NC TRANSITIONS TO COMMUNITY LIVING

ANNUAL REPORT

State Fiscal Year 2025

(July 2024-June 2025)

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

May 2026

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1 ACKNOWLEDGEMENTS

In 2012, NCDHHS entered into a Settlement Agreement with the U.S. Department of Justice (USDOJ) to expand community-based housing and services for individuals with serious and persistent mental illness (SPMI), ensuring those in or at risk of entering adult care homes (ACH) have the opportunity to live in the community.

Since its launch, the Transitions to Community Living (TCL) program has helped more than 5,800 individuals transition to or remain in community settings.

Guided by our Olmstead Principles and in partnership with our stakeholders, we remain committed to supporting individuals in living their best lives in the communities they choose. I extend my sincere thanks to all who contributed to the progress highlighted in the TCL State Fiscal Year 2025 (SFY25) Annual Report.[1]

- Centers for Independent Living (CILs) and Community Inclusion Partners
- National Alliance on Mental Illness (NAMI)
- NCDHHS Cross-Division TCL Staff
- NCDHHS Division of Aging (DA)
- NCDHHS Division of Health Benefits (DHB)
- NCDHHS Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS)
- NCDHHS Division of Social Services (DSS)
- NCDHHS Division of State Operated Healthcare Facilities (DSOHF)
- Yale University
- Temple University
- University of North Carolina (UNC) / University of North Carolina Institute of Best Practices (UNC-IBP)
- NCDHHS Division of Employment and Independence for People with Disabilities (EIPD)[2]
- NC Housing Finance Agency (NCHFA)
- NC Money Follows the Person (MFP)
- Mathematica
- The Local Management Entities/Managed Care Organizations (LME/MCOs)[3]
- The Technical Assistance Collaborative (TAC)
- U.S. Department of Housing and Urban Development (HUD)

Respectfully submitted,

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[1] The State Fiscal Year (SFY) runs from July 1 through June 30. In this report, SFY25 refers to the period July 1, 2024, through June 30, 2025. The prior TCL Annual Report covering July 1, 2023, through June 30, 2024, is referred to as SFY24 (available at: https://www.ncdhhs.gov/tcli-2023-2024-annual-reportpdf/open). An earlier TCL Annual Report referred to the July 1, 2022, through June 30, 2023, fiscal year as SFY 22–23 (available at: https://www.ncdhhs.gov/tcli-2022-2023-annual-reportpdf/open).

[2] Formerly the Division of Vocational Rehabilitation

[3] 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

Transitions to Community Living (TCL)[4] is designed to ensure that individuals with serious and persistent mental illness in North Carolina (NC) have the opportunity to live in the least restrictive, community-based settings of their choice, when clinically appropriate. TCL was established under the 2012 Settlement Agreement (SA) between the State of North Carolina and the United States Department of Justice (USDOJ)[5] to ensure compliance with the Americans with Disabilities Act (ADA) and the U.S. Supreme Court's Olmstead decision[6], which affirms the right of individuals with disabilities to live in integrated community settings rather than institutions.

This TCL Annual Report provides an overview of progress, key milestones, and ongoing challenges during State Fiscal Year (SFY) 2025. It highlights efforts to support individuals transitioning from institutional settings to community living, ensuring access to the housing, services, and supports necessary for long-term success.

In partnership with the USDOJ and the Independent Reviewer (IR), the State monitors progress toward compliance with outstanding TCL requirements through regular engagement and oversight. The IR conducts annual in-person and desktop reviews across the state and issued the SFY25 Annual Report of the Independent Reviewer[7] offering recommendations to further strengthen program implementation.

In December 2024, the Sixth Modification[8] to the Settlement Agreement was signed and entered by the court, recognizing substantial compliance across several provisions and extending the agreement until July 1, 2027.

2.2 HURRICANE HELENE RESPONSE AND RECOVERY

In late September 2024, Hurricane Helene significantly impacted western North Carolina during SFY25, bringing catastrophic flooding and widespread disruption across the region. The storm impacted millions of residents and posed significant challenges for TCL members, housing providers, and community-based behavioral health services, especially in regions served by the LME/MCOs Vaya and Partners.

NCDHHS, in coordination with Vaya, Partners, housing providers, and community stakeholders, mobilized quickly to support impacted individuals who were participating in or eligible for TCL. Efforts focused on preserving permanent supportive housing placements, stabilizing individuals at risk of displacement, maintaining continuity of behavioral health and crisis services, and adapting in-reach and transition coordination activities to ensure continued engagement with TCL members. Diversion and community-

[4] Throughout this document, TCL is sometimes referred to as a "program" for conciseness. However, TCL consists of services and functions that are integrated within, and are part of, North Carolina's broader mental health service system

[5] 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

[6] 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/

[7] The SFY25 Independent Reviewer TCL Report was published on December 10, 2024. It is available on the NCDHHS website: https://www.ncdhhs.gov/fy-2025-tcl-independent-reviewer-annual-reportpdf/open

[8] 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

based alternatives remained a priority wherever clinically appropriate, even amid disaster response efforts.

NCDHHS deployed behavioral health resources, crisis counseling, and disaster-related support to affected communities. Vaya and Partners demonstrated exceptional leadership and commitment in safeguarding TCL members, coordinating local response efforts, and sustaining service delivery despite significant operational challenges. Their partnership remains instrumental in maintaining housing stability and continuity of care as part of the on-going recovery period.

As North Carolina continues the recovery period, TCL remains committed to prioritizing continuity of care, service delivery, and housing stability to continue minimizing disruptions for individuals served and working closely with Vaya and Partners to support on-going recovery needs and considerations for their networks and impacted areas. These efforts and partnerships demonstrate the commitment, strength, adaptability, and resilience of the greater State of North Carolina to respond effectively during and following a major natural disaster.

2.3 OVERVIEW

The Settlement Agreement between the State of North Carolina and the USDOJ is organized around six key pillars that support successful transitions to community living. This year's report outlines progress made across all six pillars, with each pillar addressed in a dedicated section.

1) **Community-Based Housing**: Ensuring individuals have access to affordable and stable housing options within their communities.
2) **Community-Based Mental Health Services (MHS)**: 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, maintain, and advance meaningful employment.
4) **Discharge and Transition (D&T) Process**: Developing personalized transition plans that address the specific needs and preferences of each individual.
5) **Preadmission Screening and Diversion**:[9] Implementing processes to screen and divert individuals from unnecessary institutionalization.
6) **Quality Assurance & Performance Improvement (QAPI)**:[9] Establishing a monitoring system focused on the quality of services and support provided to individuals transitioning and living in the community.

Each dedicated pillar section is organized into three subsections:

- **Progress during SFY25**: This subsection summarizes key achievements toward meeting outstanding TCL compliance requirements under the Settlement Agreement and highlights progress made during SFY25. Significant developments and enhancements relating to requirements which have already been met and discharged also are described.
- **SFY25 Supporting Data**: This subsection presents analysis and data supporting the progress and activities undertaken during SFY25, including comparisons to prior years to demonstrate the overall evolution of the project. Data sources include the TCL Dashboard, External Quality Review (EQR) reports, Constellation reviews, and TCLD data.
- **Key Focus Areas and Priorities for SFY26**: This subsection outlines key priority strategies on which the Department will focus its TCL efforts for the upcoming fiscal year, building on progress achieved and

[9] The Pre-Admission Screening & Diversion and Quality Assurance & Performance Improvement (QAPI) pillars have successfully met all TCL compliance requirements. The respective pillar sections for Pre-Admission Screening & Diversion and QAPI describe the progress that led to compliance and the continued refinement and maturation of related strategies.

identifying areas for continued strengthening and sustainability.

The Pre-Admission Screening & Diversion and Quality Assurance & Performance Improvement (QAPI) pillars have successfully discharged all TCL compliance requirements. These sections focus on the progress that led to compliance, as well as the continuation, refinement, and maturation of ongoing strategies.

2.4 LOOKING AHEAD: SFY26 PRIORITIES

1) Community-Based Housing

- **Continue and Refine Housing Pilot:** In January 2025, the Housing Pilot expanded to all four LME/MCOs. The team will look to continue to improve access to housing for TCL eligible individuals and improve tenancy outcomes.
- **Engage with Public Housing Authorities:** Continue engagement with NC's PHAs to address housing needs, provide training, and enhance financial sustainability through federal vouchers.
- **Establish and adopt a Permanent Supportive Housing (PSH) framework:** NC developed a PSH framework throughout SFY24 and continued to work in SFY25 to expand adoption throughout state divisions that assist with housing efforts in NC.

2) Community-Based Mental Health Services

- **Strengthen Community-Based Provider Capacity:** Improve quality and effectiveness of community mental health providers through targeted coaching, technical assistance (TA), and performance monitoring to support stable community living and improved outcomes.
- **Enhance Service Quality and Accountability:** Advance Assertive Community Treatment (ACT), Individual Placement and Support (IPS), Transition Management Service (TMS), and Community Support Team (CST) service quality through coaching, collaboratives, UNC-IBP training, strengthened contract monitoring, and use of data tools; CST Monitoring Tool, Quality Measurement Report (QMR), and QAPI to identify gaps and drive improvement.
- **Expand Crisis and Recovery-Oriented Supports:** Invest in peer respite, recovery centers, Behavioral Health Urgent Care (BHUC), crisis services, and modernized Clubhouses to strengthen the continuum of community-based supports.
- **Strengthen Community Integration and Peer Support:** Expand Community Inclusion (CI) statewide through provider growth, increase in Centers for Independent Living (CIL), LME/MCO participation, communities of practice, program evaluation, and enhanced peer training to reduce barriers, promote inclusion, and sustain recovery.

3) Supported Employment

- **Implement IPS Landing Page:** Continue to develop the centralized IPS Landing Page for training, guidance, and information to streamline IPS services and support Tailored Care Manager (TCM) onboarding and referrals.
- **Grant for Integrated Mental Health and Supported Employment Services:** Develop and implement a grant to connect high-performing Integrated Mental Health and Supported Employment providers by proposing grant startup funds to develop integrated teams and improve service quality and community placement success.
- **Employment Discovery & Engagement Education:** Explore and pursue opportunities to improve engagement skills and motivational interviewing (MI) for staff that serve TCL individuals.

4) Discharge and Transition Process

- **Improve Transition Coordination and Transition Team (TT):** Provide in-person and virtual training to see training's positive impact and set next fiscal year improvements; member coached and leads their

transition team; In-Reach/TCL Tool's person-centered information structures transition team meeting(s), actions, and Person-Centered Planning (PCP); and coach and strengthen community mental health providers' role.

- **Improve Desk/In Person Review Insights:** Continue learning from Independent Reviewer and Constellation desk and in-person reviews to develop interventions and improvements in subsequent training, one-on-ones with LME/MCOs, and settlement agreement compliance interventions and improvements
- **Collaborate and communicate with LME/MCO Transition Teams:** Continue NCDHHS attendance in LME/MCO TCL transition team meetings to provide immediate feedback to TCL teams.
- **Empower Informed Choice:** Monitoring the facilitation of community visits during in reach to educate individuals about supportive housing options and community-based services and supports, allowing individuals to make an informed decision about where they live and work.

5) Pre-Admission Screening and Diversion

- **Ongoing evaluation of the Referral Screening Verification Process (RSVP):** The Department continues to monitor and assess the RSVP tool to identify opportunities to improve functionality, data quality, and consistency in pre-admission screening determinations. Ongoing monitoring and quality reviews support timely eligibility decisions and appropriate linkage to services.
- **Sustaining informed choice practices**: Oversight continues to ensure individuals diverted from institutional settings are informed of all alternatives to ACH admission. Monitoring efforts support consistent documentation of informed choice and the use of individualized planning approaches by LME/MCOs to address concerns and preferences, including targeted education for younger individuals regarding permanent supportive housing options.

6) Quality Assurance & Performance Improvement

- **Improve QAPI Tools:** Enhance and refine established NCDHHS TCL QAPI system processes and tools, including Quality Assurance Committee (QAC) functions; performance measure monitoring and QAPI cycle activities and reporting; TCL dashboard measures and functionality; and Quality of Life (QoL) survey content and methodology.
- **Strengthen Cross-Pillar Collaboration:** Provide consulting and partner with other TCL SMEs to enhance quality and performance monitoring, data analysis, and improvement planning and activities.
- **Support LME/MCO QAPI Planning and Activities:** Support LME/MCOs to meet Medicaid contract requirements and strengthen regional TCL QAPI systems, including through targeted technical assistance to identify and address system gaps and improve interventions, data use, outcomes measurement, and documentation.

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 local agencies, such as the North Carolina Housing Finance Agency (NCHFA) and Public Housing Authorities (PHAs). 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 percent 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. The Office of the Secretary partners with the Division of Aging and their Approved Referral Agencies in order to ensure individuals with disabilities have access to the Low-Income Housing Tax Credit properties funded by NCHFA. These are set asides in often large-scale apartment complexes that allow individuals with disabilities to live and play near and with individuals who may not have a disability.

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 SFY25

The SA outlines nine substantive requirements related to Community-Based Housing for North Carolina[10]. The table below lists key progress made during SFY25 in meeting the three outstanding requirements.

3.1.1 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 has expanded this through the HUD 811PRA grants received in 2019 and again in 2023. • NCHFA was awarded a technical assistance contract from VERA institute, which will look at the tenant selection plans for NCHFA properties and identify areas to increase access.

[10] 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).

Outstanding TCL Compliance Requirements	Key Progress
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 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.	• The state increased the number of TCL housing individuals from population 1-3 by net a number of 21 (from 995 to 1016) during SFY25.
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 and encouraged for all individuals if they choose to accept them. Housing is scattered site, and individuals have access to community inclusion services to assist with integrating into their chosen community.

During SFY25, the department continued to monitor its compliance with the six community-based housing requirements that were met[11], as shown in the table below.

The Settlement Agreement outlines nine substantive requirements related to Community-Based Housing. As reflected in prior court modifications, multiple housing requirements have been met and discharged. During SFY25, the Department continued to perform previously established processes and activities to sustain compliance with these requirements, while also advancing progress on remaining housing obligations, as described below.

3.1.2 SUSTAINED PROGRESS MADE UNDER HOUSING REQUIREMENTS ALREADY MET AND DISCHARGED

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	• 904 individuals from one of these priority populations received new housing slots in SFY25

[11] 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).

TCL Requirements that Have Been Met and Discharged	Key Progress
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.	
III(B)(3). The State will provide access to 3,000 Housing Slots (…) (h) By July 1, 2021, the State will provide Housing Slots to at least 3,000 individuals.	• At the end of SFY25, there were 3998 individuals living in NC with a housing slot, including 2334 from population 5,642 from population 4, and 1,022 from population 1-3. As of the end of SFY25, TCL housed 7,271 individuals over the life of the program which includes 3462 from population 5,1270 from population 4, and 2,539 from population 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. An individual 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 (HSPA) sponsored by U.S. Department of Housing and Urban Development (HUD), with one of the key areas of work being to inventory available housing and tenancy support programs in NC. This work has continued with

TCL Requirements that Have Been Met and Discharged	Key Progress
	the NC Strategic Housing Plan services workgroup and ongoing work done by the HSPA group.
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 residences that comply with permanent supportive housing principles, which exclude congregant and licensed settings.
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)(PSS) 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.

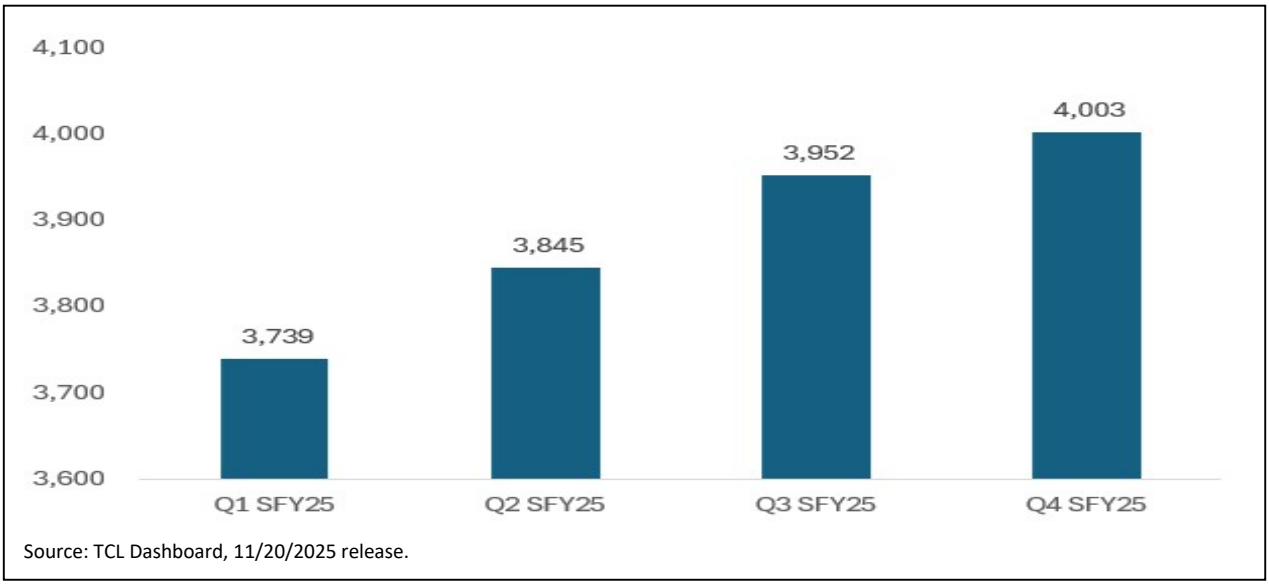
3.2 SFY25 SUPPORTING DATA

Figure 1 and Figure 2 show a steady increase in the number of individuals living in the community with a housing slot during SFY25, rising from 3,739 in Q1 to 4,003 in Q4. The increase was driven primarily by Population 5 (Diversion), which grew from 2,129 in Q1 to 2,341 in Q4, while Populations 1–3 and 4 remained relatively stable with modest increases by Q4.

3.2.1 INDIVIDUALS IN HOUSING

Figure 1 shows a steady increase in the number of individuals living in the community with a TCL housing slot across all four quarters of SFY25.

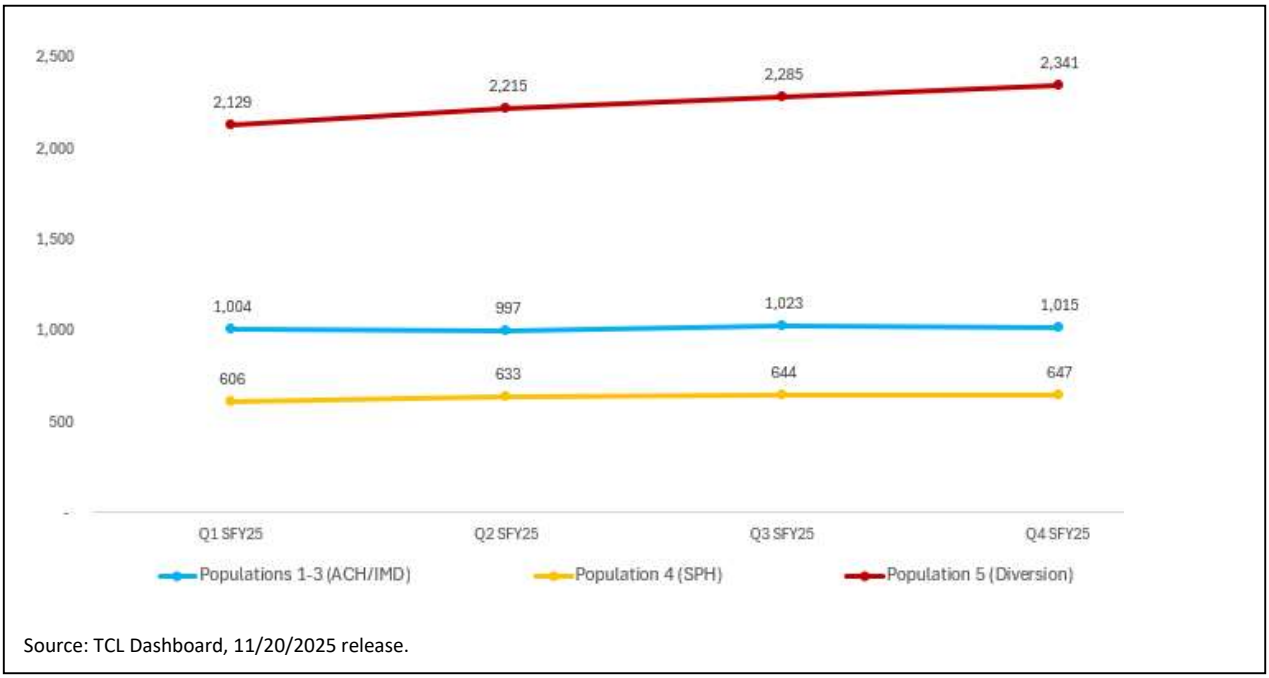
Figure 1. Number of Individuals Living in the Community with A Housing Slot (By State Fiscal Year Quarters)



Source: TCL Dashboard, 11/20/2025 release.

Figure 2 illustrates the distribution of individuals with a TCL housing slot by population category during SFY25, highlighting growth trends across Populations 1–3, 4, and 5.

Figure 2. Count of Individuals Housed with a TCL Slot by Population Category (By State Fiscal Year Quarters)



Source: TCL Dashboard, 11/20/2025 release.

