# STATE OF NORTH CAROLINA
# DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

November 8, 2019

**SENT VIA ELECTRONIC MAIL**

The Honorable Joyce Krawiec, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 308, Legislative Office Building
Raleigh, NC 27603

The Honorable Josh Dobson, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 307B, Legislative Office Building
Raleigh, NC 27603

The Honorable Donny Lambeth, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 303, Legislative Office Building
Raleigh, NC 27603

Dear Chairmen:

North Carolina General Statute 122C-20.15 requires the Department of Health and Human Services to report annually to the Joint Legislative Oversight Committee on Health and Human Services on the number of individuals within each LME/MCO catchment area who transitioned into housing slots available through the North Carolina Supportive Housing Program during the preceding calendar year. Pursuant to the provisions of law, the Department is pleased to submit the attached report.

Should you have any questions, please contact Kody Kinsley, Deputy Secretary for Behavioral Health and Intellectual/Developmental Disabilities, at 919-733-7011.

Sincerely,

Mandy Cohen, MD, MPH
Secretary

Kody H. Kinsley
Deputy Secretary for Behavioral Health & IDD
North Carolina Department of Health and Human Services

cc:

| | | | | | |
|---|---|---|---|---|---|
| Matt Gross | Hattie Gawande | Dave Richard | Jared Simmons | Kody Kinsley |
| Joyce Jones | Rob Kindsvatter | Lisa Wilks | Theresa Matula | Luke MacDonald |
| Erin Matteson | Marjorie Donaldson | Zack Wortman | Mark Collins | Jessica Meed |
| Deborah Landry | Katherine Restrepo | Susan G. Perry | reports@ncleg.net | |

# 2018-2019 Annual Report on North Carolina Supportive Housing Program

# Opening the Door to Community: The Transitions to Community Living Initiative

## NCGS 122C-20.15

**Report to the**

**Joint Legislative Oversight Committee on**

**Health and Human Services**

**North Carolina Department of Health and Human Services**

**November 8, 2019**

## TCLI Vision Statement: Opening the Door to Community

For people living with serious mental illness or severe and persistent mental illness, permanent housing, combined with supportive services, promotes stability, wellness, recovery, meaningful relationships and the opportunity to become a contributing member of the community. The North Carolina Department of Health and Human Services puts these core concepts into practice in the Transitions to Community Living Initiative (TCLI). For people who are coming out of, or are at risk of entering, institutions, TCLI's Permanent Supportive Housing is integrated into the community and incorporates enhanced, clinically appropriate and innovative services. Its person-centered services and supports and array of individualized, innovative approaches assist people in making the informed choices -- choices that promote health, employment, education and well-being. For each person we serve, TCLI is opening the door to community, a good life and a place to call home.

## Lives Transformed: Comments from TCLI Participants

"I never thought I would have my own place. The support helped me push through it... I'm living a normal, successful life..."

"I used to think I wouldn't be able to work because of my disability, that it would be too hard and everything. When I got linked up with Supported Employment, I see that there is a job out there for everyone. You just have to find the right job for you, and everything is possible."

"I feel like I've been truly blessed to be in this program and I'd just like to thank God for that and the people that have helped me and the whole program... I'm really good now that I'm on my own."

"I have free will to do what I want; eat when I want; take a shower in my own bathroom; and have privacy. I have more things to do: shoot pool, walk around and go to restaurants. You all helped me so much; [TCLI] exceeded my expectations."

"My Transition Coordinator...brought me back to life inside and I'm loving it. I now am living in a very nice two-bedroom apartment with two bathrooms."

"I am so happy. This is the first time I have had the opportunity to live on my own."

"The most important thing for me is to not go back into the hospital and so far, it has been great. I'm just happy. I achieved this. ...I had help, but I did it."

# Table of Contents

# I. Summary Tables[1]

Transitions to Community Living Initiative (TCLI) opens this year's report with a set of summary tables. While these do not cover all aspects of the program, the information they convey is emblematic of the work the State has done to advance core components of the program. These components are addressed in all monthly reports to the United States Department of Justice (DOJ).

**Table 1. LME/MCO Totals for Start of 2018-19**

| LME/MCO | In-Reach Planning[2] | Transition Planning[3] | Individuals Housed (LOP[4]) | Individuals Currently in Housing | RSVP[5] Screenings Processed | ACT[6] Served |
|---|---|---|---|---|---|---|
| Alliance Behavioral Healthcare | 1059 | 60 | 271 | 218 | 246 | 1127 |
| Cardinal Innovations | 1661 | 54 | 623 | 476 | 498 | 1363 |
| Eastpointe | 659 | 14 | 208 | 140 | 187 | 347 |
| Partners Behavioral Health Management | 633 | 27 | 286 | 202 | 259 | 546 |
| Sandhills Center | 577 | 19 | 241 | 170 | 136 | 282 |
| Trillium | 904 | 10 | 273 | 187 | 252 | 316 |
| Vaya Health | 731 | 13 | 266 | 187 | 245 | 1298 |
| **Total** | **6224** | **197** | **2168** | **1580** | **1823** | **5279** |

**Table 2. LME/MCO Supported Employment Totals for Start of 2018-19**

| LME /MCO | Fidelity Supported Employment Teams[7] | Teams Working Towards Fidelity | Total Served by Fidelity Teams | Total Served by all teams | Total Served by Fidelity Teams for the Priority Population |
|---|---|---|---|---|---|
| Alliance Behavioral Healthcare | 6 | 0 | 798 | 798 | 339 |
| Cardinal Innovations | 6 | 0 | 999 | 1026 | 568 |
| Eastpointe | 4 | 0 | 581 | 581 | 84 |
| Partners Behavioral Health Management | 2 | 1 | 218 | 314 | 42 |
| Sandhills Center | 3 | 0 | 323 | 331 | 104 |
| Trillium | 7 | 0 | 634 | 634 | 361 |
| Vaya Health | 3 | 0 | 827 | 827 | 307 |
| **Total** | **31** | **1** | **4378** | **4509** | **1805** |

[1] Under the Department of Justice Settlment Agreement, the State is required to develop and utilize a template for published annual progress reports. The format of this Annual Report follows the basic template that the State has developed and uses each year, with some additions and improvements.
[2] In-Reach is an engagement, education and support effort designed to accurately and fully inform adults who have a serious mental illness (SMI) or a serious and persistent mental illness (SPMI) about community mental health services (including Individual Placement and Supported Employment (IPS-SE)) and Permanent Supportive Housing).
[3] TCLI transition planning assists individuals, identified through the In-Reach or diversion process, who voiced a desire to explore other possible opportunities for living in the community with individualized services and supports.
[4] LOP is Life of Program, the number of individuals placed in housing since the start of TCLI.
[5] As of November 1, 2018, the Referral Screening Verification Process (RSVP) replaced Pre-Admission Screening and Resident Review (PASRR). The RSVP tool screens individuals for TCLI eligibility.
[6] Assertive Community Treatment (ACT) consists of a group of community medical, behavioral health and rehabilitation professionals who use a team approach to meet the needs of an individual with severe and persistent mental illness.
[7] The foundation for this service definition is the Individual Placement and Support (IPS) evidence-based Supported Employment (SE) model and SE Fidelity Scale developed by the Dartmouth Psychiatric Research Center and promoted by the US Substance Abuse and Mental Health Services Administration (SAMHSA).

**Table 3. LME/MCO Totals for End of 2018-19**

| LME/MCO | In-Reach Planning | Transition Planning | Individuals Housed (LOP) | Individuals Currently in Housing | ACT Served | Total receiving In-Reach or Transition Supports |
|---|---|---|---|---|---|---|
| Alliance Behavioral Healthcare | 1075 | 49 | 408 | 291 | 773 | 65 |
| Cardinal Innovations | 1638 | 103 | 863 | 615 | 1014 | 416 |
| Eastpointe | 575 | 47 | 279 | 174 | 391 | 29 |
| Partners Behavioral Health Management | 670 | 17 | 392 | 264 | 602 | 222 |
| Sandhills Center | 516 | 7 | 323 | 233 | 362 | 36 |
| Trillium | 972 | 32 | 415 | 289 | 399 | 44 |
| Vaya Health | 699 | 30 | 358 | 248 | 1285 | 266 |
| **Total** | **6145** | **285** | **3038** | **2114** | **4826** | **1078** |

**Table 4. LME/MCO Supported Employment Totals for 2018-19**

| LME/MCO | Fidelity Supported Employment Teams | Total Served by Fidelity Teams | Total Served by all Teams | Total Served by Fidelity Teams for the Priority Population |
|---|---|---|---|---|
| Alliance Behavioral Healthcare | 6 | 932 | 932 | 392 |
| Cardinal Innovations | 8 | 1263 | 1290 | 680 |
| Eastpointe | 5 | 731 | 731 | 107 |
| Partners Behavioral Health Management | 2 | 320 | 425 | 93 |
| Sandhills Center | 4 | 545 | 563 | 151 |
| Trillium | 7 | 898 | 899 | 448 |
| Vaya Health | 4 | 940 | 944 | 351 |
| **Total** | **36** | **5626** | **5781** | **2222** |

**Table 5. Summary of Transition Expenses**

| LME/MCO | Rent | TYSR | CLA |
|---|---|---|---|
| Alliance | 1,148,163 | $227,200 | $571,571 |
| Cardinal | 3,316,655 | $395,363 | $450,907 |
| Eastpointe | 631,365 | $130,722 | $351,360 |
| Partners | 925,887 | $187,706 | $409,807 |
| Sandhills | 801,574 | $156,444 | $281,492 |
| Trillium | 1,164,231 | $157,321 | $282,160 |
| Vaya | 535,597 | $137,416 | $169768 |
| Total | **8,523,472** | **$1,392,174** | **$2,517,066** |

# II. Housing

In FY 2018-19, the strong partnership between the NC Department of Health and Human Services (DHHS) and the Local Management Entity/ Managed Care Organizations (LME/MCO) yielded dividends. The State met the Settlement Agreement's target number for housing for the first time. The DHHS' continued use of Bridge Housing has also helped transitions to be timely and person-centered. Bridge Housing allows the LME/MCOs to stabilize individuals who are in need of immediate housing while they plan for living in the community. Over 85 percent of those individuals who utilized Bridge Housing were able to transition to living in the community. In FY18-19, the LME/MCOs began to administer their own Bridge Housing Programs. This allowed LME/MCOs to be more flexible and responsive to needs in their respective communities. Hotel stays have historically been used to assist in the transition to community-based housing and are part of Bridge Housing. DHHS also supported TCLI's housing efforts by providing additional funding to the LME/MCOs, advancing partnerships with temporary housing providers and expanding and establishing new contracts with community service providers.

Inspections of all potential housing units, employing Housing and Urban Development (HUD) Quality Standards (HQS), ensure safe, sanitary and secure housing for TCLI participants. This task is carried out by the LME/MCOs. Units are re-inspected annually, as well as on an ad hoc basis, if a health and safety issue arose or a tenant or support provider has cause to request a re-inspection. In FY18-19, $218,248 was spent to ensure housing units subsidized for TCLI participants met the HQS upon initial lease execution. Additionally, the Senior Advisor on the Americans with Disabilities Act (ADA) for DHHS visited individuals in the community all across the State and met with each LME/MCO to review processes and TCLI living situations.

The Community Living Integration Verification (CLIVe) system is now fully operational and actively utilized. CLIVe is a payment reimbursement system that supports LME/MCO housing activity by providing a mechanism to input data and receive reimbursement consistent with DHHS' established program policy and procedures. CLIVe also manages and organizes workflow, as well as serving as the system of record for Transition to Community Living Voucher (TCLV)[8] tenancies. Ultimately, CLIVe is the system of record for tenancies for all individuals participating in TCLI. The CLIVe system provides oversight functions that allow for quality review of the TCLV program. These include, but are not limited to, rental costs incurred by each LME/MCO; tracking of late inspections; a record of reasons for "move outs"; and length of stay in housing.

The Targeting Program is a partnership between North Carolina Housing Finance Agency (NCHFA) and DHHS to provide access to affordable housing for low income households in which people with disabilities reside. Properties developed using the federal Low-Income Housing Tax Credit (LIHTC) are required to participate in the Targeting Program. This means that LIHTC properties must set aside at least 10 percent, but no more than 20 percent of their units, and make them available for eligible participants as identified by DHHS. During June 2017, there were 4,866 housing units available upon turnover. In June 2018, there were 5,439

[8] This voucher provides a rental subsidy utilized to access quality affordable housing.

units available upon turnover, an expansion of 573 units. As of June 2019, more than 6,400 apartments in 814 properties across the state were set aside as Targeted units. An additional 1,000 units will be added by the end of 2020.

NCHFA and DHHS have redesigned Targeting Unit Agreements, Property Profiles, and Pre-Leasing Notifications and, additionally, instituted bi-weekly operational and monthly strategic meetings. Revisions to processes have made the Targeted Units more accessible to people in TCLI. To support substantial compliance with the Settlement Agreement, the Targeting Program has implemented a prioritization for TCLI participants. The Vacancy and Referral System creates real-time reports of all vacant units. As a result, DHHS housing coordinators can more efficiently offer TCLI participants units that meet their needs. As of June 2019, there were 606 TCLI households residing in Targeted Units.

Socialserve[9], https://www.socialserve.com, continues to contact landlords for satisfaction surveys. When landlords are dissatisfied, NCHFA follows up with the LME/MCO. LME/MCOs then conduct outreach to the landlord, service provider and/or tenant, resulting in saved tenancies. For purposes of Quality Assurance and Performance Improvement, the data is compiled and analyzed to track and trend the results, allowing DHHS to determine training needs, accessibility issues, areas of concern and successes. Socialserve also continues to provide assistance to LME/MCOs in landlord outreach and engagement.

In FY18-19, DHHS partnered with NCHFA to develop the Integrated Supportive Housing Program (ISHP), a program providing interest-free loans to community developments where up to 20 percent of the units are integrated and set aside for households participating in the TCLI program. These developments are affordable and integrated into the community, with a focus on access to services, grocery stores and other amenities. A total of 11 projects were awarded, bringing 144 additional set-aside units to communities throughout the state. At the end of FY19, DHHS and NCHFA were gearing up to release a Notice of Funds Available for a second round of ISHP funding, with funds committed from both DHHS and NCHFA. This collaborative effort will fund development of additional housing units in all seven LME/MCO catchment areas.

In FY18-19, DHHS worked with the LME/MCOs and Public Housing Agencies (PHA) throughout North Carolina to apply to HUD for funding for the Mainstream Voucher Program. These efforts brought the State approximately 246 additional vouchers, the majority of which resulted from the partnership between the LME/MCOs and PHAs. In late FY18-19, HUD funds again became available for the Mainstream Voucher Program. DHHS began a partnership with the Department of Administration Commission on Indian Affairs' Public Housing Authority and applied for 150 vouchers, with the goal of spreading these throughout counties with high housing need. LME/MCOs also collaborated with PHAs. The result was a significant increase in the number of vouchers requested. Partnerships with the 22 PHAs led to application for over 1200 vouchers. DHHS and the Technical Assistance Collaborative (TAC) provided significant technical assistance--including a webinar, telephonic question and answer sessions--and facilitated coordination between the LME/MCO and the PHAs in the application process. Final applications will be due, and awards announced in FY19-20.

[9] Socialserve is a nonprofit, bilingual call center that connects people to housing and provides supportive, second chance employment.

DHHS, in coordination with the TAC, released the TCLI Housing Pipeline. The Pipeline lays out processes and strategies to increase available housing throughout North Carolina. This tool will assist DHHS, NCHFA and the LME/MCOs in ensuring that the number of units and subsidies are sufficient to reach the Settlement Agreement goal of 3000 by 2021.

In April 2019, DHHS petitioned HUD, requesting a remedial preference for the life of the Settlement Agreement for individuals in TCLI. This remedial preference allows all NC PHAs to amend their administrative plans to ensure that individuals involved in TCLI are provided preference on their respective housing waitlists. The remedial preference was granted and DHHS will be working to implement preferences throughout North Carolina PHAs in FY20.

# III. Community Mental Health Services

This year, TCLI has continued to focus on improving the quality of its services and has sought to involve LME/MCOs actively in the process. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) has been providing LME/MCOs with full, fidelity evaluation reports for both Assertive Community Treatment (ACT)[10] and Individual Placement and Support-Supported Employment (IPS-SE).[11] To support fostering growth in these areas of service delivery, DMH/DD/SAS facilitated the first round of LME/MCO ACT and IPS-SE fidelity report reviews. DMH/DD/SAS staff compiled the most recent fidelity evaluations into Excel documents and then used these to begin discussions focused on identifying the strengths and areas of growth for each service. We also reviewed quality areas to distinguish between results of LME/MCO practices and results of network-governed provider practices; tested our assumptions; and processed potential solutions when the performance issue stemmed from an LME/MCO practice. DMH/DD/SAS plans to continue monitoring, at a minimum of every six months. This will ensure that LME/MCOs are actively advancing quality improvement efforts--for themselves, for their provider network and for the services received by state- and Medicaid-funded participants in the TCLI program.

**Assertive Community Treatment (ACT)**

In FY18-19, LME/MCOs continued to embrace Assertive Community Treatment Teams as a vital service for TCLI participants. In June of 2019 alone, TCLI saw noteworthy increases in the use of the service by recipients: Cardinal increased by 373 recipients; Alliance by 286; Vaya by 62; Eastpointe by 54; Sandhills by 46; Trillium by 40; and Partners by 1.

Twenty-four (24) Assertive Community Treatment (ACT) teams were evaluated for fidelity, using Tools for the Measurement of Assertive Community Treatment[12] (TMACT). One

[10] An Assertive Community Treatment (ACT) team consists of a group of community medical, behavioral health and rehabilitation professionals who use a team approach to meet the needs of an individual with severe and persistent mental illness.
[11] The foundation for this service definition is the Individual Placement and Support (IPS) evidence-based Supported Employment model and Supported Employment Fidelity Scale developed by the Dartmouth Psychiatric Research Center and promoted by the US Substance Abuse and Mental Health Services Administration (SAMHSA).
[12] All ACT teams operate to fidelity using either the Dartmouth Assertive Community Treatment (DACTS) model or the Tool for Measurement of Assertive Community Treatment (TMACT).

evaluation was a second TMACT, following an initial TMACT in 2016, while the remaining 23 TMACTs were third evaluations. The table below shows the shifts in practice between the most recent TMACT evaluation and the evaluation previous to it.

**Table 6. TMACT Evaluations**

| Certification Level | Team Score at Previous Evaluation | Team Score at State Fiscal Year (SFY) 2018-19 Evaluation |
|---|---|---|
| Exceptional Practice (4.2-5.0) | 0 | 2 |
| Full Certification (3.7-4.2) | 18 | 14 |
| High Provisional (3.4-3.6) | 4 | 6 |
| Low Provisional (3.0-3.3) | 1 | 1 |
| No Certification[13] | 1 | 1 |

Overall scores for all ACT teams, statewide, are as follows:

**Table 7. Statewide ACT Team Scores**

| Certification Level | Total number of ACT teams statewide |
|---|---|
| Exceptional Practice (4.2-5.0) | 11 |
| Full (3.7-4.2) | 41 |
| High Provisional (3.4-3.6) | 19 |
| Low Provisional (3.0-3.3) | 2 |
| No Certification | 0 |

State-level areas of focus for training continue to be:

- Organizational structure to support fidelity
- Medical staff role and team integration
- Co-occurring disorders
- Agency leadership/team leaders
- Person-Centered Planning/Treatment Planning
- Tenancy Supports
- Assertive Engagement

[13] During this period, an agency assumed operation of an ACT team that had previously scored below a 3.0. Under new leadership, the team name changed, and their score improved to a 3.6. During the same period, an agency that previously scored a 3.6 scored a 2.9. The agency contested and but had not scored above the minimum established in contract. As a result, the agency had ACT removed from its contract.

With regard to ACT staff, the University of North Carolina (UNC) Center of Excellence continues to facilitate both trainings on working with people with mental illness and practice circles. Trainings and the practice circles are offered free of charge and assist staff's mastery of skills and competencies.

**Community Support Team (CST)**

TCLI is implementing innovative changes to the service definition for Community Support Team (CST)[14]. The changes to this definition have been made in part to:

- Accommodate the interventions/services that were being provided by Transition Management Services (TMS)[15] teams
- Make CST more clinical so that it can be an appropriate step-down service from ACT
- Clarify the outcomes that are expected from CST
- Improve the recovery orientation of the service and specify the psychiatric rehabilitation services that are to be provided

The purpose of this service is to provide direct treatment, restorative interventions and case management. It is designed to provide:

- Symptom stability
- Restorative interventions
- Psychoeducation
- First Responder intervention (24/7/365)
- Service coordination
- Linkage to community services/resources

The expected outcomes for this service are:

- Increased ability to function across major life domains
- Reduced symptomology
- Decreased frequency/intensity of crisis episodes
- Increased community participation (e.g., working, school, social activities)
- Increased ability to live independently
- Engagement in the recovery process
- Increased ability to self-manage triggers, cues, and symptoms

North Carolina has contracted with the Technical Assistance Collaborative (TAC) to provide intensive training and technical assistance to LME/MCOs, as well as to community service providers, during the rollout of this service. Intensive technical assistance to the LME/MCOs on the new Community Support Team service will ensure that it is implemented within a Permanent

[14] CST services consist of community mental health and substance abuse rehabilitation services and necessary supports provided through a team approach to assist adults in achieving rehabilitative and recovery goals.
[15] Transition Management Services (TMS) is a service provided to individuals participating in the Transition to Community Living Initiative (TCLI). TMS is a rehabilitation service intended to increase and restore an individual's ability to live successfully in the community by maintaining tenancy.

Supportive Housing framework.[16] TCLI's innovative service array and clear focus on implementation will give people the tools to obtain and successfully maintain housing in the community.

**Individual Placement and Support - Supported Employment**

North Carolina continues to engage in the Individual Placement and Support - Supported Employment (IPS-SE) International Learning Collaborative. This year, DMH/DD/SAS sent three staff to the international conference in Denver, Colorado. At this event, two staff facilitated break out groups on IPS-SE implementation in a managed care environment and implementation of IPS-SE in First Episode Psychosis teams. The State continues to benefit from participation in the Collaborative and it has the added benefit of providing researchers on IPS-SE at Westat direct access to staff.

Currently, 38 teams are providing IPS-SE services across the State. During SFY18-19, one team closed in Trillium and two teams in Sandhills merged under the same agency.

In FY18-19, 23 IPS-SE evaluations were completed. Of these, four were baseline/first reviews. The average baseline score for the year was 92 (Fair Fidelity). Of teams that had had a prior review, 15 of 19 (79%) increased their scores during this fiscal year. The average fidelity score for the 15 teams who improved was 97. Three teams saw scores decrease from their prior fidelity review, and one team's score remained the same. The average score for the four teams who saw their score decrease/remain the same was 88.5. For the year, the overall, average fidelity score for the 23 teams was 94.65.

**Table 8. IPS-SE Fidelity Scores**

| Certification Level | Team Score at Previous Evaluation | Team Score at SFY18-19 Evaluation |
|---|---|---|
| Exemplary (115-125) | 0 | 0 |
| Good (100-114) | 6 | 9 |
| High Fair (90-99) | 6 | 5 |
| Low Fair (74-89) | 11 | 4 |
| No Certification | 1 | 0 |

Overall, we have seen an improvement for the IPS-SE teams we have evaluated, with teams achieving IPS-SE fidelity scores at the following certification levels:

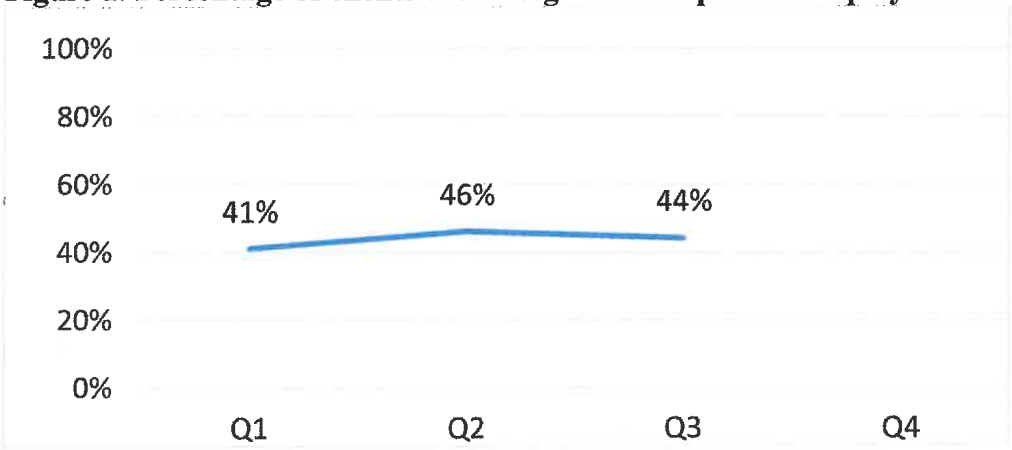
[16] Permanent Supportive Housing combines housing and services for people with low-incomes who have disabilities. This housing model aims to reduce homelessness, promote independence for people with disabilities, improve an individual's health and help individuals retain employment.

