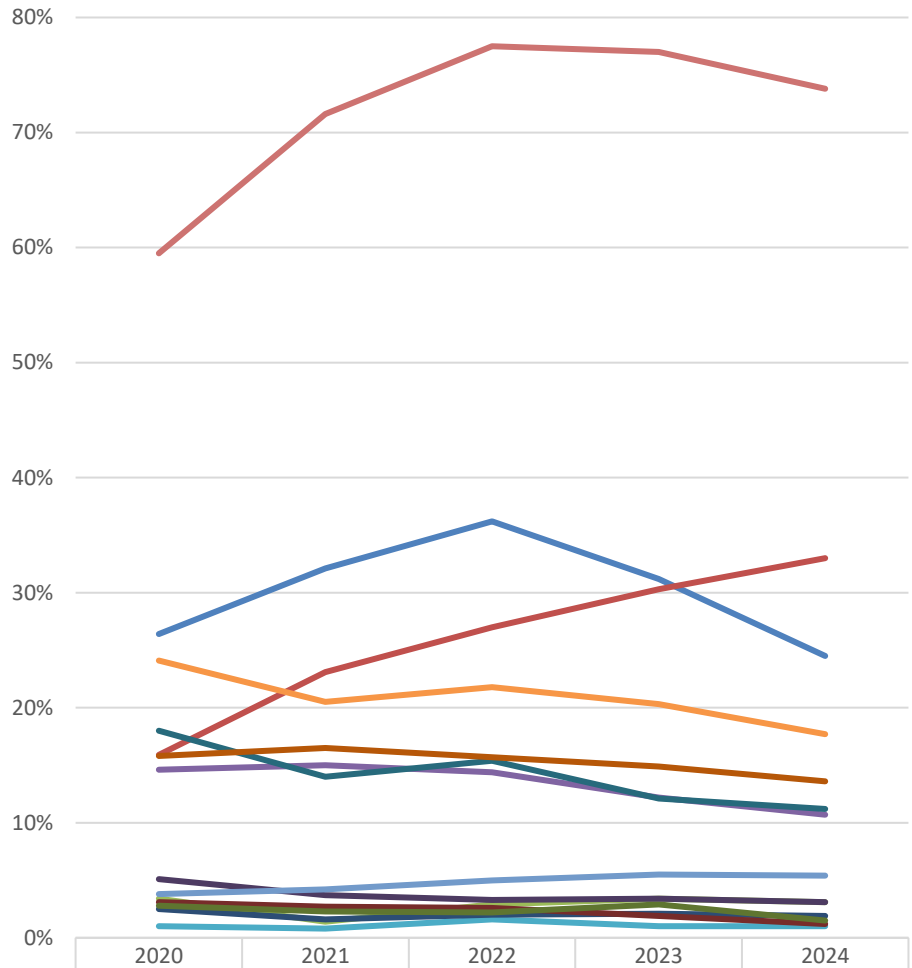
	2020	2021	2022	2023	2024
ACT	9%	9%	7%	5%	7%
CST	3%	3%	3%	2%	2%
TMS	0%	0%	0%	0%	0%
PEER	1%	1%	1%	1%	1%
AES	4%	3%	5%	6%	6%
E&M	8%	7%	6%	7%	5%
FBC	0%	0%	0%	0%	0%
IPS	0%	0%	1%	0%	0%
MCM	1%	0%	1%	1%	1%
PSR	1%	1%	1%	1%	1%
Psychotherapy	3%	3%	1%	2%	1%
PsyDx/Testing	13%	13%	7%	9%	7%
SUD	1%	1%	1%	1%	0%
Any of ACT, CST, TMS, PEER	30%	30%	27%	21%	24%

Figure 49. Participants in SPH Outreach



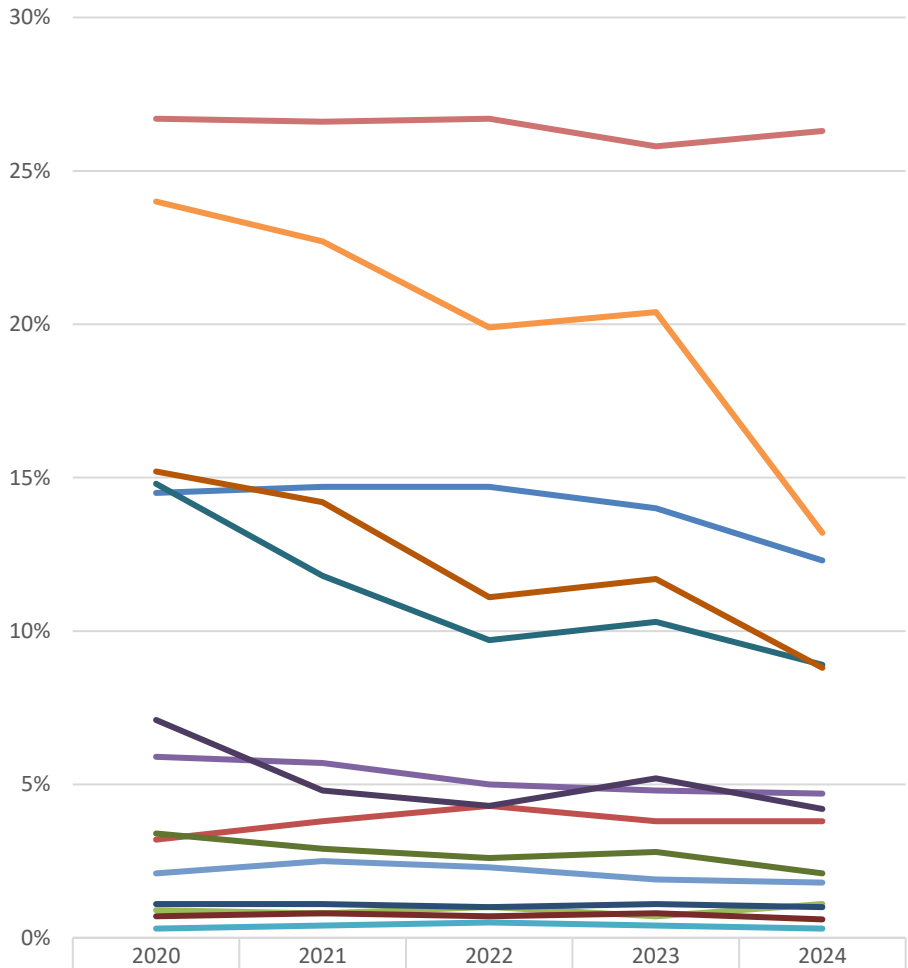
	2020	2021	2022	2023	2024
ACT	19%	19%	19%	17%	18%
CST	6%	8%	7%	7%	9%
TMS	1%	1%	1%	0%	1%
PEER	4%	4%	4%	4%	5%
AES	1%	2%	4%	2%	3%
E&M	26%	26%	28%	25%	25%
FBC	3%	2%	2%	1%	2%
IPS	2%	2%	1%	1%	1%
MCM	3%	3%	3%	3%	2%
PSR	7%	5%	6%	7%	8%
Psychotherapy	14%	12%	9%	8%	8%
PsyDx/Testing	22%	19%	19%	16%	19%
SUD	3%	2%	2%	1%	3%
Any of ACT, CST, TMS, PEER	32%	34%	32%	30%	34%

Figure 50. Participants in Diversion Status



	2020	2021	2022	2023	2024
ACT	26%	32%	36%	31%	25%
CST	16%	23%	27%	30%	33%
TMS	3%	1%	3%	3%	3%
PEER	15%	15%	14%	12%	11%
AES	1%	1%	2%	1%	1%
E&M	24%	21%	22%	20%	18%
FBC	3%	2%	2%	2%	2%
IPS	3%	3%	3%	2%	1%
MCM	3%	2%	2%	3%	2%
PSR	5%	4%	3%	3%	3%
Psychotherapy	18%	14%	15%	12%	11%
PsyDx/Testing	16%	17%	16%	15%	14%
SUD	4%	4%	5%	6%	5%
Any of ACT, CST, TMS, PEER	60%	72%	78%	77%	74%

Figure 51. Participants living in the Community without a TCL Housing Slot



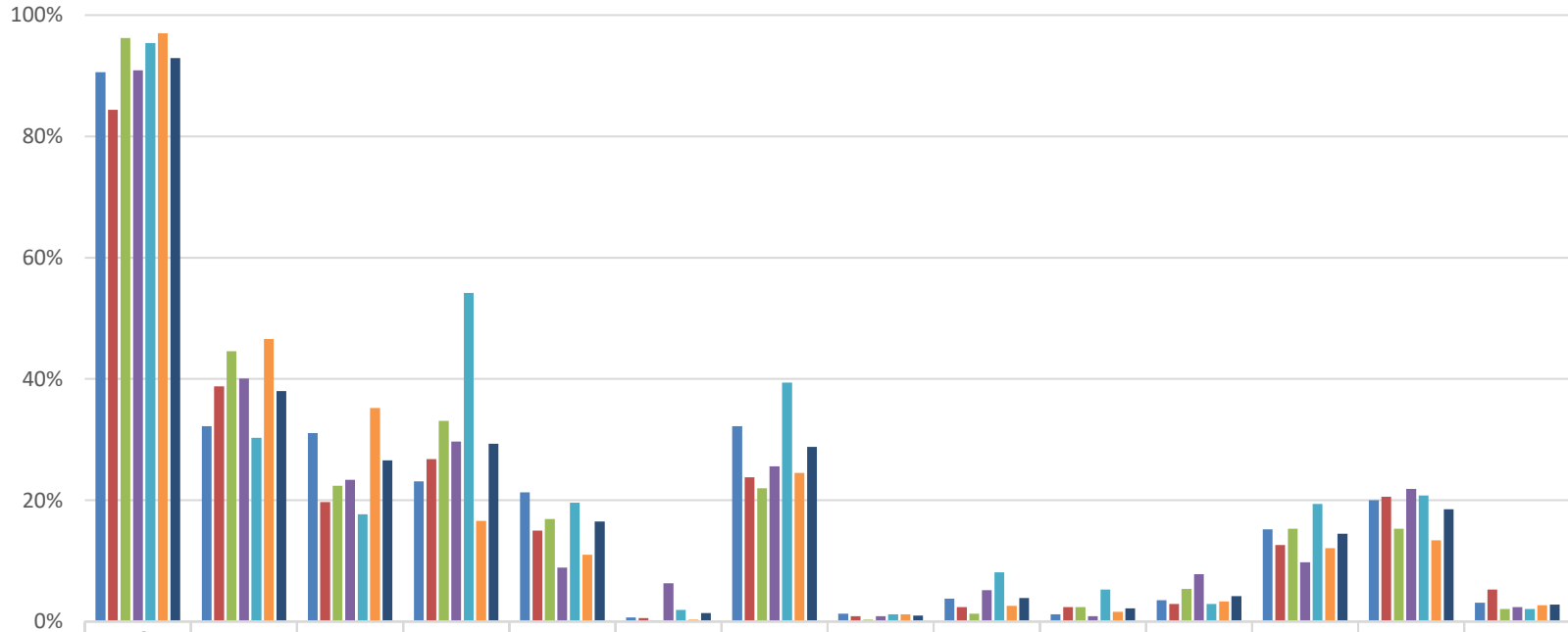
	2020	2021	2022	2023	2024
ACT	15%	15%	15%	14%	12%
CST	3%	4%	4%	4%	4%
TMS	1%	1%	1%	1%	1%
PEER	6%	6%	5%	5%	5%
AES	0%	0%	1%	0%	0%
E&M	24%	23%	20%	20%	13%
FBC	1%	1%	1%	1%	1%
IPS	1%	1%	1%	1%	1%
MCM	3%	3%	3%	3%	2%
PSR	7%	5%	4%	5%	4%
Psychotherapy	15%	12%	10%	10%	9%
PsyDx/Testing	15%	14%	11%	12%	9%
SUD	2%	3%	2%	2%	2%
Any of ACT, CST, TMS, PEER	27%	27%	27%	26%	26%