Also, as the number of individuals living in TCL housing increased throughout SFY25, quarterly housing separation rates remained relatively low and continued to decline over the year. Separation rates decreased from 4.7 percent in Q1 to 4.4 percent in both Q2 and Q3 and further declined to 4.1 percent in

Q4. These trends indicate sustained housing stability even as overall housing participation expanded. Additional TCL participant outcomes related to housing stability and maintenance of chosen living arrangements are reported in Section 8 of this report.

3.3 KEY FOCUS AREAS AND PRIORITIES FOR SFY26

3.3.1 CONTINUATION OF THE HOUSING PILOT

This strategy aims to address access for individuals in low-income housing tax credit (LIHTC) properties. It has been a focused collaboration between Division of Aging, Office of the Secretary, LME/MCOs, and the NC Housing Finance Agency and has been supported by the Technical Assistance Collaborative (TAC). In year one, two LME/MCOs were selected to pilot this initiative, and a great deal of work went into establishing meaningful workflow and objectives. This was done to ensure all parties were aware of their responsibilities, as well as to identify potential areas for improvement. Beginning in calendar year (CY) 2025, this pilot was expanded to all of the LME/MCOs as it had shown good progress with the first year of increasing utilization of LIHTC units for individuals with disabilities.

With the expansion to all four LME/MCOs, NCDHHS, NCHFA, and the LME/MCOs will be revisiting the process map and identifying areas for improvement.

3.3.2 IMPROVING TENANCY SUPPORTS

The State is working to improve the quality of tenancy support services provided in the community, both to reduce separations of individuals and improve their quality of life. The major strategy that is being considered is strong collaboration with the services team and LME/MCOs to expand the role of peers in the housing stabilization process and expansion of Community Inclusion services and supports statewide to ensure that all individuals who are interested in / would benefit from this service are able to access it.

4 COMMUNITY-BASED MENTAL HEALTH SERVICES

The Community-Based Mental Health Services (MHS) Pillar delivers a comprehensive continuum of recovery-oriented mental health services and supports designed to help individuals eligible for Transition to Community Living (TCL) successfully thrive in their communities.

Community MHS focuses on supporting individuals with serious mental illness (SMI) as they transition from institutional settings and return to the highest level of independence possible. A key emphasis of the pillar is ensuring that housed individuals are connected to at least one core community-based service, including Assertive Community Treatment (ACT), Community Support Team (CST), Transition Management Services (TMS), and Peer Support Services (PSS). These services work together to promote stability, continuity of care, and long-term recovery.

In addition, the MHS Pillar strengthens outcomes through effective and improved Person-Centered Planning (PCP), which enhances service coordination, supports meaningful goal setting, and ensures that services are aligned with individual strengths, preferences, and recovery goals. The pillar also prioritizes community integration by expanding access to natural supports, community resources, and opportunities within the communities in which individuals choose to live. Through coordinated, person-centered approaches, the MHS Pillar aims to improve quality of life and support sustained recovery in the community.

4.1 PROGRESS DURING SFY25

Significant progress has been made in advancing priority TCL MHS initiatives, including finalizing and initiating implementation planning for the PCP Learning Collaborative to strengthen person-centered practice (PCP) statewide, as well as planning for the implementation of enhanced service monitoring activities across ACT, CST and PCP.

Concurrently, DMH/DD/SUS advanced its Strategic Plan priorities by expanding peer workforce capacity through CPSS trainings and scholarships, launching a standardized and free CPSS certification curriculum, broadening peer training offerings, and establishing a new associate's degree pathway for Qualified Professionals in partnership with the NC Community College System.

These DMH/DD/SUS Strategic Plan priorities — including increasing access to care statewide, preventing substance misuse and overdose, building and strengthening the behavioral health workforce, strengthening the crisis system, expanding services for individuals involved in the justice system, and amplifying recovery-oriented and community-based services — also advance and reinforce progress within TCL MHS.

The Settlement Agreement outlines 10 substantive requirements related to Community-Based Mental Health Services (MHS) for North Carolina. The table below lists key progress made during SFY25 in meeting these requirements.

4.1.1 KEY PROGRESS MADE TO MEET OUTSTANDING MENTAL HEALTH 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	• Strengthened service access through statewide technical assistance and provider training supporting ACT, CST, TMS, Peer Support, and PSH-aligned services.

Outstanding TCL Compliance Requirements	Key Progress
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.	• Conducted service gap analyses using Capacity Reports and QMR thresholds to identify and address access barriers for housed individuals; findings are summarized in Table 7.

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.	• Utilized Capacity Reports to monitor service availability for all individuals with SMI, regardless of housing status, across all LME/MCOs.
	• Maintained statewide access to Medicaid-covered and State-funded community mental health services for individuals with SMI not receiving housing
	• Expanded access to treatment and harm-reduction services for individuals not receiving housing slots, including:
	  ○ Expanded naloxone purchasing and distribution across multiple counties.
	  ○ Deployed Mobile OTP services to reach underserved communities.
	• Continued statewide availability of ACT, CST, Peer Support, TMS, and crisis services for individuals at risk of adult care home entry.

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.	• CST Coaching (Service Quality and Workforce Development)
	  ○ Implemented a four-pronged CST coaching model through TAC:
	  ▪ 117 one-on-one Team Lead coaching engagements
	  ▪ 208 Agency Leadership coaching engagements
	  ▪ 56 LME/MCO accountability and oversight TA engagements, with 100% LME/MCO participation
	  ▪ Cross-training and community collaboration activities
	  ○ Delivered seven Direct Care Track trainings and eight Leadership Community of Practice trainings to strengthen trauma-informed, person-centered CST service delivery.
	• CST Monitoring and Training
	  ○ Developed and piloted a CST Monitoring Tool to formally assess CST service quality and adherence to service expectations.

Outstanding TCL Compliance Requirements	Key Progress
	○ Incorporated feedback from TCL members, LME/MCOs, providers, and NCDHHS. ○ Structured the tool to assess four core performance domains: ▪ Agency infrastructure ▪ Team composition and staff training ▪ Assessment and person-centered service planning ▪ Service delivery and implementation ○ Conducted training sessions for LME/MCO staff on use of the monitoring tool. ○ Completed a pilot monitoring review of eight CST teams: ▪ Seven teams participated in follow-up coaching and technical assistance. ○ Used pilot findings to refine the monitoring tool and inform future statewide CST monitoring efforts. • Transitional Management Services (TMS) Coaching ○ Delivered 15 TMS coaching and technical assistance sessions reaching 61 attendees. ○ Facilitated six TMS collaboratives with 56 participants from 12 provider agencies. ○ Conducted four clinical consultation sessions for TMS supervisors focused on IPS case consultation, benefits counseling, and engagement challenges. ○ All LME/MCOs were offered a 15-hour PSH training every other month, with on-demand PSH refresher training available statewide. • Community Inclusion (CI) ○ Expanded Community Inclusion services to strengthen natural supports and community integration: ▪ Launched SouthLight CI on July 1, 2024, serving 28 individuals across two counties by October 2024. ▪ Approved funding for two additional CI providers, achieving statewide CI coverage by July 1, 2025. ▪ Ensured 100% Tailored Care entity participation, with each supporting at least one CI team. ▪ Delivered nine statewide CI webinars and established the NC Community of Practice for Community Inclusion in partnership with Temple University.
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	• Continued statewide reliance on ACT, CST, Peer Support, TMS, PSR, and PSH-aligned services as the primary service array for individuals with SMI. • Increased penetration of core services among housed individuals: ○ By Q4, 84.2% of housed individuals received at least one core service. • Supported consistent implementation of core services through recurring statewide PSH training and technical assistance.

Outstanding TCL Compliance Requirements	Key Progress
any other services as set forth in Sections III(C)(1) and (2) of this Agreement.	

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.	• Completed 24 TMACT fidelity reviews during SFY25, including:
	  ○ 89 TCL chart reviews embedded within fidelity assessments.
	• ACT Coaching (Quality and Fidelity Improvement)
	  ○ Delivered 45 ACT coaching and technical assistance sessions with 197 total attendees.
	  ○ Implemented mandatory ACT coaching effective July 1, 2024, for teams scoring 3.00–3.34 on TMACT:
	  ▪ Eight ACT teams participated.
	  ▪ Three teams completed the six-month coaching requirement.
	  ○ 100% of participating teams requested additional coaching, indicating sustained engagement and measurable quality improvement indicating that implementing the coaching initiatives have led to positive feedback regarding the coaching both from the provider staff and the LME/MCO.
	  ○ Coaching focused on fidelity to TMACT, recovery-oriented practices, crisis prevention, employment supports and coordinated care. Teams responded so well to the coaching that they requested to continue with these topics after the coaching requirement had ended.

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. 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.	• Achieved 100% quarterly submission compliance for Person-Centered Planning (PCP) monitoring across all LME/MCOs.
	  ○ Full participation in monitoring submissions from all four LME/MCOs
	  ○ Submissions enabled review by the NCDHHS Services team
	  ○ Review findings were shared with each LME/MCOs
	  ○ One-on-One meetings with LME/MCOs provided opportunities to discuss:
	  ▪ Progress with PCP implementation
	  ▪ Interventions currently in place
	  ▪ Strategies for continued system improvement
	• Required all LME/MCOs to implement PCP monitoring processes assessing:
	  ○ Individual goals and preferences
	  ○ Crisis prevention and intervention planning
	  ○ Coordination across service providers
	• Initiated drafting of contract language to formalize PCP monitoring as a contractual requirement beginning in SFY 2026.
	• Advanced planning for the implementation of a statewide PCP Learning Collaborative, with a focus on establishing goals, curriculum, and infrastructure for future implementation, including:
	  ○ Onboarding a dedicated PCP Consultant
	  ○ Developing a state-approved kickoff and orientation framework for LME/MCOs

Outstanding TCL Compliance Requirements	Key Progress
	○ Identifying subject matter experts (SME) to support curriculum development ○ Creating the Collaborative structure and proposed meeting schedule • Focused PCP Learning Collaborative efforts on foundational planning and contract execution, including: ○ Defining the goals, agenda, and curriculum for the Collaborative ○ Advancing the project through the State contract approval and governance process • In partnership with Yale University, delivered 10 PCP-focused trainings in SFY25 — reaching approximately 1,900 participants across providers, LME/MCOs, and related organizations. ○ Topics included crisis prevention and approaches, partnering with individuals and guardians, natural supports, and long-term recovery goals.
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 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.	• Capacity Report Improvements: ○ In collaboration with the LME/MCOs the State standardized the Capacity Report template across all LME/MCOs and streamlined the submission process by integrating an Annual submission into PCDU. ○ Finalized a statewide Capacity Report dashboard visualizing ACT, CST, Peer Support, TMS, and Crisis Services capacity. ○ Conducted quality improvement efforts using Capacity Reports to: ▪ Assess performance against prioritization thresholds ▪ Identify service gaps. ▪ Provided structured feedback to LME/MCOs. ▪ Received constructive suggestions and recommendations from the LME/MCOs regarding the template structure, reflecting a collaborative approach and strong working relationships with the LME/MCOs. ○ Used Capacity Report findings to support State oversight of PIHP/LME accountability for provider network sufficiency.
III(C)(8). Each PIHP and/or LME will provide publicity, materials and training about the crisis hotline,	• Launched bilingual (English/Spanish) crisis communications with strong engagement:

Outstanding TCL Compliance Requirements	Key Progress
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 (TYSR), 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.	○ 119,000 LME/MCO webpage visits ○ 58,500 TCM webpage visits ○ 26,800 1915(i) visits/downloads • Distributed crisis materials to 285 organizations across 100 counties, reaching 236,889 individuals. • Hosted five statewide Town Halls, reaching 115,000+ participants. • Published 40 bilingual PSAs and launched an Open Access Walk-In Clinic Directory. • Distributed 988 Suicide & Crisis Lifeline general campaign materials to 190 partners across 87 counties, reaching more than 172,000 individuals statewide. • Distributed 988 youth-focused campaign materials to 320 partners across 98 counties, reaching nearly 250,000 individuals statewide.
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.	• Exceeded ACT capacity targets by maintaining 86 ACT teams statewide. • Increased ACT penetration among housed individuals by nine percentage points. • Strengthened ACT service quality through fidelity reviews and mandatory coaching. • ACT vocational specialists consistently participate in IPS trainings, strengthening service fidelity and coordination between treatment and employment supports to improve competitive employment outcomes for members
III(C)(10). Crisis Services: The State shall require that each PIHP and/or 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	• Invested $131 million in statewide crisis system expansion, including: ○ $15 million for Behavioral Health Urgent Care sites ○ $20 million for BH SCAN enhancements, with 3,100+ beds reporting availability ○ $25+ million for Community Crisis Centers and peer respite

Outstanding TCL Compliance Requirements	Key Progress

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.	• Expanded mobile crisis, MORES, and co-responder services through more than $2 million in targeted investments to strengthen community-based crisis response.
	• Conducted a 988 Lifeline Quantitative Survey (April 2025) to assess awareness, access, and utilization. Based on survey findings, the following strategies were implemented, with additional efforts planned:
	  ○ Updated media and print messaging to emphasize that 988 is confidential, free, and easy to access
	  ○ Launched a Social Media Influencer campaign to promote 988 to diverse audiences across multiple platforms, highlighting that services are free, always available, and provided by judgment-free counselors
	• Ensured all LME/MCOs maintain comprehensive crisis plans that:
	  ○ Detail their crisis service systems and available services
	  ○ Demonstrate capacity to provide timely and accessible support for individuals experiencing serious mental health or substance use crisis.
	  ○ Meet legislative requirements for biennial updates.
	• Required all LME/MCOs to monitor and report service gaps or weaknesses to the State as part of their contractual obligations.
	• Strengthened North Carolina's crisis system through General Assembly investments, including:
	  ○ Development of new crisis centers, primarily in rural counties
	  ○ Expansion of 24/7 access to immediate mental health evaluations, short-term observation and stabilization, medication management, substance use interventions, and referrals to longer-term care
	  ○ Use of telehealth to support Co-Response Teams, Mobile Crisis Management Teams, and MORES teams
	  ○ Reducing strain on emergency departments and law enforcement by expanding community-based crisis alternatives
	• Advanced Behavioral Health Urgent Cares (BHUC) and Facility-Based Crisis (FBC) network, including:
	  ○ Identification of 13 BHUCs needed statewide
	  ○ Opening of seven BHUCs since May 2024
	  ○ Opening of one FBC since May 2025
	  ○ Continued planning to expand facility-based crisis capacity across the state
	• Implemented three new Behavioral Health Urgent Care Centers during the fiscal year, all of which demonstrated hospital and emergency department diversions.
	  ○ The State is working to streamline data collection from BHUCs and FBCs to provide a more comprehensive and unified view of crisis system outcomes.

4.2 SFY25 SUPPORTING DATA

A fundamental objective of TCL is to provide individuals with access to the services and supports they need to successfully transition and live in community-based settings. Appendix Subsection 10.3 of this annual

report includes annual summaries of numbers of individuals in various TCL statuses and settings in SFY25 who received each core TCL service described in the Settlement Agreement, as well as other types of community-based services including psychotherapy, psychological diagnosis and testing, evaluation and management visits, and substance use disorder (SUD) services.

4.2.1 SERVICE PATTERNS IN TCL HOUSING

NCDHHS monitors ACT utilization statewide, along with other core services that include a tenancy supports component – Community Support Team (CST), Transition Management Services (TMS), and Peer Support Services (PSS) through a quarterly Priority Measure Review and QAPI Cycle and associated Quality Measures Reports, and through ongoing engagement with LME/MCOs to ensure appropriate service matching and coordination across the service continuum. Overall, observed trends in SFY25 suggest sustained statewide capacity to connect housed TCL participants to appropriate community-based supports, including tenancy-related and recovery-oriented services.

Service coverage remained consistently high for individuals in TCL housing, with 90.8 percent in TCL housing during SFY25 receiving one or more core community-based service – Assertive Community Treatment (ACT), Transition Management Services (TMS), Community Support Team (CST), or Peer Support Services (PSS) during SFY25, during the year, and more than 84 percent receiving these core services each quarter. For purposes of this analysis, core services are defined as services that include a tenancy supports component.

The number of housed TCL participants receiving core services increased from 3,313 individuals in Q1 to 3,526 individuals in Q4, reflecting growth in the overall housed population. The percentage receiving services remained stable, ranging narrowly from 84.6 percent to 85.3 percent per quarter, indicating that service access kept pace with housing expansion over the course of the fiscal year.

Across the fiscal year, the number of housed individuals receiving ACT increased modestly from 1,325 in Q1 to 1,381 in Q4, while the share of housed individuals receiving ACT remained relatively stable, declining slightly from 33.9 percent to 33.1 percent. This pattern reflects a stabilized housed TCL population in SFY25, with ACT utilization growing in absolute terms but remaining appropriately targeted to individuals with the highest clinical needs, while others were supported through lower-intensity services.

4.2.2 SERVICE PATTERN TRENDS ACROSS TCL STATUSES AND SETTINGS

Also, of note in SFY25 were several observable shifts in relative rates of core TCL services of varying intensity, both among the TCL housed population, and in the TCL population overall. While ACT remained the service most frequently provided to TCL housed individuals, small increases in CST and PSS rates mirrored a decrease in TMS utilization compared to SFY24.

Increasing PSS utilization for individuals in TCL housing was part of a larger trend in the TCL population overall, 15 percent of whom received PSS during the year, representing approximately a 25 percent relative increase compared to the previous SFY. SFY25 also saw a relative increase of 50 percentage points in the number of individuals living in the community without a TCL housing slot and received core TCL services, from 27 percent in SFY24 to 42 percent in SFY25. These and other service patterns are described in Appendix 10.3.

4.2.3 TCL PARTICIPANT SERVICE ACCESS AND OUTCOMES

SFY25 North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS) interviews with participants across TCL statuses and settings, together with the services data presented in Appendix 10.3, indicate that among individuals engaged with community-based service providers, few experience service-

related barriers to treatment, and most report positive outcomes as a result of the services they receive.[12]

NC-TOPPS is a web-based assessment system that collects outcome and performance data for individuals receiving mental health and substance use services. Assessments are conducted by providers at admission, periodically throughout treatment, and at discharge. NC-TOPPS is required for substance use services and enhanced community-based mental health services (e.g., ACT, CST, IPS/SE, and TMS), making data available for most individuals in TCL supportive housing. However, assessments may not align exactly with the reporting period, and some sections are optional.

Less than two percent of TCL participants assessed reported service-related access barriers to receiving treatment that meets their needs. The percentage varied minimally by TCL status and setting, with slightly larger percentages of individuals in In-reach (2.8%), Transition/Rehousing Planning (2.7%), and Diversion (2.2%) reporting service access barriers compared to individuals in State Psychiatric Hospital (SPH) Outreach (1.3%), living in the community without a slot (0.9%), and living in TCL housing (0.8%).[13]

Half or more of individuals also reported the services they received were "very helpful" versus "somewhat helpful" or "not helpful" for increasing or improving their housing status (59.8%), quality of life (also 59.8%), hope about the future (54.9%), and control over their lives (50.3%), and for decreasing their mental health symptoms (50%).[14]

4.3 KEY FOCUS AREAS AND PRIORITIES FOR SFY26

4.3.1 STRENGTHEN PERSON CENTERED PLANNING (PCP) THROUGH THE PCP LEARNING COLLABORATIVE

The PCP Learning Collaborative will serve as the primary strategy to strengthen Person-Centered Planning across LME/MCOs by creating a structured forum for shared learning, problem-solving, and continuous improvement.

This initiative is critical to improving the quality and consistency of PCP practices, ensuring plans meaningfully reflect member goals, preferences, and needs, and supporting better service alignment and outcomes.

In SFY26, the team will continue convening the Learning Collaborative, advance quarterly reporting and shared metrics, incorporate findings from PCP monitoring activities, and refine content based on LME/MCO feedback, recognizing that priorities may evolve as learning progresses.

4.3.2 ENHANCE QUALITY OF OVERSIGHT OF SERVICES THROUGH MONITORING AND COACHING

This priority focuses on increasing and formalizing the quality monitoring of key services, including PCP, ACT, and CST, to drive consistency, fidelity, and improved outcomes statewide.

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[12] As shown in subsection 10.3 in the Appendix, significantly smaller percentages of TCL participants in in-reach and in community-based settings other than TCL housing receive core TCL services compared to those in or planning for transition to TCL housing. Additional information about NC-TOPPS is available at https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-use-services/reports/nc-topps-reports/nc-treatment-outcomes-and-program-performance-system-nc-topps.

[13] Percentages are based on responses of 3,696 TCL participants who received community-based services and had NC-TOPPS assessments in SFY 2025.

[14] Measure values are based on responses of 1,835 TCL participants across TCL statuses and settings who received community-based services and whose SFY 2025 interviews included an optional section of the NC-TOPPS assessment.

Strengthened monitoring is essential to ensure services are delivered as intended, identifying gaps early, and supporting Tailored Plans and providers with actionable feedback.

In SFY26, the team will advance plans to formalize PCP monitoring as a contractual requirement, establish a baseline process for measuring intensity, frequency and quality of ACT services by leveraging TAC's monitoring proposal alongside increasing the frequency of ACT fidelity reviews conducted by the University of North Carolina (UNC), and launching a new iteration of CST monitoring and coaching informed by lessons learned from the initial CST pilot.

4.3.3 EXPAND ACCESS TO AND IMPACT OF PEER SERVICES AND COMMUNITY INCLUSION

Expanding access to peer services, with a focus on Community Inclusion, is a key strategy to support recovery, social connection, and long-term stability for members across the state.

This priority is important to reduce geographic disparities, increase member engagement, and strengthen non-clinical supports that complement clinical services.