**Table 9. IPS-SE Certification Levels**

| Certification Level | Total statewide number of IPS-SE teams[17] |
|---|---|
| Exemplary (115-125) | 1 |
| Good (100-114) | 11 |
| High Fair (90-99) | 15 |
| Low Fair (74-89) | 10 |
| No Certification | 0 |

DMH/DD/SAS began tracking IPS-SE outcomes using the Dartmouth Quarterly Outcomes Report, with some minor modifications. There has been 100% reporting compliance for three quarters, and we can report the following information:

**Figure 1. Percentage of clients with integrated competitive employment[18]**




[17] The 38th team is new and has completed an initial fidelity evaluation.
[18] The data point in Figure 1 indicates that IPS-SE teams in NC are producing employment-related outcomes in line with national trends reported by Westat.

**Table 10. Employment Rate by LME/MCO[19]**

| Provider Average | Q1 | Q2 | Q3 |
|---|---|---|---|
| **Alliance** | 39% | 42% | 41% |
| **Cardinal** | 48% | 45% | 44% |
| **Eastpointe** | 53% | 41% | 43% |
| **Partners** | 43% | 46% | 28% |
| **Sandhills** | 50% | 47% | 44% |
| **Trillium** | 39% | 43% | 43% |
| **Vaya** | 48% | 48% | 41% |
| **All Providers** | 45% | 44% | 42% |

Training for FY19-20 will focus on increasing knowledge and understanding of the IPS-SE model among LME/MCO In-Reach staff. An Adult Mental Health Team staff member from DMH/DD/SAS has been assigned as the lead for improving the connections among In-Reach, Transition and IPS. This position will develop linkages among In-Reach coaches; identify specific barriers encountered by IPS-SE teams; and work with IPS-SE teams, LME/MCOs, and In-Reach and Transition staff to remove barriers.

Another area of focus this year will be the IPS-SE Milestone Payment Pilot (NC CORE), a collaboration among the Division of Vocational Rehabilitation (DVR), DMH/DD/SAS, NC Medicaid, Vaya Health, and the IPS-SE teams in the Vaya network. Vaya's Milestone Payment Pilot will take current, federal and state fee-for-service funding[20] and shift these to an outcome-based reimbursement system. We anticipate this pilot going live on October 1, 2019.

In 2018-2019, trainings for Supported Employment included:

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[19] **Note**: Table 10 data points indicate that, as IPS-SE fidelity scores have increased, the integrated competitive employment rate is above the 35% employment rate for North Carolinians with disabilities.

[20] In DVR's milestone system, organizations are administered funds when an individual receiving services within their program has achieved designated goals or "milestones" on their way toward the goal of integrated competitive employment.

- Foundations of Supported Employment and Recovery
- Strengths-based services
- IPS-SE and DVR integration
- Case consultation
- Career profile development
- Vocational unit meeting
- Documentation and disclosure
- Employment Peer Mentor
- Benefits Counseling for Recovery
- Job Development

**Personal Care Services**

Personal care services (PCS) provides hands-on assistance for individuals with unmet needs for assistance with Activities of Daily Living (ADL). ADLs are activities such as bathing, dressing, toileting, ambulation, or feeding.[21] Access to PCS is a critical element for participants in the TCLI program to support a successful transition. The ability to perform activities of daily living impacts an individual's ability to function independently.

In 2016, NC Medicaid developed an expedited process for accessing personal care services for TCLI-eligible members. An expedited assessment entitles a person to an immediate review for eligibility for the service, once a request is faxed and the review is completed by phone. The addition of an expedited assessment is critical as people transition from an institution to the community. Many coming out of institutional settings have lost skills; others come with chronic illnesses that making navigating the community more difficult. Timely access to PCS is critical for ensuring success in the community.

If eligible, an individual is immediately, temporarily approved for up to 60 hours of PCS, and is sent to the primary care physician of their choice. If the person needs names of physicians in the area who conduct PCS-related assessments, they will be provided a list of doctors from which to choose. On average, TCLI participants who receive PCS get a total of 46 hours through the mini-assessment and an average of 39 hours during the full face-to-face assessment.

**Deaf and Hard of Hearing Participants**

TCLI strengthened its work in FY18-19 with the Division of Services for Deaf and Hard of Hearing (DSDHH). Building on its involvement with the NC Institute of Medicine's Task Force on Health Services for Individuals who are Deaf and Hard of Hearing Task Force, TCLI engaged with DSDHH's leadership around transitions to the community for deaf and/or hard of hearing individuals in the State's only psychiatric unit specific to this population, at Broughton Hospital. Working through the Barriers Committee, TCLI is promoting policies and practices designed to promote better communication access for deaf and hard of hearing participants in its program.

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[21] Set-up, supervision, cueing, prompting, and guiding, are included when provided as part of the hands-on assistance with qualifying ADLs. PCS also provides assistance with those home management Instrumentals of Daily Living (IADLs) that are directly related to the beneficiary's qualifying ADLs and essential to the beneficiary's support at home.

This includes consideration of the challenges to recruitment, retention and geographic access of participants to the interpreter workforce. Calling on the consultative skills of interpreters experienced in working in the mental health system, DSDHH, DMH/DD/SAS and TCLI will collaborate to assist LME/MCOs, TCLI coordinators, Broughton Hospital staff and providers to remove the unique service barriers encountered by deaf and hard of hearing TCLI participants.

**Community Mental Health Service Patterns**

This portion of the report summarizes Calendar Year (CY) 2017 and 2018 services data. This year's DHHS annual report includes CYs 17 and 18 Mental Health service claims data summaries for 1) individuals in supported housing, 2) individuals in in-reach, and 3) individuals within the 90-day window before transition, i.e., the transition planning period.

Analyses are based on NCTracks[22][23] Medicaid and DMH/DD/SAS paid professional (non-institutional) behavioral health service claims. Claims-based data are reported for calendar years rather than state fiscal years to allow sufficient lag time for claims processing after the end of the time period examined.

Claims data were retrieved for the following categories of TCLI participants:

- 1,549 individuals who were in Permanent Supportive Housing for one or more days of Calendar Year 2017 or who previously had been housed and subsequently were re-housed by April 2019.
- 2,046 individuals who were in Permanent Supportive Housing for one or more days of Calendar Year 2018 or who previously had been housed and subsequently were re-housed by April 2019.
- 10,363 individuals who had documented In-Reach during Calendar Years 2017 or 2018, including:
    - 1,437 who subsequently transitioned into Permanent Supportive Housing before April 2019, and
    - 8,926 who had not yet transitioned into Permanent Supportive Housing by April 2019.

[22] NCTracks is the multi-payer Medicaid Management Information System for the NC Department of Health and Human Services.

[23] The 2018 annual report claims summary was based on a combination of DMH/DD/SAS adjudicated claims from NCTracks and LME/MCO paid Medicaid claims that were collected through Community Care of North Carolina (CCNC). Due to known claims processing issues that resulted in incomplete data in the NCTracks system, year-to-year differences should be interpreted with caution. The exact degree of data completeness and the extent to which resulting service use estimates are affected are unknown. Up to 20 percent of Medicaid encounters may not be represented in NCTracks for some months in 2017, for example. This may have a greater impact on estimates of numbers of relatively rare events, such as hospital admissions and emergency department (ED) visits, compared to estimates of numbers of individuals who received ongoing services, for which the opportunity to "detect" a service based on the presence of a claim may be greater due to the larger number of claims. Timely filing limits also may affect the completeness of data currently available, especially for 2018 Medicaid encounters. For reasons such as these, the summaries presented here are most helpful for understanding general service patterns and the array of services provided.

**Community Mental Health Service Use Patterns for Housed TCLI Participants**

Table 11, below, shows numbers of housed individuals for whom NCTracks queries returned behavioral health claims, by LME/MCO and as percentages of individuals housed one or more days during 2017 or 2018 or later re-housed. By virtue of the method used to retrieve claims, one hundred percent of these individuals received one or more post-transition community mental health service in the calendar years examined.

These individuals first transitioned to Permanent Supportive Housing between 2 days and 5.1 years (2017) or 2 days and 6.1 years (2018) prior to the last day of the calendar year. On the last day of the calendar year, the average time since transition for these individuals was 1.5 years (2017) and 1.8 years (2018), with a median of 1.2 years (2017) and 1.5 years (2018).

**Table 11. Housed Participant Populations for Community Mental Health Services Analysis**[24]

| Current LME/MCO on Record | CY 2017 | CY 2018 |
|---|---|---|
| Alliance Behavioral Health | 191 | 276 |
| Cardinal Innovations Healthcare Solutions | 472 | 631 |
| Eastpointe | 123 | 168 |
| Partners Behavioral Health Management | 213 | 281 |
| Sandhills Center | 161 | 191 |
| Trillium Health Resources | 202 | 264 |
| Vaya Health | 187 | 235 |
| Total | 1,549 | 2,046 |
| Individuals housed one or more days or later re-housed | 1,586 | 2,107 |
| Percent of possible | 97.7% | 97.1% |

Table 12, below, shows numbers and percentages of individuals, counted in Table 12, who had paid claims for core, TCLI community mental health services and other supports. Participants in housing received a variety of other mental health and support services, including, for example, New and Established Outpatient Office Visits (5%, 32%, 2017; 5%, 33%, 2018); b(3)[25] Individual Supports (5%, 3%); Ambulatory, Outpatient, Social Setting, Inpatient Detox services (0.7% combined, both years); and Medication Assisted Treatment (0.7%, 0.6%).

[24]Individual participants and their associated service claims are summarized under the current LME/MCO, which may not be the LME/MCO that housed the individual and/or that managed the reported service. Approximately four percent of TCLI participants have transferred across catchment areas since initially transitioning to Permanent Supportive Housing.

[25] b(3) services are supports for individuals who have Medicaid. They are in addition to the services available to that person under the Medicaid State Plan. These services focus on helping individuals remain in their homes and communities and avoid hospitalization or living in an institution.

**Table 12. Calendar Years 2017 and 2018 Community Mental Health Service Rates for Housed TCLI Participants**

| Calendar Year 2017 | Transition Management Services[26] (TMS) | | Assertive Community Treatment Team (ACT) | | Community Support Team (CST) | | Psychosocial Rehabilitation[27] (PSR) | | Individual Placement and Support-Supported Employment (IPS-SE)[28] | | Peer Support Services | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % |
| Alliance | 111 | 58% | 80 | 42% | 27 | 14% | 16 | 8% | 26 | 14% | 11 | 6% |
| Cardinal | 261 | 55% | 205 | 43% | 43 | 9% | 50 | 11% | 32 | 7% | 93 | 20% |
| Eastpointe | 76 | 62% | 44 | 36% | 13 | 11% | 12 | 10% | 3 | 2% | 2 | 2% |
| Partners | 96 | 45% | 111 | 52% | 18 | 8% | 14 | 7% | 11 | 5% | 78 | 37% |
| Sandhills | 90 | 56% | 77 | 48% | 7 | 4% | 27 | 17% | 11 | 7% | 48 | 30% |
| Trillium | 141 | 70% | 65 | 32% | 38 | 19% | 21 | 10% | 24 | 12% | 70 | 35% |
| Vaya | 88 | 47% | 108 | 58% | 31 | 17% | 18 | 10% | 10 | 5% | 17 | 9% |
| Total | 863 | 56% | 690 | 45% | 177 | 11% | 158 | 10% | 117 | 8% | 319 | 21% |
| Calendar Year 2018 | TMS | | ACT | | CST | | PSE | | IPS-SE | | Peer Support Services | |
| | N | % | N | % | N | % | N | % | N | % | N | % |
| Alliance | 157 | 57% | 128 | 46% | 45 | 16% | 21 | 8% | 35 | 13% | 22 | 8% |
| Cardinal | 358 | 57% | 257 | 41% | 65 | 10% | 64 | 10% | 41 | 6% | 181 | 29% |
| Eastpointe | 100 | 60% | 54 | 32% | 14 | 8% | 17 | 10% | 4 | 2% | 17 | 10% |
| Partners | 135 | 48% | 144 | 51% | 17 | 6% | 23 | 8% | 12 | 4% | 96 | 34% |
| Sandhills | 101 | 53% | 89 | 47% | 12 | 6% | 24 | 13% | 10 | 5% | 57 | 30% |
| Trillium | 191 | 72% | 76 | 29% | 36 | 14% | 16 | 6% | 55 | 21% | 87 | 33% |
| Vaya | 115 | 49% | 125 | 53% | 33 | 14% | 23 | 10% | 11 | 5% | 49 | 21% |
| Total | 1,157 | 57% | 873 | 43% | 222 | 11% | 188 | 9% | 168 | 8% | 509 | 25% |

[26] Transition Management Services (TMS) is a service provided to individuals participating in the Transition to Community Living Initiative (TCLI). TMS is a rehabilitation service intended to increase and restore an individual's ability to live successfully in the community by maintaining tenancy.
[27] Psychiatric Rehabilitation (Psychosocial Rehabilitation) is a rehabilitative service in a licensed facility designed to assist adults (age 18 and older) with psychiatric disabilities to restore their ability to live successfully in the community.
[28] IPS-SE, provided as a b(3) services under the Innovations waiver, was excluded in error from IPS-SE rates reported in the 2018 DHHS Annual TCLI Report.

**Table 12. (cont.). Calendar Years 2017 and 2018 Community Mental Health Service Rates for Housed TCLI Participants**

| Calendar Year 2017 | Psychological Diagnostic, Evaluation, and/or Testing | | Psychotherapy (Individual, Group, and/or Family) | | Mobile Crisis Management (MCM) | | Facility-Based Crisis (FBC) | | Substance Abuse Intensive Outpatient Program (SAIOP) | | Substance Abuse Comprehensive Outpatient Treatment (SACOT) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % |
| Alliance | 45 | 24% | 48 | 25% | 2 | 1% | 9 | 5% | 1 | 1% | 1 | 1% |
| Cardinal | 99 | 21% | 78 | 17% | 18 | 4% | 8 | 2% | 4 | 1% | 5 | 1% |
| Eastpointe | 26 | 21% | 24 | 20% | 3 | 2% | 2 | 2% | 5 | 4% | 6 | 5% |
| Partners | 37 | 17% | 59 | 28% | 15 | 7% | 4 | 2% | 1 | 0% | 1 | 0% |
| Sandhills | 58 | 36% | 23 | 14% | 6 | 4% | 1 | 1% | | 0% | 2 | 1% |
| Trillium | 57 | 28% | 59 | 29% | 21 | 10% | 4 | 2% | 2 | 1% | | 0% |
| Vaya | 38 | 20% | 43 | 23% | 11 | 6% | 2 | 1% | 2 | 1% | | 0% |
| Total | 360 | 23% | 334 | 22% | 76 | 5% | 30 | 2% | 15 | 1% | 15 | 1% |
| **Calendar Year 2018** | **Psychological Diagnostic, Evaluation, and/or Testing** | | **Psychotherapy (Individual, Group, and/or Family)** | | **MCM** | | **FBC** | | **SAIOP** | | **SACOT** | |
| | N | % | N | % | N | % | N | % | N | % | N | % |
| Alliance | 65 | 24% | 68 | 25% | 5 | 2% | 7 | 3% | 2 | 1% | | 0% |
| Cardinal | 127 | 20% | 118 | 19% | 19 | 3% | 6 | 1% | 6 | 1% | 5 | 1% |
| Eastpointe | 36 | 21% | 35 | 21% | 10 | 6% | 2 | 1% | 6 | 4% | 11 | 7% |
| Partners | 54 | 19% | 73 | 26% | 14 | 5% | 9 | 3% | 1 | 0% | 1 | 0% |
| Sandhills | 45 | 24% | 27 | 14% | 3 | 2% | 1 | 1% | 1 | 1% | 5 | 3% |
| Trillium | 63 | 24% | 71 | 27% | 26 | 10% | 5 | 2% | 4 | 2% | | 0% |
| Vaya | 43 | 18% | 57 | 24% | 25 | 11% | 7 | 3% | 5 | 2% | | 0% |
| Total | 433 | 21% | 449 | 22% | 102 | 5% | 37 | 2% | 25 | 1% | 22 | 1% |

## Community Mental Health Service Use Patterns for TCLI Participants During In-Reach and Transition Planning

Table 13 shows, by LME/MCO, the numbers of individuals who had one or more In-Reach contacts documented in the Transitions to Community Living Database (TCLD)[29] during Calendar Years 2017 and 2018; had not transitioned to Permanent Supportive Housing as of January 1, 2017; and matched to client data in the NCTracks claims data warehouse.[30] Analysis of services provided during In-Reach for these individuals is based on Calendar Years 2017 and 2018 behavioral health service claims, excluding the 90 days prior to transition for those who moved into Permanent Supportive Housing before April 1, 2019.

Calendar Years 2017 and 2018 claims for the subset of 14 percent of individuals who transitioned to Permanent Supportive Housing between January 3, 2017 and March 29, 2019 were retrieved for up to the 90 days prior to each individual's transition date. These claims were examined separately to evaluate services provided during the period that included transition planning. Services provided to the same individuals more than 90 days before their transition dates, are included in the summary of services provided during In-Reach.[31]

**Table 13. In-Reach and Transition Planning Populations for Current Service Data Analysis**

| | Individuals with Calendar Year 2017 or 2018 In-Reach | Subset with Initial Transition to Permanent Supportive Housing before April 2019 | |
|---|---|---|---|
| Current LME/MCO on Record | | N | % |
| Alliance Behavioral Health | 1,572 | 227 | 14% |
| Cardinal Innovations Healthcare Solutions | 2,765 | 464 | 17% |
| Eastpointe | 1,222 | 116 | 9% |
| Partners Behavioral Health Management | 1,184 | 187 | 16% |
| Sandhills Center | 881 | 122 | 14% |
| Trillium Health Resources | 1,565 | 175 | 11% |
| Vaya Health | 1,174 | 146 | 12% |
| Total | 10,363 | 1,437 | 14% |
| Total number with documented In-Reach | 10,738 | 1,437 | 13.4% |
| Percent of possible | 96.5% | 100% | |

[29] Transition to Community Living Database (TCLD) is a system developed for the NC Department of Health and Human Services to track and report activity related to the TCLI. Those involved in the initiative use the system to record contact and progress of individuals affected by the initiative.

[30] An additional 273 individuals with initial transition dates of January 1, 2017 and earlier were excluded from this analysis. These individuals were previously housed and received In-Reach during the period examined after leaving housing and/or had post-transition visits documented as In-Reach contacts in error. Another 102 individuals with documented In-Reach contacts did not match to the claims data warehouse, either because they were not Medicaid enrolled with a valid Common Name Data Service (CNDS) Medicaid identification number or because of CNDS error.

[31] The length of the transition planning period may vary across individuals. Including services provided more than 90 days before transition in the In-Reach claims summary may result in slight overestimates of service rates, to the extent that transition planning extended beyond 90 days for some individuals.

Across the service period examined, 65 percent of 10,363 individuals with documented In-Reach received one or more community mental health service. Of the 1,437 individuals who subsequently transitioned to Permanent Supportive Housing before April 2019, 95 percent received one or more community mental health services prior to transitioning.[32]

Table 14 shows overall rates of any paid community mental health service claim for individuals with documented In-Reach, excluding the 90 days before transition, and limited to the period up to 90 days before transition to Permanent Supportive Housing for the subset who transitioned.

**Table 14. Calendar Years 2017 and 2018 Community Mental Health Service Rates Among Individuals with In-Reach Contacts During Same Period**

| | Individuals with In-Reach | | Subset with Transition Dates | |
|---|---|---|---|---|
| Current LME/MCO on Record | Number with Any MH Service | % of Total with In-Reach | Number with Any MH Service in 90 days Prior | % of Total with Transition |
| Alliance Behavioral Health | 980 | 62% | 200 | 88% |
| Cardinal Innovations | 1,823 | 66% | 441 | 95% |
| Eastpointe | 561 | 46% | 91 | 78% |
| Partners Behavioral Health | 845 | 71% | 165 | 88% |
| Sandhills Center | 456 | 52% | 98 | 80% |
| Trillium Health Resources | 993 | 63% | 161 | 92% |
| Vaya Health | 841 | 72% | 132 | 90% |
| Total | 6,499 | 63% | 1,288 | 90% |

Table 15 shows numbers and percentages of individuals with paid claims for core, TCLI community mental health services and other supports. In addition, rates of new and established Outpatient Office Visits combined were 30 percent for individuals with documented In-Reach and 19 percent during the period up to 90 days before Transition. Smaller percentages of individuals received other services and supports, such as b(3) Individual Supports (1%, 3%); Detox services (1%, 0.3%); and Medication Assisted Treatment (0.3%, 0.6%) during In-Reach or in the 90 days prior to Transition.

As expected, individuals within 90 days of transition were much more likely to receive Transition Management Services. Also consistent with their lower rates of Psychotherapy and of Diagnostic, Evaluation, and Testing services, individuals in the 90-day pre-transition period were twice as likely, or more, as individuals in In-Reach to receive ACT, CST, IPS-SE, and Peer Support services. The mobile Crisis service rate was 75 percent lower for individuals within 90 days of transition and use of Facility Based Crisis beds was 67 percent lower. This is a significant finding that demonstrates the effectiveness of housing and supports overall.

[32] This percentage is based on all CY 2017 and 2018 service dates, including those prior to the 90-day pre-transition period. Percentages with any paid mental health service, including institutional claims, across the two-year claims period examined were 74% among all individuals with documented In-Reach and 99% for the subset who subsequently transitioned.

**Table 15. Calendar Years 2017 and 2018 Community Mental Health Service Rates During In-Reach and Transition**

| In-Reach | Transition Management Services (TMS) | | Assertive Community Treatment Team (ACT) | | Community Support Team (CST)[33] | | Psychosocial Rehabilitation (PSR) | | Individual Placement and Support-Supported Employment (IPS-SE) | | Peer Support Services | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % |
| Alliance | 67 | 4% | 295 | 19% | 172 | 11% | 205 | 13% | 33 | 2% | 129 | 8% |
| Cardinal | 64 | 2% | 498 | 18% | 151 | 5% | 239 | 9% | 38 | 1% | 263 | 10% |
| Eastpointe | 6 | 0.5% | 112 | 9% | 46 | 4% | 106 | 9% | 3 | 0.2% | 15 | 1% |
| Partners | 13 | 1% | 237 | 20% | 54 | 5% | 110 | 9% | 24 | 2% | 139 | 12% |
| Sandhills | 6 | 1% | 83 | 9% | 21 | 2% | 52 | 6% | 6 | 1% | 27 | 3% |
| Trillium | 61 | 4% | 128 | 8% | 97 | 6% | 184 | 12% | 51 | 3% | 47 | 3% |
| Vaya | 19 | 2% | 364 | 31% | 97 | 8% | 122 | 10% | 16 | 1% | 158 | 13% |
| Total | 236 | 2% | 1717 | 17% | 638 | 6% | 1018 | 10% | 171 | 2% | 778 | 8% |
| Up to 90 Days Before Transition | TMS | | ACT | | CST | | PSR | | IPS-SE | | Peer Support Services | |
| | N | % | N | % | N | % | N | % | N | % | N | % |
| Alliance | 98 | 43% | 79 | 35% | 38 | 17% | 19 | 8% | 12 | 5% | 11 | 5% |
| Cardinal | 131 | 5% | 197 | 7% | 68 | 2% | 27 | 1% | 18 | 1% | 109 | 4% |
| Eastpointe | 11 | 10% | 31 | 27% | 13 | 11% | 11 | 9% | 0 | 0.0% | 3 | 3% |
| Partners | 33 | 18% | 75 | 40% | 16 | 9% | 18 | 10% | 6 | 3% | 49 | 26% |
| Sandhills | 23 | 19% | 44 | 36% | 11 | 9% | 13 | 11% | 2 | 2% | 7 | 6% |
| Trillium | 100 | 57% | 47 | 27% | 25 | 14% | 10 | 6% | 25 | 14% | 30 | 17% |
| Vaya | 26 | 18% | 68 | 47% | 16 | 11% | 17 | 12% | 4 | 3% | 17 | 12% |
| Total | 422 | 29% | 541 | 38% | 187 | 13% | 115 | 8% | 67 | 5% | 226 | 16% |

[33] See footnote 27.