Annual Client Counts and Service Rates by LME/MCO, SFY23

Table 23. Participants in TCL Supportive Housing, SFY23

LME/MCO	Total N	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psycho-therapy	PsyDx/ Testing	SUD
Alliance	1,202	1,089	387	374	278	256	9	387	16	46	15	42	183	241	37
Eastpointe	340	287	132	67	91	51	2	81	3	8	8	10	43	70	18
Partners	626	602	279	140	207	106	1	138	2	8	15	34	96	96	13
Sandhills	461	419	185	108	137	41	29	118	4	24	4	36	45	101	11
Trillium	581	554	176	103	315	114	11	229	7	47	31	17	113	121	12
Vaya	693	672	323	244	115	76	2	170	8	18	11	23	84	93	19
Statewide	3,897	3,620	1,480	1,036	1,143	644	54	1,123	40	151	84	162	564	722	110

Figure 52. Participants in TCL Supportive Housing, SFY23

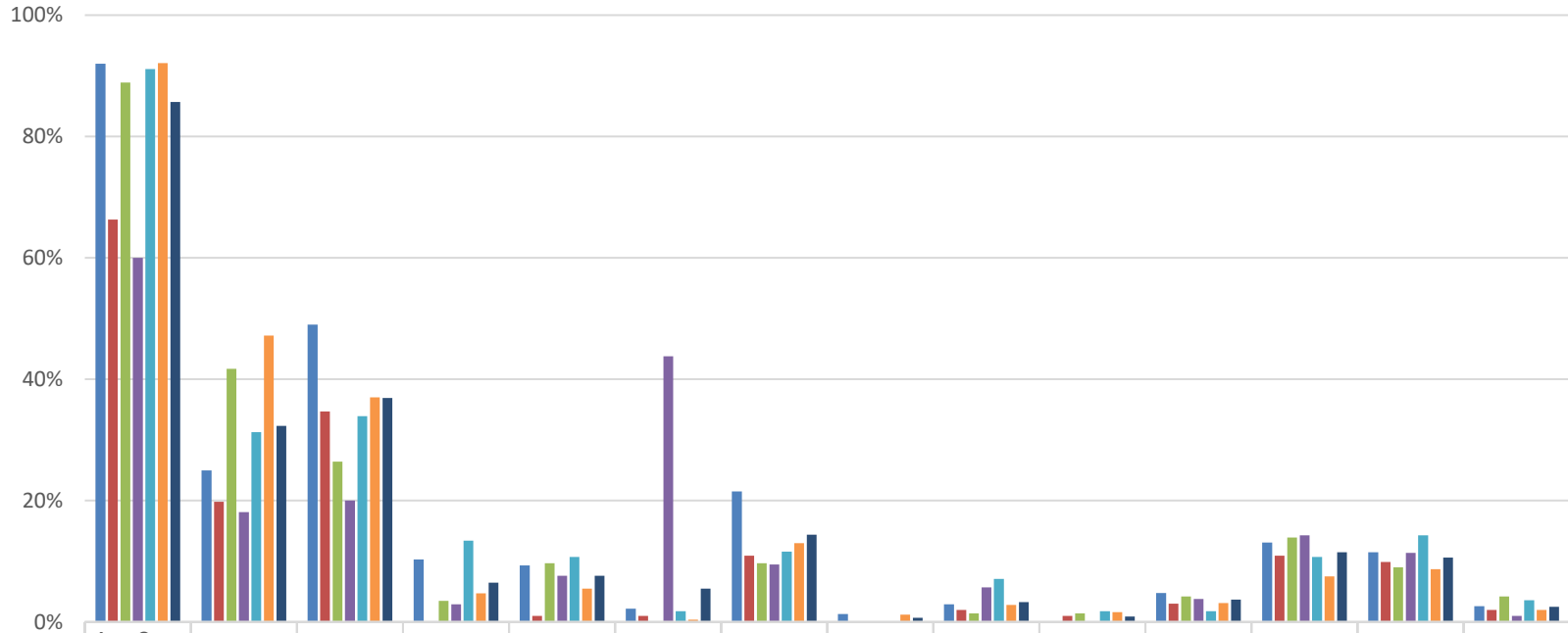


	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psychotherapy	PsyDx/Testing	SUD
	Living in the community with a TCL housing slot: Housed													
Alliance	91%	32%	31%	23%	21%	1%	32%	1%	4%	1%	4%	15%	20%	3%
Eastpointe	84%	39%	20%	27%	15%	1%	24%	1%	2%	2%	3%	13%	21%	5%
Partners	96%	45%	22%	33%	17%	0%	22%	0%	1%	2%	5%	15%	15%	2%
Sandhills	91%	40%	23%	30%	9%	6%	26%	1%	5%	1%	8%	10%	22%	2%
Trillium	95%	30%	18%	54%	20%	2%	39%	1%	8%	5%	3%	19%	21%	2%
Vaya	97%	47%	35%	17%	11%	0%	25%	1%	3%	2%	3%	12%	13%	3%
Statewide	93%	38%	27%	29%	17%	1%	29%	1%	4%	2%	4%	15%	19%	3%

Table 24. Participants in Transition Planning, SFY23

LME/MCO	Total N	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	312	287	78	153	32	29	7	67	4	9	0	15	41	36	8
Eastpointe	101	67	20	35	0	1	1	11	0	2	1	3	11	10	2
Partners	144	128	60	38	5	14	0	14	0	2	2	6	20	13	6
Sandhills	105	63	19	21	3	8	46	10	0	6	0	4	15	12	1
Trillium	112	102	35	38	15	12	2	13	0	8	2	2	12	16	4
Vaya	254	234	120	94	12	14	1	33	3	7	4	8	19	22	5
Statewide	1,028	881	332	379	67	78	57	148	7	34	9	38	118	109	26

Figure 53. Participants in Transition Planning, SFY23

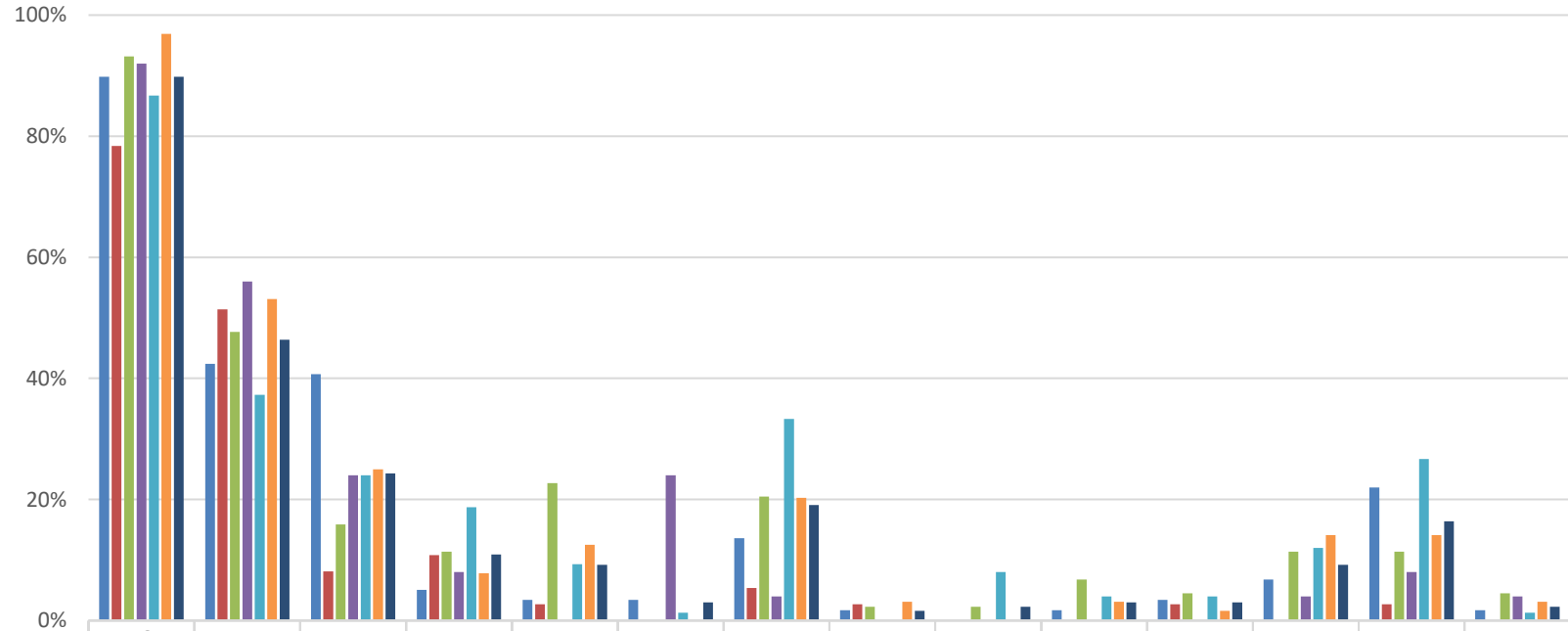


	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psychotherapy	PsyDx/Testing	SUD
	Transition Planning													
Alliance	92%	25%	49%	10%	9%	2%	22%	1%	3%	0%	5%	13%	12%	3%
Eastpointe	66%	20%	35%	0%	1%	1%	11%	0%	2%	1%	3%	11%	10%	2%
Partners	89%	42%	26%	4%	10%	0%	10%	0%	1%	1%	4%	14%	9%	4%
Sandhills	60%	18%	20%	3%	8%	44%	10%	0%	6%	0%	4%	14%	11%	1%
Trillium	91%	31%	34%	13%	11%	2%	12%	0%	7%	2%	2%	11%	14%	4%
Vaya	92%	47%	37%	5%	6%	0%	13%	1%	3%	2%	3%	8%	9%	2%
Statewide	86%	32%	37%	7%	8%	6%	14%	1%	3%	1%	4%	12%	11%	3%

Table 25. Participants in Rehousing Planning, SFY23

LME/MCO	Total N	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	59	53	25	24	3	2	2	8	1	0	1	2	4	13	1
Eastpointe	37	29	19	3	4	1	0	2	1	0	0	1	0	1	0
Partners	44	41	21	7	5	10	0	9	1	1	3	2	5	5	2
Sandhills	25	23	14	6	2	0	6	1	0	0	0	0	1	2	1
Trillium	75	65	28	18	14	7	1	25	0	6	3	3	9	20	1
Vaya	64	62	34	16	5	8	0	13	2	0	2	1	9	9	2
Statewide	304	273	141	74	33	28	9	58	5	7	9	9	28	50	7