In SFY26, the team will work toward expanding Community Inclusion projects to all Tailored Plans, increasing the number of participating providers and counties, and streamlining tracking and monitoring approaches to consolidate key metrics and better assess reach, utilization, and impact.

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 SFY25 progress has focused on financially and operationally stabilizing the service. With the introduction of 1915(i) services, there was a heavy focus on increasing collaboration between IPS and TCM providers as well as adapting the milestone-based payment model to reflect that collaboration and new process flow. Additionally, the Supported Employment pillar focused on a successful launch of DB101 and subsequent trainings to optimize the use of this tool to serve the individuals of North Carolina.

5.1 PROGRESS DURING SFY25

The Settlement Agreement outlines three substantive requirements related to Supported Employment for North Carolina. Significant progress in SFY25 included discharge of the obligation in section III(D)(3) in the Sixth Modification. During SFY25, the Department continued to perform previously established processes and activities to meet remaining section III(D) requirements, implemented process improvements and refinements, and carried out data collection and analysis to monitor and ensure ongoing compliance.

5.1.1 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 integrated, paid, competitive employment. Services offered may include job coaching,	• The State continues to provide Supported Employment services to individuals with SMI who are in or at risk of entry to adult care homes. These services are provided through the IPS-SE service, as well as by ACT team employment specialists. • Supporting data show continued growth in the number of individuals who have received these services, as well as in the effectiveness of SE services for achieving intended objectives such as obtaining and maintaining integrated, paid, competitive employment. • Worked with LME/MCOs to increase referrals ○ Each LME/MCO continues to host 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.

Outstanding TCL Compliance Requirements	Key Progress
transportation, assistive technology assistance, specialized job training, and individually tailored supervision.	○ Each LME/MCO conducted monthly IPS collaborative meetings for IPS providers to share data and success stories, learn about progress to initiatives, hear about updates from stakeholders, and bring up issues or questions for discussion and guidance from the LME/MCO. The LME/MCOs also invited the UNC-IBP to provide training on IPS fidelity items in these meetings. ○ NCDHHS developed a workgroup with LME/MCOs and IPS providers to identify and problem solve challenges with timely access to the IPS service through the Medicaid 1915(I) eligibility process. DHB collected a comprehensive list of referrals in the process to better understand where the barriers were. 100% of the cases that were submitted had follow-up by the LME/MCOs. ○ Supported Employment Specialists have allowed for subject matter experts at each LME/MCO to support IPS providers, provide education on IPS and employment, and to help with shifting the culture in each LME/MCO around recovery through employment. • Worked cross departmentally and with IPS providers to address barriers in providing IPS, identify growth areas, and provide training. ○ NCDHHS developed and facilitated IPS training for Tailored Care Managers through AHEC and supplied an IPS FAQ and IPS provider contact list to assist with IPS education and commonly identified barriers, which contributed to timelier IPS access. ○ EIPD provided bimonthly IPS milestone and documentation training that is available to IPS providers and EIPD staff. ○ IPS 101 training through UNC Center of Excellence is provided to new IPS staff and ACT SE specialists on a bimonthly basis. ○ The EIPD Program Specialist for Behavioral Health continued 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. ○ EIPD Program Specialist for Behavioral Health provided 27 program reviews with specific IPS teams and EIPD Units. Those meetings are used to bring together IPS teams and their respective EIPD Units to discuss progress and areas of growth with the collaboration. Others invited are representatives from the LME/MCO and UNC Center of Excellence IPS Trainer. • With the May 2025 go-live of DB101 and provision of North Carolina Association of People Supporting Employment First (NCAPSE) benefits counseling training, the State increased efforts to provide access to benefits counseling and to dispel misconceptions around the impact of work on benefits ○ Efforts to expand access to benefits counseling included launching DB101 and achieving a total of 5,422 new users by the end of June 2025. ○ NCAPSE successfully provided benefits counseling training to 40 people by June 2025.

Outstanding TCL Compliance Requirements	Key Progress

	• The State team has also taken steps to improve the reliability of SE data provided by the LME/MCOs to enhance SE service access and quality monitoring.
	  ○ As part of the team's quality monitoring system, IPS Population and Utilization Report data was collected for the entire fiscal year. Through this report, the team collected quarterly outcomes on SE population and utilization data, including IPS referrals and enrollments, and ACT SE access.
	  ○ The Department utilizes this data to identify trends and review the dashboards with the LME/MCOs in the bi-monthly 1:1s.
	  ○ This data provides a more accurate view of the state of standalone IPS services. The Department is also able to track progress against targets in serving the TCL population.
	  ○ The team regularly monitored progress against the IPS Strategic Plan during bi-monthly 1:1s with the LME/MCOs.
	• Revised and expanded the three original EIPD milestones into eight to help align fidelity among the different payment and finance tasks for supported employment.
	  ○ The revised EIPD milestones for the IPS North Carolina Community Outreach and Resource Engagement (NC CORE) model went into effect on November 1st, 2024. This revision expanded the original three IPS milestones that go through EIPD into eight milestones.

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 Administration supported employment toolkit.	• The State continues to use the Supported Employment Fidelity Scale adopted in 2014 to evaluate IPS services and to provide services with fidelity to the vast majority of IPS clients in NC. • Significant progress in SFY25 included implementation and provision of required technical assistance to teams assessed at the Fair fidelity level, observable improvements year over year as well as biannual report fidelity trends, and IPS provider expansion, with a total of 30 IPS Fidelity teams active during the year. • Related to the grant with MFP for increased integration of mental health and supported employment services, which was under development in SFY25, further improvements in this aspect of IPS fidelity are anticipated.

5.1.2 SUSTAINED PROGRESS MADE UNDER SUPPORTED EMPLOYMENT REQUIREMENTS ALREADY MET AND DISCHARGED

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.	• By the end of SFY25, the number of individuals in or at risk of ACH placement who had received IPS-SE was 2,905[15], or 16.2 percent higher than the required 2,500, which was met in SFY 2022.

5.2 SFY25 SUPPORTING DATA

5.2.1 PROVISION OF SUPPORTED EMPLOYMENT SERVICES

Quarterly reporting by LME/MCOs indicated that SFY25 IPS enrollment overall averaged 1,075 participants per quarter, with an average Competitive Integrated Employment (CIE) rate of 38 percent. The average quarterly TCL/CIE rate was 32 percent. Approximately 50 percent of IPS participants in SFY25 also received job development and support services through EIPD.

The TCL Settlement Agreement requirement to provide IPS services to 2,500 individuals in or at risk of entering an adult care home was achieved in SFY22. By the end of SFY25, the State surpassed this mandate by more than 16 percent, with fidelity teams serving a total of 2,905 in or at-risk individuals, including 633 TCL participants as captured by monthly In or At-Risk Reporting.

New data collection efforts with LME/MCOs identified 1,125 TCL individuals who were active TCL participants during SFY25 who had received employment services through ACT, either during the same SFY or earlier. While the new data collection methodology does not allow for retrospective estimation of the number of individuals who previously received ACT employment services and are no longer active TCL participants, it provides additional context and detail related to provision of SE services through ACT for recent and current TCL participants.

[15] This figure is derived from our In or At-Risk reporting.

5.2.2 SUPPORTED EMPLOYMENT SERVICES FIDELITY

A total of 16 IPS fidelity evaluations were conducted during SFY25. Fidelity scores for providers reviewed between July and November 2025 increased by an average of four points, from 83 to 87, compared to the same providers' previous fidelity reviews. Even greater gains were observed in the later part of the SFY, when providers reviewed through April 2025 improved by an average of nine points, from 81 to 92, compared to their previous reviews.

Nine teams participated in required technical assistance as a result of receiving a Fair fidelity score rating during SFY25, with three completing all required TA by the end of the year. In all, IPS TA and training were provided to 2,330 (duplicated) IPS staff. This included technical assistance for 1,324; trainings attended by 841; and 165 in distinct IPS Support Calls.

5.3 KEY FOCUS AREAS AND PRIORITIES FOR SFY26

5.3.1 IPS LANDING PAGE

This is a continued strategy 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. Much progress has been made thus far and this effort continues.

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 Tailored Care Manager (TCM) onboarding, and help non-IPS providers with understanding why and how to refer to IPS.

5.3.2 GRANT FOR INTEGRATED MENTAL HEALTH AND EMPLOYMENT SERVICES

This grant expands the presence and capacity of high-performing Integrated Mental 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. The Supported Employment team continues to work collaboratively to progress on the development and implementation of this grant.

This state-funded grant initiative is in line with the Department's demonstrated commitment to whole person care, creating sustainable supports for people with SPMI and SUD.

5.3.3 EMPLOYMENT DISCOVERY & ENGAGEMENT EDUCATION

The Supported Employment time will strategically focus on exploring the education available regarding employment discovery and engagement within other services. Depending on the findings, the team will pursue opportunities to improve engagement skills and understanding of TCL members' motivations for working.

This strategic effort works toward increasing the availability of accurate information regarding benefits or employment as a tool for recovery for any interested individuals.

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, most 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 (IDMT). 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.

6.1 PROGRESS DURING SFY25

The Settlement Agreement outlines 14 substantive requirements related to the Discharge and Transition Process. [16] Several of these requirements have been met and discharged in prior court modifications. During SFY25, the Department continued to perform previously established processes and activities to sustain compliance with these requirements, while also advancing progress on remaining Discharge and Transition obligations, as described below.

6.1.1 KEY PROGRESS 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	• In State Psychiatric Hospitals (SPHs), LME/MCO TCL teams remained adequately staffed despite some In-Reach Specialist (IRS) turnover. NCDHHS continued to provide technical assistance to IRSs, in addition to TCL team training, with a focus on presenting service array options in a person-centered manner. • NCDHHS conducted on-site role-play sessions for LME/MCOs, using mock scenarios and technical assistance to improve engagement with TCL individuals and guardians, as applicable, and to identify potential barriers during in-reach and informed decision-making discussions. A total of 50 attendees participated.

[16] 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

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.	• As of June 30, 2025, 394 individuals made an informed choice not to transition to the community and continue to receive six-month check-ins for ongoing engagement.
	• During SFY25 Q4:
	  ○ A new informed choice step was added to the In-Reach process.
	  ○ The step applies to individuals with SMI/SPMI in:
	  ○ State Psychiatric Hospitals (SPHs).
	  ○ Adult Care Homes (ACHs).
	• In June 2025, NCDHHS delivered a virtual presentation to LME/MCO TCL staff outlining the new informed choice step and required discontinuation letter elements, followed by one-to-one technical assistance on documentation and re-engagement expectations. The initial phase of the new informed choice step was implemented on July 1, 2025.

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 visitation was tracked as one of 10 Settlement Agreement (SA) transition team factors in SPHs; however, Incapable to Proceed (ITP) court status and involuntary commitments – often far from the individual's home community – posed logistical barriers.
	  ○ Beginning FY26, community visits will be tallied by each TCL team and regularly monitored by NCDHHS.
	• In response to USDOJ reviews, NCDHHS issued additional SFY25 guidance allowing reduced in-reach frequency for TCL participants remaining under ITP court orders for more than six months, while maintaining engagement expectations.
	• NCDHHS delivered multiple virtual and in-person learning opportunities, including:
	  ○ Three virtual trainings on addressing isolation and building community connections,
	  ○ The fifth annual In-Reach Professional Development Collaborative Conference themed *"Breaking Barriers with Hope"*,
	  ○ A peer-led Community of Practice launched in September 2024 to increase in-person in-reach and continuous improvement,
	  ○ Three in-person onsite transition team SA compliance trainings at each SPH involving SPH SWs and all TCL staff serving in SPHs, and
	  ○ Monthly technical assistance and training of all four TPs' RN and OT Evaluator Teams through DHHS contract with the UNC Center for Excellence in Community Mental Health.
	• Since issuance of JCB 415 in May 2022, face-to-face in-reach contacts increased steadily from 18.3% (SFY22Q3) to 85.2% (SFY25Q4), demonstrating sustained improvement in frequent and meaningful engagement.

Outstanding TCL Compliance Requirements	Key Progress
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.	
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 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).	• DHHS continued monitoring transition teams in SPHs and ACHs using a 10-item SA checklist, providing real-time and written technical assistance to LME/MCOs. Fifty-one SPH transition team checklists were analyzed, showing improvements in engagement, facilitation, barrier resolution, discharge preparation, and inclusion of work, volunteering, and community activities. • For ACHs, NCDHHS Discharge & Transition Specialists (DTS) attended transition team meetings and provided technical assistance to LME/MCO TCL staff in real-time. Utilizing a 10-item SA transition team checklist, written feedback with recommendations was shared with TCL leadership in bi-weekly reports.
III(E)(4) Discharge planning conducted by transition teams that include: people knowledgeable about resources, supports, services and opportunities available in the community, including community mental health	• In addition to SPH transition coordinator technical assistance, NCDHHS's provided written complex care guidance to TCL teams that their Registered Nurse and Occupational Therapist Evaluation Teams (RN/OT Evaluation Teams) may offer consultation to SPH transition teams through desk review and/or ad hoc transition team participation. Furthermore, they were encouraged to provide additional complex care recommendations to the transition team as bandwidth with the RN/OT Evaluation Team permits. • Two NCDHHS Discharge and Transition Specialists were added in October 2024 to increase ACH monitoring and support LME/MCO transition coordinators. In SFY25, DTS staff attended 214 transition team meetings statewide.

Outstanding TCL Compliance Requirements	Key Progress

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.	• During SFY25, random quality reviews revealed an increase in person-centered transitions from ACHs.
	  ○ Transition team meetings are led by the individual and Transition Coordinators (TCs) facilitate the meetings with paid and natural supports in attendance.
	  ○ Individuals are able to express their preferences, needs, choice of location(s) to live in, and are fully supported by the team throughout the transition process.

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.	• NCDHHS facilitated semi-monthly Barriers and Solutions Committees at all SPHs, participated in local and state barriers committees, and convened ad hoc Barriers Intervention Teams to resolve coordination challenges between SPH discharge mandates and TCL transition leadership. • In SFY25, NCDHHS conducted random quality reviews, utilized the transition team checklist, and provided bi-weekly feedback to LME/MCOs 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. Transitions teams utilize interpreters and adaptive communication to assist in providing a voice for the individual and ensuring comprehension of the information provided.

Outstanding TCL Compliance Requirements	Key Progress

III(E)(6) Each individual shall be given the opportunity to participate as fully as possible in his or her treatment and discharge planning.	• In SPH transition team reviews this fiscal year there was a noticeable increase in teams where the individual lead their discharge planning.
	  ○ Specific training in this fiscal year will focus on the pre-transition team leadership coaching of individual by the transition coordinator and the use of the individual's In-Reach/Transition TCL Tool information to organize how an individual can better lead their transition team, and that the transition planning is framed by the individual's preferences and goals.
	• CoP 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. Similar training and role play with transition coordinators is scheduled in SFY26.
	• 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. Since SFY23 Q4, nine hundred and forty-four IDM tools have been received & reviewed by NCDHHS, 877 (in-reach) and 67 (diversion).

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.	• SPH social workers within three days of admission contact the LME/MCO staff to begin the discharge process as well as compile assessment records key to discharge for eventual use in a transition team if chosen by the individual. Furthermore, this fiscal year continued the consistent TCL eligibility request from social workers resulting in consistent initiation of in-reach within the seven-day face-to-face expectation. • Through DHHS monitoring in SPHs 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. Discharge planning is monitored weekly by DHHS staff to ensure a multi-disciplinary team begins the process early, creates a comprehensive PCP, and supports community integration with a goal of a safe transition back into the community.
III(E)(8) The discharge planning process will result in a written discharge plan that: identifies the individual's	• NCDHHS's SPH transition team monitoring noted an increase in identifying in the transition plan work, volunteering, and community activities. This was made possible by adding DMH/DD/SUS-funded Community Inclusion providers even in service mixes that included ACT and CST.

Outstanding TCL Compliance Requirements	Key Progress
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 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.	• NCDHHS's ACH transition team monitoring noted increased collaboration, a more continuous process that included addressing post-transition follow-up appointments, crisis plans, medication management, and referrals to community-based services like ACTT, CST, peer support services, and connection to vocational/educational supports. • The IR/TCL tool is discussed during transition planning, so PCPs are individualized and involve the client, natural supports when appropriate, and a transition team that works to prevent re-institutionalization and supports the individual's well-being.

Outstanding TCL Compliance Requirements	Key Progress
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.	• NCDHHS continued monitoring a sample of SPH transition teams and facilitated semi-monthly Barriers and Solutions Committees at all three SPHs with SPH staff, DSOHF, and Tailored Plans. • Committees focused on resolving discharges not transitioning to permanent supportive housing or TCL Bridge Housing, while NCDHHS also supported Local Barriers Committees, managed elevations to the State Barriers Committee, and convened ad hoc Barriers Intervention Teams as needed.
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	• NCDHHS continued to monitor a sample of transition teams occurring in State Psychiatric Hospitals (SPH). • NCDHHS facilitated semi-monthly Barriers and Solutions Committee's at all three SPHs involving staff from the SPHs, DSOHF, and each Tailored Plan. ○ Standing agenda items included problem-solving discharges not going to permanent supportive housing or TCL Bridge Housing.

Outstanding TCL Compliance Requirements	Key Progress
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).	○ NCDHHS staff regularly attended all four Tailored Plan's TCL Local Barriers Committee, managed elevations to State Barriers Committee, and convened ad hoc NCDHHS and TCL leadership to participate in Barriers Intervention Teams. • The NCDHHS TCL IDM Review team participated in onsite transition team meetings and tracked transition barriers in real-time. There is evidence that the composition of transition teams is expanding to include natural supports and address barriers to transportation, 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 request; the State will update the written discharge plans as needed based on new information and/or developments.	• Changing the frequency of quality reviews to monitor timely reassessments for individuals in ACHs from quarterly to monthly resulted in a decrease in overdue reassessments for ACHs and SPHs. In SFY24Q4 there were 531 delayed reassessments for ACHs and SPHs, and that decreased to 157 in SFY25Q4.
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	• Incremental progress was made in transitioning individuals into permanent supportive housing within 90 days of their first transition team meeting, despite some individuals selecting community placements far from the SPH. • Some ACH transitions exceeded 90 days due to the complexity of SMI/SPMI and medical needs; NCDHHS guidance supports flexible, individualized transition timelines to promote sustained recovery once in PSH.

Outstanding TCL Compliance Requirements	Key Progress
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).	

During SFY25, the department continued to monitor its compliance with three Discharge and Transition Process requirements that were met[17], as described below.

6.1.2 SUSTAINED PROGRESS MADE UNDER DISCHARGE & TRANSITION REQUIREMENTS ALREADY MET AND DISCHARGED

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.	• Continued progress was made in identifying, resolving, and escalating imminent and systemic barriers. • NCDHHS reaffirmed annual barriers training and continued active participation in LME/MCO Local Barriers Committees (LBC). • Ad hoc Barriers Intervention Teams were convened to address urgent TCL participant issues. • Incremental progress on systemic barriers (e.g., transportation, home health, accessible housing) was advanced through State Barriers Committee and Transition Oversight Committee engagement • Transition Oversight Committee (TOC) members were briefed on longstanding systemic barriers progress and provided strategy and DHHS leadership time toward incremental resolution.
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 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	• During SFY25, the State continued to perform previously established processes and activities to meet section III(E)(13)(a)(b)(d) requirements. ○ NCDHHS continues updating and communicating those updates to the Transition Manual. In addition, DHHS provides TCL team training and technical assistance to

[17] 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
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).	improve in-reach, transition coordinator and transition teams. ○ NCDHHS continually confirms through data extracts and monitoring the uninterrupted assignment and tasks necessary for in-reach and transition in ACHs, SPHs, and the community to all TCL eligible individuals by the LME/MCOs. ○ There were no facility determinations of IMD this fiscal year.
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	• During SFY25, the State continued to perform previously established processes and activities to meet section III(E)(14) requirements and conducted in-field compliance coaching that included field observation and ad hoc technical assistance.

TCL Requirements that Have Been Met and Discharged	Key Progress
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 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.	

6.2 SFY25 SUPPORTING DATA

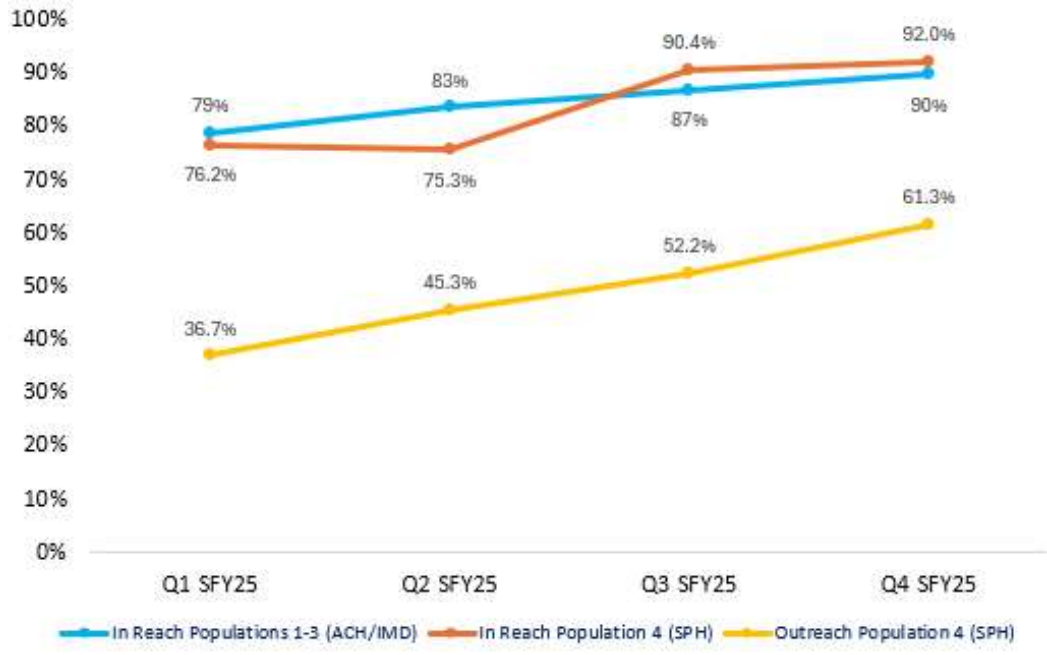
Supporting data related to Discharge and Transition requirements focus on face-to-face In-Reach contacts, outcomes of In-Reach efforts, and transition timelines to TCL supportive housing. As shown in Figure 3, the upward trend in In-Reach rates observed beginning in late SFY21 continued through each quarter of SFY25. The percentage of individuals receiving face-to-face contacts at least every 90 days increased from the first to the last quarter of the SFY for individuals receiving in-reach while residing in Adult Care Homes (ACHs) and State Psychiatric Hospitals (SPHs), as well as for individuals receiving outreach in the community following discharge from an SPH. Across these same settings, the percentage of individuals who agreed to transition to TCL housing remained relatively stable compared to SFY24, while the percentage of individuals who transitioned to TCL housing within 90 days declined slightly compared to the previous SFY.