**Table 15 (continued). Calendar Years 2017 and 2018 Community Mental Health Service Rates During In-Reach and Transition**

| In-Reach | Psychological Diagnostic, Evaluation, and/or Testing | | Psychotherapy (Individual, Group, and/or Family) | | Mobile Crisis Management (MCM) | | Facility-Based Crisis (FBC) | | Substance Abuse Intensive Outpatient Program (SAIOP) | | Substance Abuse Comprehensive Outpatient Treatment (SACOT) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % |
| Alliance | 517 | 33% | 308 | 20% | 62 | 4% | 121 | 8% | 35 | 2% | 8 | 0.5% |
| Cardinal | 986 | 36% | 789 | 29% | 175 | 6% | 53 | 2% | 17 | 1% | 16 | 1% |
| Eastpointe | 257 | 21% | 166 | 14% | 47 | 4% | 20 | 2% | 28 | 2% | 46 | 4% |
| Partners | 445 | 38% | 489 | 41% | 158 | 13% | 61 | 5% | 3 | 0.3% | 4 | 0.3% |
| Sandhills | 247 | 28% | 210 | 24% | 39 | 4% | 1 | 0.1% | 7 | 1% | 16 | 2% |
| Trillium | 541 | 35% | 450 | 29% | 167 | 11% | 36 | 2% | 30 | 2% | 12 | 1% |
| Vaya | 409 | 35% | 425 | 36% | 162 | 14% | 39 | 3% | 5 | 0.4% | 3 | 0.3% |
| Total | 3402 | 33% | 2837 | 27% | 810 | 8% | 331 | 3% | 125 | 1% | 105 | 1% |
| **Up to 90 Days Before Transition** | **Psychological Diagnostic, Evaluation, and/or Testing** | | **Psychotherapy (Individual, Group, and/or Family)** | | **MCM** | | **FBC** | | **SAIOP** | | **SACOT** | |
| | N | % | N | % | N | % | N | % | N | % | N | % |
| Alliance | 33 | 15% | 28 | 12% | 1 | 0.4% | 6 | 3% | 5 | 2% | 1 | 0.4% |
| Cardinal | 50 | 2% | 72 | 3% | 4 | 0.1% | 2 | 0.1% | 3 | 0.1% | 0 | 0.0% |
| Eastpointe | 22 | 19% | 14 | 12% | 1 | 1% | 0 | 0.0% | 3 | 3% | 6 | 5% |
| Partners | 20 | 11% | 43 | 23% | 4 | 2% | 3 | 2% | 1 | 0.5% | 2 | 1% |
| Sandhills | 27 | 22% | 16 | 13% | 4 | 3% | 0 | 0.0% | 1 | 1% | 3 | 2% |
| Trillium | 27 | 15% | 32 | 18% | 7 | 4% | 1 | 1% | 1 | 1% | 1 | 1% |
| Vaya | 18 | 12% | 22 | 15% | 4 | 3% | 1 | 1% | 1 | 1% | 1 | 1% |
| Total | 197 | 14% | 227 | 16% | 25 | 2% | 13 | 1% | 15 | 1% | 14 | 1% |

# IV. In-Reach

In November 2017, DHHS approved and released the TCLI In-Reach/Transition manual, abbreviated In-Reach/Transitions to Community Living Tool and newly developed guidance documents for the LME/MCOs. The manual and all supporting documents have been placed on the DHHS website.

In FY18-19, DMH/DD/SAS hired two In-Reach coaches. The first began on October 22, 2018 and covers the following LME/MCOs and hospitals: Cardinal (South); Partners; Sandhills; Vaya; Central Regional Hospital and Broughton Hospital. The second began on November 5, 2018 and is assigned to Alliance; Cardinal (North); Eastpointe; Trillium; Central Regional Hospital and Cherry Hospital. Regional In-Reach coaches support the In-Reach Specialists across the State, working with LME/MCOs and State Psychiatric Hospitals, as well as coordinating statewide training and technical assistance efforts.

Regional In-Reach coaches shadowed In-Reach specialists from January 2, 2019 to June 30, 2019. Over the course of six months, the Regional In-Reach coaches shadowed In-Reach specialists and participated in approximately 80 visits/contacts. During the visits at the Adult Care Homes (ACHs), Regional In-Reach coaches assisted the In-Reach specialists with identifying strengths and barriers regarding their activities and operations. Regional In-Reach coaches provided education and technical assistance to ensure that the specialists have access to supports that enable them to improve practice and quality. The coaches also provided education to ACH staff, In-Reach specialists, transition staff, guardians and other identified stakeholders to assist in continued advocacy and recovery for adults with mental illness.

The following are examples of technical assistance that coaches have provided to In-Reach specialists:

- Educating In-Reach specialists to discuss the different services to which individuals are entitled while in an ACH.
- Clarifying for In-Reach specialists that individuals are not required to remain in the LME/MCO catchment area to receive services and supports.
- Training on how file a complaint with Division of Health Services Regulations (DSHR).
- Reinforcing In-Reach specialists' use of informational materials with TCLI participants.

DMH/DD/SAS In-Reach Lead and Regional In-Reach coaches continue to present Community Integration Planning (CIP) as an ongoing process that leads to the creation of the person-centered plan (PCP) and to provide technical assistance as needed. CIP was, for example, a topic of discussion at the LME/MCO TCLD Refresher training offered at Cardinal Innovations this year.

DMH/DD/SAS In-Reach lead and Regional In-Reach coaches continue to educate the LME/MCOs about the ACH Bill of Rights; how to contact the regional Long-Term Care Ombudsman; how to access the DHSR Complaint Intake Unit when filing a complaint; and how

to use the TCLI In-Reach/Transition Manual's section on *Individual Rights and Reporting Concerns*.

In FY18-19, DHHS changed the referral process utilized by social workers at the three State Psychiatric Hospitals. On November 1, 2018, State Psychiatric Hospital social workers began submitting In-Reach referrals through a new eligibility tool, the Referral Screening and Verification Process (RSVP), to expedite the initiation of In-Reach. Referrals through RSVP require no screening. The LME/MCOs receive real-time notification once each referral is submitted, so they can begin providing In-Reach. The adoption of the new RVSP eligibility process has significantly increased LME/MCO response time for referrals.

LME/MCOs improved their rate of contacts with TCLI participants. In FY18-19, all LME/MCOs ranged between 95% and 100% compliance with the Settlement Agreement requirement of In-Reach visits every 90 days.

An In-Reach Learning Collaborative, coordinated by Alliance Health and Cardinal Innovations Healthcare, began on April 30, 2018. This group met its first milestone by creating a Steering Committee comprised of In-Reach representatives from each LME/MCO. The In-Reach coaches participate in the Collaborative and assisted with planning the first annual conference. The First Annual In-Reach Learning Collaborative Statewide Conference, funded by TCLI, was held on April 11, 2019 in Morrisville, NC, with 75 people in attendance. The group heard from a nationally recognized speaker, Matthew Federici, on the role of peer specialists in systems transformation. Other topics included community inclusion and peer support; the community resiliency model; and an update on the Settlement Agreement. DMH/DD/SAS TCLI Project Manager; DMH/DD/SAS In-Reach Lead; and the regional In-Reach coaches all attended the conference. DHHS will continue to offer technical assistance and support to the Collaborative.

**Figure 2. End of June 2019 Monthly Totals of Individuals in In-Reach Status by Population Category**

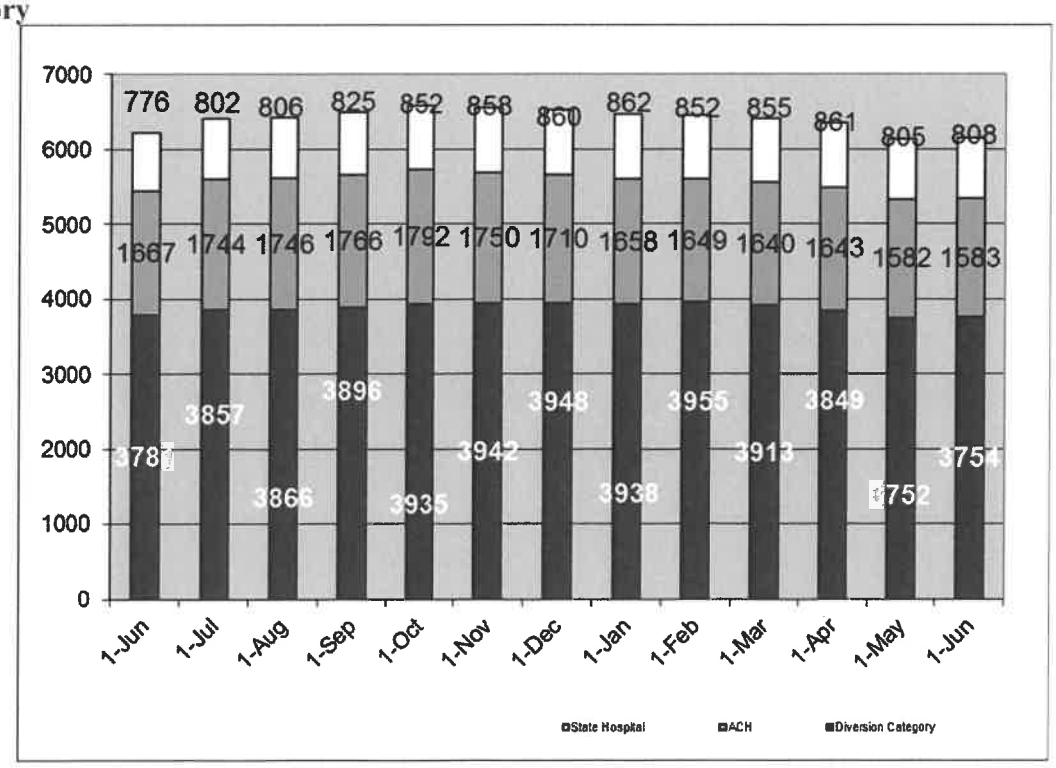


**Table 16. In-Reach Type by LME/MCO in FY 2018-19**

| LME/MCO | In-Person Visits | Phone Call/Letter | Total Visits | Percent Face-to-Face Resulted in a Yes Decision | Percent Phone Call Resulted in a Yes Decision |
|---|---|---|---|---|---|
| Alliance Behavioral Healthcare | 611 | 2545 | 3156 | 52.7% | 8.9% |
| Cardinal Innovations | 1409 | 3455 | 4864 | 45.7% | 8.3% |
| Eastpointe | 308 | 1641 | 1949 | 44.5% | 3.2% |
| Partners Behavioral Health Management | 1010 | 1891 | 2901 | 7% | 1.8% |
| Sandhills Center | 659 | 1515 | 2174 | 15.1% | .5% |
| Trillium | 1022 | 2025 | 3047 | 22.9% | 4.7% |
| Vaya Health | 1343 | 2040 | 3383 | 4.9% | 2% |
| **Total** | 6362 | 15112 | 21474 | 24.7% | 3.5% |

# V. Guardianship

Some individuals with SMI/ SPMI need decision-making supports, e.g., limited or full guardianship of the person or the estate, powers of attorney, or supported decision making.[34] To advance innovation in this area, TCLI has continued to partner with the Division of Aging and Adult Services (DAAS), DMH/DD/SAS, Division of Social Services (DSS) and the NC Council on Developmental Disabilities (NCCDD) initiative, Rethinking Guardianship. The workgroup for the Rethinking Guardianship initiative has grown to nearly 140 members over the four years of its funding. Among its members are, in addition to DHHS: clerks and assistant clerks of Superior Court; state legislators; local Department of Social Services directors and social workers; private and public guardians; elder law and disability attorneys; aging and disability advocacy and provider organizations; and families and individuals. The Steering Committee for Rethinking Guardianship, of which TCLI is a member, has met monthly to discuss issues and next steps.

Working together, Rethinking Guardianship has produced these results:

- Shared information on alternatives to guardianship. At the Rethinking Guardianship Summit of on February 25, 2019, a quarter of the clerks of court heard the American Bar Association's Erica Wood discuss less restrictive alternatives to guardianship and received materials on options to full guardianship. Subsequently, on August 27,

[34] Supported decision making (SDM) is an approach that allows people with disabilities to retain their decision-making capacity by choosing supporters to help them make choices. A person using SDM selects trusted advisors, such as friends, family members, or professionals, to serve as supporters. The supporters agree to help the person with a disability understand, consider, and communicate decisions, giving the person with a disability the tools to make her own, informed, decisions. SDM looks different for each person. It means finding tools and supports to help a person with a disability understand, make, and communicate her own choices. Examples of these tools might be: plain language materials or information in visual or audio form; extra time to discuss choices; creating lists of pros and cons; role-playing activities to help the person understand choices; and bringing a supporter into important appointments to take notes and help the person remember and discuss her options.

Rethinking Guardianship hosted "Supported Decision-Making and Less Restrictive Alternatives to Guardianship," with an audience inclusive of clerks of court.

- Collected more than 20 stories from individuals, family members, and professionals who have been impacted by guardianship, and used these to produce a common agenda for problem solving.
- Developed a website, http://rethinkingguardianshipnc.org, with Frequently Asked Questions (FAQs), stories of individuals and families and guardianship, and comprehensive resources on guardianship and its alternatives.
- Produced an educational video, *Understanding Guardianship*, for private guardians and particularly for families.
- Promulgated an informational brochure, *Rethinking Guardianship: An Introduction to Options.*
- Engaged nearly 300 guardianship stakeholders in a summit to learn about guardianship reform efforts in North Carolina and across the country, building awareness and support for legislative, policy and practice changes.
- Initiated a process to develop modifications to NCGS 35A to effect long-term changes in the guardianship system, promote less restrictive alternatives to guardianship, and ensure respect for the rights of individuals under guardianship and those facing guardianship.

The NCCDD will continue to advance alternatives to guardianship, beginning a new initiative in early 2020. TCLI will once again be at the table.

Other work relative to guardianship also continues. DAAS plays a critical role, contracting with private agencies to act as public guardians for individuals. DAAS and DMH/DD/SAS together present training quarterly, in locations across the State, to assist stakeholders who work with people who have mental illness to understand recovery and the importance of informed choice. During these trainings, a topic vital to TCLI, Permanent Supportive Housing, is reviewed along with an array of services and supports used to help TCLI participants and others to lead successful lives. LME/MCO staff are present in the trainings to explain how to navigate the service approval process. In addition, DAAS collaborates with individual county Departments of Social Services (county DSS) in their role as public guardians. DAAS also provides training, in collaboration with the Attorney General's office, for those local DSS staff members who are responsible for the day-to-day work of serving as a guardian.

TCLI has recently begun efforts to address the needs of individuals who express an interest in entering an Adult Care Home (ACH) or remaining in an ACH or State Psychiatric Hospital. TCLI seeks to ensure that each decision is an informed one. TCLI is developing a tool to establish that the information, experience and advice necessary to make a good decision has been made available to the individual.

TCLI continues to support and advance approaches to informed decision making. These are focused on education, improving practice standards and accountability. TCLI's work to support informed decision-making assists individuals to exercise their rights and to make the informed choices that pave the way to community.

# VI. Transition

State fiscal year 2018-19 saw the highest number of housing slots issued in any fiscal year since the start of TCLI. There were 971 housing slots issued in 2019, compared to 732 in 2018. The year also saw the highest number of transitions into housing since the program's inception. In FY18-19, 978 individuals transitioned to Permanent Supportive Housing. Alliance and Cardinal were able to transition the most people in 2018-19. Both LME/MCOs share in common some characteristics that help to explain their success. For example, both have a large city in their catchment area and a TCLI program with a close nexus with care coordination. Five of the seven LME/MCOs were able to meet their required number of individuals living in permanent supportive housing.

The average amount of time to transition to the community decreased for every LME/MCO this year. In the previous year, 67% of individuals transitioned did so within 90 days. In FY18-19, 71% of individuals transitioned in a timely manner.

Reliance on Bridge Housing has aided transitions in occurring in a timely, person-centered manner. Bridge Housing allows the LME/MCOs to stabilize individuals who are in need of immediate housing while they plan to live in the community. One of the elements of Bridge Housing is utilization of hotels, which has proven to be an effective and successful tool in transitioning to community based permanent supportive housing. Formerly called the Targeted Unit Transition Program (TUTP), over the life of the program, 129 TCLI individuals have accessed the service, with 112 of those transitioning directly to permanent supportive housing, and another 11 transitioning to permanent supportive housing after leaving a hotel. In addition to using hotels, LME/MCOs have created innovative programs to aid in transitions from state psychiatric hospital and adult care homes. Over 85% percent of those individuals who utilized Bridge Housing ultimately were able to be placed.

In FY 18-19, an additional 978 individuals transitioned to Permanent Supportive Housing. Over the life of the program, 3038 individuals have successfully entered the TCLI Permanent Supportive Housing program and secured qualified housing. At the end of the fiscal year, a total of 2114 individuals transitioned to and were residing in Permanent Supportive Housing, exceeding the Settlement requirement for FY18-19.

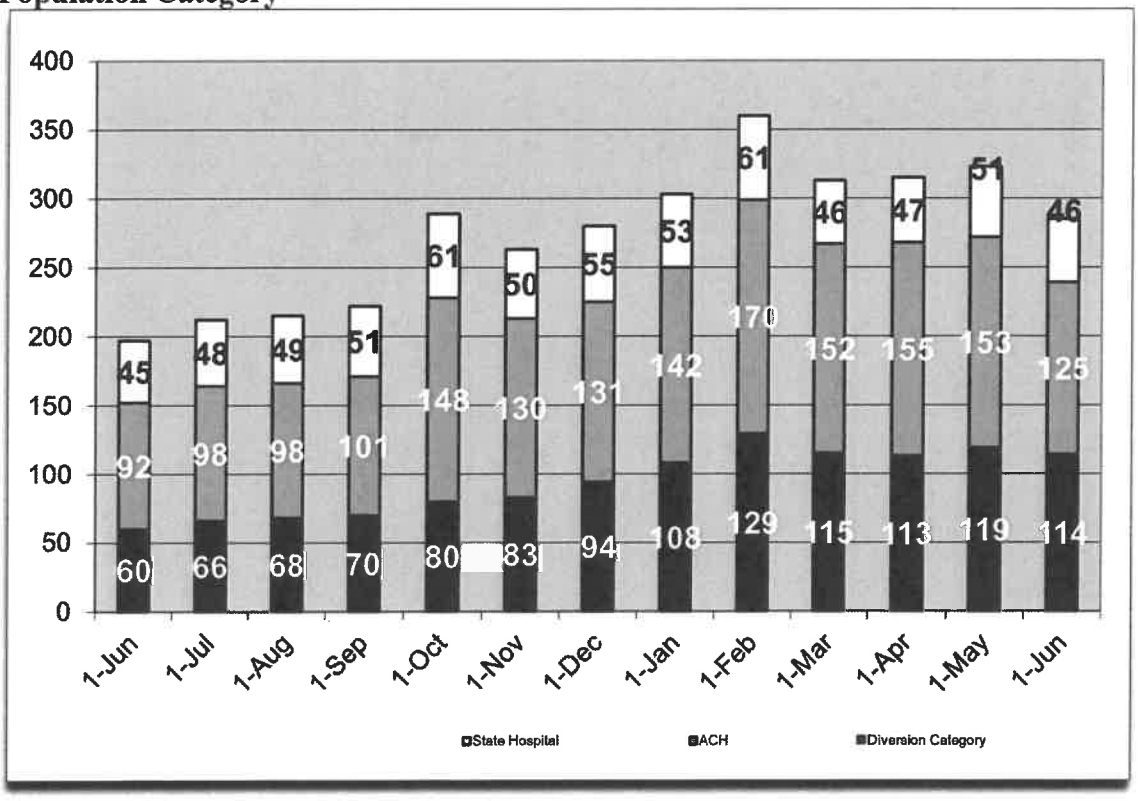
**Table 17. LME/MCO Totals of Individuals in Housing by Population Category, Life of Program End of June 2018**

| LME/MCO | Cat 1 | Cat 2 | Cat 3 | Cat 4 | Cat 5 | Total |
|---|---|---|---|---|---|---|
| Alliance Behavioral Healthcare | 5 | 117 | 9 | 183 | 94 | **408** |
| Cardinal Innovations | 28 | 444 | 16 | 77 | 298 | **863** |
| Eastpointe | 8 | 144 | 16 | 62 | 49 | **279** |
| Partners Behavioral Health Management | 23 | 203 | 21 | 46 | 99 | **392** |
| Sandhills Center | 4 | 183 | 15 | 60 | 61 | **323** |
| Trillium | 40 | 173 | 11 | 52 | 139 | **415** |
| Vaya Health | 23 | 214 | 32 | 16 | 73 | **358** |
| **Total** | 131 | 1478 | 120 | 496 | 813 | **3038** |

**Table 18. LME/MCO Totals of Individuals in Housing by Population Category, Currently Housed End of June 2019**

| LME/MCO | Cat 1 | Cat 2 | Cat 3 | Cat 4 | Cat 5 | Total |
|---|---|---|---|---|---|---|
| Alliance Behavioral Healthcare | 5 | 75 | 5 | 134 | 72 | **291** |
| Cardinal Innovations | 14 | 304 | 13 | 58 | 226 | **615** |
| Eastpointe | 5 | 77 | 12 | 48 | 32 | **174** |
| Partners Behavioral Health Management | 11 | 134 | 13 | 35 | 71 | **264** |
| Sandhills Center | 3 | 123 | 13 | 44 | 50 | **233** |
| Trillium | 19 | 111 | 9 | 36 | 114 | **289** |
| Vaya Health | 8 | 151 | 27 | 11 | 51 | **248** |
| **Total** | 65 | 975 | 92 | 366 | 616 | **2114** |

**Figure 3. End of June 2019 Monthly Totals of Individuals in Transition Status by Population Category**



# VII. Diversion

In 2018-19, DHHS developed, trained, and implemented the Referral Screening Verification Process (RSVP). This process has replaced ACH PASRR, allowing LME/MCOs to expedite identification of people being considered for admission to an ACH, and opportunity to divert them. The RSVP differs significantly from its predecessor, PASRR, placing more responsibility on LME/MCOs to screen people for TCLI.

Initially, LME/MCOs saw numerous, inappropriate referrals come through RSVP, largely as a result of referral sources misunderstanding regarding the use of the new tool. Following LME/MCO training on the tool and in-person and phone consults along public access webinars for referral sources, these problems have substantially decreased. With more appropriate referrals now taking place, LME/MCOs are better able to manage the volume of referrals.

**Table 19. Diversion Status[35] of Individuals with PASRR/ RSVP Screenings Processed for End of Fiscal Year 2018-19[36]**

| LME/MCO | Diverted (with and without slots) | Not Diverted | In Process | Withdrawn/ Removed | Total Diversion Attempts[37] |
|---|---|---|---|---|---|
| Alliance Behavioral Healthcare | 36 | 50 | 256 | 53 | 395 |
| Cardinal Innovations | 27 | 198 | 339 | 55 | 619 |
| Eastpointe | 44 | 75 | 23 | 7 | 149 |
| Partners Behavioral Health Management | 17 | 155 | 57 | 8 | 237 |
| Sandhills Center | 58 | 57 | 40 | 2 | 157 |
| Trillium | 88 | 118 | 116 | 15 | 337 |
| Vaya Health | 84 | 199 | 221 | 43 | 547 |
| **Total** | **354** | **852** | **1052** | **166** | **2441** |

[35] Tableau is the datasource for obtaining Diversion data from TCLD.
[36] Due to State Psychiatric Hospital (SPH) not requiring a pre-admission screening, as of the 11/1/18 implementation of RSVP, SPH screening are no longer included in the Diversion Results
[37] Total Diversion attempts are the screenings that resulted in a determination of TCLI Eligible. Withdrawn/Removed includes deaths, moved out of state, does not meet criteria (dementia/Alzheimer's/TBI/IDD primary diagnosis).