Figure 54. Participants in Rehousing Planning, SFY23

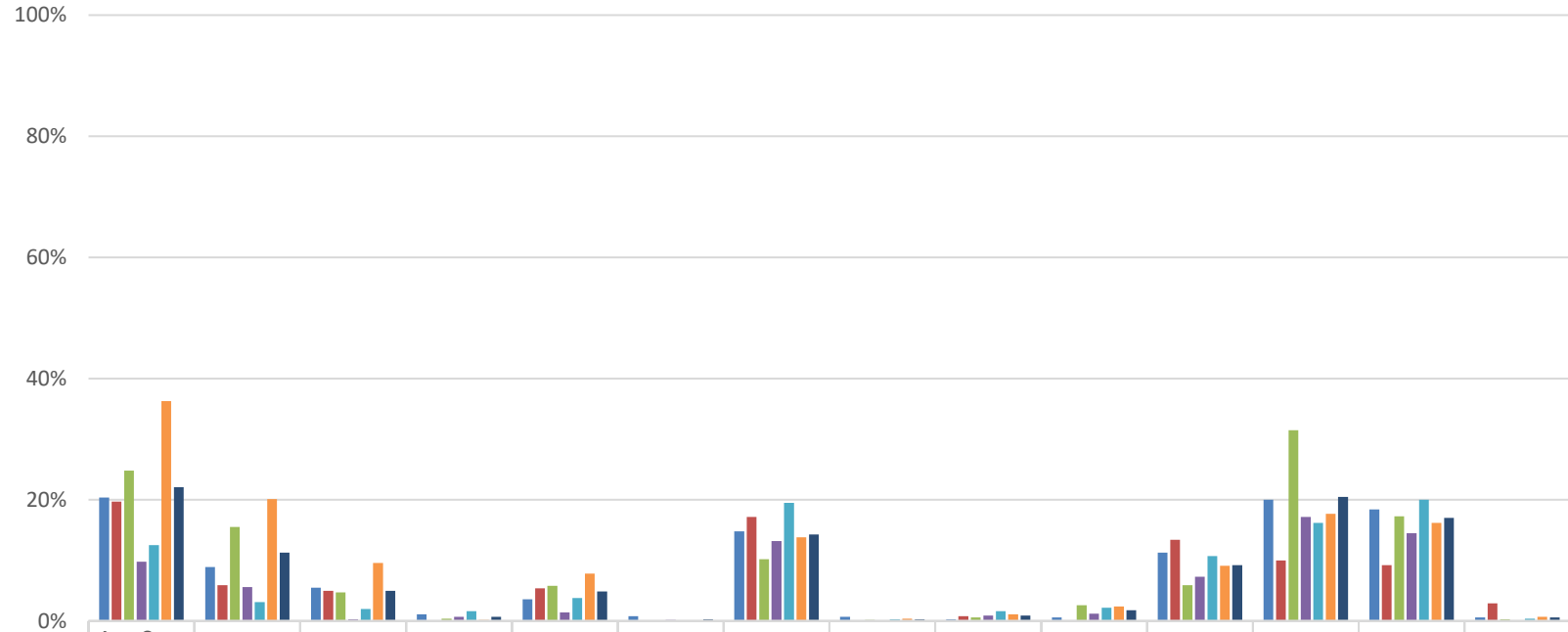


	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psychotherapy	PsyDx/Testing	SUD
	Rehousing Planning													
Alliance	90%	42%	41%	5%	3%	3%	14%	2%	0%	2%	3%	7%	22%	2%
Eastpointe	78%	51%	8%	11%	3%	0%	5%	3%	0%	0%	3%	0%	3%	0%
Partners	93%	48%	16%	11%	23%	0%	21%	2%	2%	7%	5%	11%	11%	5%
Sandhills	92%	56%	24%	8%	0%	24%	4%	0%	0%	0%	0%	4%	8%	4%
Trillium	87%	37%	24%	19%	9%	1%	33%	0%	8%	4%	4%	12%	27%	1%
Vaya	97%	53%	25%	8%	13%	0%	20%	3%	0%	3%	2%	14%	14%	3%
Statewide	90%	46%	24%	11%	9%	3%	19%	2%	2%	3%	3%	9%	16%	2%

Table 26. Participants in ACH In-Reach, SFY23

LME/MCO	Total N	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	964	197	86	53	11	35	8	143	7	3	6	109	193	177	6
Eastpointe	239	47	14	12	0	13	0	41	0	2	0	32	24	22	7
Partners	997	247	155	47	4	58	1	102	2	6	26	59	314	172	3
Sandhills	574	56	32	2	4	8	1	76	0	5	7	42	99	83	0
Trillium	765	96	24	15	12	29	1	149	2	12	17	82	124	153	3
Vaya	986	358	198	95	2	77	1	136	4	11	24	90	175	160	7
Statewide	4,522	1,000	509	224	33	220	12	647	15	39	80	414	929	767	26

Figure 55. Participants in ACH In-Reach, SFY23

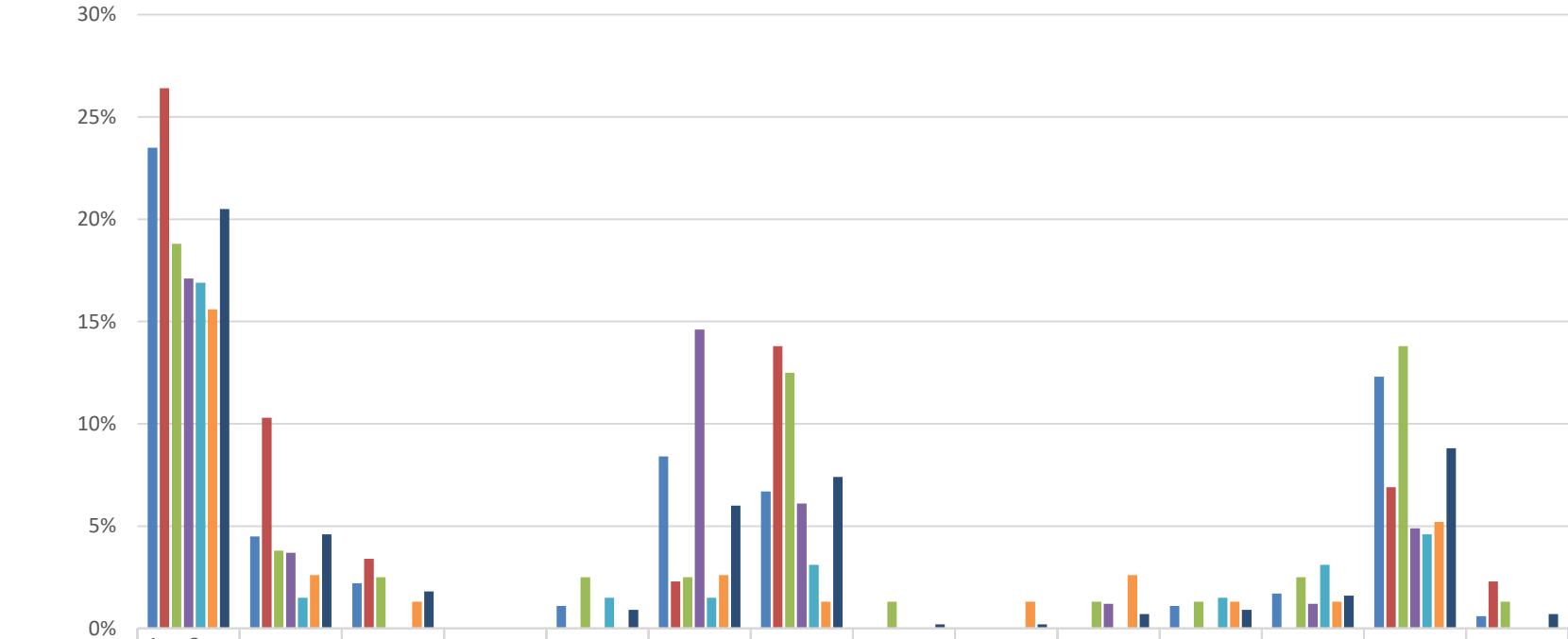


In-ReachACH/IMD (1-3)	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psychotherapy	PsyDx/Testing	SUD
Alliance	20%	9%	6%	1%	4%	1%	15%	1%	0%	1%	11%	20%	18%	1%
Eastpointe	20%	6%	5%	0%	5%	0%	17%	0%	1%	0%	13%	10%	9%	3%
Partners	25%	16%	5%	0%	6%	0%	10%	0%	1%	3%	6%	32%	17%	0%
Sandhills	10%	6%	0%	1%	1%	0%	13%	0%	1%	1%	7%	17%	15%	0%
Trillium	13%	3%	2%	2%	4%	0%	20%	0%	2%	2%	11%	16%	20%	0%
Vaya	36%	20%	10%	0%	8%	0%	14%	0%	1%	2%	9%	18%	16%	1%
Statewide	22%	11%	5%	1%	5%	0%	14%	0%	1%	2%	9%	21%	17%	1%

Table 27. Participants in SPH In-Reach, SFY23

LME/MCO	Total N	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	179	42	8	4	0	2	15	12	0	0	0	2	3	22	1
Eastpointe	87	23	9	3	0	0	2	12	0	0	0	0	0	6	2
Partners	80	15	3	2	0	2	2	10	1	0	1	1	2	11	1
Sandhills	82	14	3	0	0	0	12	5	0	0	1	0	1	4	0
Trillium	65	11	1	0	0	1	1	2	0	0	0	1	2	3	0
Vaya	77	12	2	1	0	0	2	1	0	1	2	1	1	4	0
Statewide	570	117	26	10	0	5	34	42	1	1	4	5	9	50	4