6.2.1 FACE TO FACE IN-REACH CONTACTS AND IN-REACH "YES" DECISIONS

The figure below shows the average quarterly percentages of ACH and SPH In-Reach–eligible individuals, as well as SPH outreach–eligible individuals, who had at least one face-to-face contact within the previous 90 days. Frequent in-reach and outreach activities are critical to ensuring individuals are informed of available housing and service options and to supporting successful transitions into the community. Concerted NCDHHS efforts – including written guidance, technical assistance, and ongoing monitoring of LME/MCO performance – have contributed to sustained increases in face-to-face in-reach contacts over recent state fiscal years. LME/MCOs also continued refining team-based in-reach and transition models and strengthening relationships with individuals and guardians statewide.

Targeted efforts to improve the accuracy of in-reach participant lists and increase the frequency of face-to-face contacts were most successful in ACH and SPH in-reach settings. While face-to-face visits for Population 4 improved overall during SFY25, rates remained lower in SPH outreach settings compared to ACH and SPH in-reach. These differences are attributable in part to challenges associated with locating individuals receiving outreach following SPH discharge, particularly those experiencing housing instability.

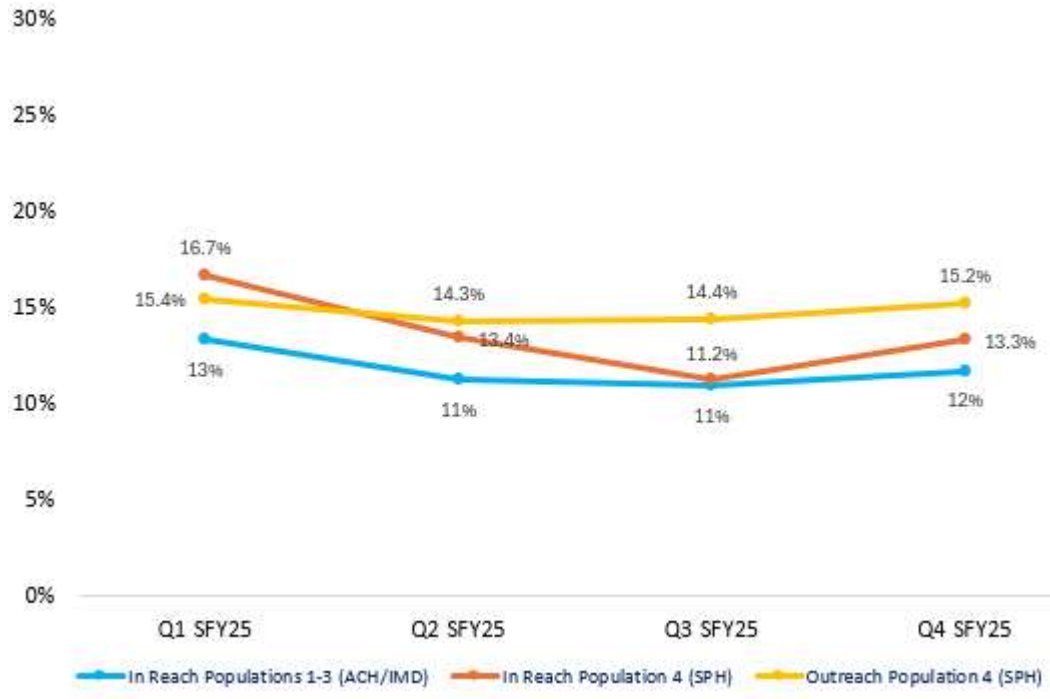
Figure 3. Percentages of *In-Reach* and outreach eligible individuals who had at least one face-to-face contact within the previous 90 days (by state fiscal year quarters)



Source: TCL Dashboard, 11/20/2025 release.

NCDHHS also monitors outcomes of in-reach and outreach activities and tracks the percentage of individuals who agree to transition to TCL housing as an indicator of in-reach effectiveness. Figure 4 shows modest quarterly variation in the percentage of individuals in ACH in-reach, SPH in-reach, and SPH outreach who decided to transition to TCL housing. The combined annual rate of "yes" decisions across all three settings in SFY25 (22 percent) remained relatively consistent with SFY24 (23.1 percent), a pattern observed across each population group individually. As illustrated, rates of "yes" decisions continued to be slightly higher among individuals in SPH in-reach and outreach compared to those in ACH in-reach. The increase observed in SFY25 Q4 may reflect the impact of ongoing quality improvement initiatives and an expanded peer workforce supporting in-reach statewide.

Figure 4. Percentage of individuals in ACH in-reach, SPH in-reach, and SPH outreach who made a yes decision to transition (by state fiscal year quarters)



Source: TCL Dashboard, 11/20/2025 release.

6.2.2 TRANSITION TIMES TO TCL HOUSING

While the settlement agreement calls for discharge to TCL housing to occur within 90 days of the individual's assignment to a transition team, provided that a Housing Slot is available, just over one-third (34.6%) of individuals who transitioned to TCL housing in SFY25 did so within 90 days of housing slot approval, a slight decrease from SFY24 (38.9%). Analysis of state-level data conducted by NCDHHS's TCL QAPI contractor, Mathematica, showed no meaningful statistical difference in subsequent housing stability for individuals transitioned within 90 days compared to those who remained in the planning period up to 11 months before transitioning.[18] However, extended transition times undoubtedly affect the allocation of LME/MCO staff resources and efforts across the stages of an individual's journey from transition planning to housed status.

Common barriers reported in SFY25 that caused delays for some individuals transitioning from State Psychiatric Hospitals (SPHs) and Diversion attempts included limited availability of appropriate housing options, particularly enhanced bridge housing; concerns related to participant safety in some hotel-based bridge housing; and challenges coordinating personal care and home health services. Additional contributing factors included assessment delays, workforce constraints, and limited availability of accessible units that meet individuals' clinical and functional needs. While transitioning to TCL housing within 90 days may not be possible for all individuals, NCDHHS continues to work toward the objectives of reducing average transition times and increasing the percentage of individuals who transition within 90 days,

[18] Prisament, S., Lynch, K., Gellar, J., Arndt, B., Fischer, B., & Thompson, G. (2025, September 4). *Relationship between transition time and stability in TCL supportive housing: Detailed memorandum.* Mathematica.

including through its barriers tracking and resolution processes.

6.3 KEY FOCUS AREAS AND PRIORITIES FOR SFY26

6.3.1 FACILITATING COMMUNITY VISITS DURING IN REACH

The first strategy for SFY26 is to increase community visits during in-reach. This strategy is intended to increase community visits facilitated during in reach in ACHs and SPHs to promote community inclusion and social connection. This strategy will not only help meet the settlement agreement requirement in III(E)(2), it would also help advance a key principle of the Olmstead decision that people with disabilities have a right to live in the community when community-based services are appropriate, they do not oppose the treatment, and their transition can be reasonably accommodated. Community involvement plays a vital role in improving overall health. Community visits help reduce isolation and loneliness by increasing connectivity with others. People with healthy relationships are more likely to make healthy choices that will improve their mental and physical health. Transitions are based on an individual's choice and desire to move into the community. Facilitating community visits that offer opportunities to meet with other individuals with disabilities who are living, working and receiving services in integrated settings as well as their families, and community providers afford individuals the chance to monitor services that they could receive and request reasonable accommodations to be put in place before the transition occurs. Key actions to achieve this include monthly collaboration with the LME/MCOs to confirm individuals have the opportunity to have community visits during in reach, evaluate the methods used to track the number of community visits that occur each quarter, and assist in developing proactive strategies to eliminate potential barriers identified during community visits that would delay transitioning out of institutional settings.

6.3.2 PERSON-CENTERED TRANSITION PLANNING

The second strategy for SFY26 focuses on strengthening person-centered transition planning for individuals moving into community-based settings. Insights gathered through transition team oversight will inform transition coordinator instruction in both State Psychiatric Hospitals (SPHs) and Adult Care Homes (ACHs). Training will emphasize core Settlement Agreement requirements related to person-centered planning, including supporting individuals to lead their transition teams through pre-meeting coaching, enhancing the person-centeredness of transition plans through use of the In Reach/Transition TCL Tool, and working with providers to clearly link proposed interventions to an individual's stated transition goals.

This strategy also prioritizes rebalancing transition team discussions away from a narrow focus on disability-related limitations and toward individuals' life goals, strengths, and preferences, including the development of life skills, recovery-oriented choices, meaningful social roles, and community participation. Transition progress will continue to be guided by individual readiness, service coordination, and barrier resolution rather than fixed time thresholds, in order to support sustainable and person-centered transitions to community living.

6.3.3 PUBLIC GUARDIANSHIP

The third strategy for SFY26 is to improve relationships with guardians. Providing education to guardians about how PSH will allow individuals access to community-based services and supports and encourage full participation in their community will help guardians support the individual's right to pursue valued personal interests. DSS or their contracted agency guardians for individuals in TCL will strengthen support to individuals under guardianship by helping them understand and exercise their rights, eligibility, and opportunities under the TCL Settlement Agreement. NCDHHS will publish Guardianship Manual guidelines

clarifying the guardian's role in working with wards in compliance with the TCL Settlement Agreement. A communication and training plan will be created and enacted for both DSS and their hired agency guardians. NCDHHS will monitor a sample of individuals in in-reach to determine Settlement Agreement compliance.

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 TCL 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.

  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 SFY25

The Settlement Agreement outlines three substantive requirements related to Pre-Admission Screening and Diversion for North Carolina[19]. During SFY25, the department continued to perform previously established processes and activities to continue to meet substantial compliance for section III(F) requirements, implemented process improvements and refinements, and carried out data collection and analysis to monitor and ensure ongoing compliance, as shown in the table below.

7.1.1 SUSTAINED PROGRESS MADE UNDER PRE-ADMISSION SCREENING & DIVERSION REQUIREMENTS ALREADY MET AND DISCHARGED

[19] 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).

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.	• NCDHHS conducted quarterly quality reviews of all individuals referred for diversion to evaluate the screening tool and identify risks that could potentially jeopardize diversion from ACHs.
	  ○ To reduce risks and maintain the 90% diversion rate, NCDHHS held monthly 1:1 meetings with each LME/MCO to discuss concerns and trends.
	  ○ By addressing systemic gaps, we improved the ability to provide integrated community care for individuals who would otherwise require institutional placement.
	• 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 SFY25, all LME/MCOs completed screening and determined TCL eligibility within 30 days of the referral submission. This indicates a person-centered approach to determining the appropriate levels of care and who needs immediate services.

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.	• Annual quality review was conducted to measure the impact of community integrated planning procedures and operational workflows within the LME/MCOs. Using systemic evaluations assisted in planning initiatives that improved person-centered plans and overall member wellness.
	• Monthly quality reviews were conducted on all individuals determined as TCL eligible and diverted from ACHs.
	  ○ Reviews aligned with the ADA and *Olmstead* and confirmed whether 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 SFY25, only 20 individuals were not diverted and entered ACHs, and 541 were diverted from ACHs, which is a 96.4% diversion rate. That's in comparison to SFY20, during which 434 individuals were not diverted, and 651 individuals were diverted (60% diversion rate).

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	• Monthly quality reviews were conducted on all TCL individuals who were not diverted and entered an ACH. ○ Reviews ensured that individuals that chose to transition to an ACH were fully informed and connected to In-Reach for future engagement and education. • Additional reviews were conducted by NCDHHS TCL IDM Review team that determined whether the TCL individuals were fully informed of all

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.	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 5 TCL DOJ populations. IDM discussions were person-centered and led by TCL individuals who were later provided with a copy of the IDM tool. ○ All individuals who entered ACHs were assigned a CPSS to conduct a reassessment at least quarterly in addition to receiving frequent In-Reach visits; this provided acknowledgement that individuals were provided with the opportunity to change their decision about PSH. ○ Reviews conducted showed a significant increase in the number of 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 SFY25 SUPPORTING DATA

Pre-admission screening and Diversion data shows a continued steady increase in the percentage of individuals diverted from ACHs. SFY25 quarterly percentages show a pattern of continued compliance with the State's goal of 90 percent and an all-time high percentage of 96.4 percent which can be contributed to the all-time low number of 20 individuals that were not diverted from ACHs. These patterns of improvement have been consistent since the implementation of RSVP in November of 2018 along with ongoing monitoring and quality improvement activities.

7.3 KEY FOCUS AREAS AND PRIORITIES FOR SFY26

7.3.1 REFINING SCREENING PROCESSES FOR MONITORING AND SUSTAINING SUCCESS

NCDHHS will continue to assess and refine the current Referral, Screening, and Verification Process (RSVP) tool to strengthen functionality and data capture. Monthly monitoring and quality reviews will continue to verify timely screening completion, prompt eligibility determinations, and linkage to services, and to confirm that individuals are educated on alternatives to adult care home (ACH) admission and that informed choice is documented in RSVP, TCLD, or the recommended IDM tool for Population Category 5 individuals. Annual reviews will evaluate community integration planning and LME/MCO workflows to support ongoing compliance with Settlement Agreement requirements. In addition, NCDHHS will continue targeted monthly monitoring (initiated April 2025) for individuals age 30 and under who entered an ACH following RSVP screening to confirm education occurred prior to admission and that frequent in-reach and transition planning follow-up are in place.

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 meet individuals' needs and safeguard their health, safety, and welfare. Data-driven and proactive, the QAPI system leverages information from a variety of sources 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; and 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 (QA), 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 individual level to systemic, and from long-term to emergent and urgent. Generalizable QAPI frameworks that may be applied to any TCL component or requirement are described in the NCDHHS TCL QAPI Plan,[20] 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, pre-screening and diversion, in-reach, discharge and transition, community mental health and employment services, and individual outcomes. Measure data 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 needs and availability of new data elements and sources.

  As part of a quarterly QAPI cycle, NCDHHS TCL SMEs select and prioritize 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 issues and reporting needs daily, using administrative data, participant surveys and assessments,

[20] The NCDHHS TCL Quality Assurance and Performance Improvement Plan is available at https://www.ncdhhs.gov/about/department-initiatives/transitions-community-living.

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 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 measures to include analysis of relationships among variables, and evaluation of progress toward achieving key TCL 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 variables.

  Because TCL participant outcomes are real world data that are not collected in carefully controlled experiments and 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 and 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 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 implementation lies with the NCDHHS Deputy Secretary for Health, 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, as well as to contractually required LME/MCO QAPI processes and activities related to TCL. Primary data sources include contract quality and performance measures, services data, provider review reports, network access and adequacy data, LME/MCO QAPI Plan submissions, and database entries. External Quality Reviews (EQR), which entail extensive data and documentation to review and 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 may 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.

- **QAPI consulting:** TCL Quality Leads provide or arrange support for NCDHHS TCL SMES to address quality issues that may be identified through routine, periodic activities and require targeted support and more complex follow-up actions. QAPI consulting builds upon informal, ad hoc activities carried out to support SMEs and may leverage other NCDHHS Division quality assurance, performance evaluation, and data analytic staff and contractor resources. In supporting follow-up and preparation for routine QAPI activities, QAPI consulting strengthens connections between other core QAPI processes and daily TCL operations. It is also a key component contributing to the flexibility and comprehensiveness of the TCL QAPI system overall, to the range of quality and performance issues that can be addressed, and to the diversity of resources and methods that can be applied. QAPI consulting may be initiated by TCL SMEs who identify a need and request support, or by QAPI Leads who identify a quality issue through routine

monitoring or other means.[21]

Ideally, the TCL QAPI system 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 content areas and across operational levels, including state leadership and oversight, NCDHHS TCL administration and activities, local LME/MCO performance and execution of contracted TCL functions, and the provision of TCL services.

8.1 PROGRESS DURING SFY25

The Settlement Agreement outlines eight substantive requirements related to Quality Assurance and Performance Improvement for North Carolina. The sixth modification entered by the Court on December 11, 2024, established that the State met all substantive obligations of sections III(G)(1) through (8). During SFY25, the Department continued to perform previously established processes and activities to meet section III(G) requirements, implemented process improvements and refinements, and carried out data collection and analysis to monitor and ensure ongoing compliance.

8.1.1 SUSTAINED PROGRESS MADE UNDER QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT REQUIREMENTS ALREADY MET AND DISCHARGED

TCL Requirements that Have Been Met and Discharged	Additional Activities and 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	• The State completed its first annual update of the NCDHHS TCL QAPI Plan describing the State's TCL QAPI system at the end of SFY25.
	  ○ The most significant revision was the addition of a sixth core QAPI process. Formally recognizing QAPI Consultation as a distinct process further strengthens connections between other core processes and daily TCL operations and the flexibility and comprehensiveness of the TCL QAPI system overall.
	  ○ Together, the six core QAPI processes, which also include measure monitoring and improvement cycles, barriers identification and resolution, contract monitoring, and activities of the Quality Assurance Committee and the Transition Oversight Committee, represent ongoing, repeatable procedures and methods that support overarching goals of the TCL and its QAPI system.
	• Additional SFY25 activity and growth of the State's QAPI monitoring system included work with LME/MCOs to develop and improve local TCL QAPI systems:
	  ○ LME/MCOs developed inventories of existing and planned TCL QAPI processes and their associated objectives, tasks, and goals to monitor and improve the quality of core components related to TCL services and supports, operations, participant outcomes, and data and reporting.

[21] QAPI consulting was formally incorporated as a core QAPI process effective June 30, 2025, as part of the annual NCDHHS TCL QAPI Plan review.