**Table 20. Cumulative Diversion Results from January 2013 through the end of June 2019[38]**

| LME/MCO | Diverted (with and without slots) | Not Diverted | In Process | Withdrawn/ Removed | Total Diversion Attempts[39] |
|---|---|---|---|---|---|
| Alliance Behavioral Healthcare | 508 | 1013 | 263 | 165 | 1949 |
| Cardinal Innovations | 706 | 2036 | 465 | 347 | 3554 |
| Eastpointe | 326 | 900 | 23 | 46 | 1295 |
| Partners Behavioral Health Management | 305 | 1249 | 101 | 66 | 1721 |
| Sandhills Center | 262 | 723 | 43 | 24 | 1052 |
| Trillium | 411 | 1234 | 129 | 87 | 1861 |
| Vaya Health | 408 | 1396 | 226 | 115 | 2145 |
| **Total** | **2926** | **8551** | **1250** | **850** | **13577** |

# VIII. Olmstead

To comply with the Americans with Disabilities Act's (ADA) integration mandate, a public entity must "reasonably modify" policies, procedures, or practices when necessary to avoid discrimination against people with disabilities. In a key case, stemming from Title II of the ADA, *Olmstead v. L.C.*[40], the US Supreme Court held that unjustified institutionalization of individuals with disabilities constitutes illegal discrimination on the basis of disability. It also held, however, that the right to receive services in the least restrictive environment is not unqualified. Specifically, the Court held that the failure of a state agency to place an individual with disabilities in a community-based setting, when it is medically appropriate and the individual so desires, is a violation of Title II of the ADA unless the state can prove that providing a community-based setting for the individual would be a fundamental alteration. The Supreme Court's *Olmstead v. L.C.* ruling suggested that a state would not be in violation of the ADA if it "were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable modifications standard would be met." As part of the reinvigoration of its Olmstead Plan, DHHS has placed staff on the TCLI team to assist in expanding TCLI's work

[38] See Note 34

[39] PASRR totals reflect the number of PASRR screenings processed not the number of individuals processed. Total PASRR Screening Processed totals do not include those that were sent to the LME/MCO and in a Diverted Status of In Process when withdrawn due to a determination made that the individual was either moved out of state, was deceased, had a primary diagnosis of dementia, IDD, or was not SMI/SPMI, not medically or psychiatrically stable, or private pay (538). Totals also do not include any PASSR/RSVPs received by Earthmark that were determined to fall into any of the aforementioned categories or were cancelled and were not sent to the LME/MCOs (2066).

[40] 527 U.S. 581 (1999).

to other disability groups within the Department. In fall of 2019, TCLI released a Request for Proposals for technical support to assist in addressing the charge and will begin engaging stakeholders in Olmstead Plan development in early 2020.

# IX. Quality Management

The State has designed its Quality Assurance System to ensure that community placements and services provided through TCLI are developed and delivered in accordance with the Settlement Agreement, and that individuals who receive services or housing slots, pursuant to the Agreement, are provided with the services and supports they need for their health, safety, and welfare. Development of a comprehensive Quality Assurance/ Performance Improvement (QA/PI) Plan was a key focus of State team efforts this year. The Plan is designed to ensure that all of the State's mental health and other services/supports are of good quality and are sufficient to help individuals achieve increased independence and greater community integration; obtain and maintain stable housing; avoid harm; and reduce the incidence of hospital contacts and institutionalization.

**Quality Assurance System Structure**

The State's Senior Advisor on the American Disabilities Act oversees the development and implementation of the QA/PI Plan. Quality assurance and performance improvement activities are planned, carried out, and evaluated by committees and agencies of DHHS, the North Carolina Housing Finance Agency, LME/MCOs and the External Quality Review Organization (EQRO)[41]. Primary Quality Assurance areas relate to substantive provisions of the TCLI Settlement Agreement, including Pre-Admission Screening and Diversion, Discharge and Transition, Permanent Supportive Housing, and community mental health services. Annual progress in these areas is described in other sections of this Annual Report. The fifth area, Participant Outcomes, is addressed later in this report section.

**TCLI Oversight Committee**

The DHHS established the TCLI Transition Oversight Committee (TOC) this year under the leadership of the Deputy Secretary for Behavioral Health and Intellectual and Developmental Disabilities, its chairperson. Through TOC, the DHHS' executive leadership provides guidance and monitors monthly progress in implementation of the Settlement Agreement. Each of the following entities report to the TOC on progress being made to achieve TCLI goals: Division of Health Benefits (NC Medicaid); Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS); Division of State Operated Healthcare Facilities (DSOHF); State Hospital Team Lead and CEOs; Money Follows the Person (MFP) Program; and LME/MCOs. The NC Housing and Finance Agency (NCHFA) and DHHS Divisions of

[41] An External Quality Review (EQR) is the analysis and evaluation by an external quality review organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that an MCO or PIHP, or their contractors, furnish to Medicaid recipients. An EQRO must meet the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review, other EQR-related activities as set forth in 42 CFR 438.358, or both.

Aging and Adult Services (DAAS), Vocational Rehabilitation (DVR) and Health Service Regulation (DHSR) report to TOC as needed.

**DHHS Transition Team and Barriers Subcommittee**

The state-level Transition Team was also formally established this year. This team offers state-level guidance and addresses barriers to transitioning to the community. The team oversees local transition teams to ensure that State Psychiatric Hospital facilities and their leadership and LME/MCO Transition Coordinators are adequately trained and that individuals are effectively informed of community opportunities. When individuals decide to remain in an Adult Care Home or State Psychiatric Hospital, this team monitors to ensure that individuals are informed about options; barriers to transition to a more integrated setting are identified; local teams attempt to address the barriers; and local team members continue to engage and educate the individual about community living options.

The Transition Team includes DHHS agency representatives who have expertise in the resolution of problems that arise during discharge planning and in the implementation of discharge plans. The team meets bi-monthly and includes staff from DMH/DD/SAS, NC Medicaid, DSOHF, DAAS, DHSR, DVR, Office of Rural Health, Division of Services for the Deaf and Hard of Hearing, and LME/MCOs. Other agencies are invited on an ad hoc basis.

The Barriers Subcommittee receives information related to In-Reach and person-centered discharge and community placement efforts, including successful and unsuccessful placements and problems transitioning individuals to, or maintaining individuals in, the most integrated setting. The Subcommittee reviews this information on a semi-annual basis; develops and implements measures to overcome barriers; and assists local transition teams to identify, address, and overcome identified barriers.[42]

**TCLI Quality Assurance Committee**

TCLI also established he Quality Assurance Committee this year. Chaired by the State's Senior Advisor on American Disabilities Act, the Quality Assurance Committee works with policy and program subject matter experts across DHHS to evaluate program data and assess the sufficiency of TCLI processes to meet substantive provisions of the Settlement Agreement. The committee provides input into TCLI requirements; content for LME/MCO annual Network Adequacy and Accessibility analyses, External Quality Reviews, and quarterly Intradepartmental Monitoring Team reviews; evaluates LME/MCO submissions and responses; and provides feedback and follow-up with LME/MCOs as needed. Committee members also aggregate, review, and analyze data to meet monitoring and reporting requirements and to ensure program quality. The Quality Assurance Committee includes representatives from the DHHS Secretary's Office, DMH/DD/SAS, NC Medicaid and NCHFA.

[42] The requirement for a semi-annual measure review stems from the Settlement Agreement and applies to in-reach, discharge, and community placement efforts i.e., to information on successful and unsuccessful placements; barriers to transition; and efforts to keep individuals in most integrated setting. Barriers data and separation review data are both reviewed semi-annually.

**Local Management Entities/ Managed Care Organizations**

The Department's contracted regional Lead Management Entities/ Managed Care Organizations (LME/MCOs) are responsible for managing service capacity and quality of publicly funded mental health, developmental disabilities, and substance abuse services and for oversight of network providers. Standard performance contract scopes of work include governance and capacity; business management and accounting; information management and data analysis; service claims processing and reimbursement; provider network management and monitoring; benefit plan management; consumer access and referrals; care coordination; community collaboration; customer service; and quality management.

Additional LME/MCO contract responsibilities are specific to TCLI. These include, but are not limited to, meeting annual TCLI housing goals; performing transition planning functions, including Diversion and In-Reach; providing and ensuring care coordination, person-centered service planning, and access and referrals to community mental health services; and monitoring services for the TCLI population.

DHHS monitors LME/MCO functions, services and identified gaps, as well as the implementation and success of LME/MCO strategies to address service gaps, using multiple methods and processes, including but not limited to: contract performance measures and reporting; consumer adverse incident reporting; LME/MCO management reports; annual LME/MCO Network Adequacy and Accessibility Analysis; Local Business Plans; Network Development Plans; LME/MCO quality management and performance improvement projects and consumer surveys; quarterly Intra-Departmental Monitoring Team reviews; and annual External Quality Reviews. LME/MCO TCLI gaps analyses are addressed in Section XI and Appendix B to this Annual Report.

**Intra-Departmental Monitoring Team**

The DHHS Intra-Departmental Monitoring Team (IMT) provides routine monitoring and oversight of LME/MCO contract functions. NC Medicaid leads the IMT, which includes DMH/DD/SAS and the LME/MCOs. The IMT also participates in External Quality Reviews and ensures the effective operation of LME/MCOs and compliance with state and federal requirements.

The IMT uses a Continuous Quality Improvement (CQI) approach to review LME/MCO performance. It routinely interprets performance indicators, reports and data, and timeliness of submission of reports. Monitoring objectives include identification of problems, deficiencies, and barriers to desired performance of contracted functions; development of improvement strategies; determination of need for Corrective Action Plans (CAPs); and monitoring of CAP implementation.

IMT Quarterly Monitoring reviews include TCLI-specific agenda items pertaining to service gaps and the initiatives to address them, as well as LME/MCO activities, barriers, and achievements relevant to key Settlement Agreement provisions.

**External Quality Review Organization**

The State's EQRO conducts annual reviews of mental health service system policies and processes. The EQR includes extensive review of LME/MCO documentation; staff and stakeholder interviews; and data validation, with focus on service monitoring, grievances and appeals, medical chart review, and individual provider follow-up. EQR provides the State with monitoring information related to LME/MCO marketing; program integrity; information made available to beneficiaries; grievances; timely access to services; Primary Care Provider /specialist capacity; coordination/ continuity of care; coverage/ authorization; provider selection; and quality of care. The EQR also includes TCLI-specific content. EQR findings are presented in Section X of this Annual Report.

**Quality Assurance System Activities**

The State's Quality Assurance System is designed to be comprehensive and ongoing. When fully implemented, it will cover all aspects of TCLI, inclusive of all substantive provisions of the Settlement Agreement. The system incorporates data from multiple sources for monitoring and evaluation of progress toward TCLI goals; program quality and effectiveness; and impacts of performance improvement activities. Ongoing QA/PI Plan activities correspond to four interrelated processes:

- **Data collection for ongoing monitoring** includes developing and implementing databases such as TCLD and RSVP, as well as tools and protocols for ongoing monitoring and evaluation, such as dashboard and contract performance measures.

- **Data aggregation, analysis, and evaluation** entails the use of data to evaluate the quality of services and supports and progress toward intended outcomes of increased integration, stable integrated housing, and decreased hospitalization and institutionalization. These processes are largely carried out by Quality Assurance system committees.

- **Quality assurance and performance improvement activities** involve the use of data to determine when action is needed to meet program goals, and the evaluation of performance improvement activities and outcomes. These activities may range from data cleaning and validation to revising service definitions.

- **Progress and performance reporting** consist of developing and publishing monitoring and progress reports, including internal reports, as well as monthly progress reports and this Annual Report.

**Personal Outcomes**

The State's approach to the measurement of personal outcomes flows from a best practice, articulated in the Settlement Agreement. Specifically, services are to "be flexible and individualized to meet the needs of each individual." This requires that measurement focus not on a standard of sufficiency of services based, for example, on the quantity, intensity, billing

units or the frequency of delivery of a service. Instead, TCLI's measures are centered on outcomes, designed to assess the quality of life of its participants. Key activities of the State's Quality Assurance System include collecting, monitoring, evaluating, and reporting data related to personal outcomes for participants. These outcomes generally relate to the State's use of institutional settings and its work to support quality of life and community integration for TCLI participants. In short, success may mean something different for each TCLI participant. Personal outcomes are, then, reflective of the program's capacity to tailor an array of services and supports to meet each participant's unique needs and, in doing so, to facilitate the successful transition of a particular person to a full life in his or her community. Collectively, these outcomes measure the success of TCLI as a whole.

**Use of Institutional Settings**

Institutional census tracking and length of stay are monitored through the State Psychiatric Hospital Healthcare Enterprise Accounts Receivable Tracking System (HEARTS)[43] and through the NCTracks claims data warehouse. State Psychiatric Hospital census, admissions, and discharge data are reported in Section IX of this report.

Analyses reported here with regard to State Psychiatric and Inpatient Psychiatric admissions/ re-admissions and Emergency Department visits/ repeat visits are based on Calendar Year (CY) 2017 and Calendar Year 2018 NCTracks paid Medicaid institutional claims and State Psychiatric Hospital and Alcohol and Drug Abuse Treatment Center (ADATC) admissions data from HEARTS. Institutional claims and encounters and State Psychiatric and ADATC admissions records were retrieved for all TCLI participants in Permanent Supportive Housing for one or more days of Calendar Years 2017 or 2018 and for TCLI participants who had previously been housed and were re-housed as of the end of April 2019.

**State Psychiatric Hospital Admissions and Re-Admissions**

Table 21 shows numbers admitted to a State Psychiatric Hospital in 2017 and the percentage that were re-admitted that year or the following year. Approximately 27 percent of admitted individuals in 2017 and 12 percent in 2018 were readmitted within the same calendar year. Forty-six percent of individuals with one or more 2017 admission were readmitted in 2018.[44,45]

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[43] HEARTS is the basis of reporting on State Psychiatric Hospital census, admission and discharge data.

[44] Updated 2017 HEARTS admission data and 2018 data were matched by CNDS number to TCLI participants in housing or who subsequently were re-housed. Admissions were included in the analysis if they occurred after individuals' initial transitions to Permanent Supportive Housing. Administrative re-admissions following direct discharges or transfers to and from medical visits or other facilities were excluded.

[45] Current year analyses incorporate a revised methodology and population definition that retains individuals who were not in Permanent Supportive Housing for the calendar years examined but who subsequently were re-housed. This revision may account for the larger number of 2017 admissions (2.6% of TCLI population) retrieved and reported in the current summary compared to the 2018 DHHS Annual Report (1.4% of TCLI population).

**Table 21. Calendar Year 2017 and 2018 State Psychiatric Hospital Admissions and Re-Admissions**

| | Individuals with 2017 SPH Admissions | Percent of Housed | Subset with 2017 Re-Admissions | Individuals with 2018 SPH Admissions | Percent of Housed | Subset with 2018 Re-Admissions | Subset with 2017 to 2018 Re-Admissions |
|---|---|---|---|---|---|---|---|
| Alliance | 11 | 5.8% | 2 | 20 | 7.2% | 2 | 6 |
| Cardinal | 6 | 1.3% | 0 | 9 | 1.4% | 0 | 1 |
| Eastpointe | 8 | 6.5% | 3 | 18 | 10.7% | 3 | 4 |
| Partners | 4 | 1.9% | 0 | 7 | 2.5% | 2 | 1 |
| Sandhills | 5 | 3.1% | 3 | 4 | 2.1% | 0 | 3 |
| Trillium | 5 | 2.5% | 3 | 6 | 2.3% | 1 | 3 |
| Vaya | 2 | 1.1% | 0 | 3 | 1.3% | 0 | 1 |
| Total | 41 | 2.6% | 11 | 67 | 3.3% | 8 | 19 |

## Inpatient Psychiatric Admissions and Re-Admissions

Table 22 shows numbers of individuals with inpatient admissions and re-admissions within each calendar year, and numbers with 2018 re-admissions after one or more 2017 admission. Among individuals with 2017 and 2018 admissions, 33 and 36 percent were readmitted within the same calendar year. Thirty-seven percent of individuals with 2017 admissions had one or more 2018 admission.[46] Figures 4 and 5 show estimated numbers of participants with between one and seven or more admissions.

**Table 22. Calendar Year 2017 and 2018 Psychiatric Inpatient: Community Hospital and Psychiatric Facility**

| | Individuals with 2017 Admissions | Percent of Housed | Subset with 2017 Re-Admissions | Individuals with 2018 Admissions | Percent of Housed | Subset with 2018 Re-Admissions | Subset with 2017 to 2018 Re-Admissions |
|---|---|---|---|---|---|---|---|
| Alliance | 26 | 13.6% | 6 | 39 | 14.1% | 13 | 9 |
| Cardinal | 40 | 8.5% | 13 | 78 | 12.4% | 30 | 18 |
| Eastpointe | 19 | 15.4% | 6 | 24 | 14.3% | 8 | 7 |
| Partners | 36 | 16.9% | 16 | 37 | 13.2% | 14 | 15 |
| Sandhills | 24 | 14.9% | 5 | 18 | 9.4% | 5 | 5 |
| Trillium | 27 | 13.4% | 12 | 49 | 18.6% | 20 | 11 |
| Vaya | 24 | 12.8% | 7 | 28 | 11.9% | 9 | 7 |
| Total | 196 | 12.7% | 65 | 273 | 13.3% | 99 | 72 |

[46] Community Hospital and Psychiatric Facility claims were analyzed for participant admissions and re-admissions that occurred after individuals' transitions to housing. Series of claims for the same individual with consecutive service dates are counted as single events. Each new series of claims with consecutive dates is counted as a re-admission if the date of service is more than three days after the previous date of service. This method may result in overestimates of admissions due to claims lag and missing data and/or in underestimates in cases of true re-admissions within three days. Inpatient admission estimates also may be affected by missing data in NCTracks, especially for 2017 Medicaid encounters, and by timely filing limits, especially for 2018 Medicaid encounter claims.

**Figure 4. Calendar Year 2017 Estimated Inpatient Psychiatric Admissions and Re-Admissions**

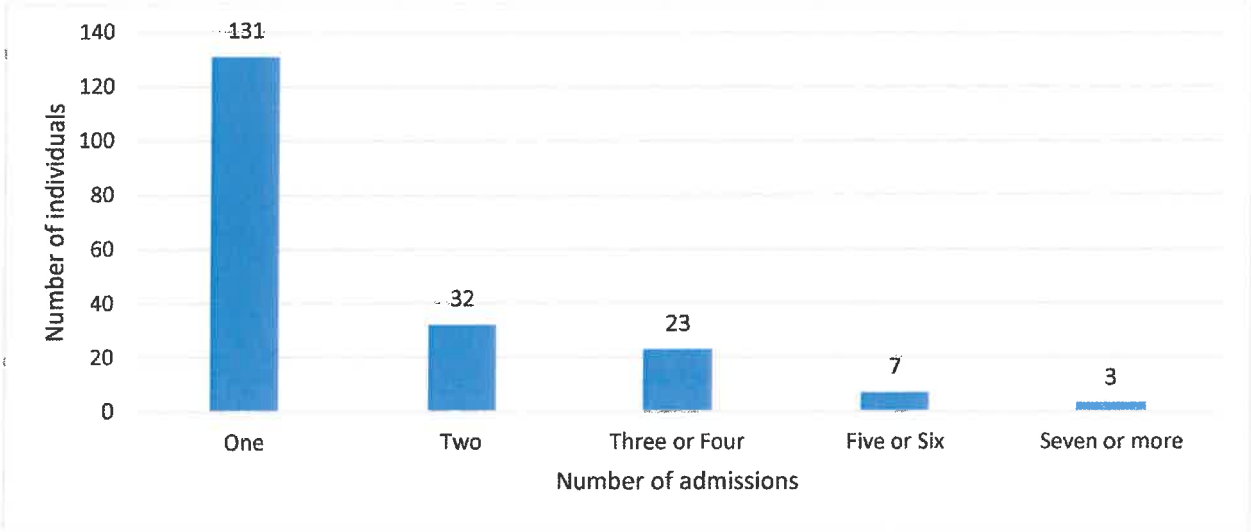
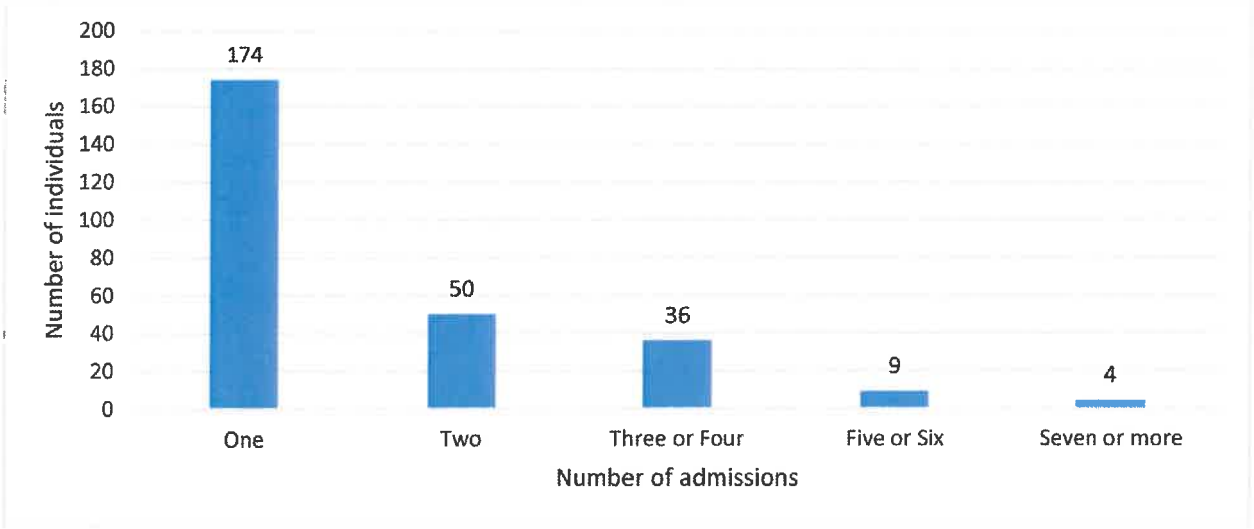



**Figure 5. Calendar Year 2018 Estimated Inpatient Psychiatric Admissions and Re-Admissions**




## Emergency Department Visits and Repeat Visits

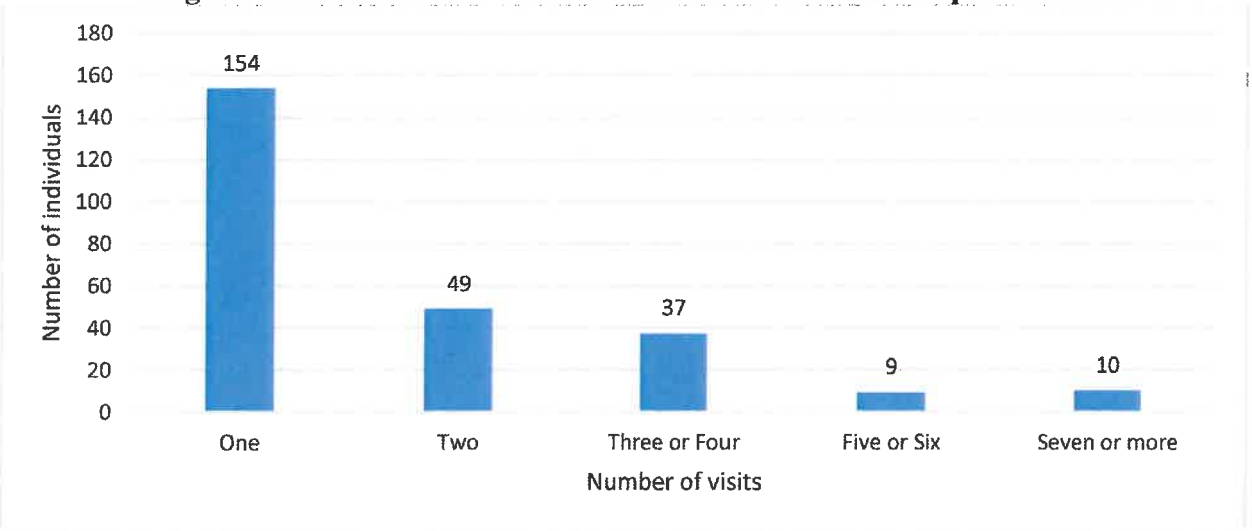
Table 23 shows numbers of individuals with paid claims for Emergency Department (ED) visits and repeat visits within each calendar year, and numbers with 2018 ED visits after one or more in 2017. Approximately 41 and 43 percent of individuals with 2017 and 2018 ED visits, respectively, had repeat visits within the same calendar year. Forty-three percent of individuals

with 2017 ED visits also had one or more 2018 visit.[47,48] Figures 6 and 7 show estimated numbers of individuals with between one and seven or more ED visits

**Table 23. Calendar Year 2017 and 2018 Emergency Department Visits and Repeat Visits**

| | Individuals with 2017 ED Visits | Percent of Housed | Subset with 2017 Repeat Visits | Individuals with 2018 ED Visits | Percent of Housed | Subset with 2018 Repeat Visits | Subset with 2017 to 2018 Repeat Visits |
|---|---|---|---|---|---|---|---|
| Alliance | 27 | 14.1% | 13 | 58 | 21.0% | 23 | 14 |
| Cardinal | 77 | 16.3% | 29 | 118 | 18.7% | 50 | 35 |
| Eastpointe | 21 | 17.1% | 12 | 34 | 20.2% | 18 | 13 |
| Partners | 36 | 16.9% | 12 | 44 | 15.7% | 19 | 8 |
| Sandhills | 30 | 18.6% | 12 | 35 | 18.3% | 10 | 13 |
| Trillium | 40 | 19.8% | 17 | 47 | 17.8% | 23 | 13 |
| Vaya | 28 | 15.0% | 10 | 35 | 14.9% | 15 | 15 |
| Total | 259 | 16.7% | 105 | 371 | 18.1% | 158 | 111 |

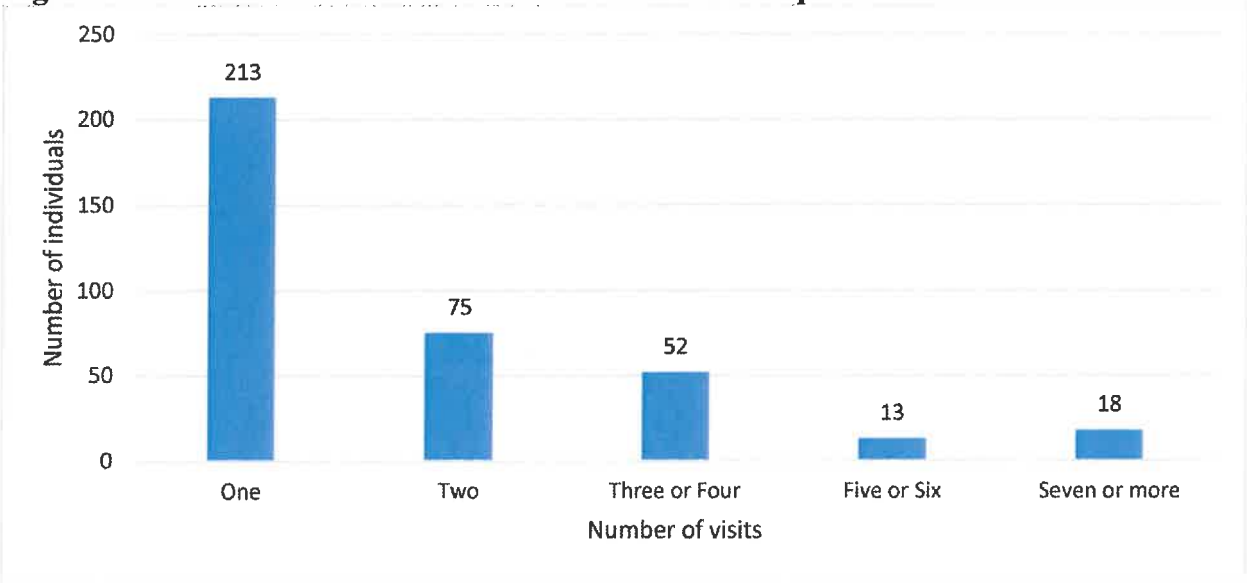
**Figure 6. Calendar Year 2017 Estimated ED Visits and Repeat Visits**




[47] Emergency Department claims were analyzed for participant visits and repeat visits that occurred after individuals' transition dates. Claims for the same individual with consecutive service dates are counted as single events. 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 date of service. 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. ED visit estimates also may be affected by missing data in NCTracks, especially for 2017 Medicaid encounters, and by timely filing limits, especially for 2018 Medicaid encounter claims.