Figure 56. Participants in SPH In-Reach, SFY23

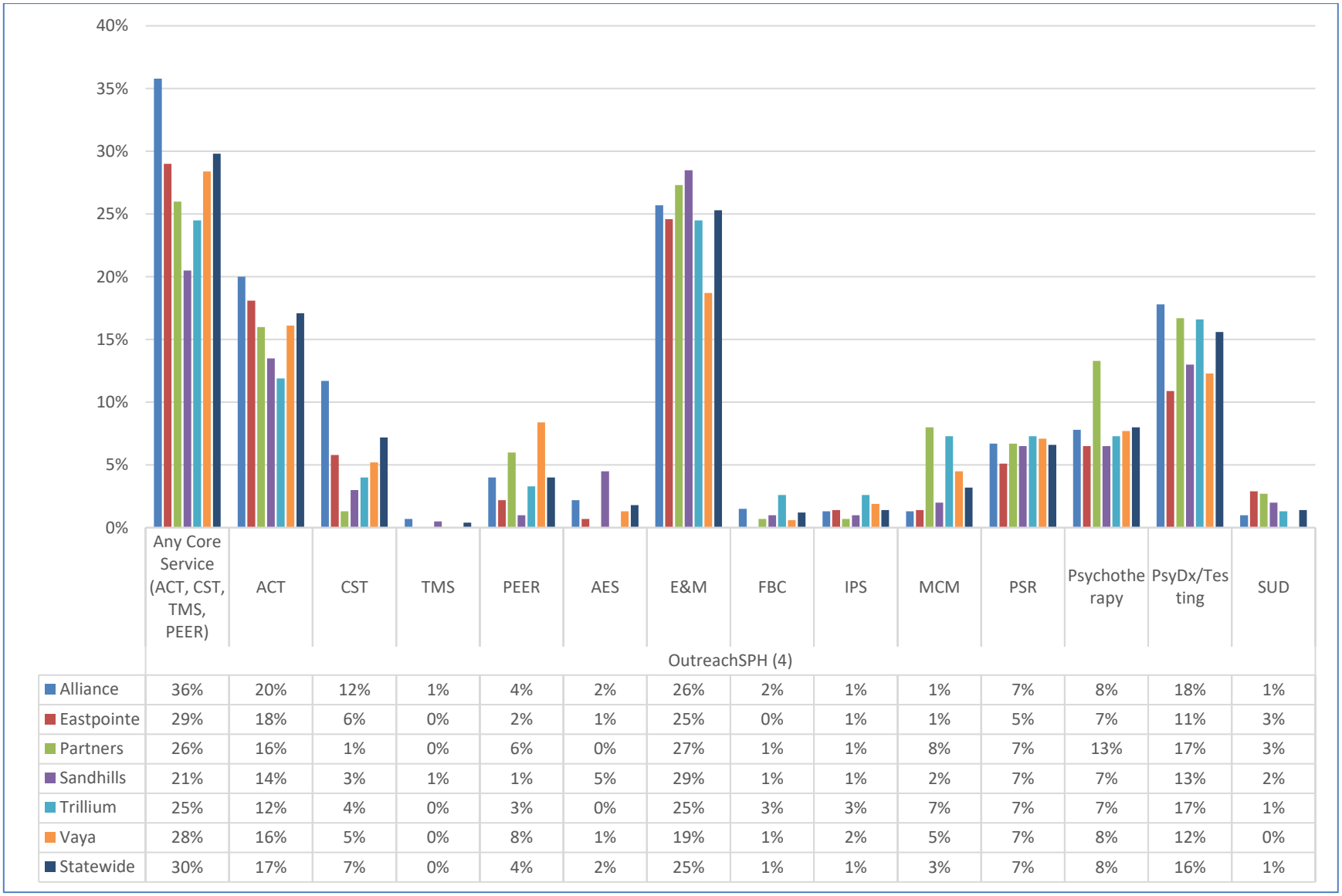


	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psychotherapy	PsyDx/Testing	SUD
	In-ReachSPH (4)													
Alliance	24%	5%	2%	0%	1%	8%	7%	0%	0%	0%	1%	2%	12%	1%
Eastpointe	26%	10%	3%	0%	0%	2%	14%	0%	0%	0%	0%	0%	7%	2%
Partners	19%	4%	3%	0%	3%	3%	13%	1%	0%	1%	1%	3%	14%	1%
Sandhills	17%	4%	0%	0%	0%	15%	6%	0%	0%	1%	0%	1%	5%	0%
Trillium	17%	2%	0%	0%	2%	2%	3%	0%	0%	0%	2%	3%	5%	0%
Vaya	16%	3%	1%	0%	0%	3%	1%	0%	1%	3%	1%	1%	5%	0%
Statewide	21%	5%	2%	0%	1%	6%	7%	0%	0%	1%	1%	2%	9%	1%

Table 28. Participants in SPH outreach, SFY23

LME/MCO	Total N	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	600	215	120	70	4	24	13	154	9	8	8	40	47	107	6
Eastpointe	138	40	25	8	0	3	1	34	0	2	2	7	9	15	4
Partners	150	39	24	2	0	9	0	41	1	1	12	10	20	25	4
Sandhills	200	41	27	6	1	2	9	57	2	2	4	13	13	26	4
Trillium	151	37	18	6	0	5	0	37	4	4	11	11	11	25	2
Vaya	155	44	25	8	0	13	2	29	1	3	7	11	12	19	0
Statewide	1,394	416	239	100	5	56	25	352	17	20	44	92	112	217	20

Figure 57. Participants in SPH outreach, SFY23

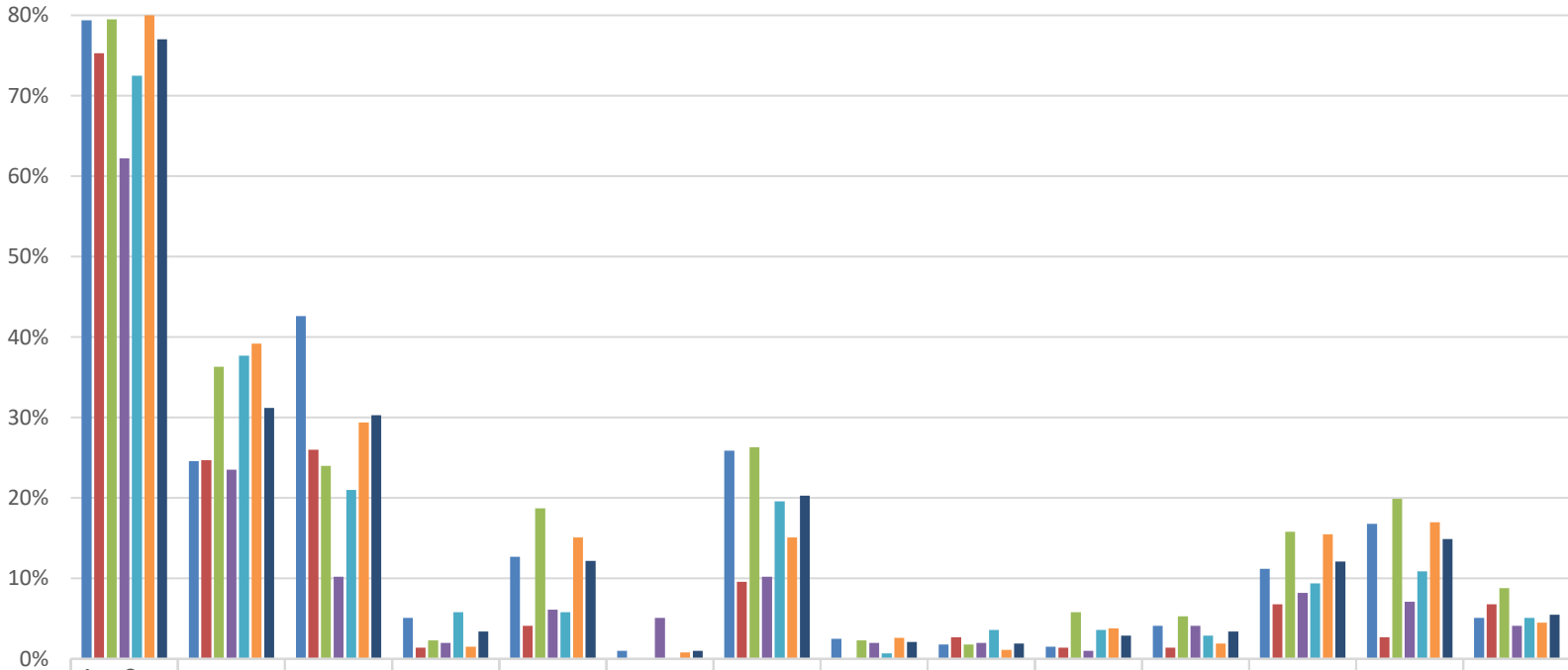


	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psychotherapy	PsyDx/Testing	SUD
	OutreachSPH (4)													
Alliance	36%	20%	12%	1%	4%	2%	26%	2%	1%	1%	7%	8%	18%	1%
Eastpointe	29%	18%	6%	0%	2%	1%	25%	0%	1%	1%	5%	7%	11%	3%
Partners	26%	16%	1%	0%	6%	0%	27%	1%	1%	8%	7%	13%	17%	3%
Sandhills	21%	14%	3%	1%	1%	5%	29%	1%	1%	2%	7%	7%	13%	2%
Trillium	25%	12%	4%	0%	3%	0%	25%	3%	3%	7%	7%	7%	17%	1%
Vaya	28%	16%	5%	0%	8%	1%	19%	1%	2%	5%	7%	8%	12%	0%
Statewide	30%	17%	7%	0%	4%	2%	25%	1%	1%	3%	7%	8%	16%	1%

Table 29. Participants in Diversion Status, SFY23

LME/MCO	Total N	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	394	313	97	168	20	50	4	102	10	7	6	16	44	66	20
Eastpointe	73	55	18	19	1	3	0	7	0	2	1	1	5	2	5
Partners	171	136	62	41	4	32	0	45	4	3	10	9	27	34	15
Sandhills	98	61	23	10	2	6	5	10	2	2	1	4	8	7	4
Trillium	138	100	52	29	8	8	0	27	1	5	5	4	13	15	7
Vaya	265	212	104	78	4	40	2	40	7	3	10	5	41	45	12
Statewide	1,138	876	355	345	39	139	11	231	24	22	33	39	138	169	63