TCL Requirements that Have Been Met and Discharged	Additional Activities and Progress
decrease the incidence of hospital contacts and institutionalization.	○ The State team reviewed and provided individualized written feedback on multiple iterations of each LME/MCO's inventory and quarterly QAPI activity updates. ○ State team feedback and technical assistance focused on coverage of critical TCL objectives and functions, alignment of QAPI activities and data with stated objectives, and tools for LME/MCO self-assessment. • The end of SFY25 marked the conclusion of the initial phase of LME/MCO TCL QAPI Plan development. TCL QAPI now is fully integrated into the larger organizational LME/MCO QAPI Plans, with annual reporting requirements comparable to other LME/MCO functions going forward.
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 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.	• The TCL Transition Oversight Committee (TOC) continued to meet in its role to oversee ongoing implementation of TCL. Discharge and transition measures and barriers were covered as standing items on the monthly agenda. Implementation-related topics covered in State-led discussion and presentation and LME/MCO progress reporting also included the following topics among others: ○ NCDHHS Housing Pilot, Strategic Housing Plan, Housing Guidelines updates, Regional Housing Plans, use of federal mainstream vouchers ○ Housing supply and demand, lease start delays, separation reasons, rehousing ○ Hurricane impacts and response ○ ACH In-reach review, In-reach trends, Priority Population 1-3 transitions ○ Priority Population 4 transitions, use of bridge housing ○ SPH Barriers and Solutions Committee activities, SPH Transition Team performance and TA ○ Public Guardian challenges, polypharmacy concerns ○ PCP Peer and other provider trainings, Disability Benefits (DB101) ○ Medicaid home health services ○ Updates to guidance and manuals include DSS Guardianship Manual and In-Reach, Transition & Diversion Manual ○ Updates to Informed Choice process ○ Data quality
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	• NCDHHS continues to refine and enhance data collection protocols, applications and measures for on-going monitoring and tracking. ○ Examples in SFY25 included the new Supported Employment services data collection efforts with LME/MCOs described earlier in this report. ○ Part of ongoing quality assurance and discharge planning efforts, the State Discharge and Transition team partnered with DHSOF and

TCL Requirements that Have Been Met and Discharged	Additional Activities and Progress
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)	hospital system owners to refine and improve discharge location reporting and tracking, and to enable more effective follow-up. • Additional significant progress in SFY25 included planning for the launch of an electronic health record (EHR) system for NCDHHS's Division of State Operated Healthcare Facilities, an advancement that will allow for improved and more comprehensive care, streamlined processes for staff, enhanced security for protection of patient data, and improved regulatory compliance. o With this launch, data used for census tracking and monitoring of institutional admissions, discharges, and length of stay transitions from the State Psychiatric Hospital (SPH) Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) to Epic, a leading comprehensive software system for managing patient data, streamlining workflows, and improving care coordination. • SFY25 NCDHHS TCL Dashboard updates included execution of planned quarterly data refreshes; addition of new downloadable static service utilization summaries; enhancements and refinements to existing measures and stratifications; and incorporation of new measures. For example, TCL Dashboard In-reach measures now are available separately for individuals residing in ACHs and SPHs. • The State QAPI team and its contractor Mathematica developed and implemented a new methodology to identify TCL participants in the NCDHHS Incident Reporting and Improvement System (IRIS) database, facilitating improved and more complete monitoring of TCL participant adverse incidents. New IRIS incident measures also have been incorporated into the TCL Dashboard. • NCDHHS TCL QAPI and other subject matter leads continued to conduct quarterly priority performance measure review and QAPI activity cycles and to produce related quarterly Quality Measure Reports. o Prioritized measures focused on ACH priority population transitions to supportive housing, housing transition times and separations, in-reach frequency and outcomes, and provision of ACT and other services with tenancy supports components to housed TCL participants.
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 review this information on a semi-annual basis and	• NCDHHS continues to monitor and address barriers to housing transitions through State Barriers Committee and related activities, committees, and working groups, with many barriers submitted through the TCL Barriers module within the Medicaid Help Center (MHC) and directly through the Olmstead Barriers email address. o Barriers Intervention Teams comprised of NCDHHS subject matter experts and LME/MCO staff solved imminent housing, state psychiatric admission, tenancy, and funding related problems and crises. Solutions to many of these issues were generated from continued NCDHHS participation and barriers interventions developed in LME/MCO Local Barriers Committees. • NCDHHS worked with North Carolina's Programs of All-Inclusive Care for the Elderly (PACE) programs to develop a proposal to improve home

TCL Requirements that Have Been Met and Discharged	Additional Activities and Progress
develop and implement measures to overcome the problems and barriers identified.	health service provision and decrease associated barriers. The proposal was presented to each LME/MCO for consideration in the next fiscal year. • State Psychiatric Hospital Barriers and Solutions Committees (BASCs) contributed to barriers system tracking and resolution improvements, including by increasing the involvement of: ○ Hospital and LMEMCO staff ○ TCL in-reach coordination and transition teams ○ SPH staff ○ Community mental health providers.
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.	• The original TCL Quality of Life Survey continued to be administered in SFY25 to individuals prior to transition and at 11 and 24 months after placement in TCL housing. During this time, the State QAPI team and contractor, Mathematica, made significant progress in updating the survey tool to incorporate a more person-centered approach, reduce redundancy, and lessen administration and response burden while improving the collection of actionable data. • Survey content was revised based on input from key stakeholders, including the Independent Reviewer, NCDHHS and LME/MCO TCL subject matter experts, and individuals with lived experience. Cognitive testing of the updated tool with Peers and other individuals with lived experience began in June 2025. • Planned SFY26 activities include conducting a final round of outreach and feedback with the Independent Reviewer, NCDHHS SMEs, LME/MCO staff, and Peers; finalizing survey revisions; and preparing for survey administrator training and implementation.
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 stakeholders and confirmation of data will also be initiated. The reviews will focus on monitoring services, reviewing grievances and appeals received, reviewing	• The Department's contracted External Quality Review Organization (EQRO), currently Health Services Advisory Group (HSAG), conducts an annual review of each LME/MCO, covering all federally required activities and focus areas, including network adequacy, quality of care, and data validity. • The most recent annual EQR technical report published in April 2025 covers review activities, findings, and recommendations based on 2023-24 review of LME/MCOs operating as PIHPs. LME/MCOs launched in July 2024 and will be included in the next reporting cycle.[22]

[22] The April 2025 HSAG Annual Technical Report is available at https://medicaid.ncdhhs.gov/2023-2024-eqr-technical-report/download?attachment.

TCL Requirements that Have Been Met and Discharged	Additional Activities and Progress
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).	

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.	• The State continues to meet Use of Data requirements through a combination of regular, planned, and ad hoc activities, including quarterly measure monitoring and the QAPI cycle.
	• Ongoing efforts include TCL Quality Assurance Committee (QAC) data presentations and analysis, monitoring and evaluation of service utilization data, and outcomes reporting and data tracking.
	• Findings from these activities inform policy and procedural updates, process improvements, and the planning and implementation of additional QAPI initiatives.
	• Data analytic projects completed, ongoing, or initiated in SFY25 focused on topics such as:
	  ○ Changes in the probability of core service provision across housing tenure milestones
	  ○ The relationship of tenancy supports and other services to housing stability and separations
	  ○ outcomes associated with variations in participant transition times and service delivery patterns
	  ○ CST service delivery patterns and relationships to participant outcomes, and
	  ○ associations between housing stability and social determinants of health (SDOH) risks in areas such economic climate, food accessibility, housing environment, transportation, health literacy, access to digital resources, and social connectedness.

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,	• The State continues to meet the annual reporting requirement. • Reports incorporate additional relevant data as available, including refinements to the report template to better reflect progress, and highlight key focus areas and priorities for the upcoming SFY. • Updates address progress toward compliance for Settlement Agreement provisions not yet met, ongoing compliance activities, new initiatives, and additional progress on discharged provisions.

TCL Requirements that Have Been Met and Discharged	Additional Activities and Progress
and the outcome data described above.	

8.2 SFY25 SUPPORTING DATA

A general premise underlying the NCDHHS TCL QAPI system is that there will always be room for improvement. NCDHHS leverages data and conducts iterative cycles of quality, performance, and participant outcome measure monitoring; improvement planning and implementation; and evaluation to identify, address, and resolve individual and system level obstacles in the interest of achieving central TCL objectives and outcomes. Results from field reviews and qualitative data reflecting individual participant experiences as well as quantitative analysis of TCL system data provide direction for these efforts and inform ongoing assessment of the extent to which NCDHHS TCL objectives and intended participant outcomes are being achieved, and identification of areas where additional planning and action are needed for improvement.

Supporting data presented in this section include the measures of TCL participant outcomes referenced in Section III.G. of the Settlement Agreement.[23] The key outcomes reported here primarily focus on the population of individuals in TCL housing and correspond to fundamental TCL objectives concerning housing stability; reduced hospital contacts, institutionalization, and incidents of harm; and increased independence, community integration, and quality of life.[24] Other data related to the quality and outcomes of TCL services and supports in other TCL statuses and settings are presented in earlier sections of this report.

Data presented throughout this report demonstrate significant progress toward achieving overarching TCL objectives and intended member outcomes, and highlight some areas where challenges remain. The system level data summarized in the remainder of this section show that most TCL participants who transition to permanent supportive housing maintain their housing with relatively low incidence of adverse incidents and institutional contacts, and with improvements in aspects of their experience that positively impact quality of life:

- Over the life of TCL, the average time TCL participants maintain their chosen living arrangements, including in permanent supportive housing, has increased. Individuals residing in supportive housing with TCL housing slots in SFY25 had initially transitioned, on average, more than three years and three months earlier.
- The annual adverse incident rate, expressed as the average number of adverse incidents per individual in TCL housing, has decreased over time.

[23] Specific settlement agreement requirements are referenced in each subjection heading.

[24] Unless otherwise noted, outcome measures reported in this section are based on data processed through the NCDHHS TCL Dashboard, November 20, 2025, release date. Professional and institutional service measures are based on Encounter Processing System (EPS) and NC-Tracks data warehouse claims. EPS is the NCDHHS Encounter Processing System for Medicaid Managed Care service encounter claims and 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. 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. Claims-based measures in this report section reflect claims adjudicated through September 2025. Timely filing limits may affect data completeness, especially for services provided late in SFY 2025.

- While some TCL participants do experience institutional setting admissions or contacts each year, the percentages of individuals in TCL housing with repeat Emergency Department visits or State Psychiatric Hospital, inpatient psychiatric unit (IPU), or community hospital readmissions within 12 months remains low.
- Over the life of TCL, fewer than one quarter (22%) of individuals who separated from TCL housing have been admitted to an adult care home at any time after separation. Just over one in 10 (12.5%) separated individuals later entered an adult care home as a re-admission. The percentage of individuals who separated from TCL housing in SFY25 and had an adult care home living arrangement within three months of year-end was even lower (10%).
- Congregate day programming rates remain low for TCL participants overall and are significantly lower for individuals who do not reside in adult care homes compared to those who do.
- Individuals who transition to TCL supportive housing experience gains in aspects of quality of life and satisfaction related to choice and control, meaningfulness of their daily lives, and satisfaction with their home and community.
- Aspects of community integration; social relationships, including those with natural supports; physical health; employment and education are areas in which some TCL participants continue to experience challenges, even after the transition to permanent supportive housing.

8.2.1 NUMBER OF INCIDENTS OF HARM (III.G.3.G.I.)

The figures below show annual trends in adverse incident reporting for individuals in TCL supportive housing.[25,26] Incident types reported 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.

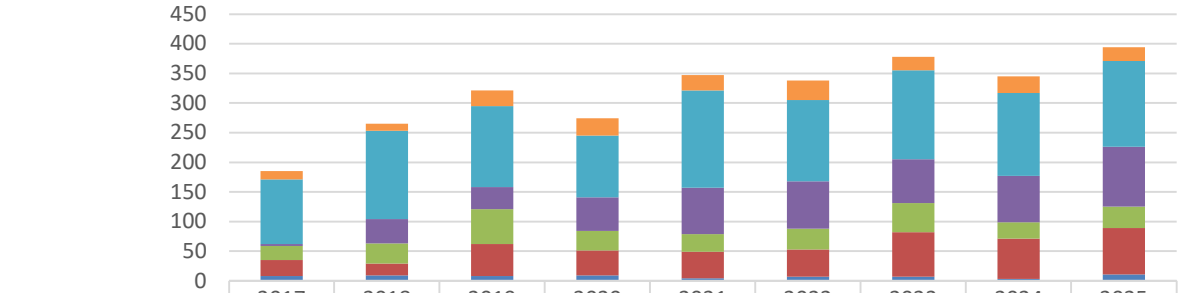
As shown in Figure 5 and Figure 6, the total count of incidents reported for individuals in TCL housing has increased over time, as the number of individuals in housing has increased. However, Figure 6 also shows that the incident rate[27] among this population has steadily declined. As shown in Figure 7, the downward trend in the incident rate is generally seen at the LME/MCO level as well as statewide.

[25]Adverse incidents are reported through the State's web-based Incident Response and Improvement System (IRIS) and processed through the NCDHHS TCL Dashboard. 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."

[26]A new solution for identifying TCL participant adverse incidents that developed late in SFY 2024 was further refined and finalized in SFY 2025. This method compares individual demographic data and identifiers documented in IRIS incident reports to participant information in the TCL Database and selects incidents based on an algorithm-based match score indicating a high probability match. This method results in a more complete incident extract compared to the pre-2024 method that required an exact match on a single identifier, the Common Name Data Service (CNDS) ID. (For Medicaid beneficiaries, the CNDS number is also the Medicaid ID.) After initial application of the new method in SFY 2024, it was determined that the test data extract was incomplete. Incident counts included in this annual report are based on full data, with the result that totals shown for previous SFYs are approximately 20 percent higher on average compared to those shown in the SFY 2024 annual report.

[27]The incident rate reflects the average number of incidents per member in TCL housing and is also closely tied to the percentage of individuals experiencing adverse incidents. As fewer members experience such incidents, and those who do experience smaller numbers of incidents, the overall rate will decrease.

Figure 5. TCL Housed Individual Total Adverse Incident Counts by SFY and Incident Type



	2017	2018	2019	2020	2021	2022	2023	2024	2025
Abuse	14	12	26	29	26	33	23	28	23
Consumer Behavior	109	149	137	104	164	137	150	140	145
Death	3	41	37	57	78	80	74	78	101
Injury	24	34	59	33	30	35	49	28	36
Other	27	20	54	42	45	46	75	68	78
Low-incidence*	8	9	8	9	4	7	7	3	11

*Low-incidence categories reported together include Fire, Restrictive Intervention, Medication Error, and Suspension/Expulsion from Service.

Figure 6. TCL Housed Individual Adverse Incident Totals and Average Incidents per Participant

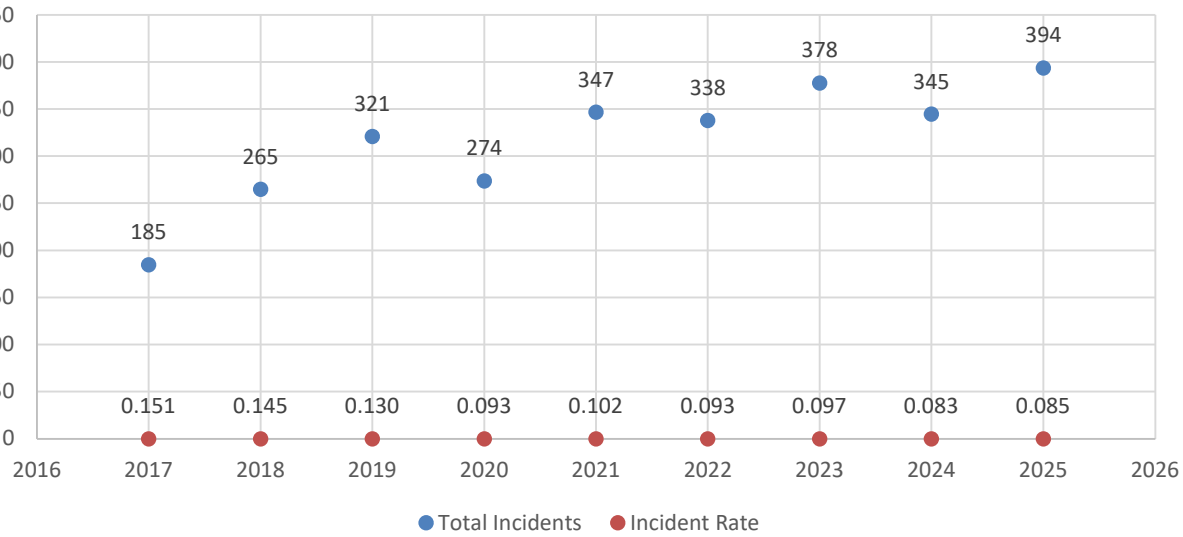
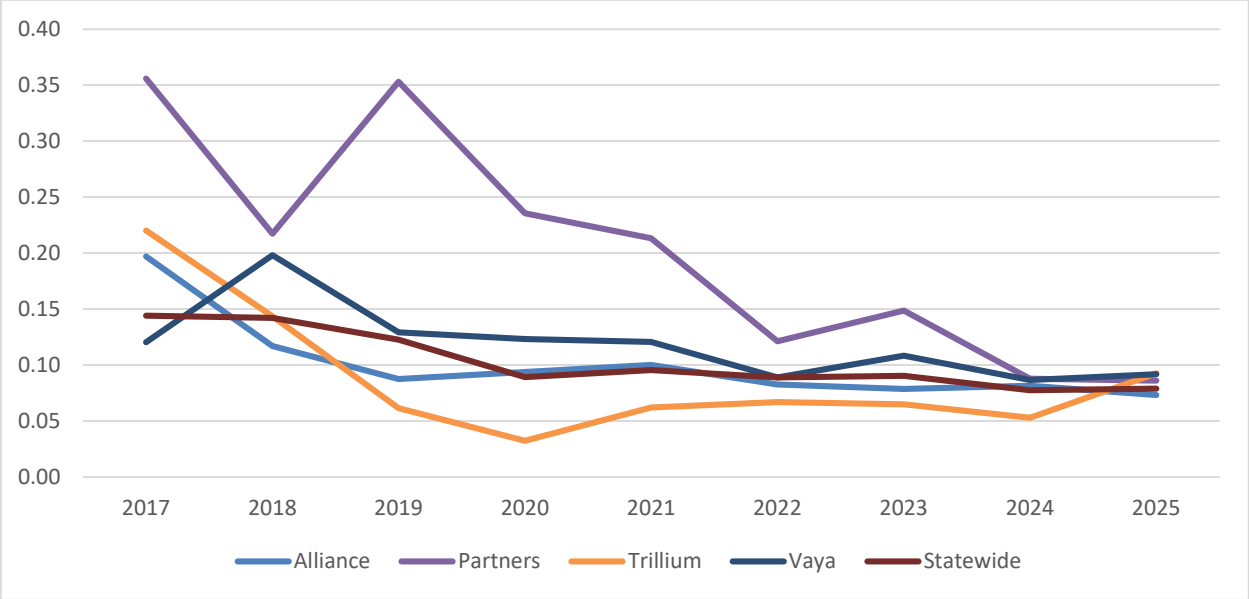


Figure 7. TCL Housed Individual Adverse Incident Rate by LME/MCO



8.2.2 NUMBER OF REPEAT ADMISSIONS TO STATE HOSPITALS, INPATIENT PSYCHIATRIC FACILITIES, AND ADULT CARE HOMES (III.G.3.g.ii.)

8.2.2.1 State Psychiatric Hospital Readmissions

Twenty-one (0.5%) individuals in TCL housing experienced State Psychiatric Hospital admissions in SFY25. For 10 (48%) of these individuals, a SFY25 admission was a repeat admission within the previous 12 months.[28]

8.2.2.2 Inpatient Psychiatric Unit and Community Hospital Readmissions

Of 441 (9.6%) individuals in TCL housing who experienced inpatient psychiatric unit or community hospital admissions in SFY25, the admissions were repeat admissions within the previous 12 months for just over half (N=225, 51%).

8.2.2.3 Adult Care Home Readmissions

Seventy-three individuals who separated from TCL housing (10% of individuals who separated) in SFY25 subsequently showed a NCTracks living arrangement code indicating the person resided in an adult care home.[29] Of these, more than 40% (N=31) had a living arrangement code other than adult care home immediately following housing separation, indicating the adult care home admission did not occur directly from TCL Housing. Most (N=56, 77%) of these individuals had either resided in an adult care home at the time of their TCL eligibility determination or entered TCL through the diversion process and were admitted to an adult care home prior to transitioning to TCL housing, such that the post-separation adult care home admission was a readmission.

Over the life of the TCL program, an estimated 711 individuals have been admitted to adult care homes any

[28] SPH admission and readmission data are based on NCDHHS DSOHF HEARTS database records and processed through the NCDHHS TCL Dashboard.

[29] Adult care home admission counts are based on ad hoc analysis of NCTracks living arrangement begin dates through June 2025 and may change in future reporting periods if individuals are rehoused and if additional individuals are later admitted to adult care homes.

time after a final TCL housing separation. Thus, approximately 22 percent of individuals separated over life of program (LOP) subsequently entered adult care homes. Most of these individuals had either resided in adult care homes at TCL eligibility determination (40%) or were not diverted from adult care home admissions before transitioning to TCL housing (17%). In other words, over LOP, 57 percent of post-separation admissions to adult care homes were readmissions, and 43 percent were first time admissions.

8.2.3 USE OF CRISIS BEDS AND COMMUNITY HOSPITAL ADMISSIONS (III.G.3.g.iii.)

Thirty-two (0.7%) individuals in TCL housing received Facility Based Crisis services in SFY25, and 441 individuals (9.6%) experienced inpatient psychiatric unit or community hospital admissions.

8.2.4 REPEAT EMERGENCY ROOM VISITS (III.G.3.g.iv.)

Two hundred twenty-seven (4.9%) of individuals in TCL housing experienced a single Emergency Department visit in SFY25. An additional 100 individuals (2.2%) experienced two or more ED visits during the year.[30]

8.2.5 TIME SPENT IN CONGREGATE DAY PROGRAMMING (III.G.3.g.v.)

The table below summarizes the number and percent of individuals in each TCL status and setting who received Psychosocial Rehabilitation Services in SFY25, as well as the average number of weeks of PSR during the year, and the average hours of service per week. PSR rates and time spent in PSR continue to be highest for individuals in ACH In-reach, and higher for individuals in SPH Outreach compared to other TCL statuses and settings.

Table 1. SFY25 TCL Participant Average Weeks and Hours per Week of Psychosocial Rehabilitation Services

TCL Status/Setting	N	Percent of Total in Status/Setting	Average Weeks	Average Hours/Week
Diversion	38	3.0%	11.6	19.1
In-reach	493	10.7%	27.6	21.3
Community Housing	34	4.3%	25.0	19.6
SPH Outreach	99	7.6%	26.1	23.4
Rehousing Planning	11	2.5%	23.2	23.0
Transition Planning	70	5.4%	13.2	20.6
TCL Housing	188	4.1%	23.6	15.1

8.2.6 NUMBER OF PEOPLE EMPLOYED, ATTENDING SCHOOL, AND ENGAGED IN COMMUNITY LIFE (III.G.3.g.vi.)

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

Results of SFY25 NC-TOPPS outcomes assessments with individuals in TCL housing[31] indicated that 7.8 percent of those interviewed sustained or newly obtained employment. Of those, 75.9 percent sustained or increased their pay rate above minimum wage, and 19.7 percent sustained or newly received any employee benefits.

Small percentages of housed TCL participants reported enrollment in college (1.3%), high school or GED classes (2.2%), vocational school (1.0%), or adult education, leisure, or recreational classes (0.3%) at their most recent NC-TOPPS assessment in SFY25.