[48] This analysis is limited to standalone behavioral health-related ED visits that do not overlap or immediately precede (result in) psychiatric inpatient admissions reported in the previous section.

**Figure 7. Calendar Year 2018 Estimated ED Visits and Repeat Visits**




## Other Crisis Bed Use

As reported in the Section III of this Annual Report, NCTracks service claims analysis indicated that two percent of housed individuals in both CY 2017 and CY 2018 used Facility Based Crisis beds. Table 24 shows ADATC admissions for 0.6 percent of the population in both years, and few re-admissions within or across calendar years.

**Table 24. Calendar Year 2017 and 2018 Alcohol and Drug Abuse Treatment Center Admissions and Re-Admissions**

| | Individuals with 2017 ADATC Admissions | Percent of Housed | Subset with 2017 Re-Admissions | Individuals with 2018 ADATC Admissions | Percent of Housed | Subset with 2018 Re-Admissions | Subset with 2017 to 2018 Re-Admissions |
|---|---|---|---|---|---|---|---|
| Alliance | | 0.0% | | 1 | 0.4% | | |
| Cardinal | 3 | 0.6% | 1 | 2 | 0.3% | | |
| Eastpointe | 2 | 1.6% | | 1 | 0.6% | | |
| Partners | | 0.0% | | 2 | 0.7% | | |
| Sandhills | | 0.0% | | 1 | 0.5% | | |
| Trillium | | 0.0% | | 2 | 0.8% | | |
| Vaya | 4 | 2.1% | | 3 | 1.3% | 1 | 1 |
| Total | 9 | 0.6% | | 12 | 0.6% | | |

## Community Integration and Quality of Life

TCLI participant quality of life is assessed through standardized surveys administered to individuals during the transition planning period and again at 11 and 24 months after transition.

An updated summary of results for surveys administered through SFY 2019 is presented in Appendix A to this Annual Report.

In all LME/MCOs, individuals who transitioned to Permanent Supportive Housing reported more positive perceptions and experiences than individuals surveyed prior to transition. Analysis of the same individuals' responses across the three survey points (pre-transition and at 11 and 24 months, post-transition) confirms improvements in reported quality of life and satisfaction after transitioning to Permanent Supportive Housing, and of maintenance of those gains through the second year in housing.

Survey results from the most recent year again indicate positive perceptions and experiences among most individuals in Permanent Supportive Housing. This relates to areas such as services and staff support; housing; and choice and control in daily activities. While greater percentages of housed individuals reported positive experiences in virtually every domain queried, substantial numbers also reported obstacles to health and wellness, meaningful day, community integration, and natural supports.

**Community Integration and Engagement in Community Life**

This year's annual report includes Quality of Life survey data on community integration and engagement in community life, inclusive of information on daily activities, employment, school attendance, and natural supports networks.

Results of analysis of Quality of Life Survey items most related to community integration is also reported in Appendix A. On average, 19 percent more individuals in housing compared to those surveyed pre-transition reported satisfaction with daily activities, having enough to do, and going out into the community to do things when they want or choose.

Pre-transition and housed individuals did not differ, on average, in the number of daily activities they reported as typical; however, they did differ in the rates at which they selected specific activities. More individuals in housing selected cooking/cleaning, and fewer selected physical activity, work, volunteering, and socializing, although the rate of socializing at 24 months was higher than at 11 months. Percentages who said they go into town/community did not differ by transition status.[49] Significantly lower percentages of individuals in housing said that doing nothing/sitting around/resting/sleeping were typical daily activities.

**People Employed or Attending School[50]**

Reports of work and school as typical daily activities in Quality of Life survey responses were lower among individuals in housing compared to those surveyed before transition. Five percent

[49] However, as reported immediately above, significantly larger percentages of individuals in supportive housing did report going out into the community to do things *when they want or choose*.

[50] Effective October 2019, NC-TOPPS assessments will be required for TMS as well as for ACT and other enhanced services, with the effect that more outcomes data will be available on a more frequent basis for virtually all TCLI participants in supportive housing. NC-TOPPS assessments are administered by provider agency staff and include outcomes related to work, educational program enrollment, and other social determinants and outcomes. When available, data from these assessments will be used to enhance monitoring of these and other personal outcomes, potentially to include problems interfering with daily functioning, participation in positive community activities, thoughts of self-harm and suicide, criminal justice system involvement, readiness to address recovery, mental health symptoms, and functioning in other major life domains.

of 11-month survey respondents and six percent of 24-month respondents reported work as a typical daily activity, compared to 15 percent of pre-transition respondents. Six and four percent of individuals at 11 and 24 months reported performing odd jobs, compared to 13 percent pre-transition. Three and four percent of 11-month and 24-month respondents reported school, compared to six percent prior to transition, although this was not a significant difference.

**Natural Supports Networks**

Analysis of Quality of Life survey items related to the strength of individuals' community and natural supports networks indicates that an average of 10 percent more survey respondents in housing reported positive experiences and perceptions. Larger percentages of housed individuals reported visiting or talking in the past 30 days with family or friends who support their recovery; having someone to talk to when sad, angry, upset or lonely; and that family or friends help them become the person they want to be. Individuals in Permanent Supportive Housing were approximately one-third less likely to report feeling lonely in the past week.

**Time Spent in Congregate Day Programming**

Calendar Years 2017 and 2018 rates of Psychosocial Rehabilitation service use for individuals in housing are reported in Section III of this report. Results of additional analysis of paid NCTracks claims for PSR are shown in Table 25.

**Table 25. Calendar Year 2017 and 2018 Time in Congregate Day: Psychosocial Rehabilitation[51]**

| | N (2017) | Average Duration (Weeks) | Average Total Hours | Average Hours/ Week | N (2018) | Average Duration (weeks) | Average Total Hours | Average Hours/ Week |
|---|---|---|---|---|---|---|---|---|
| Alliance | 16 | 16.1 | 277.2 | 19.5 | 21 | 18.1 | 262.7 | 15.3 |
| Cardinal | 50 | 26.9 | 280.5 | 12.5 | 64 | 30.0 | 338.9 | 13.2 |
| Eastpointe | 12 | 21.9 | 523.9 | 24.4 | 17 | 28.3 | 564.9 | 20.6 |
| Partners | 14 | 21.5 | 267.6 | 11.9 | 23 | 26.9 | 379.3 | 14.0 |
| Sandhills | 27 | 23.3 | 464.0 | 19.8 | 24 | 31.0 | 588.8 | 18.4 |
| Trillium | 21 | 21.6 | 258.7 | 13.2 | 16 | 26.8 | 364.8 | 12.9 |
| Vaya | 18 | 18.1 | 256.9 | 17.9 | 23 | 28.5 | 267.2 | 11.4 |
| Total | 158 | 22.6 | 323.3 | 16.0 | 188 | 27.8 | 381.1 | 14.6 |

[51] Time spent in congregate day programming is expressed both in terms of duration, the length of the interval between the earliest and latest PSR service claim dates of service within the calendar year, and as average hours spent in PSR per week for the duration of the service. Each reimbursed 15-minute service unit is converted into hours and aggregated to derive each individual's total hours of PSR in the calendar year. Time spent in PSR is expressed as the average number of PSR hours per week. Average hours of PSR per week was previously calculated for the 2018 DHHS Annual Report based on the number of calendar year days each individual was in housing rather than on the length of the service interval.

**Community Tenure and Separation**

For the life of the program, 69.5 percent of individuals transitioned to Permanent Supportive Housing were in that housing at the end of SFY 2019, with an average of 657 days (1.8 years) from their initial transition dates. For those no longer in housing, the average length of time from the initial transition was 476 days.

The State also tracks where people go after they leave housing or leave the TCLI program. Over the life of the program, 924 individuals left supportive housing. Of that number, 223 returned to an ACH. In-Reach services were provided to those individuals who moved or returned to ACHs, and a substantial proportion were subsequently re-housed.

In fiscal year 18-19, TCLI staff began conducting clinical reviews of the files of individuals who had recently left housing. TCLI's efforts will identify reasons that people separate from housing and assist in generating systemic improvements. The first round of these reviews and a statewide summary will be completed in early fiscal year 19-20. These reviews focus on the intensity, duration, and access to services by TCLI recipients, helping to ensure that appropriate services and plans are in place when individuals transition to the community.

Table 26 shows numbers and percentages of individuals in housing three months to two years after the initial transition date. Table 27 shows attrition rates by year. Table 28 shows the total number of individuals who have left housing over the life of the program, including numbers and percentages deceased or who returned to Adult Care Homes or other facilities.

**Table 26. Life of Program Maintenance of Housing[52]**

| Threshold | Total Possible | Total that have stayed in housing this long | Percent to meet this threshold |
|---|---|---|---|
| Not Applicable[53] | 278 | | |
| 3 Months | 2755 | 2619 | 95% |
| 6 Months | 2473 | 2210 | 89.3% |
| 1 Year | 2059 | 1630 | 79.2% |
| 1.5 Years | 1676 | 1209 | 72.1% |
| 2 Years | 1337 | 883 | 66% |

[52] The State has defined "maintenance of chosen community arrangement," a requirement in the Settlement Agreement, as tenure in supported housing.

[53] Not Applicable refers to those individuals who were placed less than three months ago and thus aren't applicable for this table.

**Table 27. Based on Attrition Rate/Year Housed**

| Year Housed | Number housed in relevant year | 2012-13 | 2013-14 | 2014-15 | 2015-16 | 2016-17 | 2017-18 | 2018-19 |
|---|---|---|---|---|---|---|---|---|
| 2012-13 | 46 | 2% | 15% | 11% | 11% | 8% | 9% | 11% |
| 2013-14 | 201 | n/a | 10% | 21% | 11% | 9% | 9% | 4% |
| 2014-15 | 210 | n/a | n/a | 7% | 16% | 11% | 14% | 10% |
| 2015-16 | 331 | n/a | n/a | n/a | 10% | 16% | 14% | 11% |
| 2016-17 | 600 | n/a | n/a | n/a | n/a | 10% | 21% | 14% |
| 2017-18 | 692 | n/a | n/a | n/a | n/a | n/a | 9% | 21% |
| 2018-19 | 971 | n/a | n/a | n/a | n/a | n/a | n/a | 8% |

**Table 28. Life of Program Housing Separation Outcomes and Destinations, End of 2018-19**

| Outcome or Destination | N | Percent |
|---|---|---|
| Adult Care Home | 233 | 25.2% |
| Alternative Family Living (Unlicensed) | 7 | 0.8% |
| Adult Living Facility | 17 | 1.8% |
| Deceased[54] | 202 | 21.9% |
| Family/Friends | 116 | 12.6% |
| Hospice | 2 | 0.2% |
| Independent | 182 | 19.7% |
| Jail/Prison | 49 | 5.3% |
| Medical Hospital | 27 | 2.9% |
| Mental Health Group Home | 27 | 2.9% |
| Skilled Nursing Facility | 18 | 1.9% |
| State Psychiatric Hospital | 26 | 2.8% |
| Substance Use Facility | 14 | 1.5% |
| Unknown | 11 | 1.2% |
| Total | 924 | |

## Incidents of Harm

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

[54] Average age of death was 57 years.

Level I incidents are events that, in isolated numbers, do not significantly threaten the health or safety of an individual but could indicate systematic problems if they were to occur frequently. Level I incidents are not submitted to the IRIS.[55]

Level II includes any incident which involves a consumer death due to natural causes or terminal illness, or results in a threat to a consumer's health or safety or a threat to the health or safety of others due to consumer behavior.

Level III includes any incident that results in (1) a death, sexual assault or permanent physical or psychological impairment to a consumer; (2) a substantial risk of death, or permanent physical or psychological impairment to a consumer; (3) a death, sexual assault or permanent physical or psychological impairment caused by a consumer; (4) a substantial risk of death or permanent physical or psychological impairment caused by a consumer; or (5) a threat caused by a consumer to a person's safety.

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

Incidents involving TCLI participants are retrieved, reviewed, and reported in aggregate on a monthly basis. Table 29 summarizes by LME/MCO the number of incidents returned each month.

**Table 29. Aggregate Number of Level II and III Incidents Reported in IRIS, SFY18-19**

| LME/MCO | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alliance Behavioral Health | | | 2 | 1 | 2 | 2 | 5 | | 2 | 1 | 2 | 0 | 17 |
| Cardinal Innovations | 2 | 0 | 4 | 0 | 1 | 2 | 3 | 4 | 4 | 1 | 6 | 1 | 28 |
| Eastpointe | 2 | 2 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 |
| Partners Behavioral Health | 2 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 3 |
| Sandhills Center | 0 | 0 | 4 | 2 | 6 | 2 | 1 | 1 | 3 | 2 | 3 | 5 | 29 |
| Trillium | 3 | 1 | 0 | 1 | 2 | 0 | 2 | 0 | 1 | 1 | 0 | 1 | 12 |
| Vaya Health | 4 | 0 | 2 | 5 | 1 | 0 | 1 | 1 | 2 | 2 | 1 | 2 | 21 |
| **Total** | **14** | **3** | **13** | **9** | **13** | **6** | **12** | **6** | **13** | **7** | **12** | **9** | **116** |

[55] Level I incidents are documented on the provider agency's internal forms. For more information on incident response, see the DMH/DD/SAS' Incident Response and Report Manual at https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/incidentmanual2-25-11.pdf.

**Table 30. Costs to Transition Individuals**

| LME/MCO | Rent | TYSR | CLA |
|---|---|---|---|
| Alliance | $1,148,163 | $227,200 | $571,571 |
| Cardinal | $3,316,655 | $395,363 | $450,907 |
| Eastpointe | $631,365 | $130,722 | $351,360 |
| Partners | $925,887 | $187,706 | $409,807 |
| Sandhills | $801,574 | $156,444 | $281,492 |
| Trillium | $1,164,231 | $157,321 | $282,160 |
| Vaya | $535,597 | $137,416 | $169768 |
| Total | **$8,523,472** | **$1,392,174** | **$2,517,066** |

Sixty six percent (66%) of participants' monthly rental payments are funded through the TCLI program. The other 33% of participants have rental vouchers funded through other programs. Transition Year Stability Resources (TYSR) is used to purchase items necessary to set up individual apartments upon moving to community living. Community Living Assistance (CLA) is a need-based cash assistance program provided to individuals on a short-term basis to provide living expenses. Table 30, above, shows the amount of money spent on these in FY 2018-2019.

# X. State Psychiatric Hospitals

**Table 31. Hospital Census for Fiscal Year 2018-19[56]**

| Fiscal Year 2018-19 | Admits | Discharges | Average Daily Census |
|---|---|---|---|
| **Broughton** | **281** | **290** | **256** |
| Adult Admissions | 226 | 204 | 111 |
| Adult Long Term | 6 | 35 | 87 |
| Geriatric | 7 | 18 | 37 |
| Medical Unit | 21 | 12 | 9 |
| Deaf Unit | 21 | 21 | 11 |
| **Cherry** | **679** | **660** | **205** |
| Adult Admissions | 639 | 508 | 71 |
| Adult Long Term | 4 | 114 | 98 |
| Geriatric | 22 | 20 | 21 |
| Medical Unit | 14 | 18 | 13 |
| **CRH** | **762** | **768** | **340** |
| Adult Admissions | 590 | 533 | 145 |
| Adult Long Term | 0 | 59 | 74 |
| Geriatric | 53 | 54 | 37 |
| Medical Unit | 47 | 47 | 4 |
| Forensic Unit | 72 | 75 | 76 |
| **Total** | **1722** | **1718** | **800** |

[56] Adult Admissions Units are acute care units with typical length of stays around 30-60 days. Length of stay on the adult admissions units may be less than 1 month. Adult admissions units admit people 24/7/365, taking many individuals waiting in community emergency departments for psychiatric hospitalization.
-Adult Long-Term units are for individuals who need longer term care at the hospital level. Often individuals on long-term units have serious mental illness complicated by legal problems, poor response to treatment, co-occurring intellectual/developmental disabilities, chronic illness and cognitive deficits.
-Geriatric units typically serve people 64 and older but may include people in younger age ranges who have needs similar to the older individuals.
-Individuals in need of care for a medical condition that can be treated at the State Psychiatric Hospital are admitted to the medical units.
-All of these units may have individuals who qualify for TCLI; therefore, individuals on all units are referred to the LME/MCO for In-Reach.
-Discharge numbers are higher in the data compared to the following discharge destination table because transfers out for medical care cannot be removed from this data.
-Adult Long-Term Units typically do not take direct admissions. Instead, they take transfers from the admissions units. These are approximately equal to the discharges from the long-term unit.

**Table 32. Hospital Discharge Data for Fiscal Year 2018-19[57]**

| Discharge Destination | Broughton | Cherry | CRH | Grand Total |
|---|---|---|---|---|
| TCLI Housing | 9 | 4 | 20 | 33 |
| TCLI Bridge Housing | | | 2 | 2 |
| Private Residence | 96 | 364 | 305 | 765 |
| Adult Care Home | 43 | 65 | 45 | 153 |
| Correctional Facility | 56 | 67 | 99 | 222 |
| 5600 Group Home | 13 | 36 | 92 | 141 |
| Homeless Shelter | 6 | 29 | 26 | 61 |
| Hotel | 3 | 11 | 20 | 34 |
| Alcohol and Drug Abuse Treatment Center | 3 | 13 | 4 | 20 |
| Psychiatric Community Hospital | 1 | 1 | 10 | 12 |
| Developmental Disability Center | 1 | 1 | 3 | 5 |
| Therapeutic Home | | | 1 | 1 |
| Skilled Nursing Facility | 5 | 4 | 3 | 12 |
| Therapeutic Community | | 2 | | 2 |
| Neuro Medical Center | | | 6 | 6 |
| IDD Group Home | 3 | 12 | 3 | 18 |
| Halfway House | 1 | 14 | 10 | 25 |
| Boarding House | 1 | 13 | 14 | 28 |
| Community Hospital | | 1 | | 1 |
| Hospice | 1 | | | 1 |
| Alternative Family Living | 5 | 4 | 2 | 11 |
| Deceased | 1 | 2 | 5 | 8 |
| Community Detox Center | 1 | | | 1 |
| Oxford House | 1 | | 3 | 4 |
| Veteran Administration Hospital | | | 2 | 2 |
| Community PRTF | | | 1 | 1 |
| Veteran Administration Skilled Nursing Facility | 1 | | | 1 |
| Cross Area Service Provider | | | 1 | 1 |
| Supported Living | | | 1 | 1 |
| **Total** | **251** | **643** | **678** | **1572** |

[57] This table provides information about the setting to which individuals were discharged directly from State Psychiatric Hospitals. The data does not capture people that the hospitals referred to the LME/MCOs, whom the LME/MCOs subsequently discharged to an available location prior to transitioning to TCLI Permanent Supportive Housing.