Figure 58. Participants in Diversion Status, SFY23

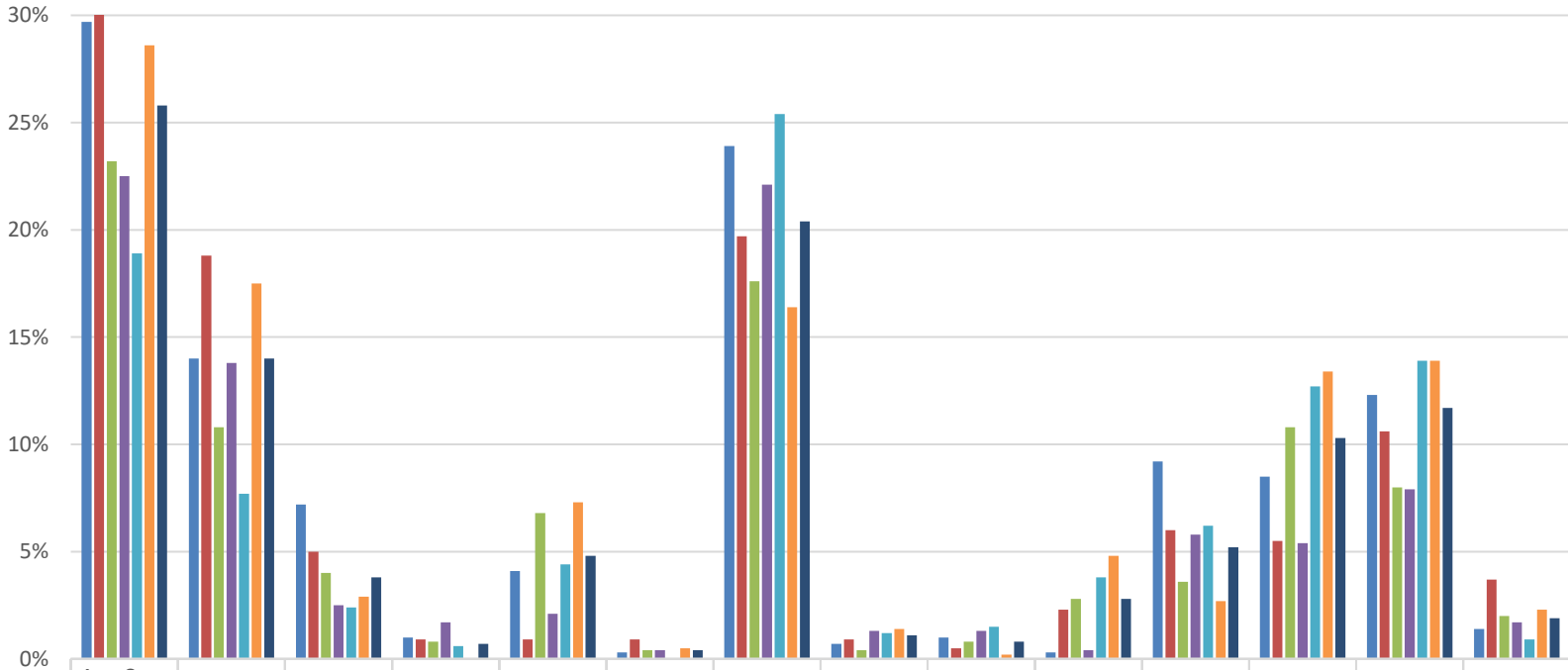


	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psychotherapy	PsyDx/Testing	SUD
	Diversion Attempt													
Alliance	79%	25%	43%	5%	13%	1%	26%	3%	2%	2%	4%	11%	17%	5%
Eastpointe	75%	25%	26%	1%	4%	0%	10%	0%	3%	1%	1%	7%	3%	7%
Partners	80%	36%	24%	2%	19%	0%	26%	2%	2%	6%	5%	16%	20%	9%
Sandhills	62%	24%	10%	2%	6%	5%	10%	2%	2%	1%	4%	8%	7%	4%
Trillium	73%	38%	21%	6%	6%	0%	20%	1%	4%	4%	3%	9%	11%	5%
Vaya	80%	39%	29%	2%	15%	1%	15%	3%	1%	4%	2%	16%	17%	5%
Statewide	77%	31%	30%	3%	12%	1%	20%	2%	2%	3%	3%	12%	15%	6%

Table 30. Participants living in the Community without a TCL Housing Slot, SFY23

LME/MCO	Total N	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	293	87	41	21	3	12	1	70	2	3	1	27	25	36	4
Eastpointe	218	66	41	11	2	2	2	43	2	1	5	13	12	23	8
Partners	250	58	27	10	2	17	1	44	1	2	7	9	27	20	5
Sandhills	240	54	33	6	4	5	1	53	3	3	1	14	13	19	4
Trillium	339	64	26	8	2	15	0	86	4	5	13	21	43	47	3
Vaya	560	160	98	16	0	41	3	92	8	1	27	15	75	78	13
Statewide	1,899	489	266	72	13	92	8	388	20	15	54	99	195	223	37

Figure 59. Participants living in the Community without a TCL Housing Slot, SFY23



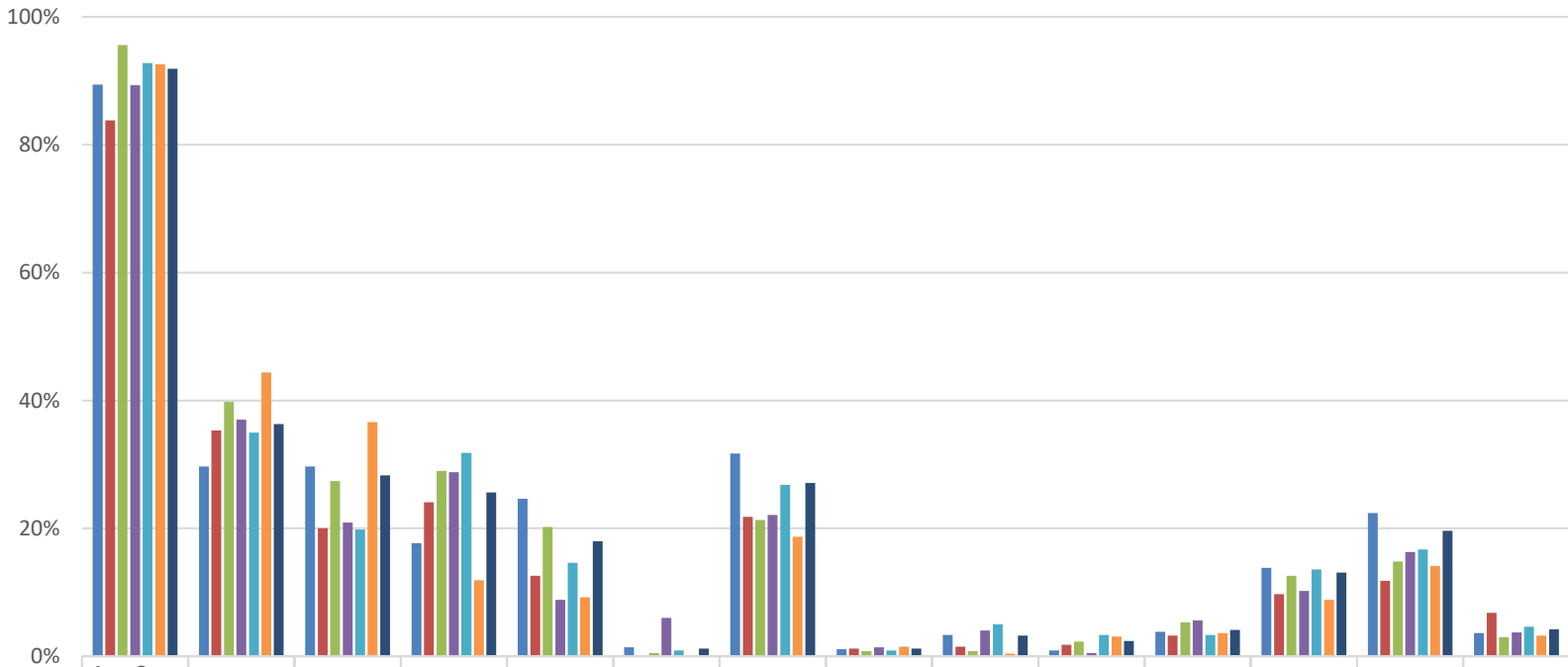
	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psychotherapy	PsyDx/Testing	SUD
	Living in the community without a slot													
Alliance	30%	14%	7%	1%	4%	0%	24%	1%	1%	0%	9%	9%	12%	1%
Eastpointe	30%	19%	5%	1%	1%	1%	20%	1%	1%	2%	6%	6%	11%	4%
Partners	23%	11%	4%	1%	7%	0%	18%	0%	1%	3%	4%	11%	8%	2%
Sandhills	23%	14%	3%	2%	2%	0%	22%	1%	1%	0%	6%	5%	8%	2%
Trillium	19%	8%	2%	1%	4%	0%	25%	1%	2%	4%	6%	13%	14%	1%
Vaya	29%	18%	3%	0%	7%	1%	16%	1%	0%	5%	3%	13%	14%	2%
Statewide	26%	14%	4%	1%	5%	0%	20%	1%	1%	3%	5%	10%	12%	2%

Annual Client Counts and Service Rates by LME/MCO, SFY24

Table 31. Participants in TCL Supportive Housing, SFY24

LME/MCO	Total N	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	1,258	1,125	373	373	223	310	17	399	14	42	11	48	174	282	45
Eastpointe	340	285	120	68	82	43	0	74	4	5	6	11	33	40	23
Partners	778	744	310	213	226	157	4	166	6	6	18	41	98	115	23
Sandhills	430	384	159	90	124	38	26	95	6	17	2	24	44	70	16
Trillium	1,291	1,198	452	256	410	188	12	346	11	64	42	43	175	216	60
Vaya	781	723	347	286	93	72	1	146	12	3	24	28	69	110	25
Statewide	4,171	3,834	1,515	1,179	1,067	751	52	1,129	52	132	100	170	546	818	174

Figure 60. Participants in TCL Supportive Housing, SFY24

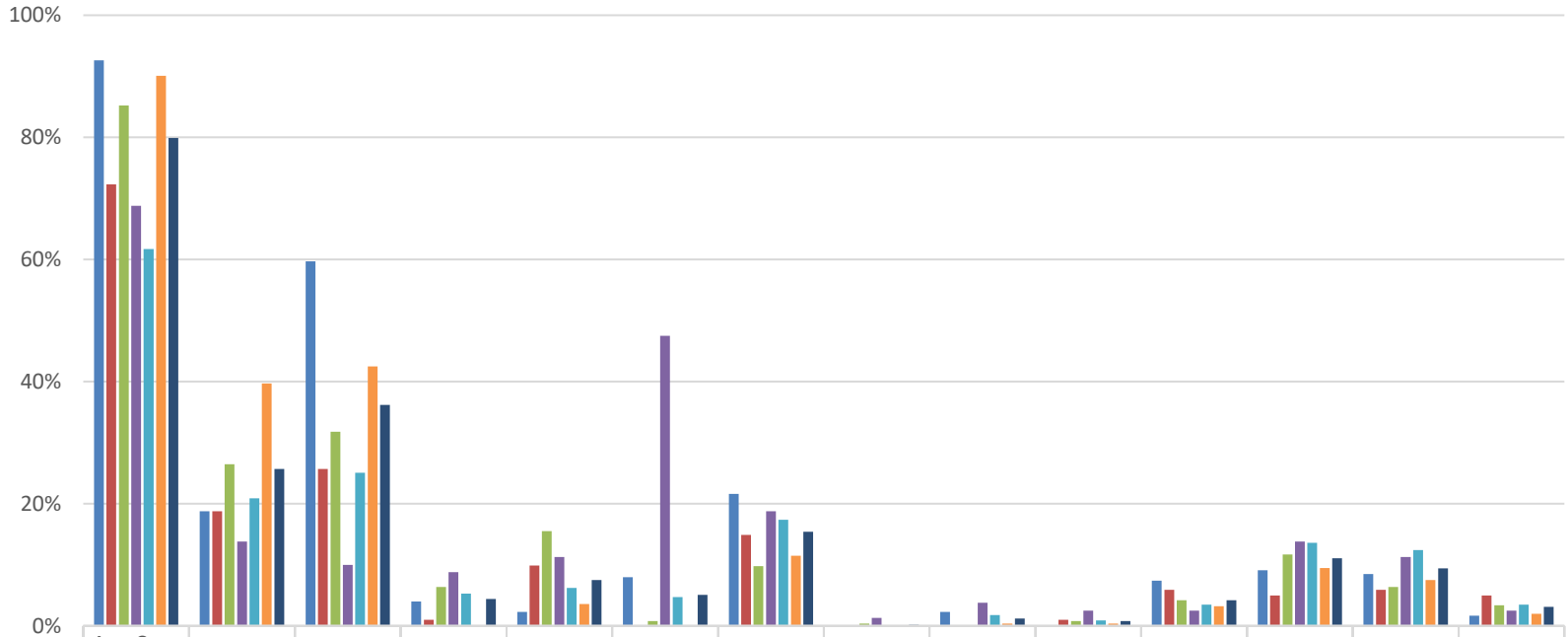


	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psychotherapy	PsyDx/Testing	SUD
	Living in the community with a TCL housing slot: Housed													
Alliance	89%	30%	30%	18%	25%	1%	32%	1%	3%	1%	4%	14%	22%	4%
Eastpointe	84%	35%	20%	24%	13%	0%	22%	1%	2%	2%	3%	10%	12%	7%
Partners	96%	40%	27%	29%	20%	1%	21%	1%	1%	2%	5%	13%	15%	3%
Sandhills	89%	37%	21%	29%	9%	6%	22%	1%	4%	1%	6%	10%	16%	4%
Trillium	93%	35%	20%	32%	15%	1%	27%	1%	5%	3%	3%	14%	17%	5%
Vaya	93%	44%	37%	12%	9%	0%	19%	2%	0%	3%	4%	9%	14%	3%
Statewide	92%	36%	28%	26%	18%	1%	27%	1%	3%	2%	4%	13%	20%	4%