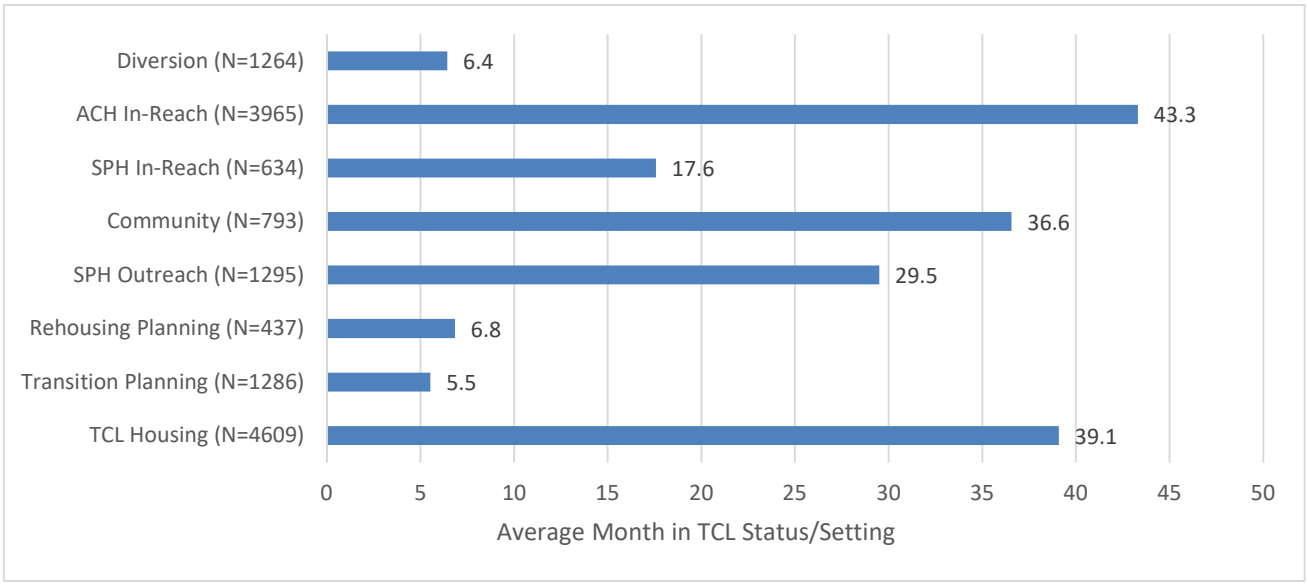
Most (73.4%) housed TCL participants reported participating in positive community/leisure activities at least a few times since their previous NC-TOPPS assessment, and nearly half (48.3%) reported they had reduced or eliminated problems interfering with work, school or daily activities. Nearly half (45.5%) also reported newly or continuing to have family and/or friends who are very supportive of their treatment and recovery efforts.

8.2.7 MAINTENANCE OF CHOSEN LIVING ARRANGEMENT (III.G.3.g.vii.)

The figure below shows the average total numbers of months individuals in TCL during SFY25 had spent in various statuses and settings, as of the earlier of the last day of the SFY or of the status end date.[32]

The Numbers in parentheses show the total number of individuals in each status and setting during SFY 2025. Individuals who changed status during the year are represented in more than one category.

Figure 8. SFY 2025 TCL Participant Average Time in TCL Status and Setting



[31] NC-TOPPS data are processed through the NCDHHS TCL Dashboard. SFY25 measure values reported here are based on assessments of 2,515 members in TCL Housing. The outcome regarding supportive family and friends is included in an optional section of the assessment that was completed for 1,331 housed TCL participants.

[32] These measures are based on TCL Database participant status categories and dates and are processed through the NCDHHS TCL Dashboard. TCL status category counts 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. When the transition to supportive housing occurred fewer than 90 days after housing slot approval, the 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 may exceed average months from housing slot approval to transition and is not used to assess performance related to a 90-day transition standard.

Among individuals in TCL housing since SFY 2017, 69.8 percent were in housing at the 24-month milestone, 75.6 percent at 18 months, and 83.3 percent at 12 months. At the end of SFY 2025, 55 percent of individuals who ever transitioned to TCL housing either had maintained housing continuously or been rehoused and still were in housing.

8.2.8 QUALITY OF LIFE (III.G.5.)

Table 2 below summarizes Pre-Transition, 11-Month, and 24-Month Quality of Life (QoL) Survey scores for individuals surveyed during SFY 2025. Composite QoL scores are derived from 28 survey questions spanning eight domains: 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 across 10 aspects of housing and community resources. All scores are reported on a scale of 0 to 100, where a score of 50 indicates positive responses to approximately half of the survey questions.[33] As in previous years, statewide scores suggest greater post-transition gains in satisfaction with home and community than in overall quality of life, and reported satisfaction was considerably more variable across respondents.[34]

Table 2. Statewide Quality of Life (QoL) and Satisfaction Index Scores (SAT), Individuals Surveyed SFY 2025

	Pre-Transition	11-Month Follow-Up	24-Month Follow-Up
Quality of Life	85.5 (N=593, SD=12.2)	86.3 (N=316, SD=14.2)	84.9 (N=361, SD=14.5)
Satisfaction	82.5 (N=593, SD=25.1)	86.1 (N=316, SD=22.1)	88.4 (N=361, SD=21.4)

Although composite QoL scores differed little between respondent groups, post-transition respondents' reports about certain aspects of Quality of Life related to Choice and Control, Meaningful Day, and Natural Supports were significantly more positive compared to pre-transition respondents. Questions in these domains focus on the individual's ability to choose how they spend their time and to do things when they want, feeling that they have enough to do and are satisfied with how they spend their day, opportunities to visit or talk with family or friends who support their recovery, and hopefulness about goals and future plans.

More positive post-transition assessments about some aspects of QoL were offset to an extent by responses to specific questions about Health and Wellness and Services, however. Post-transition respondents were more likely to report not doing usual activities due to not feeling well, going without their medicine when they needed it, not receiving all the services they needed, dissatisfaction with the help they received, and not knowing who to contact about problems with services and supports.

Post-transition survey respondents' higher satisfaction scores were largely accounted for by their more positive ratings of their home's location and related factors such as leisure/entertainment/recreation options, shopping, and parks and open space in the area.

The figures below also illustrate that the size and direction of differences between average pre-transition and post- transition survey scores varied only slightly by LME/MCO. The highest average QoL scores were observed for Vaya respondents who had transitioned to TCL housing. Vaya and Trillium average QoL scores for post-transition respondents were slightly higher than scores for pre-transition respondents, while this

[33] Quality of Life measures are based on ad hoc analysis of survey response data. SAT scores reflect ratings of the following 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.

[34] Greater variability across respondents in the Satisfaction Index is indicated by the larger standard deviation (SD), which expresses the average number of points individual respondents' scores differed from the overall average.

pattern was reversed for Alliance and Partners. Across all LME/MCOs, post-transition respondents reported higher satisfaction with home and community than pre-transition respondents.

Figure 9. Composite Quality of Life Survey Scores, Individuals Surveyed SFY 2025

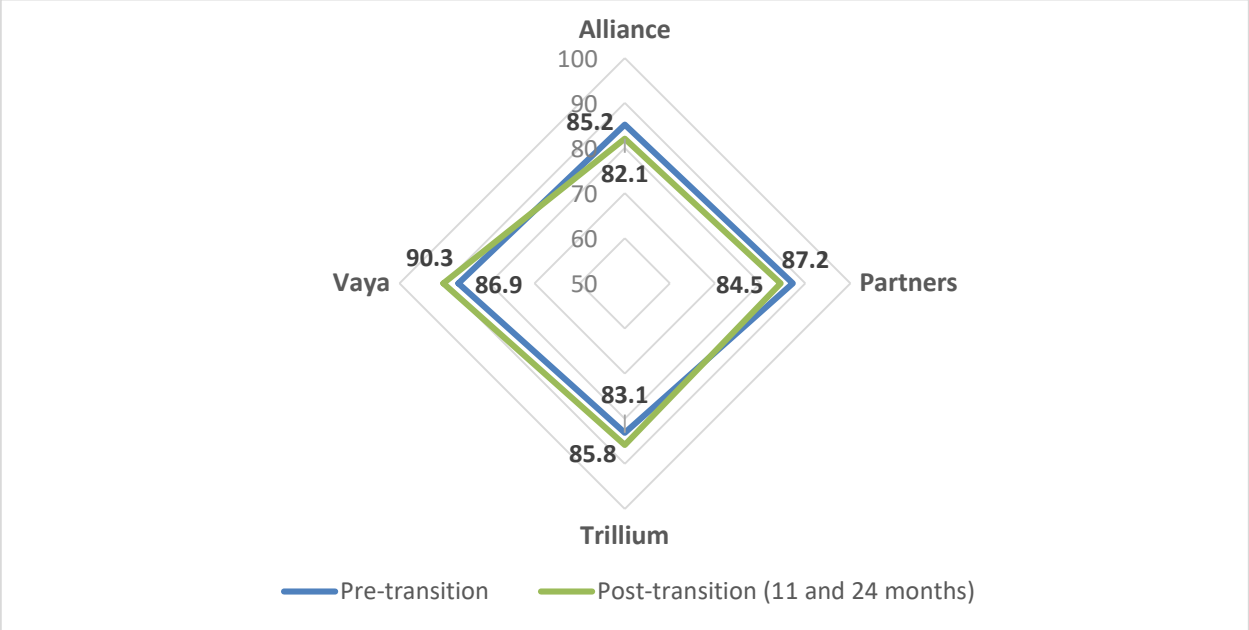
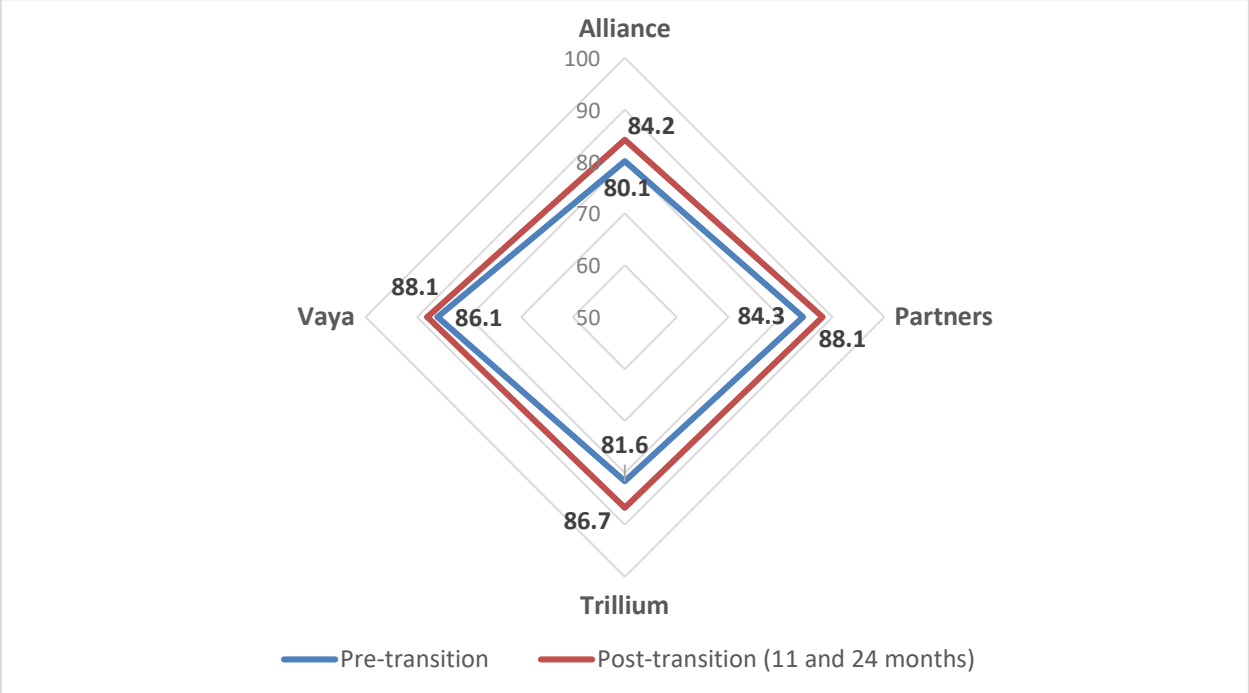
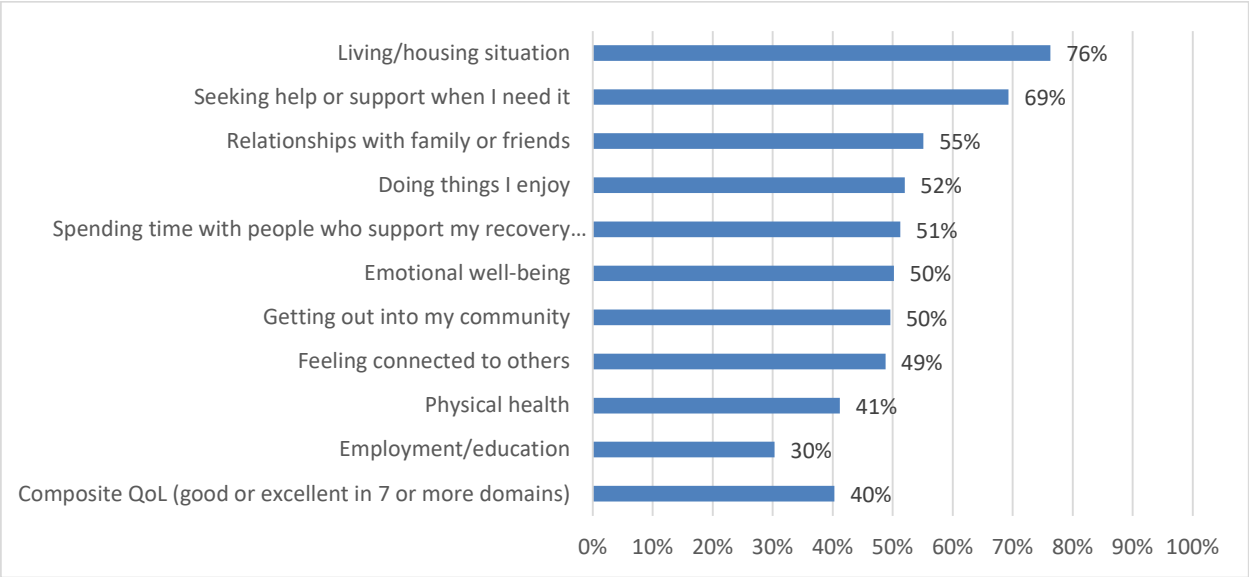


Figure 10. Satisfaction with Home and Community, Individuals Surveyed SFY 2025



The figure below summarizes responses of individuals in TCL housing to questions from their most recent NC Treatment Outcomes and Program Performance System (NC-TOPPS) assessments in SFY 2025. An alternative quality of life composite measure to the QoL survey-based measure is also shown.

Figure 11. TCL Housed Individuals Who Reported High Quality of Life (Doing "Excellent" or "Good") Across 10 Quality of Life Domains, SFY 2025[35]



Significant majorities of individuals reported doing excellent or good related to their housing situation and to seeking help or support when needed. Approximately half of respondents positively assessed areas of their life related to community integration, social relationships, and natural supports. Substantially less than half of individuals said they were doing excellent or good related to their physical health or to employment and education. While each distinct quality of life facet elicited a positive self-assessment by half or more of individuals interviewed, fewer than half (40%) positively assessed seven or more of the 10 domains.

8.3 KEY FOCUS AREAS AND PRIORITIES FOR SFY26

SFY 2026 Quality Assurance and Performance Improvement key focus areas and priorities build on progress made in the previous several years that led to the discharge of all QAPI obligations in the Sixth Modification of the Settlement Agreement in December 2024. These strategies expand and improve on established processes and represent ongoing TCL QAPI system maturation.

8.3.1 CONTINUE TO REFINE ESTABLISHED PROCESSES AND TOOLS

Multiple workstreams continuing into SFY 2026 focus on improvements to existing processes, tools, and data systems. Examples include expanding the focus of Quality Assurance Committee (QAC) activities to feature proactive, live problem-solving that leverages the broad skillset and experience of its members, and teaching quality improvement science concepts and methods through coaching and peer learning; implementing performance measure monitoring and QAPI Cycle process improvements, with goals of increasing TCL staff capacity to conduct QAPI work, and simplifying the structure of the related Quality Measure Report (QMR) to improve accessibility and better support development and implementation of impactful quality improvement activities; enhancements to the TCL Dashboard, including implementation of new participant outcome measures for use in QAPI initiatives; and ongoing work to update the TCL Quality of Life survey tool, administration methodology, and data accessibility and use to reflect a more person-

[35] Results are based on assessments of 1,331 individuals in TCL Housing who completed NC-TOPPS interviews in SFY25.

centered approach that yields actionable information about important aspects of TCL participant lives, while reducing redundancy and survey administration and response burden.

8.3.2 DEEPEN COLLABORATION WITH OTHER TCL PILLARS

The stable state and operation of established NCDHHS TCL QAPI system processes create an opportunity to deepen collaboration that has always existed with other TCL pillars. Related to QAPI Consulting, which was added as a sixth core process to the NCDHHS TCL QAPI Plan in SFY25, this strategy and SFY 2026 priority involves partnering with NCDHHS TCL Subject Matter Experts to strengthen connections to daily operations and to support monitoring, data analysis, quality improvement planning, and strategizing around opportunities for system change to improve TCL outcomes. The State will be adding two additional QAPI staff in SFY2026 to further support quality improvement and use of data across all pillars.

8.3.3 SUPPORT LME/MCO QAPI SYSTEM MATURATION

Expanding on work from the previous two years, a third SFY 2026 priority is to continue to support LME/MCOs to strengthen their TCL QAPI plans and processes in ways that reflect organizational priorities and the unique needs of each network and geographic region, while also ensuring quality monitoring and performance improvement when needed related to crucial TCL elements. LME/MCO annual organizational QAPI submissions will be reviewed with the goal of identifying opportunities for general or individualized technical assistance and feedback. NCDHHS will also continue to deliver technical assistance related to available tools and data such as NCDHHS TCL Dashboard measures, and to broader topics under the QAPI umbrella such as using TCL participant outcome measures for quality monitoring, improvement planning, and evaluation.

9 CONCLUSION

North Carolina Transitions to Community Living (TCL) continued to make meaningful progress in State Fiscal Year 2025 (SFY25) in strengthening community-based systems of care for adults with serious and persistent mental illness. 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 – and sustained compliance for met requirements demonstrates the State's sustained commitment to community integration. The collaborative efforts of LME/MCOs, housing partners, providers, the Independent Reviewer, and the United States Department of Justice have remained instrumental in advancing the goals of the Settlement Agreement.

Throughout SFY25, TCL showed continued advancement in several critical areas.

Community-Based Housing efforts expanded access to permanent supportive housing while advancing pilot initiatives designed to strengthen housing pathways and improve system performance. Through continued collaboration with the North Carolina Housing Finance Agency, the Division of Aging, and other partners, the State increased access to affordable housing resources, including LIHTC and HUD 811 PRA, and refined processes to better support individuals transitioning to community settings. During SFY25, individuals in Priority Populations 1–3 increased by a net 21 individuals, bringing the total served from 995 to 1,016. Ongoing collaboration and continuous quality improvement efforts focused on housing processes and cross-system coordination reinforced integration, improved operational effectiveness, and supported long-term housing stability with full tenancy rights.

Community-Based Mental Health Services advanced through targeted initiatives to strengthen workforce development, enhance fidelity monitoring, and expand oversight systems. Alignment of the DMH/DD/SUS Strategic Plan with TCL Mental Health Services efforts further reinforced strategic coordination and system-wide progress. Key indicators of advancement in SFY25 included:

- 84.2% of housed individuals received at least one core service by Q4
- 4,468 individuals served by 88 ACT teams statewide
- Completion of 24 TMACT fidelity reviews during the fiscal year
- Investment of more than $131 million in statewide crisis system expansion

Implementation of mandatory ACT coaching for teams below fidelity benchmarks, piloting of a CST monitoring tool, and expansion of Community Inclusion services strengthened service quality and accountability. Crisis system investments – including Behavioral Health Urgent Care expansion, facility-based crisis services, mobile crisis response, and 988 outreach – further reinforced North Carolina's community-based continuum of care.

Supported Employment initiatives focused on operational stabilization and improved alignment under 1915(i). Major accomplishments include the refinement of the NC Core Milestone payment structure, strengthening IPS fidelity monitoring and the statewide launch of DB101 in May 2025 which expands access to CIE and benefits counseling supports. Supported Employment provision III.D.3 has been met and was formally discharged under the Sixth Settlement Agreement modification, reflecting measurable progress in expanding employment opportunities for individuals with SMI.

The **Discharge & Transition Process** continued to mature through expanded monitoring and technical assistance. Notable improvements included:

- Face-to-face in-reach engagement increased to 85.2% by SFY25Q4
- Overdue reassessments decreased from 531 in SFY24Q4 to 157 in SFY25Q4
- Addition of two Discharge & Transition Specialists to strengthen field oversight

- Ongoing State Psychiatric Hospital transition team monitoring and quality improvement collaboration, resulting in strengthened onsite transition practices and improved compliance with Settlement Agreement requirements

Implementation of a new informed choice step further aligned transition practices with Olmstead principles, ensuring individuals are supported in making informed decisions regarding housing and community living.

Pre-Admission Screening & Diversion efforts maintained strong performance in SFY25:

- 96.4% diversion rate achieved
- 541 individuals diverted from adult care homes
- 20 individuals entered adult care homes

Ongoing monthly and quarterly quality reviews and strengthened monitoring of informed choice documentation supported sustained compliance and ensured individuals were afforded meaningful opportunities to receive services in the least restrictive appropriate settings.

Quality Assurance and Performance Improvement efforts continued to mature in SFY25. The State completed its first annual update to the TCL QAPI Plan and further embedded data-driven monitoring across program operations. Enhancements to the TCL Dashboard, strengthened incident monitoring, continued quarterly performance measure reviews and QAPI activity cycles, and targeted technical assistance to LME/MCOs reinforced accountability and continuous improvement. The Sixth Settlement Agreement modification, entered in December 2024, formally recognized substantial compliance with all QAPI substantive requirements and extended the agreement through July 1, 2027.