**Figure 8. Individuals who Started In-Reach in a State Psychiatric Hospitals for Fiscal Year 2018-2019**

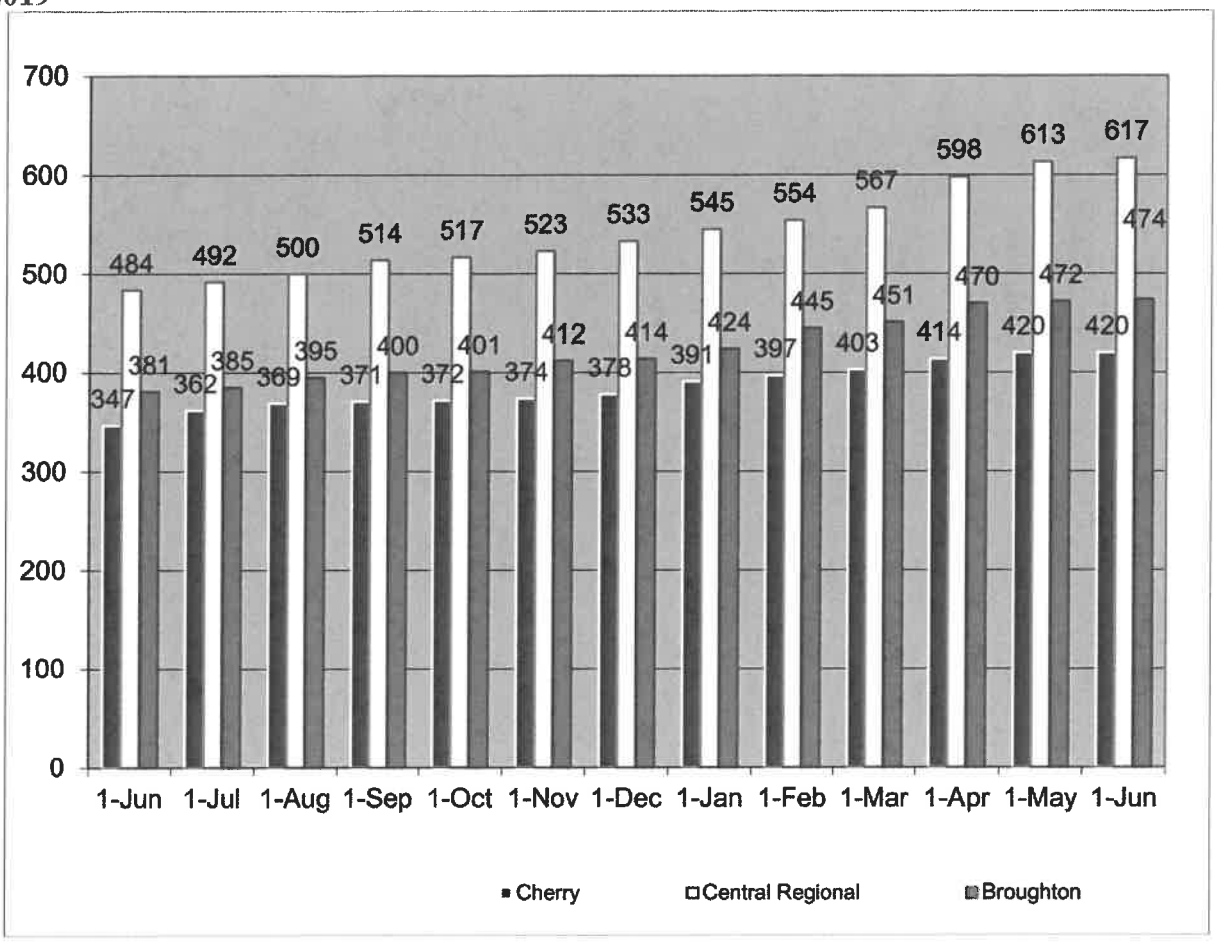



**Table 33. Number of Individuals that have started In-Reach while in a State Psychiatric Hospital, by LME/MCO[58]**

| | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Alliance** | 286 | 293 | 301 | 309 | 313 | 320 | 326 | 336 | 345 | 353 | 360 | 365 | 367 |
| **Cardinal** | 297 | 302 | 309 | 317 | 317 | 322 | 327 | 337 | 354 | 357 | 371 | 379 | 381 |
| **Eastpointe** | 120 | 127 | 128 | 128 | 128 | 129 | 129 | 134 | 136 | 138 | 142 | 146 | 146 |
| **PBHM** | 78 | 79 | 81 | 81 | 81 | 83 | 85 | 86 | 89 | 94 | 108 | 108 | 108 |
| **Sandhills** | 107 | 107 | 108 | 109 | 109 | 109 | 111 | 112 | 113 | 115 | 125 | 130 | 131 |
| **Trillium** | 168 | 173 | 176 | 179 | 179 | 179 | 180 | 182 | 184 | 189 | 197 | 198 | 198 |
| **Vaya** | 156 | 158 | 161 | 162 | 163 | 167 | 167 | 173 | 175 | 175 | 179 | 179 | 180 |
| **Total** | 1212 | 1239 | 1264 | 1285 | 1290 | 1309 | 1325 | 1360 | 1396 | 1421 | 1482 | 1505 | 1511 |

[58] Note: Totals are cumulative.

# XI. External Quality Review Findings

The annual External Quality Review (EQR) for the LME/MCOs considers various aspects of the TCLI program. The 2018 EQR included a review of the following TCLI standards:

1. TCL functions are performed by appropriately licensed, or certified, and trained staff.
2. The LME/MCO has policies and procedures that address the TCLI activities and includes all required elements, including:

    a. Care Coordination activities occur as required;
    b. Person-Centered Plans are developed as required;
    c. Assertive Community Treatment, Peer Support Services, and Supported Employment services are included in the individual's transition, if applicable;
    d. A mechanism is in place to provide one-time transitional supports, if applicable;
    e. *Quality of Life (QOL) Surveys* are administered timely.

3. A diversion process is in place for individuals considering admission into an Adult Care Home (ACH).
4. Clinical reporting requirements are met and the LME/MCO submits the required data elements and analysis to NC Medicaid within the timeframes determined by NC Medicaid.
5. The LME/MCOs has a TCLI communication plan for external and internal stakeholders, providing information on the TCL initiative, resources, and system navigation tools, etc. This plan should include materials and training about the LME/MCO's crisis hotline and services for members with limited English proficiency.
6. A review of files demonstrates the LME/MCO is following appropriate TCLI policies, procedures and processes, as required by NC Medicaid, and developed by the LME/MCO.

The EQR showed that TCLI functions are performed by appropriately licensed, or certified, and trained staff. The certification requirements for Peer Support Specialists were present in all LME/MCO policies and procedures, except for Trillium.

LME/MCO policies and procedures included details addressing TCLI activities and generally included all the required elements. There was improvement in the documentation and monitoring of "One-time Transitional Funds" this year. Details regarding these funds and the process for accessing and monitoring them were within all of the LME/MCOs' policies and procedures. Additional detail was needed in some instances, resulting in best practice recommendations from the External Quality Review Organization (EQRO).

The completion of *Quality of Life (QOL) Surveys* continued to improve for all LME/MCOs in the past year. Sandhills did not monitor the completion of the 11 and 24-month QOL surveys and, as a result, several of the files reviewed were lacking these surveys. Nonetheless, the State

has fully complied with the QoL survey requirement for at least both of the last two SFYs.[59] Over the life of the program, TCLI has received 84% of surveys for individuals who transitioned and/or reached 11 and/or 24 months in housing. That reflects 77% of expected surveys in SFY15, 75% in SFY16, 76% in SFY17, 89% in SFY18, and 86% in SFY19.[60] These figures are stronger indicia of compliance than previous dashboard measures, e.g., "timely" survey administration and submission.

The LME/MCOs demonstrated that they have a diversion process in place for individuals considering admission into an ACH. Each of the LME/MCO clinical reporting requirements were met. Performance measures and performance improvement projects were validated by the EQRO and show high confidence.

The LME/MCOs had materials available used to educate internal and external stakeholders about TCLI. The EQRO made some recommendations to improve the availability of these materials. Trillium was asked to add information about TCLI in their *Provider Manual* and Sandhills was asked to include information about TCLI in their *Member Handbook.* Alliance and Sandhills did not have materials designed for individuals with limited English proficiency. Partners needed to add additional information regarding the availability of the TCLI program to the *Member Handbook* reflecting the availability of materials about the crisis hotline and the availability of information for members with limited English proficiency. Notably, Eastpointe had a *TCLI Communication Plan* that outlined different tiers of education provided to internal staff across the organization and training provided to providers at stakeholder meetings.

The EQRO completed file reviews for a select number of TCLI members. Eastpointe's progress notes did not mention Peer Support or Supported Employment, even in instances where the notes reflect that the member wants to obtain employment. Vaya's progress notes did not mention the use of One-Time Transitional Funds. Alliance did not target the member's individual goals, such as employment, in Person-Centered Plans. The EQRO recommended that Alliance enhance the monitoring process of Person-Centered Plans to ensure TCLI members are receiving the support and quality of services to address their identified needs. Cardinal files showed that members are regularly linked to Assertive Community Treatment (ACT) services, but rarely linked with Supported Employment services, even when members identified seeking employment as a goal. The LME/MCOs made necessary corrective actions during the last phase of the EQR process. The implementation of best practice recommendations will be monitored during the quarterly Intra-Departmental Monitoring Team process.

[59] From inception, TCLI expanded the Settlement Agreement's survey requirement (those transitioning out of facilities) to include individuals *diverted* from ACH admission.
[60] Survey participation is voluntary, so we do not expect 100% completion.

## XII. Monitoring of Service Gaps

LME/MCOs are required on an annual basis to analyze and report on service gaps in accordance with their DHHS Performance Contracts. These analyses are part of a continuous assessment and action process that drives development of LME/MCO local business plans and network development plans, and implementation of strategic plans through quality improvement actions. The DHHS distributed process and report guidelines in January 2019 for SFY 2019 LME/MCO Network Adequacy and Accessibility Analysis (previously called the Gaps and Needs Analysis), with a July 1, 2019 report submission deadline.

LME/MCOs report on network availability and accessibility for Medicaid and non-Medicaid Outpatient, Location-Based, Community/Mobile, Crisis, Inpatient, Specialized and Waiver services; use geo-mapping to report provider locations; address obstacles and barriers to service-specific geographic, cultural or special populations; and report on direct input from consumers and other stakeholders regarding service gaps.

Analysis requirements also include evaluating and describing LME/MCO gaps, needs, obstacles, barriers, and initiatives around Permanent Supportive Housing, community mental health services and supports, and Crisis Service for the TCLI population (See Table 34).

## Table 34. 2019 LME/MCO Network Adequacy and Accessibility Analysis Requirements, Transitions to Community Living Initiative

A. Permanent Supportive Housing Slots
   1. Describe service gaps and needs, obstacles and barriers, and recent activities and projects in the LME/MCO to:
      a. Identify and engage eligible individuals in the TCLI priority population;
      b. Provide access and transition individuals to community Permanent Supportive Housing;
      c. Transition individuals within 90 days of assignment to a transition team; and
      d. Support individuals' housing tenure and ability to maintain Permanent Supportive Housing.

B. IPS-Supported Employment
   1. Describe the network adequacy of IPS-Supported Employment services including:
      a. number of fidelity teams;
      b. location of fidelity teams;
      c. capacity of fidelity teams;
      d. the LME/MCO's total service capacity requirements (including but not limited to the TCLI population); and
      e. service gaps and needs.
   2. Describe obstacles and barriers, as well as recent activities and projects, to engage and refer individuals in the TCLI priority population, including individuals with SMI living in Permanent Supportive Housing and individuals living in or at risk of entry to Adult Care Homes.

C. Community Mental Health Services
   1. Describe the array and intensity of community mental health services provided to individuals living in Permanent Supportive Housing, as well as their sufficiency.
   2. Describe personal outcomes indicative of greater integration in the community. Personal outcomes addressed in response should include the following:
      a. Permanent Supportive Housing tenure and maintenance of chosen living arrangement;
      b. hospital, Adult Care Home, or inpatient psychiatric facility admissions;
      c. use of crisis beds and community hospital admissions;
      d. emergency room visits;
      e. incidents of harm;
      f. time spent in congregate day programming;
      g. employment;
      h. school attendance/enrollment; and
      i. engagement in community life.
   3. Describe gaps and needs in the community mental health services provided to individuals in TCLI Permanent Supportive Housing.[61]
   4. Describe obstacles and barriers as well as recent activities and projects to address gaps in the array, intensity, and sufficiency of community mental health services provided to individuals in Permanent Supportive Housing.

D. Crisis Services
   1. Describe the network adequacy of the LME/MCO crisis service system including:
      a. the geographic availability of services,
      b. the crisis service array and intensity of services,
      c. the sufficiency to offer timely and accessible services and supports to individuals experiencing a behavioral health crisis, and
      d. service gaps and needs.[62]
   2. Describe the extent to which crisis services are provided in the least restrictive setting and consistent with an already developed individual community crisis plan or in a manner that develops such a plan as a result of the crisis situation, and in a manner that prevents unnecessary hospitalization, incarceration or institutionalization.
   3. Describe obstacles and barriers as well as recent activities and projects to address gaps related to crisis service availability, delivery, sufficiency, and outcomes.

[61] This item refers to gaps and needs related to the provision and outcomes of services for the TCLI population, and not solely to the access and choice standards.
[62] This item refers to gaps and needs related to the provision and outcomes of services for the TCLI population, and not solely to the access and choice standards addressed in Section One.

LME/MCO excerpted responses to the 2019 Analysis TCLI requirements are presented in Appendix B of this Annual Report. Summaries of service gaps/obstacles and initiatives identified by the LME/MCOs are presented in Tables 35 through 38, below

**Table 35. Summary of Identified Service Gaps, Obstacles, and Initiatives in Permanent Supportive Housing**

| | Gap, Needs, Obstacles, and Barriers | Activities and Initiatives |
|---|---|---|
| Alliance | Limited housing in Wake/Durham.<br>Limited housing that meets individual requirements.<br>High volume of Diversion screening referrals.<br>In-Reach and Transition Coordinator caseloads at capacity<br>Dual responsibilities of Transition Coordinators<br>Backlog in Transition planning status 90+days.<br>Increase in housing separations.<br>Limited capacity to monitor tenancy supports providers. | FY18 Landlord Incentive program.<br>Landlord risk-mitigation resources to assist with landlord recruitment. |
| Cardinal | Lack of transportation.<br>Ongoing tenancy support.<br>Member and group home provider education about transportation.<br>Ability to complete Comprehensive Clinical Assessments (CCA) for ACH residents.<br>Separations due to evictions and abandonment. | Asking group homes to improve transportation capabilities.<br>Education about Medicaid transportation.<br>Online tool for searching local social services resources.<br>Provider learning collaborative to improve tenancy support.<br>Post-transition population health management.<br>Increased nursing support.<br>Monitoring number of ACT Team visits.<br>Bridge Housing pilot. |
| Eastpointe | Lack of understanding of eligibility.<br>Environmental obstacles, aftermath of natural disasters and impact on housing.<br>Delays related to provider assessments and referral documentation.<br>Provider RSVP learning curve.<br>Housing/member preference matching.<br>Family involvement in housing decision.<br>Member stability in housing, including related to Substance Use Disorder.<br>Fragmented data sources. | Quality Improvement project to educate members and providers about TCLI eligibility and benefits.<br>Provider forums.<br>Housing presentations and housing collaborative meetings for ACHs.<br>Staff follow-up with members beyond 90 days post-transition.<br>Community inclusion pilot.<br>Close monitoring of individuals with hospital admissions, ACH return, inpatient admissions.<br>Collaborative work with State Psychiatric Hospitals around admission notifications.<br>Bridge Hotel pilot program. |
| Partners | Member criminal history.<br>Member financial and medical problems.<br>Lack of housing options in preferred location.<br>Lack of accessible units.<br>Contractual issues involving care coordination. | Housing fund grant applications.<br>Landlord education and training.<br>Hired additional Housing Coordinator.<br>Pursuing Master Leasing option.<br>Exploring alternative for diversion in Burke Co.<br>Increasing housing units via building proposals.<br>Weekly calls with Transition Management Services (TMS). |
| Sandhills | Natural supports may discourage members from independent living.<br>Member concerns about losing benefits.<br>Isolation among those who transition into the community.<br>Criminal and credit background barriers to transition.<br>Limited affordable housing in preferred areas.<br>Limited availability of targeted key units. | Weekly workgroup to discuss barriers.<br>Monthly member-focused meetings with TMS providers.<br>Monthly follow-up with members in In-Reach.<br>Hired staff to perform community integration activities with eligible individuals, including viewing units, touring Psychosocial Rehabilitation (PSR) programs, meeting with others who have transitioned.<br>Expanding role of housing specialists to develop landlord relationships.<br>Annual breakfast meeting to recruit landlords.<br>Retroactive and current reviews of how to meet member needs in the community.<br>Clinical team meetings for members who are struggling. |
| Trillium | Transportation, especially in rural counties.<br>Available affordable housing.<br>Member criminal and credit backgrounds<br>Accessible housing.<br>Limited access to PCS and difficulty. establishing PCS in timely manner.<br>Damaged housing due to hurricane. | Continuous provider education.<br>Implementation of revised contracts.<br>Establishing bridge housing.<br>Re-housed members displaced by hurricane.<br>TCLI and Housing staff work with private property owners around new housing opportunities.<br>Monthly post-transition follow-up.<br>Added nursing staff to TCLI program. |
| Vaya | | TCLI Community Liaison educates around TCLI and RSVP.<br>TCs request monthly updates from Tenancy Support providers.<br>Worked with TMS to build addition team for new members.<br>Monthly meeting with TMS to forecast potential gaps and barriers.<br>ACT Team Learning Collaborative that addresses tenancy support and separation rates. |

**Table 36. Summary of Identified Service Gaps, Obstacles, and Initiatives in IPS-Supported Employment**

| | Gap, Needs, Obstacles, and Barriers | Activities and Initiatives |
|---|---|---|
| Alliance | One out of seven teams have a waitlist.<br>Insufficient rates for licensed clinicians to attend meetings.<br>Availability/funding of benefits counselors.<br>Outreach to ACHs is not billable.<br>High turnover rate on teams.<br>Provider uncertainty related to pending CST policy changes. | Limited new authorization of services to in/at risk population.<br>Converted non-UCR allocations to fund service.<br>Requested additional fund conversion.<br>Prioritizing TCLI referrals<br>Focus on increasing TCLI eligible in all phases (In-Reach, Transition, Housed)<br>Monthly IPS-Supported Employment (IPS-SE) Collaborative.<br>Use of a TCLI referral form.<br>IPS-SE training for In-Reach staff.<br>IPS-SE teams expanding to accommodate increasing number of referrals. |
| Cardinal | Staff turnover.<br>Coordination of Primary Care Providers (PCP) across providers.<br>Lack of viable employment options.<br>Lack of staff training in Benefits Counseling.<br>Inadequate state funding to continue provider milestone payments.<br>Provision of service to TCLI population. | DVR training for providers about milestone payments.<br>Added second team in Mecklenburg Co. |
| Eastpointe | Lack of understanding of service definition and eligibility requirements.<br>Member concerns about losing benefits.<br>Effectiveness of benefits counseling.<br>Lack of employer awareness of time and salary constraints and job constraints.<br>Limited jobs in the community.<br>Number of vocational and job training support programs.<br>Member concerns about stigma in educational and employment settings. | Participation in provider steering committee an IPS-SE Coalition training. |
| Partners | Service capacity requirements in catchment area exceed provider capacity.<br>Rate structure.<br>How fidelity scoring is implemented. | Employment option training.<br>Benefits counseling.<br>Additional fidelity provider anticipated in 2019.<br>Providers hiring staff and increasing capacity.<br>RCA to explore recruiting difficulties.<br>Ongoing TA from Supported Employment/Enhanced Services Learning Collaborative.<br>QIP around marketing IPS-SE to all individuals.<br>Developing strategic IPS-SE communication and marketing plan.<br>Provider contract incentives for serving in/at risk population. |
| Sandhills | One provider recently unable to accept new clients; some rural counties without coverage.<br>Member concerns about losing benefits.<br>Natural supports may discourage members from returning to work.<br>Members may not believe they are able to work.<br>Burden of providing increasing amount of documentation to demonstrate in/at-risk. | Request for Proposals (RFP) for additional providers and identification of provider to cover some of the rural counties without coverage.<br>Added Community Integrated Work Program (CWIPs) and Community Work Incentive Coordinators (CWICs) to service definition allowing for higher rate.<br>Use of Supported Employment fact sheet to assist in engaging members. |
| Trillium | Nash and Columbus not covered.<br>Provider education needed to increase referrals.<br>Low incentive to hire more staff due to low referrals.<br>Displaced staff due to hurricane; staff team numbers have decreased.<br>Displaced members due to hurricane; members discharged due to moving out of area to find affordable housing.<br>Low employer participation; many teams in rural areas with few employers; employer numbers have decreased due to hurricane.<br>Access to transportation to make employment sustainable.<br>Member concerns about loss of benefits. | Completed RFP and new team serving Nash and Columbus effective 2019; non-UCR funds awarded for this purpose.<br>IPS Workgroup to work with IPS-SE teams and providers.<br>Dedicated Contract Mangers to work with IPS-SE teams.<br>Regional IPS-SE Coalition.<br>Provider allocations of non-UCR funds for benefits counseling. |
| Vaya | One team is at capacity.<br>Private and paid guardian understanding of TCLI and member capabilities for independent living.<br>Limited housing stock.<br>Lack of natural supports. | TCLI participants are prioritized in the case of a waitlist. |

**Table 37. Summary of Identified Service Gaps, Obstacles, and Initiatives in Community Mental Health Services**

| | Gap, Needs, Obstacles, and Barriers | Activities and Initiatives |
|---|---|---|
| Alliance | Need for increased focus on tenancy and employment supports.<br>Service capacity for non-Medicaid is reduced<br>Peer Support underutilized.<br>Various obstacles related to tracking personal and service outcomes.<br>Unclear how RSVP will impact network capacity. | ACT and TMS provider training on Community Inclusion.<br>Value-based payment Community Inclusion Initiative for providers.<br>Develop strategies for performance-based payment.<br>Increase provider accountability.<br>Education for TMS and Peer Support to increase utilization of Peer Support.<br>Monthly ACT Collaborative.<br>Work with ACT providers on outcomes monitoring and reporting.<br>Data analysis to evaluate trends, payment methods, impact of ongoing initiatives. |
| Cardinal | Choice of fidelity ACT Team providers.<br>Effective service delivery.<br>Coordination of care.<br>Social isolation. | Bi-monthly ACT Team Learning Collaborative.<br>Person-Centered Planning training. |
| Eastpointe | | (See additional initiatives listed under housing.) |
| Partners | Members previously reported difficulty reaching providers.<br>Member-provider conflict.<br>Geographic limits on certain service availability, e.g., Surry, Yadkin, Iredell counties.<br>Member medication adherence.<br>Limited funding for b(3) peer services. | Peer training in support for daily living skills, adherence to leases, and financial guidance.<br>Implemented formal process for providers to notify if fired by member.<br>Focus on solving transportation issues.<br>Education around medications. |
| Sandhills | Four counties with limited CST coverage: Anson, Montgomery, Richmond, Moore.<br>Providers have differing views about individuals with SMI living in the community; some opt to assist members to return to congregate living.<br>Member isolation and loneliness. | Anticipate expanding CST with revised service definition.<br>Coordinated with UNC Center for Excellence in Community Mental Health on ACT Team provider training, with TMS and CST providers also invited.<br>Member education on Medicaid transportation, and peer provision of transportation. |
| Trillium | No data included. | No data included. |
| Vaya | Service gaps in the most rural counties limit choice.<br>Lack of transportation.<br>Lack of dentistry accepting Medicaid.<br>Tenancy support provider education. | Increased TMS provider capacity. |

**Table 38. Summary of Identified Service Gaps, Obstacles, and Initiatives in Crisis Services**

| | Gap, Needs, Obstacles, and Barriers | Activities and Initiatives |
|---|---|---|
| Alliance | Maintaining sufficient services to meet needs.<br>Lack of inpatient psychiatric beds.<br>Uneven county availability of all levels of crisis continuum.<br>High volume at local crisis facilities.<br>Lack of funding to expand walk-in services.<br>High utilizers, use of Emergency Department for primary behavioral health care. | Ongoing resource investment to expand service continuum.<br>County-level Crisis Collaboratives.<br>Provider contracting process detailed expectations.<br>Expanded Behavioral Health Urgent Care to Wake.<br>Wake EMS Enhanced Mobile Crisis Pilot.<br>Selected new provider for Cumberland Co. Crisis. |
| Cardinal | | Provider Crisis Plan development training.<br>ACT Team provider involvement with members using Emergency Department (ED) or inpatient. |
| Eastpointe | ED recidivism.<br>Lack of community engagement and integration to prevent and mitigate crisis events.<br>Lack of substance use services.<br>Lack of resources for mobile crisis teams. | Emphasis on identifying facility admissions, care coordination, and early discharge planning.<br>Increased referrals for Peer Support.<br>Added RN to staff.<br>Increasing services delivered in the community.<br>Community inclusion/crisis planning.<br>Use of mystery shoppers to evaluate provider responsiveness.<br>Crisis collaboratives and provider meetings.<br>MH First Aid training with first responders.<br>Evaluating START Program for potential implementation.<br>Non-hospital detox program involvement in post-overdose rapid response team.<br>Quality Improvement Plan to reduce ED utilization.<br>Technical assistance for Mobile Crisis Management (MCM) providers<br>Pilot program for transportation after crisis episode |
| Partners | TMS providers do not have training to conduct assessments in a crisis. | Provided training for TMS to assist with crisis referral process. |
| Sandhills | | New contract for adult Facility-Based Crisis (FBC)/ Comprehensive Care Center (CCC) in Randolph Co.<br>Constructing a child FBC/CCC in Richmond Co. to open 2020. |
| Trillium | | Collaboration with Wellness Cities.<br>Root Cause Analyses conducted in the event of three crisis episodes.<br>Expanded MCM into Columbus Co.<br>Offered contracts to all Eastpointe MCM providers who had served Columbus Co. members in past year. |
| Vaya | Member use of ED when lower level of care appropriate. | Education around FBC and Behavioral Health Urgent Care.<br>Working to ensure these facilities become designated Involuntary Commitment (IVC) drop offs.<br>Comprehensive Case Management pilot for adults with MH and SUD treatment needs. |

# XIII. Budget

For SFY 18-19, we were able to make changes to our budgeting processes to improve oversight and collaboration with the LME/MCOs for increased optimization and management of the TCLI funds.

As a result of our changes, we implemented the following:

- Monthly budget reporting for leadership staff and LME/MCOs
- Additional budget reviews with LME/MCOs to ensure alignment.
- Quarterly reviews for reallocation of funds in a timely manner.