Table 32. Participants in Transition Planning, SFY24

LME/MCO	Total N	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	176	163	33	105	7	4	14	38	0	4	0	13	16	15	3
Eastpointe	101	73	19	26	1	10	0	15	0	0	1	6	5	6	5
Partners	264	225	70	84	17	41	2	26	1	0	2	11	31	17	9
Sandhills	80	55	11	8	7	9	38	15	1	3	2	2	11	9	2
Trillium	339	209	71	85	18	21	16	59	0	6	3	12	46	42	12
Vaya	252	227	100	107	0	9	0	29	0	1	1	8	24	19	5
Statewide	1,142	912	294	413	50	86	58	176	2	14	9	48	127	107	35

Figure 61. Participants in Transition Planning, SFY24

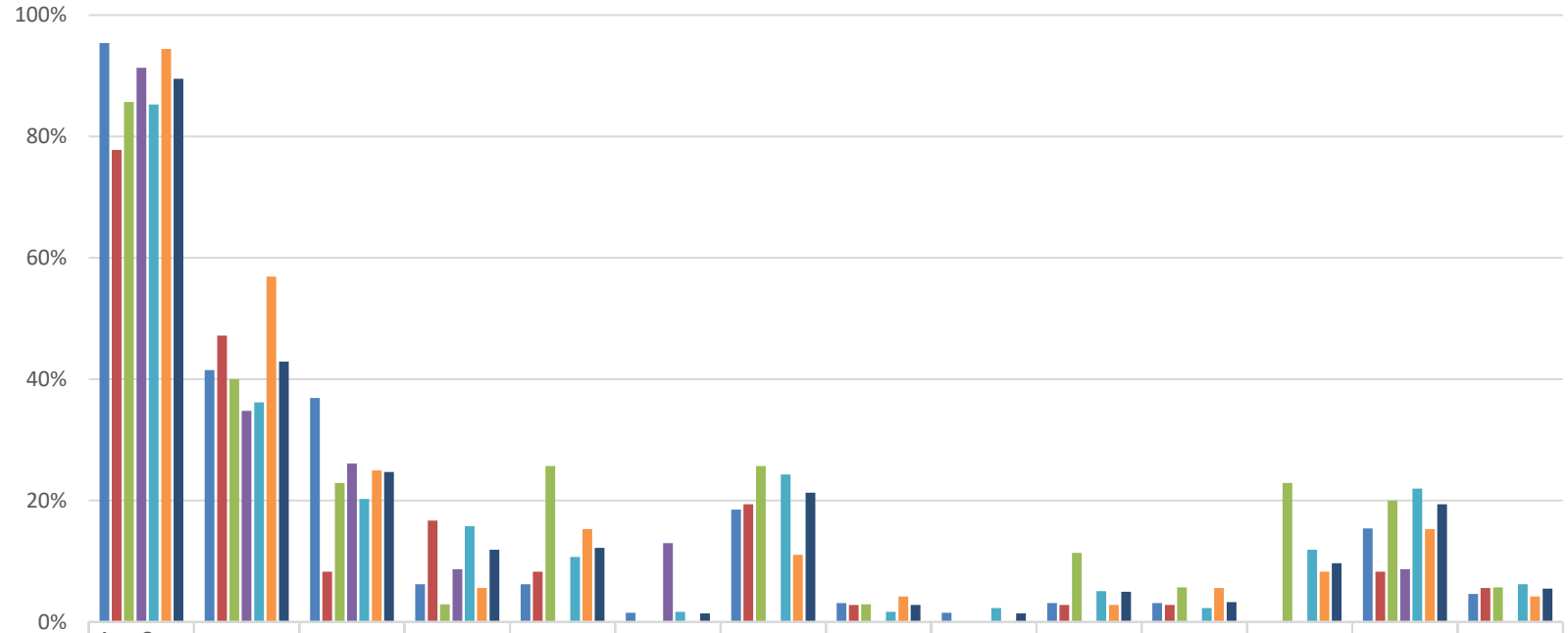


	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psychotherapy	PsyDx/Testing	SUD
	Transition Planning													
Alliance	93%	19%	60%	4%	2%	8%	22%	0%	2%	0%	7%	9%	9%	2%
Eastpointe	72%	19%	26%	1%	10%	0%	15%	0%	0%	1%	6%	5%	6%	5%
Partners	85%	27%	32%	6%	16%	1%	10%	0%	0%	1%	4%	12%	6%	3%
Sandhills	69%	14%	10%	9%	11%	48%	19%	1%	4%	3%	3%	14%	11%	3%
Trillium	62%	21%	25%	5%	6%	5%	17%	0%	2%	1%	4%	14%	12%	4%
Vaya	90%	40%	43%	0%	4%	0%	12%	0%	0%	0%	3%	10%	8%	2%
Statewide	80%	26%	36%	4%	8%	5%	15%	0%	1%	1%	4%	11%	9%	3%

Table 33. Participants in Rehousing Planning, SFY24

LME/MCO	Total N	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	65	62	27	24	4	4	1	12	2	1	2	2	0	10	3
Eastpointe	36	28	17	3	6	3	0	7	1	0	1	1	0	3	2
Partners	35	30	14	8	1	9	0	9	1	0	4	2	8	7	2
Sandhills	23	21	8	6	2	0	3	0	0	0	0	0	0	2	0
Trillium	177	151	64	36	28	19	3	43	3	4	9	4	21	39	11
Vaya	72	68	41	18	4	11	0	8	3	0	2	4	6	11	3
Statewide	361	323	155	89	43	44	5	77	10	5	18	12	35	70	20

Figure 62. Participants in Rehousing Planning, SFY24

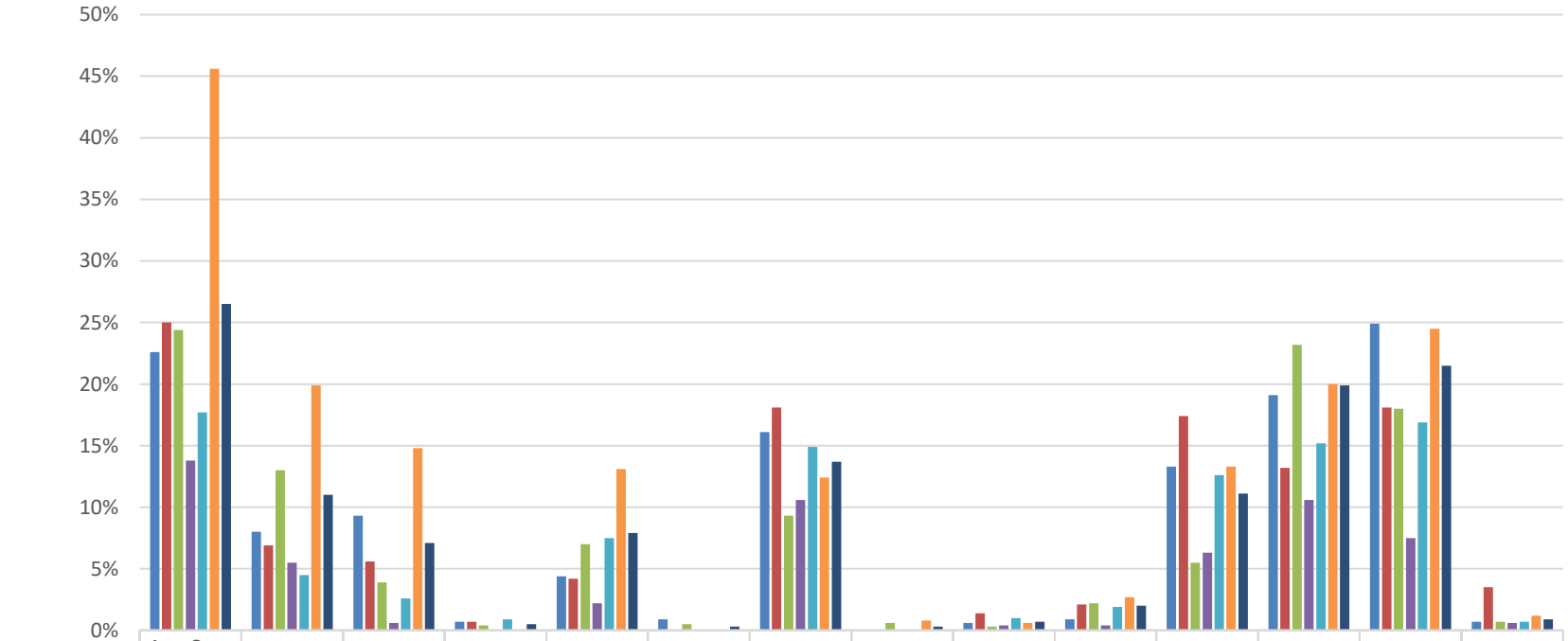


	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psychotherapy	PsyDx/Testing	SUD
	Rehousing Planning													
Alliance	95%	42%	37%	6%	6%	2%	19%	3%	2%	3%	3%	0%	15%	5%
Eastpointe	78%	47%	8%	17%	8%	0%	19%	3%	0%	3%	3%	0%	8%	6%
Partners	86%	40%	23%	3%	26%	0%	26%	3%	0%	11%	6%	23%	20%	6%
Sandhills	91%	35%	26%	9%	0%	13%	0%	0%	0%	0%	0%	0%	9%	0%
Trillium	85%	36%	20%	16%	11%	2%	24%	2%	2%	5%	2%	12%	22%	6%
Vaya	94%	57%	25%	6%	15%	0%	11%	4%	0%	3%	6%	8%	15%	4%
Statewide	90%	43%	25%	12%	12%	1%	21%	3%	1%	5%	3%	10%	19%	6%

Table 34. Participants in ACH In-Reach, SFY24

LME/MCO	Total N	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	884	200	71	82	6	39	8	142	0	5	8	118	169	220	6
Eastpointe	144	36	10	8	1	6	0	26	0	2	3	25	19	26	5
Partners	1,120	273	146	44	5	78	6	104	7	3	25	62	260	202	8
Sandhills	509	70	28	3	0	11	0	54	0	2	2	32	54	38	3
Trillium	1,139	202	51	30	10	85	0	170	0	11	22	144	173	193	8
Vaya	858	391	171	127	0	112	0	106	7	5	23	114	172	210	10
Statewide	4,081	1,081	447	290	22	323	14	559	14	27	81	452	813	878	35