The State of North Carolina continues to prioritize TCL as a cornerstone of its overall Olmstead commitment. The measurable progress achieved in SFY25 reflects strengthened infrastructure, sustained collaboration, and continued dedication to help ensure adults with serious and persistent mental illness (SPMI) have the opportunity to live, work, and thrive in an integrated community setting of their choice.

10 APPENDIX

10.1 TCL SETTLEMENT AGREEMENT (SA) MET & DISCHARGED REQUIREMENTS

The table below summarizes the TCL Settlement Agreement requirements that were discharged and met as of the sixth modification in December 2024. The sixth modification is referenced in the accompanying footnote.[36]

Table 3. Discharged Requirements

Met Requirement Citation	Brief Description of the Requirement	Modification # that discharged requirement
Discharged III(B) Housing Requirements		
III(B)(2)	Defines priority groups for Housing Slots (POPs 1-5).	6th
III(B)(3)	Access to 3,000 Housing Slots with milestones from 2013 through 2020	4th
III(B)(4)	Establish eligibility processes/rules for Housing Slots	4th
III(B)(6)	Ability to use existing housing assistance programs to meet Housing Slot obligations if they meet required supported-housing criteria	4th
III(B)(8)	Prohibits using Housing Slots in licensed/congregate settings (e.g., adult care homes, family care homes, group homes, nursing facilities, etc.)	6th
III(B)(9)	Individuals are free to choose other appropriate/available housing after being fully informed about supported housing and available supports (and clarifies limits on counting non-criteria housing)	6th
Discharged III(D) Supported Employment Requirements		
III(D)(3)	Provide Supported Employment Services to 2,500 individuals by July 1, 2019	6th
Discharged III(E) Discharge & Transition requirements		
III(E)(9)	State-level transition team to help local transition teams overcome barriers to integrated placement/discharge	4th
III(E)(13)(a)	Develop LME/MCO requirements/materials for in-reach and transition coordinators/teams	4th
III(E)(13)(b)	LME/MCO begin ongoing in-reach, and residents are assigned to a transition team consistent with in-reach requirements	4th
III(E)(13)(d)	Additional procedures for adult care homes deemed "at risk" of IMD determination	4th
III(E)(14)	Monitor Adult care homes for compliance with the Adult Care Home Residents' Bill of Rights (and related rights protections)	6th
Discharged II(F) Pre-admission screening & Diversion Requirements – *all requirements have been met*		
III(F)(1)	Process for an independent SMI determination as appropriate and the person to LME/MCO for service eligibility	4th
III(F)(2)	Requires development/implementation of a community integration plan once eligible for MH services, aligned with discharge planning provisions	4th
III(F)(3)	Process for documentation of informed choice, individualized strategies to address concerns, and ongoing monitoring, and appropriate in-reach/transition planning	6th
Discharged III(G) Quality Assurance & Performance Improvement (QAPI) – *all requirements have been met*		

[36] The 6th modification refers to the Sixth Modification of the Settlement Agreement (available at: https://www.ncdhhs.gov/20241211-6th-modification-settlement-agreement/open).

Met Requirement Citation	Brief Description of the Requirement	Modification # that discharged requirement
III(G)(1)	Requires a QA/Performance Improvement monitoring system to ensure placements/services align with the agreement and individuals receive supports for health/safety/welfare (quality, stable housing, reduced institutionalization)	6th
III(G)(2)	Requires an NCDHHS Transition Oversight Committee to monitor monthly implementation progress and receive reporting on key discharge/transition measures.	6th
III(G)(3)	Requires concrete QA/PI steps (e.g., monitoring protocols, census tracking, LOS/readmission/community tenure reporting, dashboards, housing data system, annual progress reports template, outcomes measures)	6th
III(G)(4)	Quality Assurance System, including ongoing collection/aggregation/analysis of data on in-reach/discharge/placements (including barriers), semi-annual review, and implementing measures to address identified problems	6th
III(G)(5)	Quality-of-life surveys for individuals transitioning out (pre-transition, ~11 months post, ~24 months post)	6th
III(G)(6)	Annual External Quality Review (EQR) process for LME/MCO policies/processes, with document review, interviews, stakeholder input, and monitoring focus areas	6th
III(G)(7)	Use of aggregated data to evaluate outcomes and drive performance improvement	6th
III(G)(8)	Publish annual public report	6th

10.2 SFY25 BUDGET

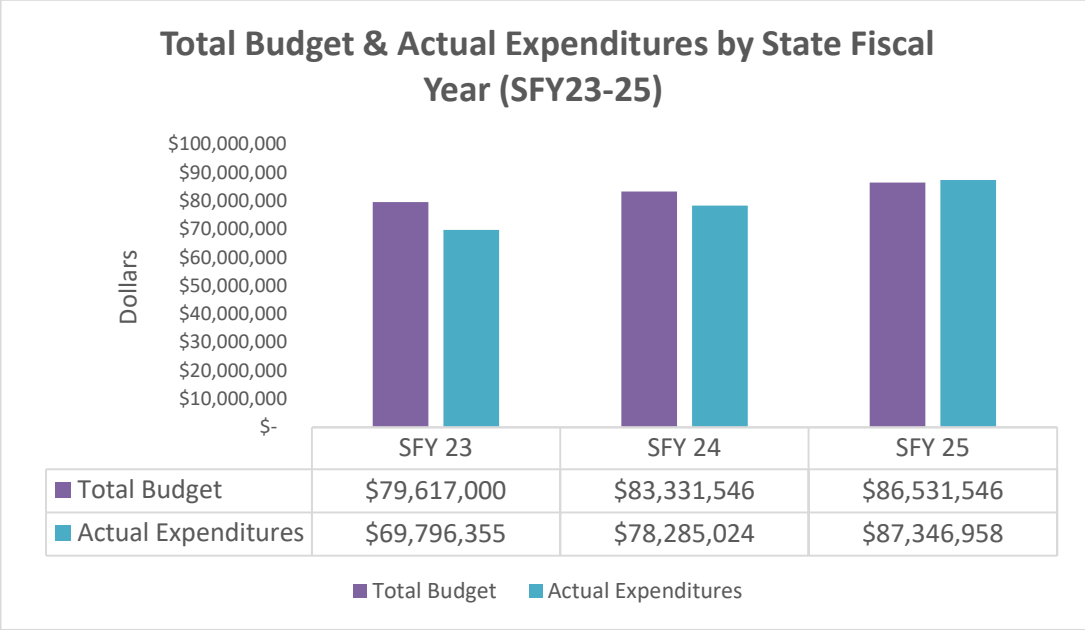
In SFY25, the TCL Team continued strategic budget management practices to plan/issue allocations, monitor and optimize funds. The team successfully carried out the following key budget activities:

- **Strategic Financial Planning** – Conducted annual financial planning by analyzing prior year expenditures, assessing current operational needs, and allocating funds to align with TCL goals and priorities.
- **Proactive Expenditure Monitoring** – Performed monthly expenditure reviews to address shortfalls and identify emerging needs, allowing for timely budget reallocations and additional funding, when possible.
- **Quarterly Financial Reviews** – Partnered with DMH/DD/SUS Finance Office for funding reviews with LME/MCOs to evaluate expenditures and implement necessary budgetary adjustments.
- **TCL Incentive Plan** – 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 that was contingent upon available funding.

The TCL budget increased in SFY25 to support rising program needs and ensure continued progress toward stronger performance outcomes. To help meet these needs, the budget was supplemented with $3.2 million in unused DHB funds, bringing the total operating budget to $86,513,868.

A comparative analysis of budget expenditures is summarized as follows:

Figure 12. Total Budget and Expenditures by State Fiscal Year



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

Table 4. Additional Details on Total Budget by SFY

SFY	Base Budget	Total Budget	Actual Expenditures	Additional Details
SFY23	$67,577,653	$79,617,000	$69,796,355	**Additional DHB Carry Forward:**[37] $12,336,530
SFY24	$83,331,546[38]	$83,331,546	$78,285,024	
SFY25	$83,331,546	$86,531,546	$79,267,579	**Additional Funding:** $3,200,000

Table 5. Key Expenditures Comparison

Cost Category	Total	
	SFY24	SFY25
Rental Assistance	$31,496,330	$40,723,733
DMH/DD/SUS LME/MCO Services Costs[39]	$22,347,112	$20,552,752[40]
Medicaid LME/MCO Staffing Costs	$16,403,147	$12,421,417
Division of Aging and Adult Services Staffing	$535,290	$521,034

[37] North Carolina Office of State Budget and Management (OSBM) approved Carry Forward of appropriations from SFY2022 to SFY2023.

[38] The SFY24 base budget was established as a new appropriation for that fiscal year.

[39] DMH/DD/SUS LME/MCO Services Costs is reflective of the TCL Services budget shown in Table 6.

[40] SFY25 DMH/DD/SUS Services Costs of $20,552,752 does not include the Enhanced Bridge Costs of $727,026 paid out by American Recovery and Reinvestment Act (ARPA) for Home and Community-Based Services (HCBS).

Cost Category	Total	
	SFY24	SFY25
NCDHHS Staffing and Operational Costs	$732,544	$743,712
Contracts	$6,681,694	$4,231,901
Olmstead Planning	$88,907	$73,030
Total	**$78,285,024**	**$79,267,579**

Table 6. Breakdown of Budget LME/MCO for SFY25

Key TCL Service	Alliance	Partners	Trillium	Vaya
Transition Year Stability Resources (TYSR)	$473,883	$459,199	$461,644	$227,293
Community Living Assistance (CLA)	$1,034,157	$665,917	$1,704,714	$584,661
Emergency Housing Funds	$46,328	$203,487	$142,229	$32,601
LME/MCO Transition Coordinators	$180,000	$90,000	$60,667	$180,000
Bridge Housing	$887,418	$295,055	$1,431,329	$359,222
Mental Health Services	$868,510	$794,485	$1,426,988	$1,282,366
Supported Employment	$309,224	$262,628	$448,801	$250,565
In-Reach Collab	$0	$33,000	$0	$0
Community Inclusion	$180,000	$317,579	$0 [41]	$0
Freedom Funds[42]	$5,000	$10,000	$15,000	$0
Subsidy Administration	$180,000	$90,000	$180,000	$180,000
LME/MCO Diversion Staff	$900,000	$336,000	$575,021	$630,000
Assertive Engagement	$101,000	$37,642	$71,485	$18,000
TCL Incentive Payments	$295,313	$229,687	$30,000	$218,750
Enhanced Bridge[43]	$536,464	$625,426	$0	$325,040
Totals[44]	**$5,993,297**	**$4,450,105**	**$6,547,878**	**$4,288,498**

[41] FY25 Community Inclusion funds for Trillium of $554,562, were allocated through a partnership with DMH/DD/SUS using the Mental Health Block Grant (MHBG) and not TCL Funds—a federal funding program that provides grants to states to support comprehensive, community-based mental health services for adults with Serious Mental Illness (SMI).

[42] Freedom Funds are set-aside funds that allow individuals receiving Community Inclusion services to purchase goods or services that enhance their health, wellness, and independence. These requests are identified by consumers and reviewed and approved by the Tailored Plans.

[43] The funding for Enhanced Bridge of $727,026, was provided through the American Recovery and Reinvestment Act (ARPA) for Home and Community-Based Services (HCBS).

[44] Total amount for al 4 TPs budget is $21,279,778.

10.3 REPORTING ON SERVICE PATTERNS

10.3.1 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. Service summaries are shown for the full SFY25 by LME/MCO and statewide. Service summaries are based on EPS and NCTracks Medicaid and DMH/DD/SUS adjudicated claims for the TCL participant populations and services described in the table below.[45]

Table 7. SFY 2025 TCL Participant Populations by Status and Setting[46]

Participant Status and Service Setting	Description	SFY25
TCL Supportive Housing	Individuals in TCL supportive housing during the reporting period	4,609
Transition Planning[47]	Individuals with approved TCL supportive housing slots who had an initial transition attempt in progress	1,286
Rehousing Planning	Individuals separated from TCL supportive housing who had a subsequent transition attempt in progress	437
ACH In-Reach	Individuals residing in an adult care home	3,965
SPH In-Reach	Individuals residing in a State Psychiatric Hospital	634
SPH Outreach	Individuals residing in the community after SPH discharge	1,295
Diversion	Individuals who had an adult care home Diversion attempt in progress	1,264
Living in the Community without a TCL Housing Slot	Individuals living in community settings other than TCL supportive housing	793
Unduplicated Total	**Total count of participants, each counted once regardless of transitions across setting and status**	**11,141**

[45] 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.

[46] Population counts for each category include all individuals with the status at any time during the state fiscal year (SFY). 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.

[47] 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.

Table 8. 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[48]
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 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 (SUS) and Treatment	Alcohol/Drug Group Counseling, Halfway House, and Residential Ambulatory, Inpatient, and Social Setting Detox

[48] IPS measure values include only individuals with NC CORE milestone claims processed via NCTracks or EPS and do not capture all individuals receiving IPS services.

Service Category	Services Included
	Cessation counseling for smoking and tobacco use Medication Assisted Treatment (MAT) Substance Abuse Comprehensive Outpatient Treatment (SACOT) Substance Abuse Intensive Outpatient Treatment (SAIOP) Non-Medical and Medically Monitored Community Residential Treatment[49]
MCM	Mobile Crisis Management
FBC	Facility-Based Crisis

10.3.2 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 2025. Timely filing limits may affect data completeness, especially for services provided late in the state fiscal year.
- Service rates are based on counts of all TCL participants per status documented in TCLD and CLIVe during the reporting period.
- Statewide client counts and service rates may include a small amount of duplication due to client LME/MCO transfers within measurement periods.
- Medicaid and State-funded IPS-SE services provided under the NC CORE value-based payment model are reimbursed only when individual 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 do not reflect all individuals who received IPS-SE services. Since NC Core implementation, claims-based IPS measure values are most appropriately interpreted as numbers and percentages of individuals with NCTracks or EPS processed NC CORE milestone payments.
- The TCL 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.

10.3.3 SUMMARY OF SERVICE TRENDS

[49] Procedure codes for these services were added to the SUD measure calculation for the August 2025 dashboard release and are effective retrospectively.

SFY 2025 service claims data showed the following trends:

- Relative rates of core TCL services among individuals in TCL housing shifted somewhat in SFY 2025. ACT service rates continued to be higher than lower intensity CST, TMS, and peer-support services. However, as CST rates gradually increased and TMS decreased, their relative rates among housed individuals shifted from approximately equal in SFY 2024 to approximately 50 percent higher CST than TMS in SFY 2025. The size of the relative difference between ACT and CST rates was also smaller in SFY 2025.
- Individuals in Transition Planning and Diversion statuses were approximately twice as likely to receive CST as ACT in SFY 2025, compared to the one-third to 40 percent higher CST than ACT rates in these statuses in SFY 2024.
- Individuals planning for rehousing after a separation continued to be more likely to receive ACT than CST, and this difference was even more pronounced in SFY 2025 compared to the previous year.
- TMS rates were lower overall in SFY 2025 compared to the previous year, with noticeably lower rates among individuals in Diversion status, Transition and Rehousing Planning, and TCL housing.
- Peer Support Service rates increased by approximately 25 relative percentage points across TCL statuses and settings, such that nearly 15 percent of all TCL participants received PSS in SFY 2025. PSS rates were approximately one-third higher among individuals in Diversion status and nearly double the SFY 2024 rates among individuals living in the community without a TCL housing slot. Smaller relative year-over-year increases were observed for all other TCL statuses and settings.
- Rates of each of ACT, CST, and Peer Support Services were higher in SFY 2025 compared to the previous year among individuals living in the community without a TCL housing slot, such that the percentage of individuals in this status receiving a core TCL service increased by more than half, from 27 percent in SFY 2024 to 42 percent in SFY 2025.
- Percentages of participants receiving services in congregate day programming through Psychosocial Rehabilitation Services remained low across participant statuses and settings and, as in previous years, were highest for individuals in ACH In-Reach, followed by individuals in SPH Outreach.
- Use of standalone crisis services (e.g., Facility-Based Crisis and Mobile Crisis Management) remained low across statuses and settings, though claims data do not reflect crisis services provided by ACT and CST teams.
- Individuals in SPH Outreach or living in the community without a TCL housing slot continued to receive SUD services at lower rates than individuals with TCL housing slots or those in Diversion status, and individuals in In-Reach status remained least likely to receive SUD services.
- Higher apparent rates of SUD services in SFY 2025 across TCL statuses and settings, 6.4 percent compared to three percent in SFY 2024, reflect the July 2025 transition of LME/MCOs to Medicaid Tailored Plans that now also manage medical services.[50]
- Evaluation and Management service rates were nearly 60 percent higher in SFY 2025 compared to the previous SFY, because medical office visits also now are covered under Medicaid Tailored Plans.

[50] Separate service claims analysis indicates this apparent increase in the number of TCL participants with a SFY 2025 SUD service primarily reflects provision of tobacco use cessation counseling, which, when provided by medical service providers prior to the transition to Tailored Plans, would not have been included NCTracks or EPS service claims data.

10.3.4 SERVICE SUMMARIES BY TCL STATUS AND SETTING

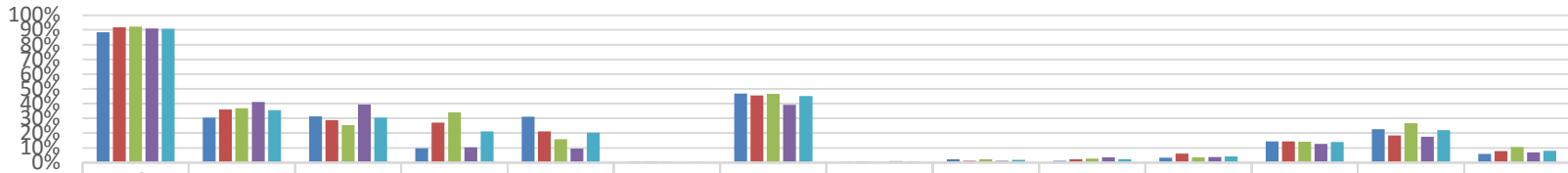
The remainder of this section includes counts and percentages of TCL participants in each status and setting previously described.

Table 9. Individuals in TCL Supportive Housing

LME/MCO	Total Number	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS Mile-stone[51]	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	1,366	1,207	415	429	134	426	10	639	8	31	17	46	197	310	79
Partners	917	842	329	264	248	194	6	417	7	12	20	56	132	168	72
Trillium	1,457	1,344	536	372	499	232	11	679	7	33	39	53	207	387	155
Vaya	873	794	360	345	90	83	2	341	10	11	31	33	110	153	61
Statewide	4,609	4,183	1,639	1,408	972	936	29	2,077	32	87	107	188	647	1,019	367

[51] IPS measure values include only individuals with NC CORE milestone claims processed via NCTracks or EPS and do not capture all individuals receiving IPS services.