With the updated processes, ongoing oversight and monthly reporting, appropriate allocations and utilization improved which decreased the amount of reverted funds to $750,000 (a vast decrease from the $7.2 million reversion the previous year). The SFY 18-19 budget also included a move of $3.5 million towards housing development plans.

For SFY19-20, ongoing planning exercises occurred from February to June of 2019 to review spending, determine proposed allocations and make timely budget decisions for the SFY19-20 budget. As a result, we were able to issue allocation letters to all LME/MCOs the first week of July 2019.

Our priority areas for SFY 19-20 funding are: Housing, Bridge Housing, IPS-Supported Employment, and Diversion. Investments have been made in priority areas to allow for effective planning and implementation.

Other important areas may have received less funding this year. However, we will closely monitor spending throughout the year. When necessary, we will redistribute funding to line items that are critical to achieving compliance with the Settlement Agreement.

# XIV. Closing Statement

In SFY 2018-2019, the Transitions to Community Living Initiative (TCLI) renewed and strengthened its commitment to meeting the requirements of the Settlement Agreement with the United States Department of Justice. This commitment was evident in the area of supportive housing, one of the pillars of the Agreement. An exceptional partnership among the State, Local Management Entities/ Managed Care Organizations and NC Housing Finance Agency produced significant, statewide expansion in voucher subsidized housing units. In another achievement at the heart of the Agreement, TCLI developed the Referral/ Screening Verification Portal (RSVP) tool, demonstrably increasing diversion from Adult Care Home entry.

Collection, monitoring and analysis of data to evaluate progress and outcomes continue to be a hallmark of TCLI's work. The commitment to data-driven quality outcomes saw TCLI bring to

the table stakeholder expertise in a newly formed Barriers Committee. Professionals removed challenges to living in the community in "real time." The Barriers Committee members escalated complex, systemic issues to the Department's top leadership in another, new element of policy infrastructure: The Transition Oversight Committee.

In all facets of its work, TCLI continued to innovate. This was particularly apparent in the rollout of a re-envisioned Community Support Team service definition. Ascertaining that its partners in policy and practice--the LME/ MCOs and their provider networks--were fully engaged in TCLI's system change work was crucial to this year's success. Extensive stakeholder training opportunities and the provision of top-flight technical assistance helped to ensure that TCLI's gains would be sustainable.

As TCLI moves into State Fiscal Year 2019-2020, we are reaching out to the broader community of people with disabilities contemplated by the US Supreme Court's decision in *Olmstead v. L.C.* We anticipate that the State's investments in this exceptional undertaking will open the door to community for North Carolinians for years to come.

In closing, the NC Department of Health and Human Services thanks the NC General Assembly in advance for its consideration of the *2018 - 2019 Annual Report, Opening the Door to Community: The Transitions to Community Living Initiative.*

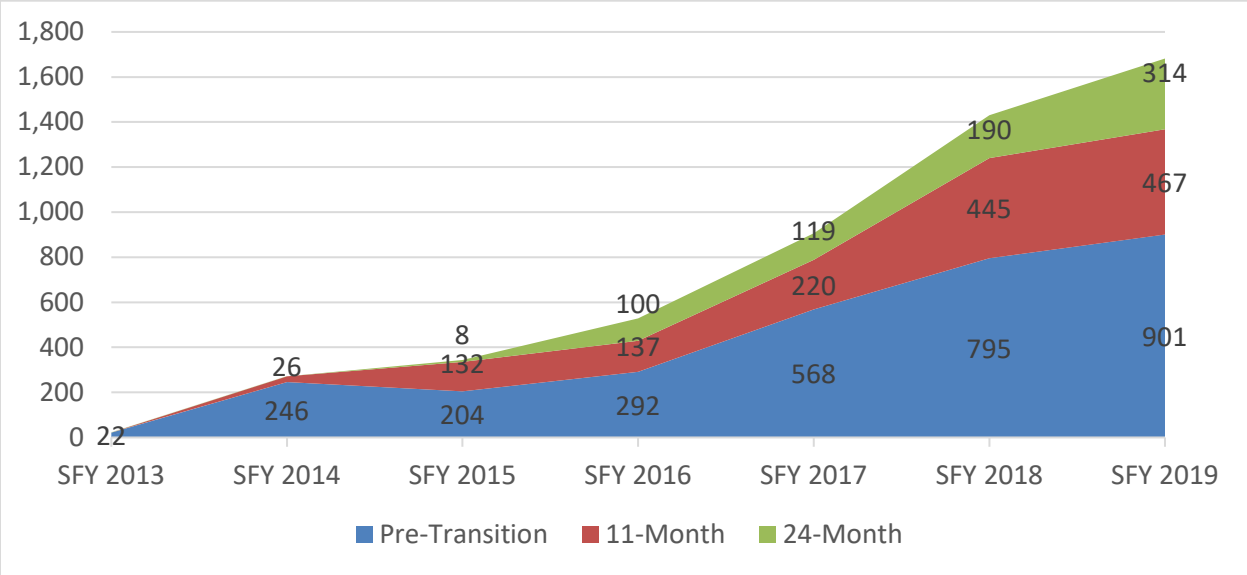
**Appendix A to the Annual Report on North Carolina Supportive Housing Program: Participant Quality of Life Survey Summary Report**

The N.C. Transitions to Community Living Initiative (TCLI) Quality of Life Surveys assess the extent to which individuals who transition to supportive housing in the community experience improvements in the quality of their daily lives, as well as areas in which they report obstacles and challenges. The surveys are designed to assess perceptions, satisfaction, and outcomes related to housing and daily living, community supports and services, and personal well-being.

LME-MCO staff administer the surveys in person during the transition planning period and again 11 and 24 months after the individual transitions to supportive housing.[1] They submit survey responses through the State's secure, web-based survey application.

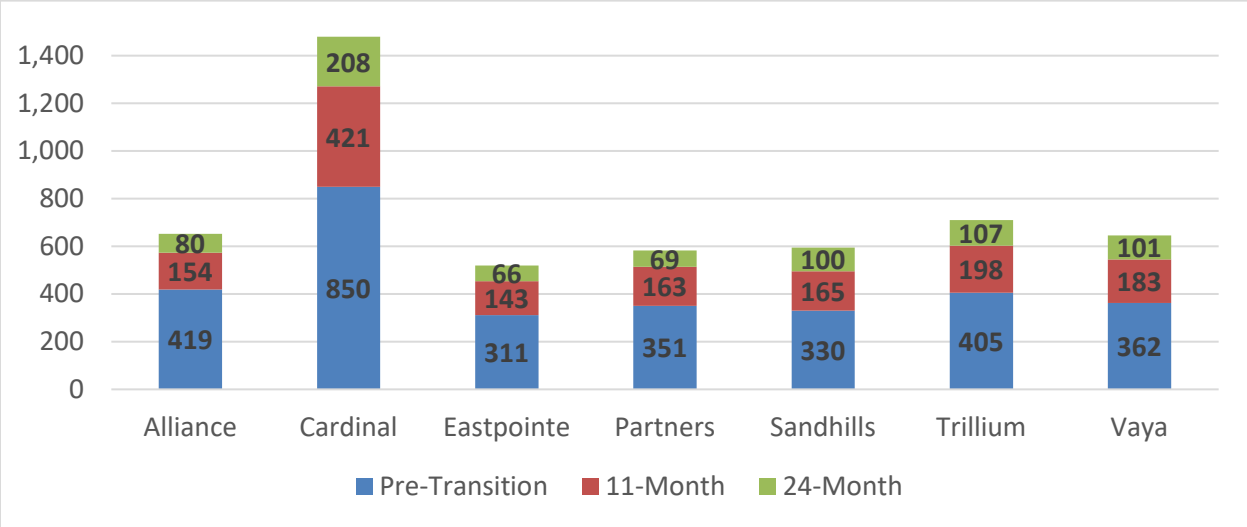
With this annual report, 3,159 individuals' responses to a total of 5,186 surveys submitted through approximately June 30, 2019 have been analyzed to date. The total number includes 3,028 pre-transition, 1,427 11-month, and 731 24-month surveys. (See Figures 1, 2 and 3.)

Figure 1: Completed Participant Surveys by State Fiscal Year



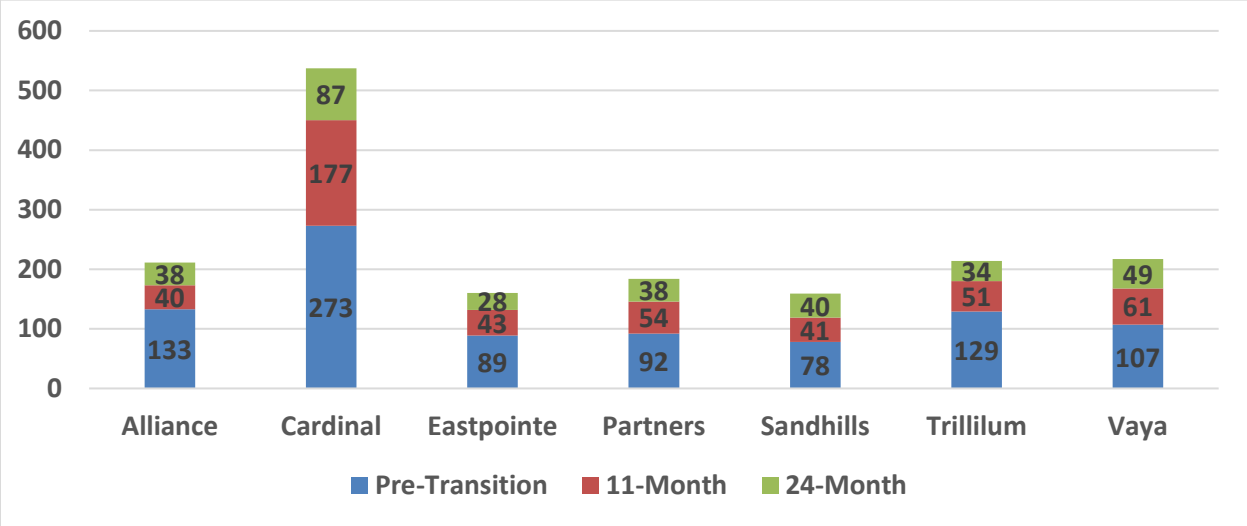

[1] Per Section III.G.5 of the State's Settlement Agreement (SA) with U.S. DOJ, the State implemented Quality of Life surveys in 2013. The SA requires the three surveys for individuals transitioning out of adult care homes or state psychiatric hospitals. The State extended the survey requirement for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

Figure 2: Completed Participant Surveys by LME-MCO Catchment Area, SFY 2013-2019[2]




Analyses of SFY 2019 data reported in this annual update are based on 1,682 surveys, as shown in Figure 3.

Figure 3: SFY 2019 Completed Participant Surveys by LME-MCO Catchment Area




[2] LME-MCO compliance with the Quality of Life survey requirement is an area of ongoing State team performance monitoring. Over the life of the TCLI program, 84% of surveys of individuals housed and/or reaching 11 or 24 months in housing have been submitted. This includes pre-transition surveys for 92% of individuals housed and follow-up surveys for 76% and 74%, respectively, of individuals housed for 11 and 24 months. The overall submission rate for surveys due in the 2018-2019 State Fiscal Year was 86% and included surveys for 96% of all individuals who transitioned to supportive housing during the year, and 75% and 78%, respectively, of individuals who reached 11 and 24 months in supportive housing. Because individual survey participation is voluntary, a 100% submission rate is not expected.

## Quality of Life and Satisfaction with Housing and Community

Figures 4A through 4H below show percentages of participants surveyed in SFY 2019 who reported positive experiences related to eight Quality of Life domains.[3,4] Pre-transition, 11-month and 24-month responses to specific questions follow the same general pattern from previous years, with similar percentages of individuals in housing selecting the response most indicative of positive experiences and satisfaction. In general, participants who had transitioned to supportive housing also were significantly more likely to report positive experiences compared to pre-transition survey respondents.

Figure 4A: Staff Support and Satisfaction

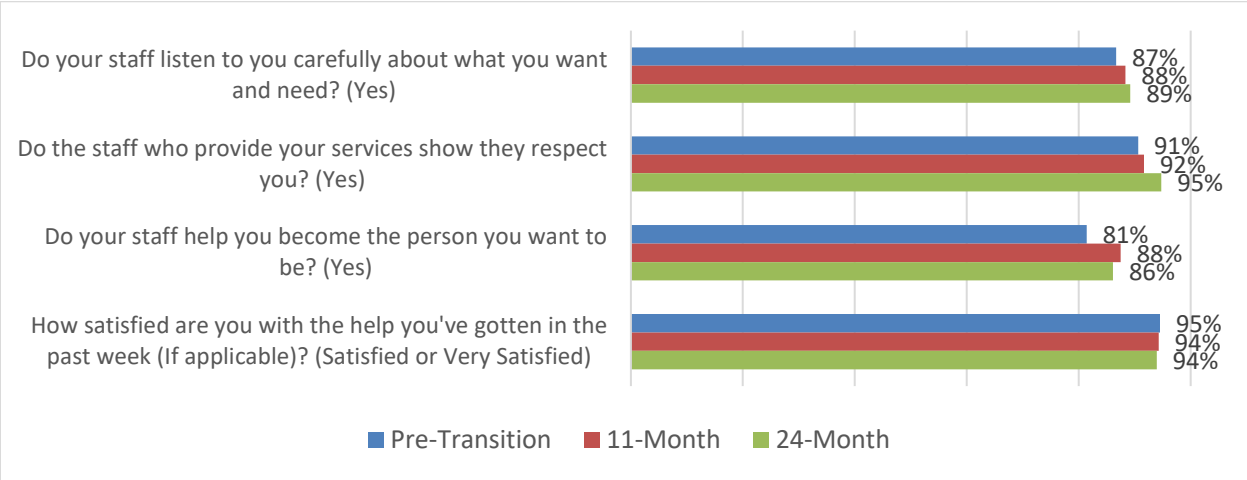
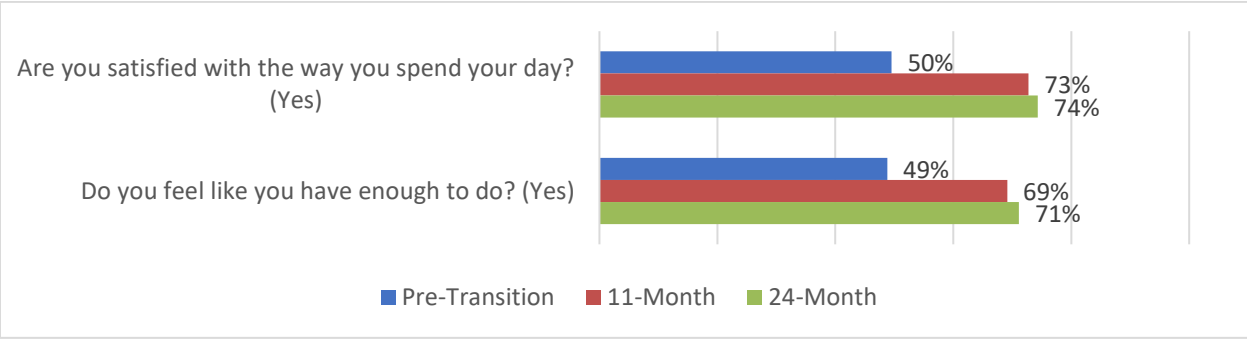



Figure 4B: Meaningful Day




[3] The eight Quality of Life facets are defined by correlated groups of survey items. Responses to items within each domain are somewhat more predictive of one another than they are of responses to items in other domains.
[4] "No Response" and "Unsure" responses are excluded from all percentage denominators.