Figure 63. Participants in ACH In-Reach, SFY24

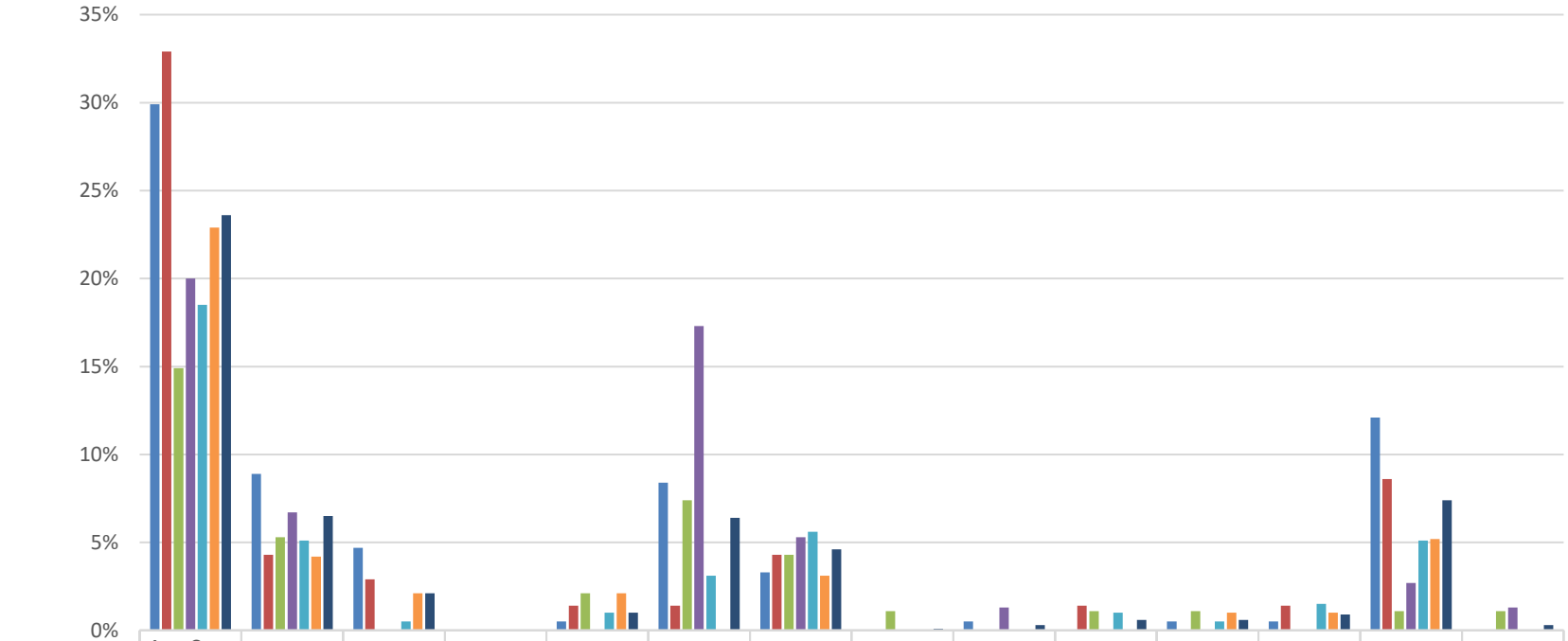


	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psychotherapy	PsyDx/Testing	SUD
	In-ReachACH/IMD (1-3)													
Alliance	23%	8%	9%	1%	4%	1%	16%	0%	1%	1%	13%	19%	25%	1%
Eastpointe	25%	7%	6%	1%	4%	0%	18%	0%	1%	2%	17%	13%	18%	4%
Partners	24%	13%	4%	0%	7%	1%	9%	1%	0%	2%	6%	23%	18%	1%
Sandhills	14%	6%	1%	0%	2%	0%	11%	0%	0%	0%	6%	11%	8%	1%
Trillium	18%	5%	3%	1%	8%	0%	15%	0%	1%	2%	13%	15%	17%	1%
Vaya	46%	20%	15%	0%	13%	0%	12%	1%	1%	3%	13%	20%	25%	1%
Statewide	27%	11%	7%	1%	8%	0%	14%	0%	1%	2%	11%	20%	22%	1%

Table 35. Participants in SPH In-Reach, SFY24

LME/MCO	Total N	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	214	64	19	10	0	1	18	7	0	1	0	1	1	26	0
Eastpointe	70	23	3	2	0	1	1	3	0	0	1	0	1	6	0
Partners	94	14	5	0	0	2	7	4	1	0	1	1	0	1	1
Sandhills	75	15	5	0	0	0	13	4	0	1	0	0	0	2	1
Trillium	195	36	10	1	0	2	6	11	0	0	2	1	3	10	0
Vaya	96	22	4	2	0	2	0	3	0	0	0	1	1	5	0
Statewide	674	159	44	14	0	7	43	31	1	2	4	4	6	50	2

Figure 64. Participants in SPH In-Reach, SFY24

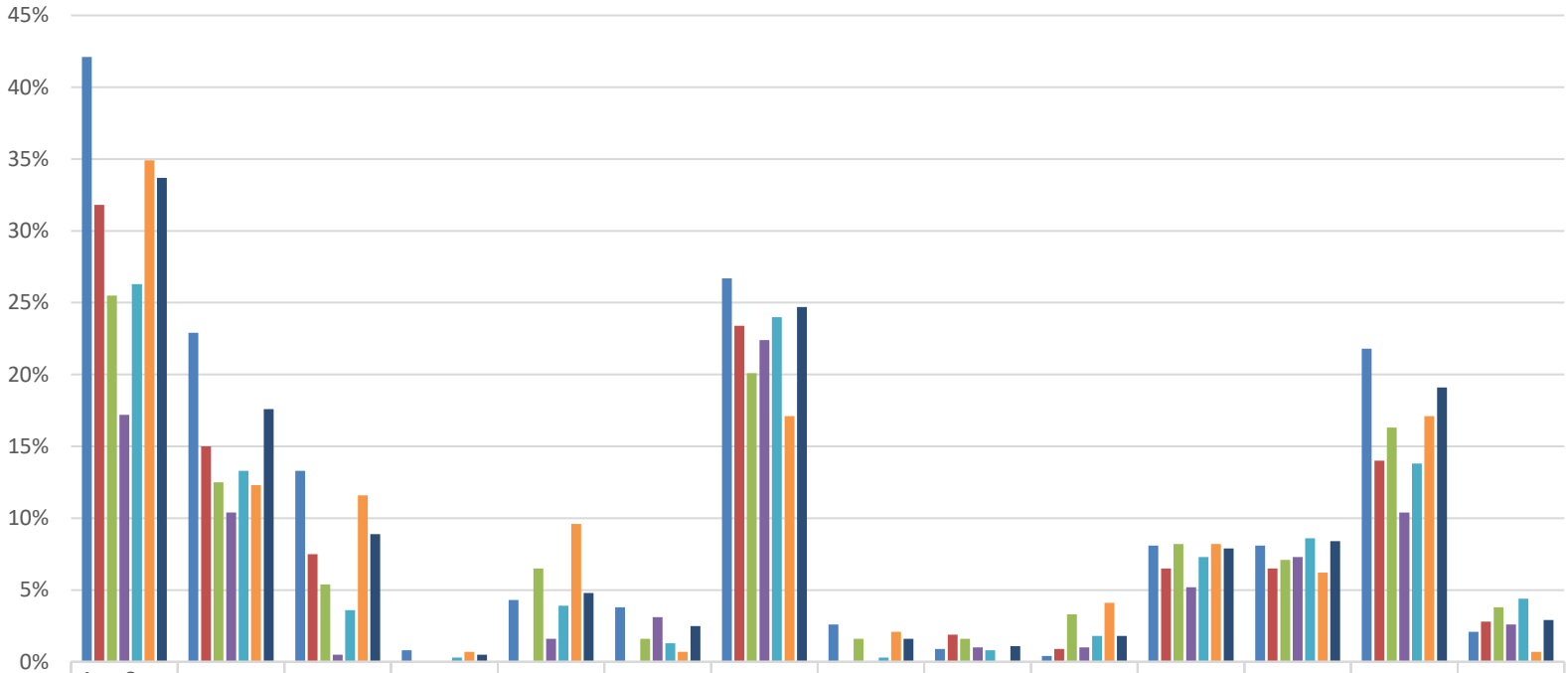


	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psychotherapy	PsyDx/Testing	SUD
	In-ReachSPH (4)													
Alliance	30%	9%	5%	0%	1%	8%	3%	0%	1%	0%	1%	1%	12%	0%
Eastpointe	33%	4%	3%	0%	1%	1%	4%	0%	0%	1%	0%	1%	9%	0%
Partners	15%	5%	0%	0%	2%	7%	4%	1%	0%	1%	1%	0%	1%	1%
Sandhills	20%	7%	0%	0%	0%	17%	5%	0%	1%	0%	0%	0%	3%	1%
Trillium	19%	5%	1%	0%	1%	3%	6%	0%	0%	1%	1%	2%	5%	0%
Vaya	23%	4%	2%	0%	2%	0%	3%	0%	0%	0%	1%	1%	5%	0%
Statewide	24%	7%	2%	0%	1%	6%	5%	0%	0%	1%	1%	1%	7%	0%

Table 36. Participants in SPH outreach, SFY24

LME/MCO	Total N	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	532	224	122	71	4	23	20	142	14	5	2	43	43	116	11
Eastpointe	107	34	16	8	0	0	0	25	0	2	1	7	7	15	3
Partners	184	47	23	10	0	12	3	37	3	3	6	15	13	30	7
Sandhills	192	33	20	1	0	3	6	43	0	2	2	10	14	20	5
Trillium	384	101	51	14	1	15	5	92	1	3	7	28	33	53	17
Vaya	146	51	18	17	1	14	1	25	3	0	6	12	9	25	1
Statewide	1,327	447	233	118	6	64	33	328	21	14	24	105	112	254	39