Figure 13. Individuals in TCL Supportive Housing

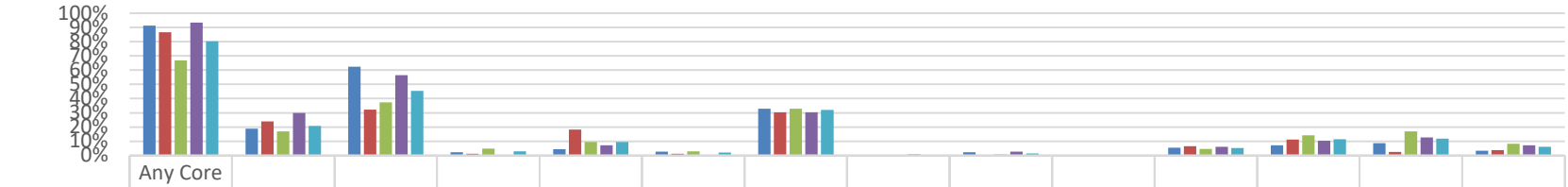


	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psychotherapy	PsyDx/Testing	SUD
	Living in the community with a TCL housing slot: Housed													
Alliance	88%	30%	31%	10%	31%	1%	47%	1%	2%	1%	3%	14%	23%	6%
Partners	92%	36%	29%	27%	21%	1%	46%	1%	1%	2%	6%	14%	18%	8%
Trillium	92%	37%	26%	34%	16%	1%	47%	1%	2%	3%	4%	14%	27%	11%
Vaya	91%	41%	40%	10%	10%	0%	39%	1%	1%	4%	4%	13%	18%	7%
Statewide	91%	36%	31%	21%	20%	1%	45%	1%	2%	2%	4%	14%	22%	8%

Table 10. Individuals in Transition Planning

LME/MCO	Total Number	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS Mile-stone [52]	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	292	266	55	182	7	13	8	96	1	7	1	16	21	25	10
Partners	230	199	55	74	3	42	3	70	1	1	1	15	26	6	9
Trillium	553	370	94	207	27	53	16	182	3	5	2	26	79	94	46
Vaya	211	197	63	119	0	15	1	64	2	6	0	13	22	27	15
Statewide	1,286	1,032	267	582	37	123	28	412	7	19	4	70	148	152	80

Figure 14. Individuals in Transition Planning



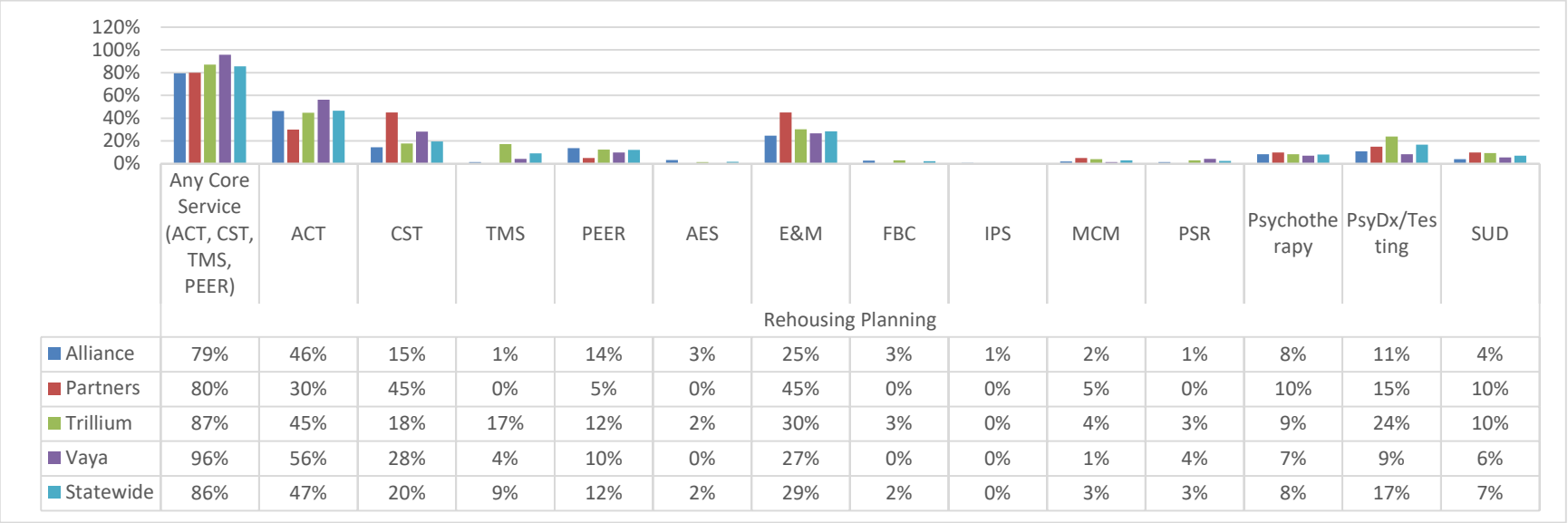
	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psychotherapy	PsyDx/Testing	SUD
	Transition Planning													
Alliance	91%	19%	62%	2%	5%	3%	33%	0%	2%	0%	6%	7%	9%	3%
Partners	87%	24%	32%	1%	18%	1%	30%	0%	0%	0%	7%	11%	3%	4%
Trillium	67%	17%	37%	5%	10%	3%	33%	1%	1%	0%	5%	14%	17%	8%
Vaya	93%	30%	56%	0%	7%	1%	30%	1%	3%	0%	6%	10%	13%	7%
Statewide	80%	21%	45%	3%	10%	2%	32%	1%	2%	0%	5%	12%	12%	6%

[52] IPS measure values include only individuals with NC CORE milestone claims processed via NCTracks or EPS and do not capture all individuals receiving IPS services.

Table 11. Individuals in Rehousing Planning

LME/MCO	Total Number	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS Mile-stone [53]	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	145	115	67	21	2	20	5	36	4	1	3	2	12	16	6
Partners	20	16	6	9	0	1	0	9	0	0	1	0	2	3	2
Trillium	201	175	90	36	35	25	3	61	6	0	8	6	17	48	19
Vaya	71	68	40	20	3	7	0	19	0	0	1	3	5	6	4
Statewide	437	374	203	86	40	53	8	125	10	1	13	11	36	73	31

Figure 15. Individuals in Rehousing Planning

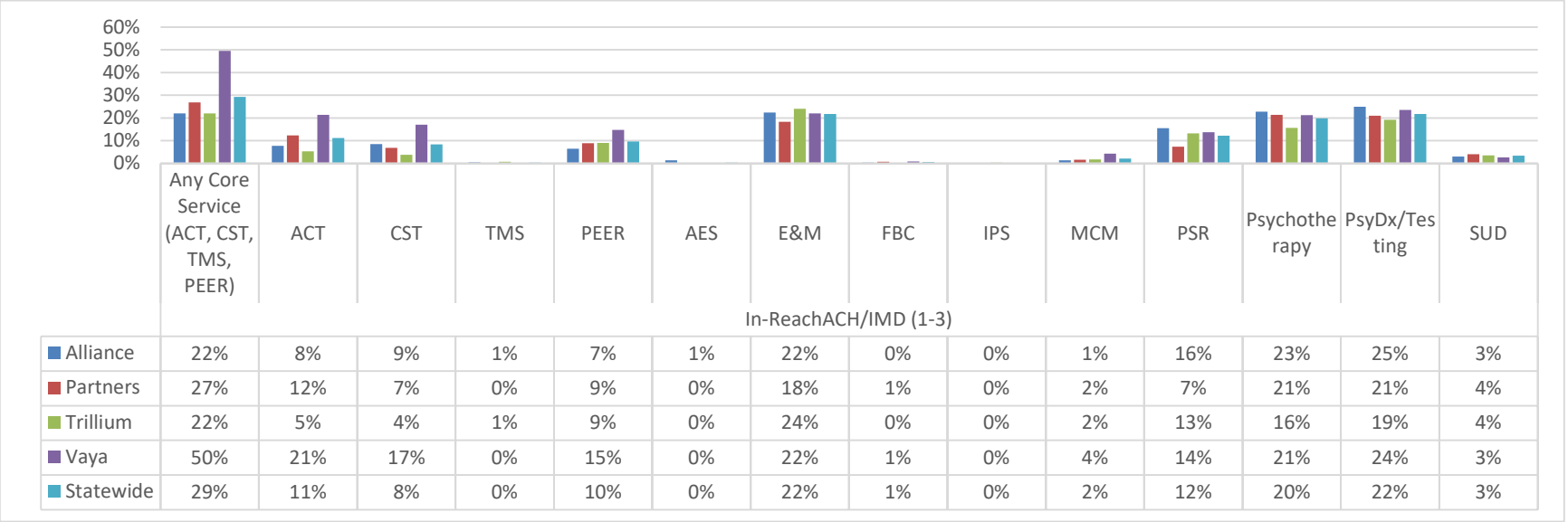


[53] IPS measure values include only individuals with NC CORE milestone claims processed via NCTracks or EPS and do not capture all individuals receiving IPS services.

Table 12. Individuals in ACH In-Reach

LME/MCO	Total Number	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS Mile-stone [54]	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	804	177	62	68	4	52	11	180	3	1	11	125	183	201	25
Partners	1,080	289	133	74	2	96	2	198	8	0	18	80	231	227	44
Trillium	1,223	269	66	46	10	110	2	293	4	5	22	161	191	235	43
Vaya	860	426	184	147	0	126	1	189	8	2	37	118	183	202	23
Statewide	3,965	1,160	444	335	16	384	16	860	23	8	88	484	788	865	135

Figure 16. Individuals in ACH In-Reach

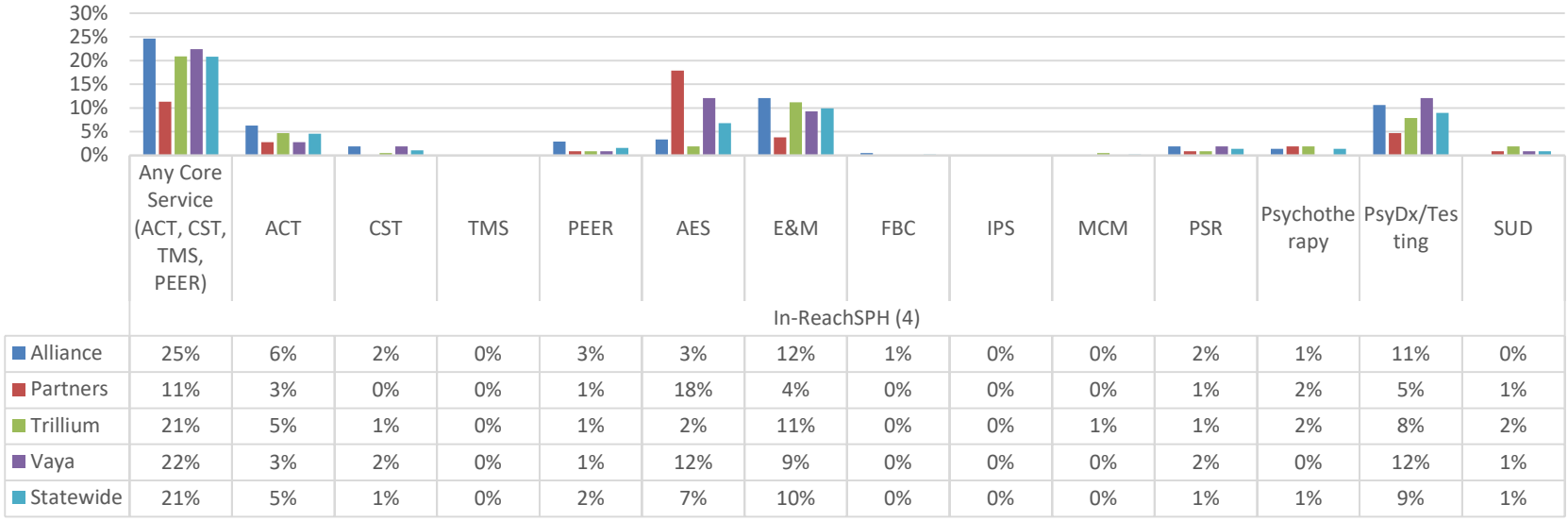


[54] IPS measure values include only individuals with NC CORE milestone claims processed via NCTracks or EPS and do not capture all individuals receiving IPS services.

Table 13. Individuals in SPH In-Reach

LME/MCO	Total Number	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS Mile-stone [55]	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	207	51	13	4	0	6	7	25	1	0	0	4	3	22	0
Partners	106	12	3	0	0	1	19	4	0	0	0	1	2	5	1
Trillium	215	45	10	1	0	2	4	24	0	0	1	2	4	17	4
Vaya	107	24	3	2	0	1	13	10	0	0	0	2	0	13	1
Statewide	634	132	29	7	0	10	43	63	1	0	1	9	9	57	6

Figure 17. Individuals in SPH In-Reach

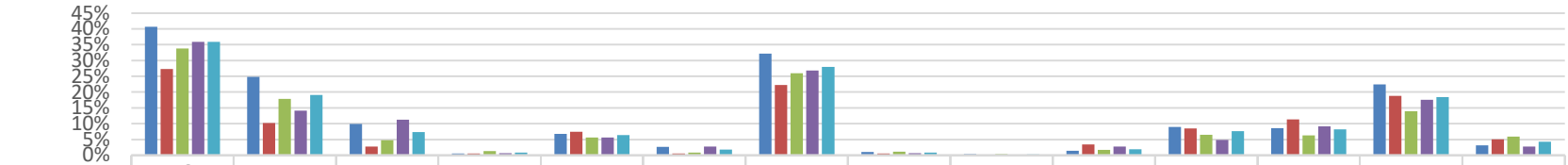


[55] IPS measure values include only individuals with NC CORE milestone claims processed via NCTracks or EPS and do not capture all individuals receiving IPS services.

Table 14. Individuals in SPH Outreach

LME/MCO	Total Number	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS Mile-stone [56]	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	532	224	122	71	4	23	20	142	14	5	2	43	43	116	11
Partners	184	47	23	10	0	12	3	37	3	3	6	15	13	30	7
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 18. Individuals in SPH Outreach



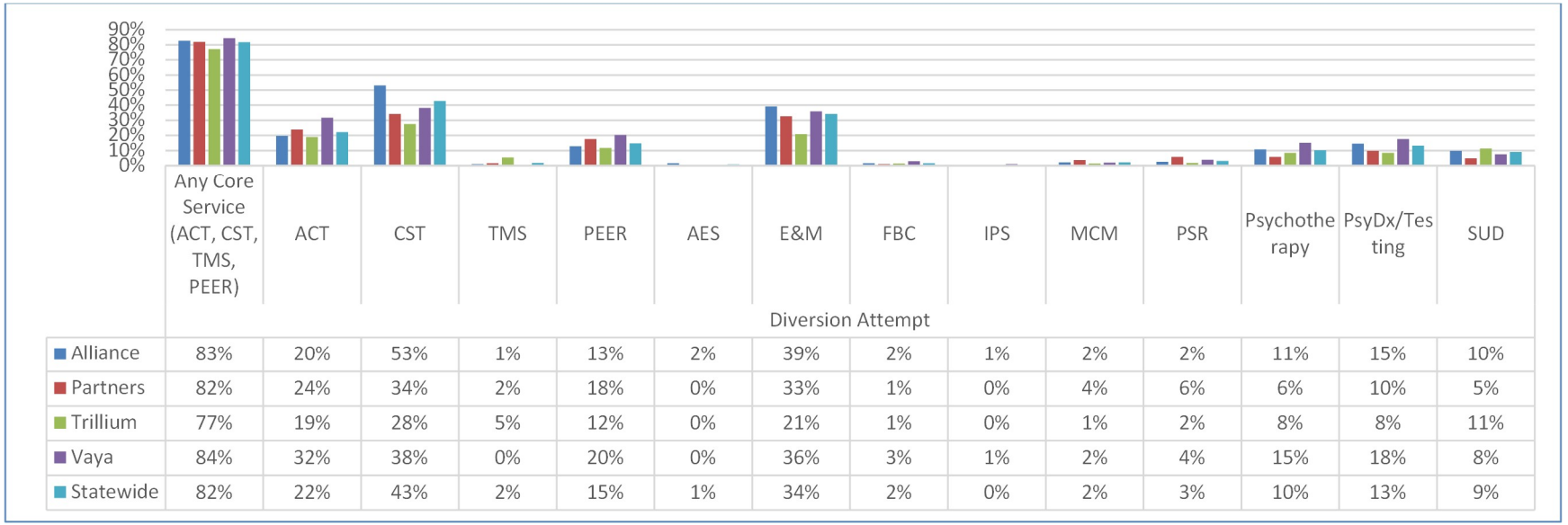
	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS	MCM	PSR	Psychotherapy	PsyDx/Testing	SUD
	OutreachSPH (4)													
Alliance	41%	25%	10%	1%	7%	3%	32%	1%	0%	1%	9%	9%	22%	3%
Partners	27%	10%	3%	1%	7%	1%	22%	1%	0%	3%	9%	11%	19%	5%
Trillium	34%	18%	5%	1%	6%	1%	26%	1%	0%	2%	7%	6%	14%	6%
Vaya	36%	14%	11%	1%	6%	3%	27%	1%	0%	3%	5%	9%	18%	3%
Statewide	36%	19%	7%	1%	6%	2%	28%	1%	0%	2%	8%	8%	18%	4%

[56] IPS measure values include only individuals with NC CORE milestone claims processed via NCTracks or EPS and do not capture all individuals receiving IPS services.

Table 15. Individuals in Diversion Status

LME/MCO	Total Number	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS Mile-stone [57]	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	619	511	122	328	6	79	10	242	9	3	13	15	66	90	60
Partners	193	158	46	66	3	34	0	63	2	0	7	11	11	19	9
Trillium	240	185	45	66	13	28	0	50	3	0	3	4	20	20	27
Vaya	212	179	67	81	0	43	0	76	6	2	4	8	32	37	16
Statewide	1,264	1,033	280	541	22	184	10	431	20	5	27	38	129	166	112

Figure 19. Individuals in Diversion Status

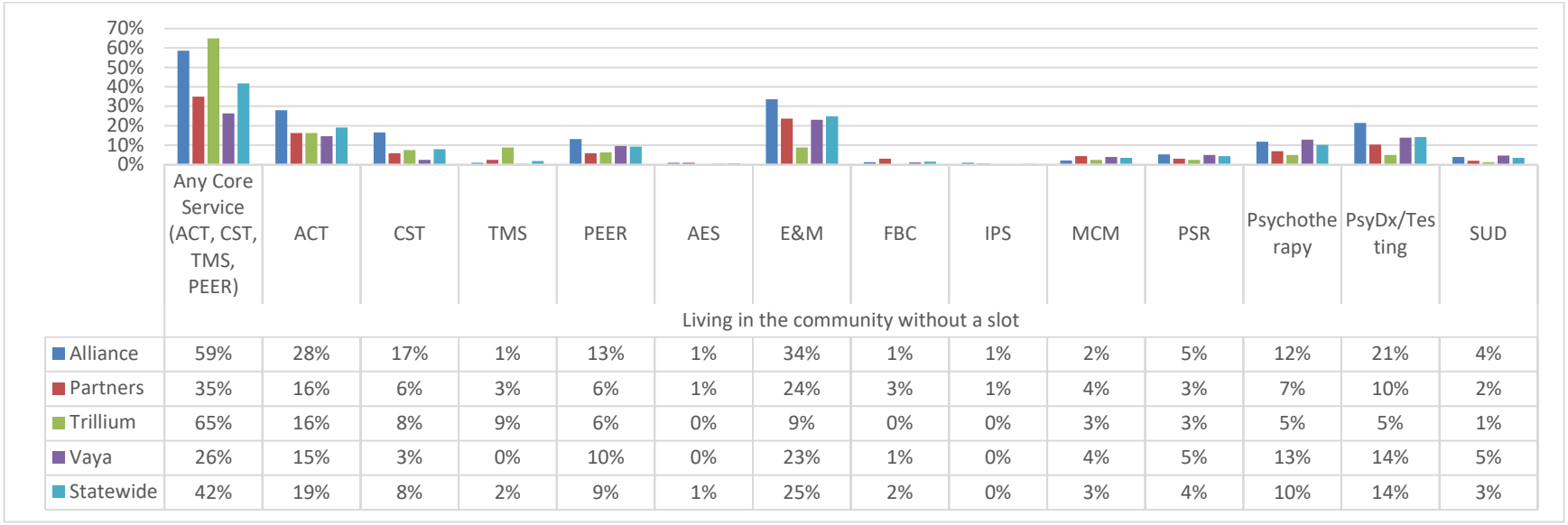


[57] IPS measure values include only individuals with NC CORE milestone claims processed via NCTracks or EPS and do not capture all individuals receiving IPS services.

Table 16. Individuals Living in the Community Without a TCL Housing Slot

LME/MCO	Total Number	Any Core Service (ACT, CST, TMS, PEER)	ACT	CST	TMS	PEER	AES	E&M	FBC	IPS Mile-stone [58]	MCM	PSR	Psycho-therapy	PsyDx/Testing	SUD
Alliance	148	73	24	19	4	8	0	32	4	2	0	14	14	23	7
Partners	266	66	26	11	3	17	1	40	4	3	7	11	26	22	4
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 20. Individuals Living in the Community Without a TCL Housing Slot



[58] IPS measure values include only individuals with NC CORE milestone claims processed via NCTracks or EPS and do not capture all individuals receiving IPS services.

10.4 LIST OF ACRONYMS

ACH: Adult Care Home.

ACT: Assertive Community Treatment.

ACTT: Assertive Community Treatment Team.

ADA: Americans with Disabilities Act.

AES: Assertive Engagement Service.

AHEC: Area Health Education Centers

ARPA: American Recover and Reinvestment Act

BHUC: Behavioral Care Urgent Care

CI: Community Inclusion.

CIE: Competitive Integrated Employment.

CIL: Centers for Independent Living.

CLA: Community Living Assistance.

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

CPSS: Certified Peer Support Specialist.

CQI: Continuous Quality Improvement.

CST: Community Support Team.

CTI: Critical Time Intervention.

CY: Calendar Year.

D&T: Discharge & Transition

DA: Division of Aging.

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.

DSS: Division of Social Services

E&M: Evaluation and Management.

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.

HCBS: Home and Community-Based Services.

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/MCOs: Local Management Entity/Managed Care Organizations.

LOP: Life Of Program.

MAT: Medication Assisted Treatment.

MCM: Mobile Crisis Management.

MFP: Money Follows the Person.

MHC: Medicaid Help Center

MHBG: Mental Health Block Grant

MHS: Mental Health Services

MI: Motivational Interviewing.

NAMI: National Alliance on Mental Illness.

NC: North Carolina

NCAPSE: North Carolina Association of People Supporting Employment First

NC CORE: North Carolina Community Outreach and Resource Engagement.

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.

NCTracks: North Carolina Tracks.

PCP: Person-Centered Planning.

PIHP: Prepaid Inpatient Health Plan.

PMP: Performance Measurement Plan

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.

QMR: Quality Measurement Report

QoL: Quality of Life.

QP: Qualified Professional

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.

SFY: State Fiscal Year.

SME: Subject Matter Expert.

SMI: Serious Mental Illness.

SPH: State Psychiatric Hospital.

SPMI: Severe and Persistent Mental Illness.

SUD: Substance Use Disorder.

SUS: Substance Use Services.

TA: Technical Assistance.

TAC: Technical Assistance Collaborative.

TCL: Transitions to Community Living.

TCLD: Transitions to Community Living Database.

TCM: Tailored Care Manager, Tailored Care Management

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.

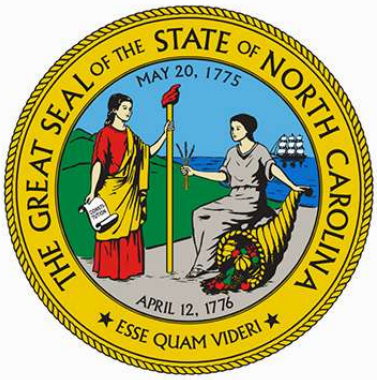
UM: Utilization Management.

UNC: University of North Carolina.

UNC-IBP: UNC Institute for Best Practices.

USDOJ: United States Department of Justice.

10.5 LIST OF FIGURES AND TABLES



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