Figure 65. Participants in SPH outreach, SFY24

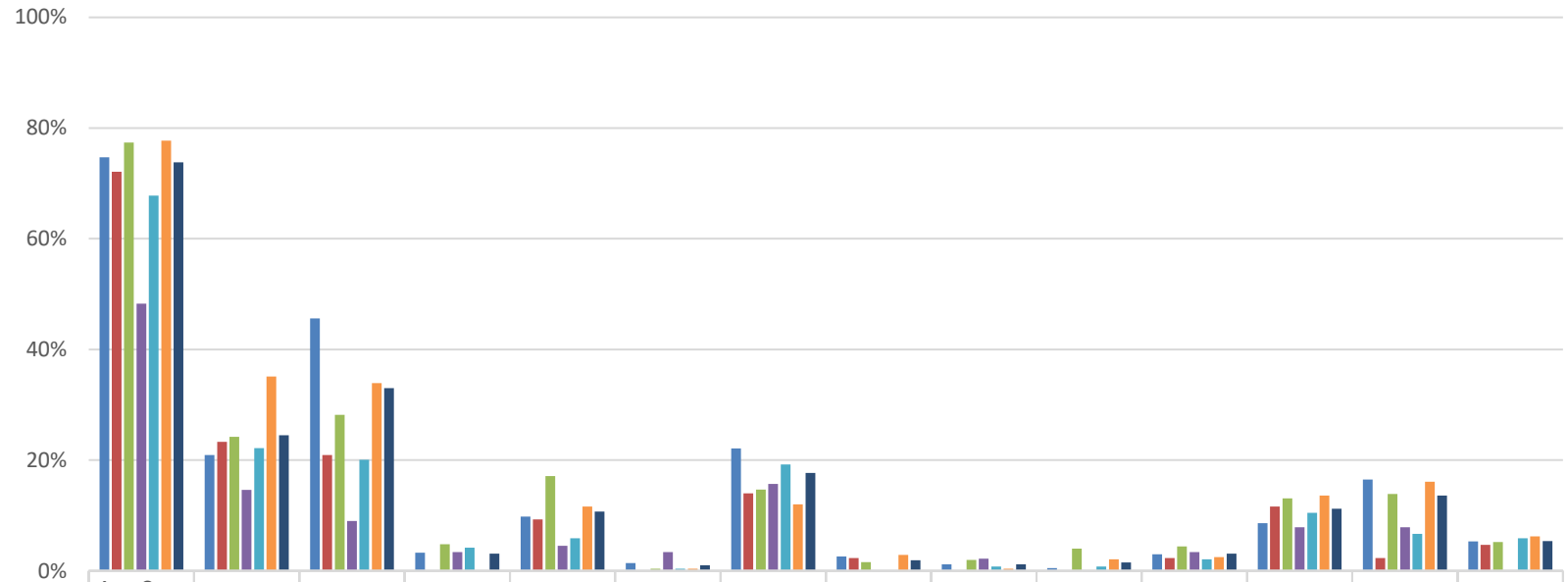


	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psychotherapy	PsyDx/Testing	SUD
	OutreachSPH (4)													
Alliance	42%	23%	13%	1%	4%	4%	27%	3%	1%	0%	8%	8%	22%	2%
Eastpointe	32%	15%	8%	0%	0%	0%	23%	0%	2%	1%	7%	7%	14%	3%
Partners	26%	13%	5%	0%	7%	2%	20%	2%	2%	3%	8%	7%	16%	4%
Sandhills	17%	10%	1%	0%	2%	3%	22%	0%	1%	1%	5%	7%	10%	3%
Trillium	26%	13%	4%	0%	4%	1%	24%	0%	1%	2%	7%	9%	14%	4%
Vaya	35%	12%	12%	1%	10%	1%	17%	2%	0%	4%	8%	6%	17%	1%
Statewide	34%	18%	9%	1%	5%	3%	25%	2%	1%	2%	8%	8%	19%	3%

Table 37. Participants in Diversion Status, SFY24

LME/MCO	Total N	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	430	321	90	196	14	42	6	95	11	5	2	13	37	71	23
Eastpointe	43	31	10	9	0	4	0	6	1	0	0	1	5	1	2
Partners	252	195	61	71	12	43	1	37	4	5	10	11	33	35	13
Sandhills	89	43	13	8	3	4	3	14	0	2	0	3	7	7	0
Trillium	239	162	53	48	10	14	1	46	0	2	2	5	25	16	14
Vaya	242	188	85	82	0	28	1	29	7	1	5	6	33	39	15
Statewide	1,240	915	304	409	39	133	12	220	23	15	19	38	139	169	67

Figure 66. Participants in Diversion Status, SFY24

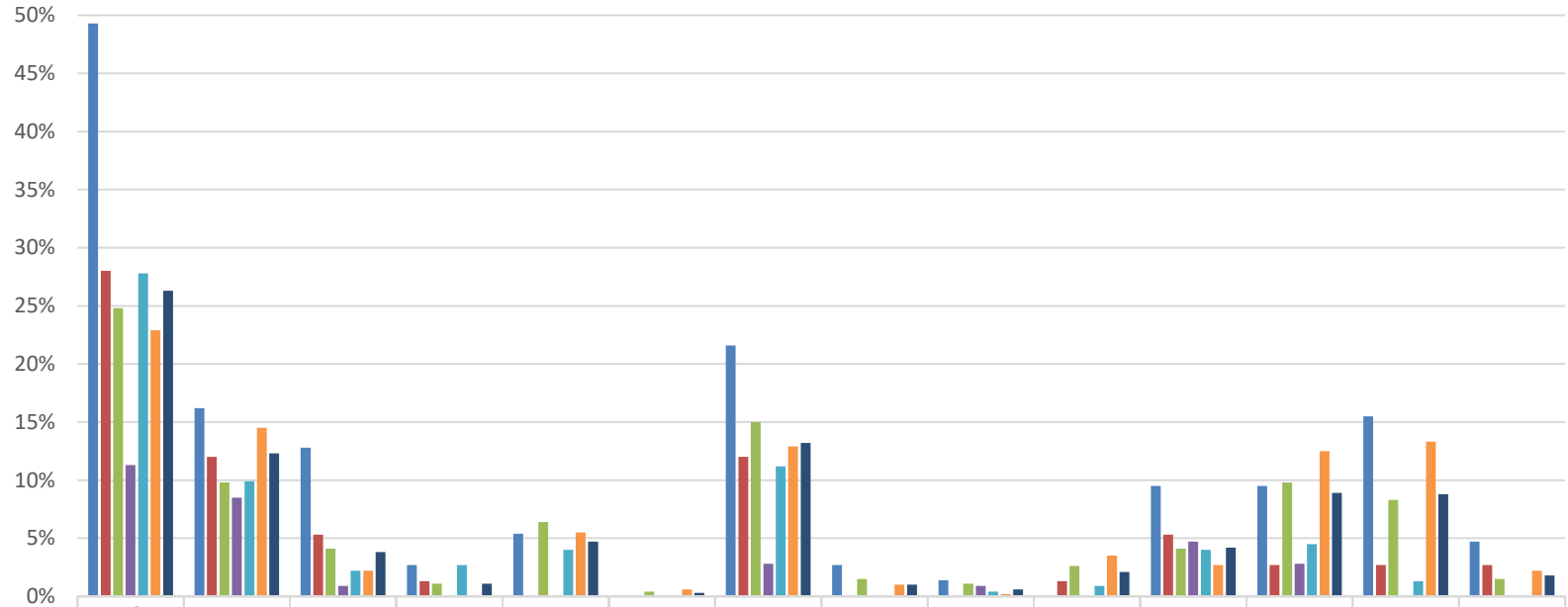


	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psychotherapy	PsyDx/Testing	SUD
	Diversion Attempt													
Alliance	75%	21%	46%	3%	10%	1%	22%	3%	1%	1%	3%	9%	17%	5%
Eastpointe	72%	23%	21%	0%	9%	0%	14%	2%	0%	0%	2%	12%	2%	5%
Partners	77%	24%	28%	5%	17%	0%	15%	2%	2%	4%	4%	13%	14%	5%
Sandhills	48%	15%	9%	3%	5%	3%	16%	0%	2%	0%	3%	8%	8%	0%
Trillium	68%	22%	20%	4%	6%	0%	19%	0%	1%	1%	2%	11%	7%	6%
Vaya	78%	35%	34%	0%	12%	0%	12%	3%	0%	2%	3%	14%	16%	6%
Statewide	74%	25%	33%	3%	11%	1%	18%	2%	1%	2%	3%	11%	14%	5%

Table 38. Participants living in the Community without a TCL Housing Slot, SFY24

LME/MCO	Total N	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	148	73	24	19	4	8	0	32	4	2	0	14	14	23	7
Eastpointe	75	21	9	4	1	0	0	9	0	0	1	4	2	2	2
Partners	266	66	26	11	3	17	1	40	4	3	7	11	26	22	4
Sandhills	106	12	9	1	0	0	0	3	0	1	0	5	3	0	0
Trillium	223	62	22	5	6	9	0	25	0	1	2	9	10	3	0
Vaya	489	112	71	11	0	27	3	63	5	1	17	13	61	65	11
Statewide	1,300	342	160	49	14	61	4	172	13	8	27	55	116	115	24

Figure 67. Participants living in the community without a TCL slot, SFY24



	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psychotherapy	PsyDx/Testing	SUD
	Living in the community without a slot													
Alliance	49%	16%	13%	3%	5%	0%	22%	3%	1%	0%	10%	10%	16%	5%
Eastpointe	28%	12%	5%	1%	0%	0%	12%	0%	0%	1%	5%	3%	3%	3%
Partners	25%	10%	4%	1%	6%	0%	15%	2%	1%	3%	4%	10%	8%	2%
Sandhills	11%	9%	1%	0%	0%	0%	3%	0%	1%	0%	5%	3%	0%	0%
Trillium	28%	10%	2%	3%	4%	0%	11%	0%	0%	1%	4%	5%	1%	0%
Vaya	23%	15%	2%	0%	6%	1%	13%	1%	0%	4%	3%	13%	13%	2%
Statewide	26%	12%	4%	1%	5%	0%	13%	1%	1%	2%	4%	9%	9%	2%

10.3. 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.

CCBHC: Certified Community Behavioral Health Clinic

CH/PU: Community Hospitals and Psychiatric Units.

CI: Community Inclusion.

CIE: Competitive Integrated Employment.

CIL: Centers for Independent Living.

CLA: Community Living Assistance.

CLIVe: Community Living Integration Verification (NC HFA application.)

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

CPSS: Certified Peer Support Specialist.

CQI: Continuous Quality Improvement.

CST: Community Support Team.

CTI: Critical Time Intervention.

CY: Calendar Year.

DB101: Disability 101.

DHB: Division of Health Benefits.

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

DSOHF: Division of State Operated Healthcare Facilities.

E&M: Evaluation and Management.

ED: Emergency Department.

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

EPS: Encounter Processing System (NC Medicaid application)

EQR: External Quality Review.

EQRO: External Quality Review Organization.

FBC: Facility-Based Crisis.

FTE: Full-Time Equivalent.

HUD: Department of Housing and Urban Development.

IDM: Informed Decision Making.

IDMT: Informed Decision-Making Tool.

IPS: Individual Placement and Support.

IPU: Inpatient Psychiatric Unit.

IR: Independent Reviewer

IRIS: Incident Reporting Information System.

ITP: Incapable to Proceed

JCB: Joint Communication Bulletin.

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.

MHC: Medicaid Help Center

MI: Motivational Interviewing.

NAMI: National Alliance on Mental Illness.

NBCC: National Board of Certified Counselors.

NCDHHS: North Carolina Department of Health and Human Services.

NCHFA: North Carolina Housing Finance Agency.

NC-TOPPS: North Carolina Treatment Outcomes and Program Performance System.

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.

TA: Technical Assistance.

TAC: Technical Assistance Collaborative.

TBI: Traumatic Brain Injury.

TCL: Transitions to Community Living.

TCLD: Transitions to Community Living Database.

TCLV: Transitions to Community Living Voucher.

TMACT: Tool for Measurement of Assertive Community Treatment.

TMS: Transition Management Service.

TOC: Transition Oversight Committee.

TP: Tailored Plan.

TT: Transition Team.

TYSR: Transition Year Stability Resources.

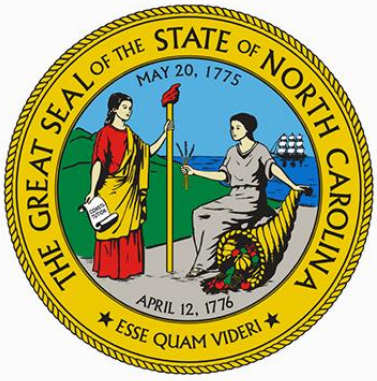
UM: Utilization Management.

UNC: University of North Carolina.

UNC-IBP: UNC Institute for Best Practices.

USDOJ: United States Department of Justice.

10.4. LIST OF FIGURES AND TABLES



NC DEPARTMENT OF
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