Figure 4C: Safety

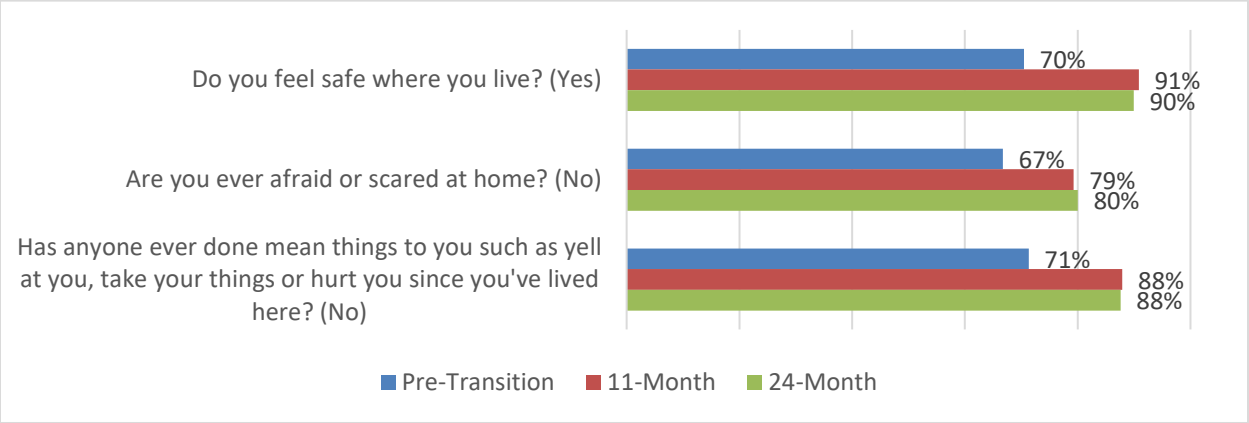



Figure 4D: Choice and Control

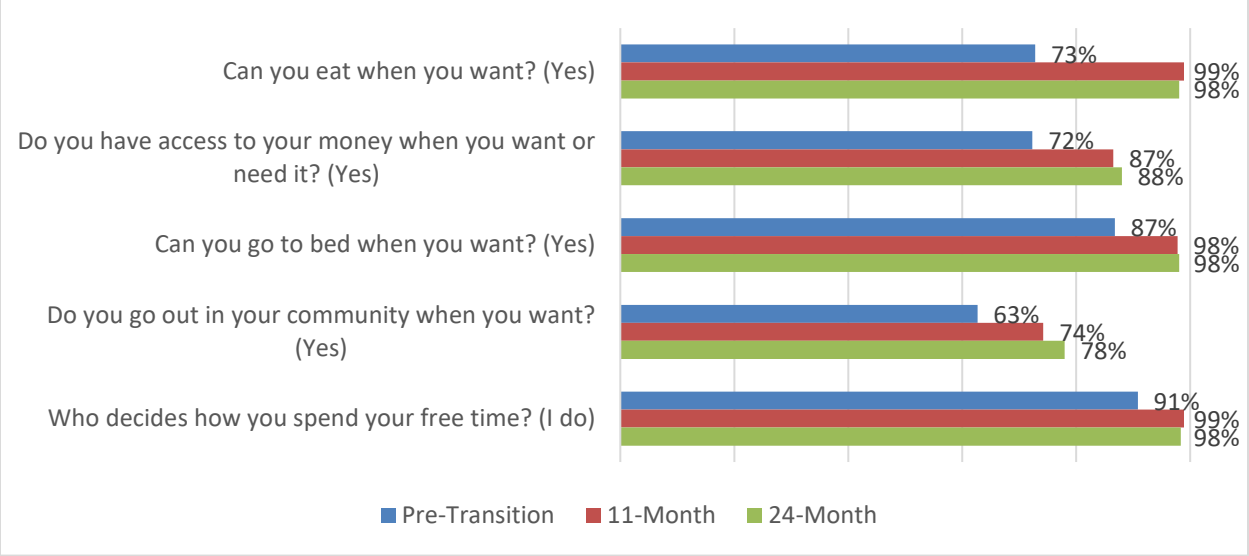



Figure 4E: Natural Supports

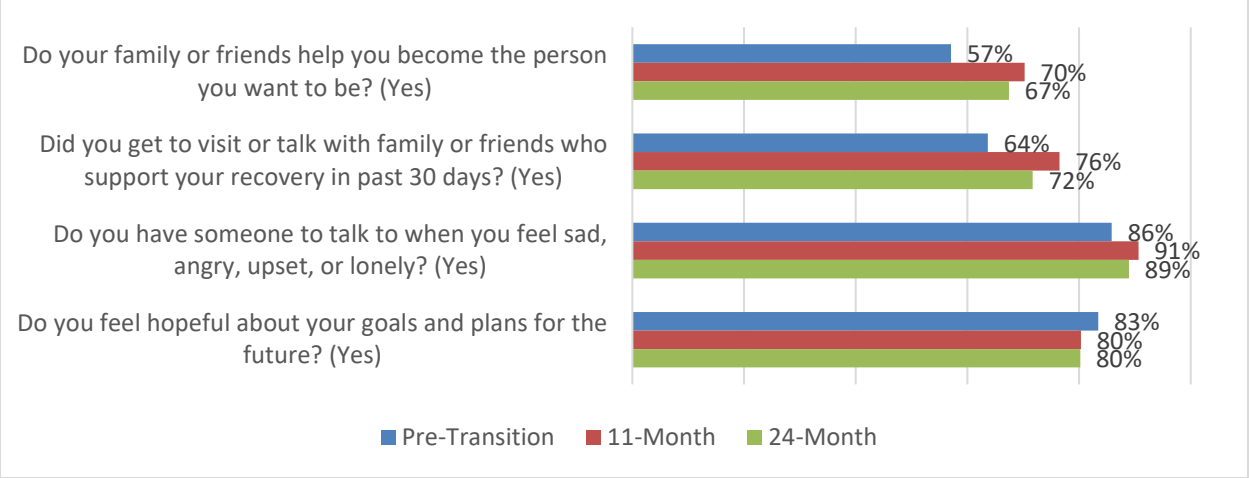


Figure 4F: Health and Wellness

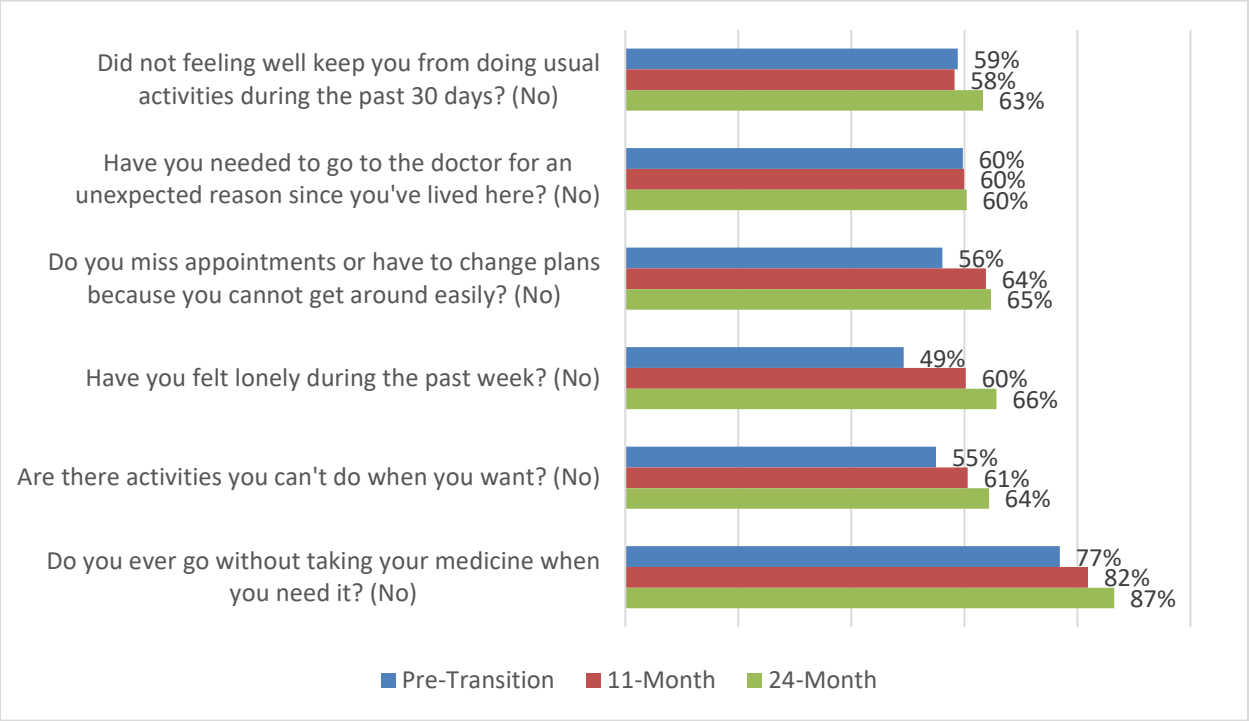



Figure 4G: Service Planning Contacts

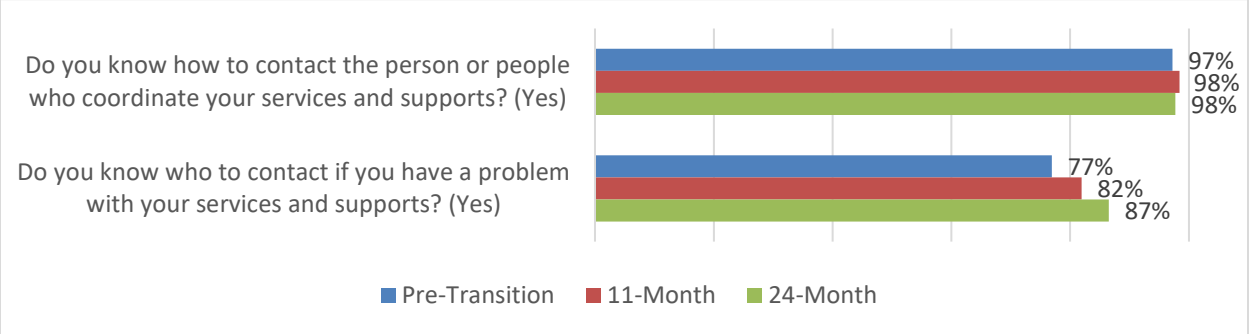



Figure 4H: Sufficiency of Services

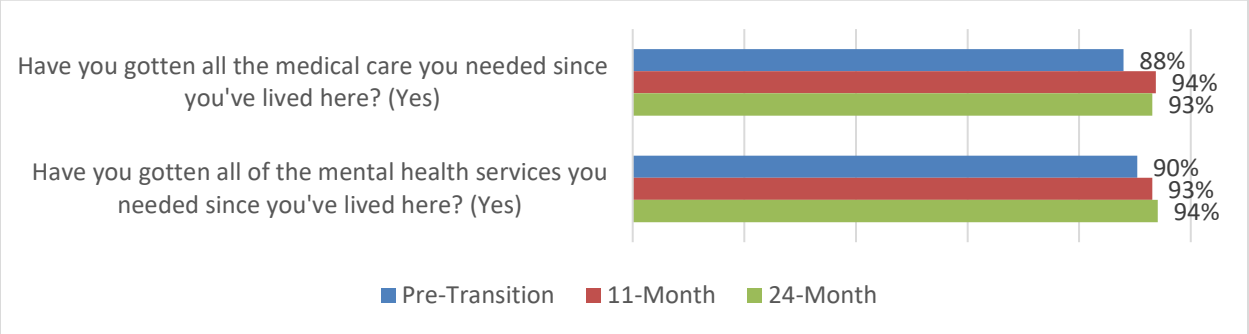
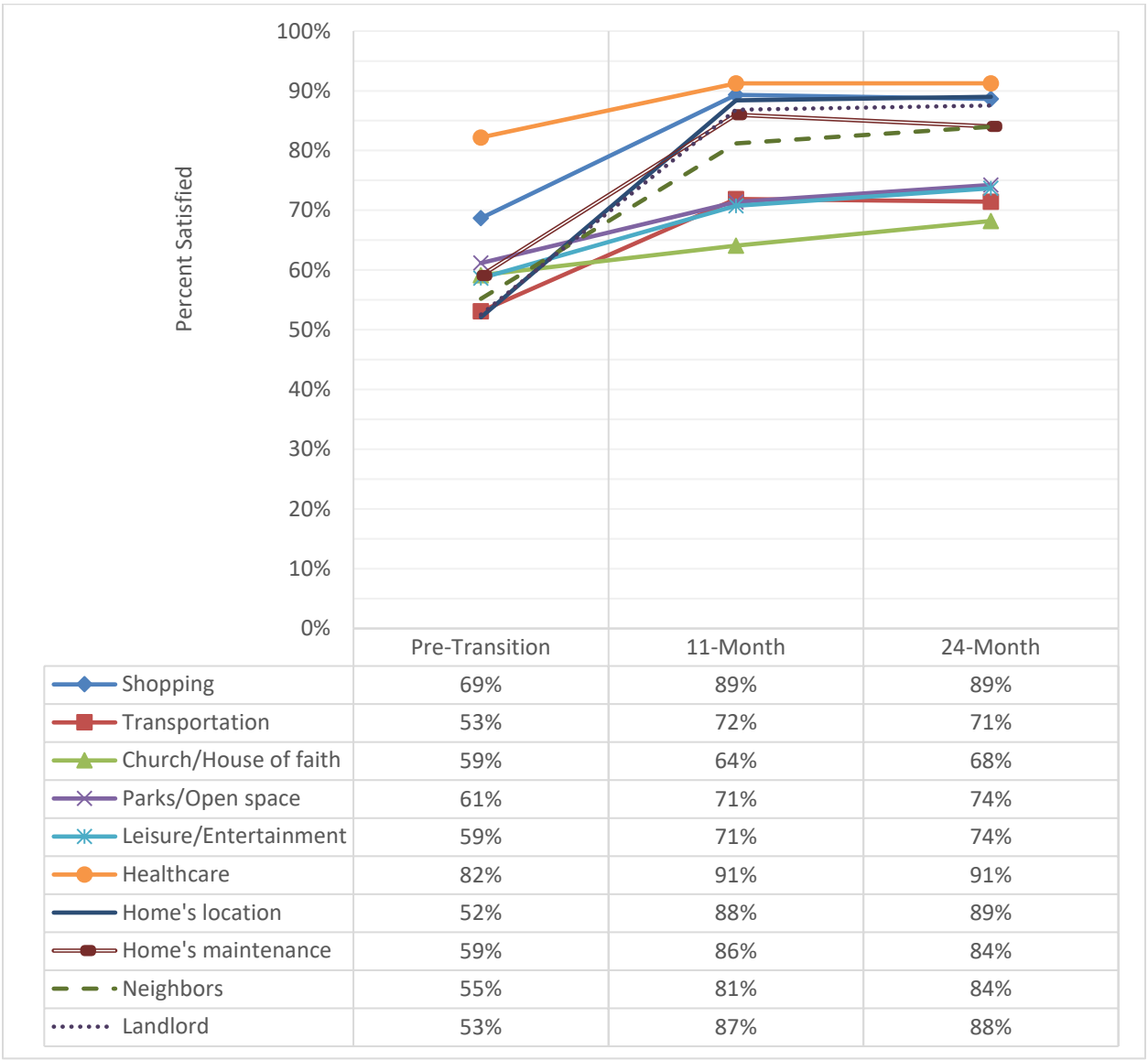


Figure 5A shows percentages of SFY 2019 survey respondents who reported being satisfied with various resources in their communities and with different aspects of their housing. As in previous years, significantly larger percentages of individuals in housing reported satisfaction in each of the ten areas compared to individuals who responded to the pre-transition survey.

Figure 5A: Satisfaction with Community Resources and Housing



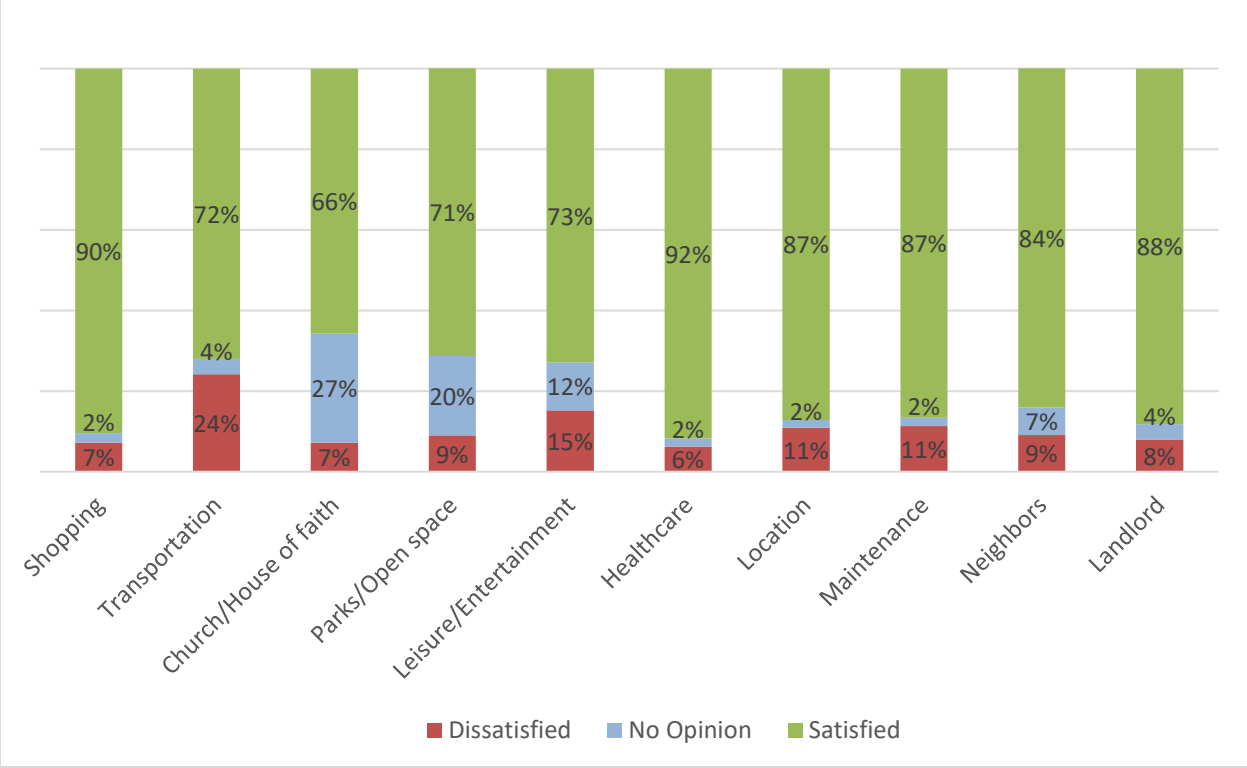

| | Pre-Transition | 11-Month | 24-Month |
|---|---|---|---|
| Shopping | 69% | 89% | 89% |
| Transportation | 53% | 72% | 71% |
| Church/House of faith | 59% | 64% | 68% |
| Parks/Open space | 61% | 71% | 74% |
| Leisure/Entertainment | 59% | 71% | 74% |
| Healthcare | 82% | 91% | 91% |
| Home's location | 52% | 88% | 89% |
| Home's maintenance | 59% | 86% | 84% |
| Neighbors | 55% | 81% | 84% |
| Landlord | 53% | 87% | 88% |

Cell values are percentages of respondents who selected “Satisfied” rather than “Dissatisfied” or “No opinion.” Non-responses are excluded from percentage denominators.

At all three points individuals were most likely to report satisfaction with their Healthcare and opportunities for Shopping in their communities. Substantially larger percentages reported satisfaction at follow-up compared to pre-transition in relation to Shopping and Transportation. The largest differences in the percentage of individuals who reported being satisfied before versus after transition were observed in relation to four aspects of housing: Location, Landlord, Neighbors, and Maintenance. Satisfaction ratings for these aspects of housing were also moderately strongly related to one another (correlations = .49 to .60)

As shown in Figure 5B, Transportation and Leisure continue to have the highest rates of post-transition dissatisfaction. Relatively lower rates of reported satisfaction with local resources such as Church and Parks reflect in part the larger percentages of participants who selected No Opinion.

Figure 5B: Satisfaction in Supportive Housing




Includes all SFY 2019 11-month and 24-month follow-up surveys.

**Community Integration and Natural Supports**

Figures 4B, 4D, 4E, and 4F above each summarize responses to survey questions that to relate to participants' engagement in community life and to their natural support networks. These factors are important as dimensions of recovery that promote well-being and stability, and as relevant personal outcomes for understanding how TCLI participants' experiences change in supportive housing. [5]

*Community Integration and Engagement*

Survey items that relate to individuals' community integration and engagement (CIE) include: *Are you satisfied with the way you spend your day? Do you feel like you have enough to do? Do you go out in your community to do things when you want or choose?* As previously shown in Figures 4B and 4D, on average, 54 percent of individuals responded affirmatively to these questions prior to transition. At 11-month and 24-month follow-up surveys, an average of 73 percent responded positively.

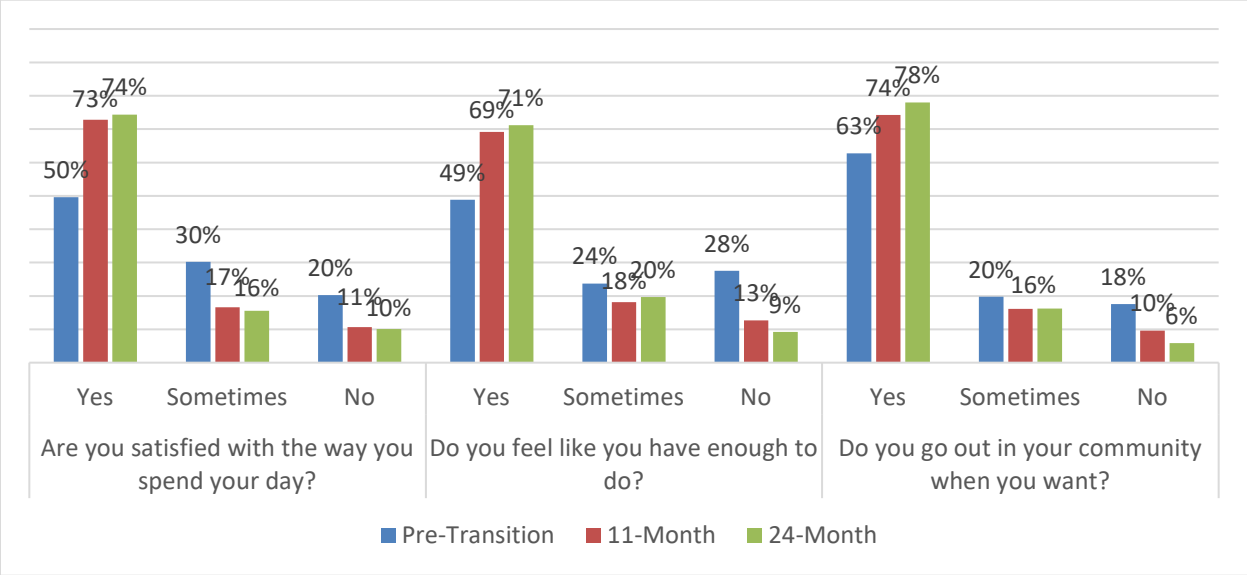
Figure 6 shows the response distributions to these three questions in greater detail. Pre-transition and post-transition respondents differed most in their reports of satisfaction with daily activities. At 24-month follow-up, 74 percent of housed individuals reported satisfaction, compared to 50 percent of pre-transition respondents. More individuals in supportive housing also reported that they have enough to do and that they go into the community when they want.

Across all three survey points, the three items combined also were associated at a low but significant level with the total number of 13 distinct activities individuals mentioned or selected when asked, *How do you usually spend your day?* This was due primarily to significant positive associations with a subset of the activities: Cleaning/Cooking, Socializing/Visiting, Work in the community, Going into town/community, Physical activity/exercise, and School.[6]

[5] Section III.G.3.g. of the SA requires the State to monitor personal outcomes including number of people employed, attending school, or engaged in community life. Section III.C.3. of the SA requires the State to provide individuals with services and supports that strengthen individuals' networks of community and natural supports. These outcomes are monitored in part through Quality of Life Surveys.

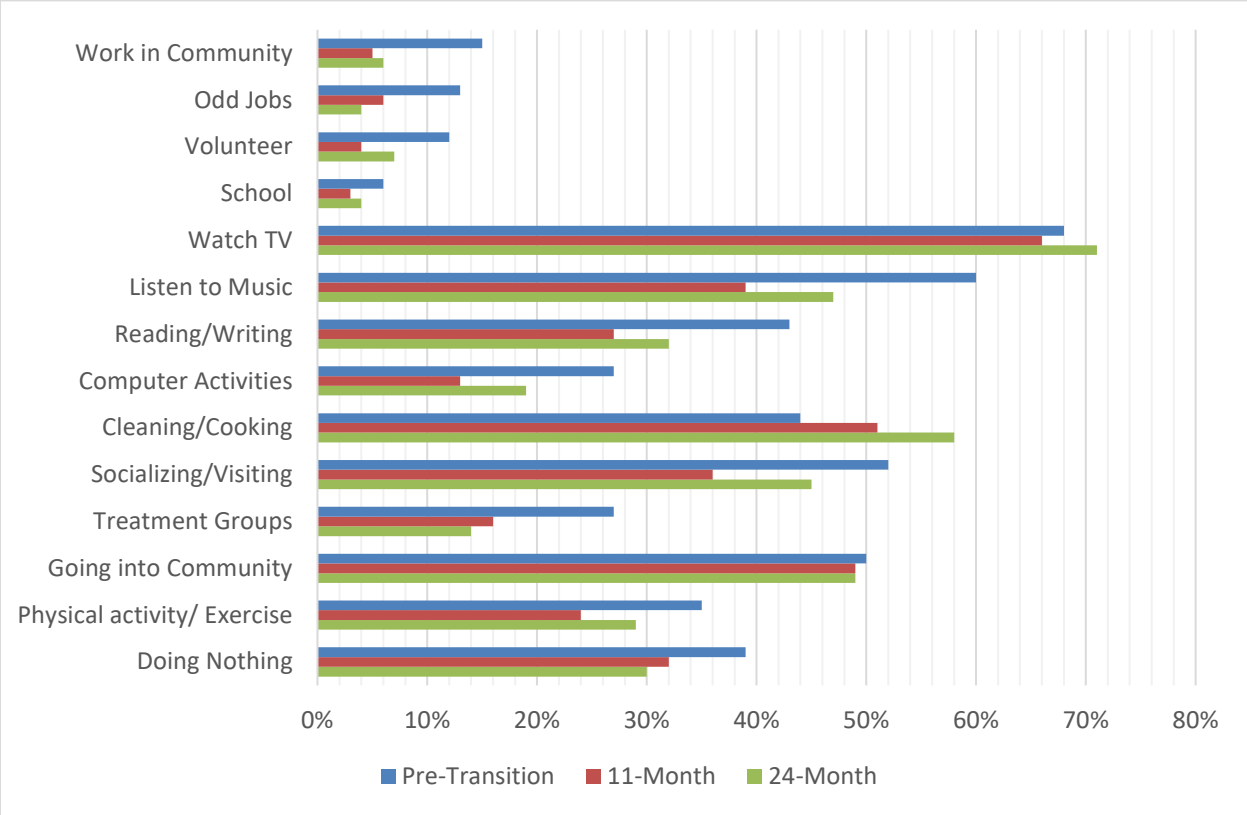
[6] Activities are listed in descending order of the strength of their association with the 3-item CIE measure.

Figure 6: Indicators of Community Integration and Engagement at Pre-Transition, 11 and 24 Months




SFY 2019 pre-transition, 11-month, and 24-month survey respondents did not differ in the average number of typical daily activities they reported (means = 4.3, 4.3, and 4.4). However, the likelihood of some specific activities differed between groups. (See Figure 7.)

Figure 7: How do you usually spend your day?



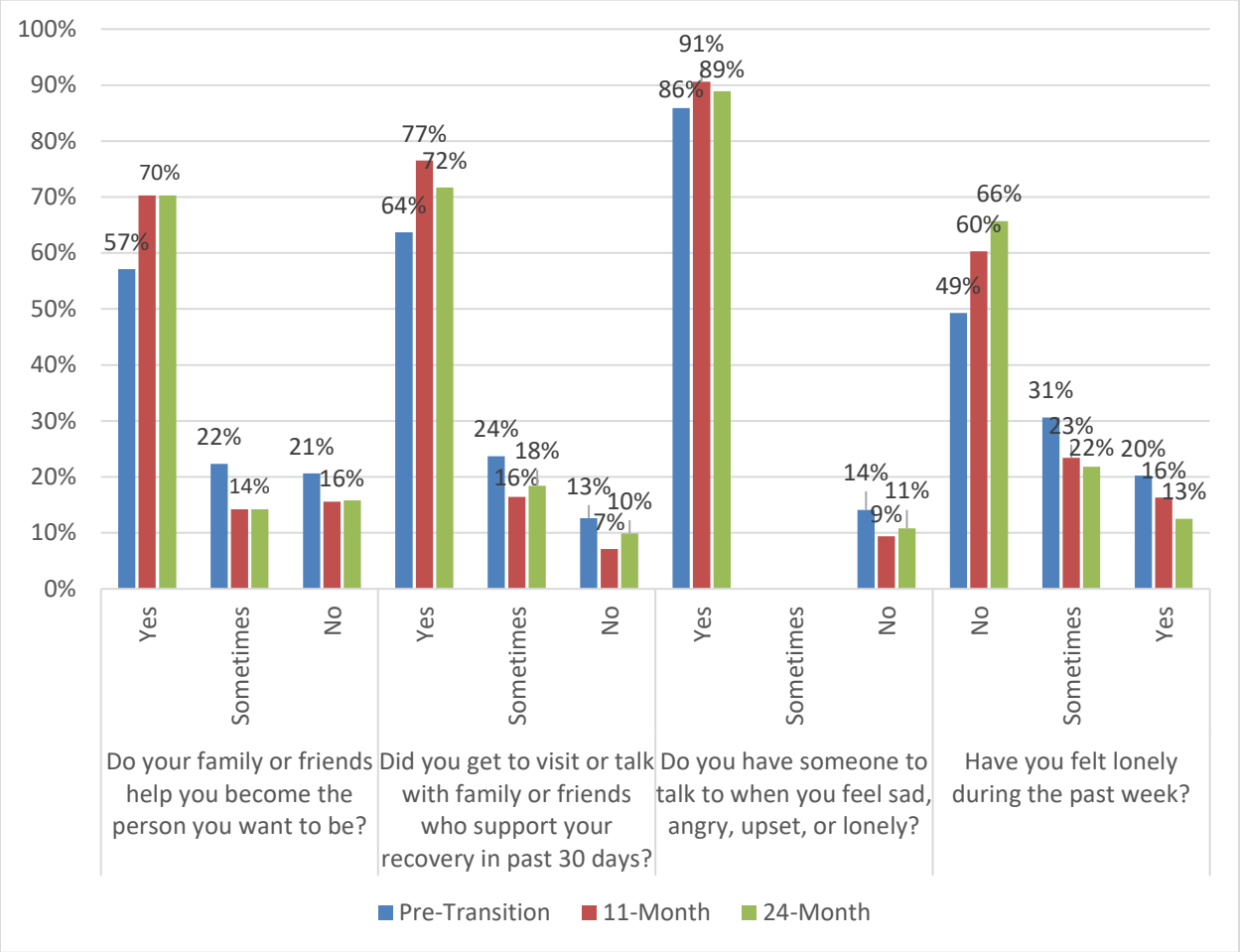
Participants in housing were more like to select Cooking/Cleaning, an activity that was positively associated with CIE, but they were less likely to select other activities associated with greater community integration, including Physical activity, Socializing, and Work. Percentages of housed individuals who selected School were non-significantly lower among post-transition respondents, and percentages who selected Going into town/community did not differ. Compared to individuals responding to pre-transition surveys, significantly lower percentages of housed individuals selected or mentioned Doing nothing/Sitting around/Resting/Sleeping.

*Natural Supports Networks*

Survey items that relate to individuals' natural supports networks (NSN) include: *Do your family or friends help you become the person you want to be? Did you get to visit or talk with family or friends who support your recovery in the past 30 days? Do you have someone to talk to when you feel sad, angry, upset, or lonely? Have you felt lonely during the past week?* As previously shown in Figures 4E and 4F, on average, 74 percent of SFY 2019 follow-up survey respondents selected the answers most indicative of positive support networks, compared to 64 percent of pre-transition respondents.

As Figure 8 illustrates in greater detail, the largest difference was observed between pre-transition and 24-months post-transition respondents' reports of loneliness. Pre-transition survey respondents were approximately one-third more likely to say they had felt lonely during the past week.

Figure 8: Indicators of Natural Supports Network Strength at Pre-Transition, 11 and 24 Months



## Quality of Life and Satisfaction Trends by LME-MCO and Transition Year

Aggregate Quality of Life (QoL) Index and Satisfaction Index scores are based on the 28 survey questions listed in Figures 3A through 3H, and on the ten housing and community satisfaction ratings in Figure 4, respectively. These two aggregate scores for SFY 2019 illustrated the same general pattern and post-transition values as previous years, with significantly higher score values for individuals surveyed at both follow-up points compared to pre-transition respondents. In all LME-MCO catchment areas individuals who had transitioned to supportive housing reported more positive perceptions and experiences.[7] (See Figures 9 and 10.)

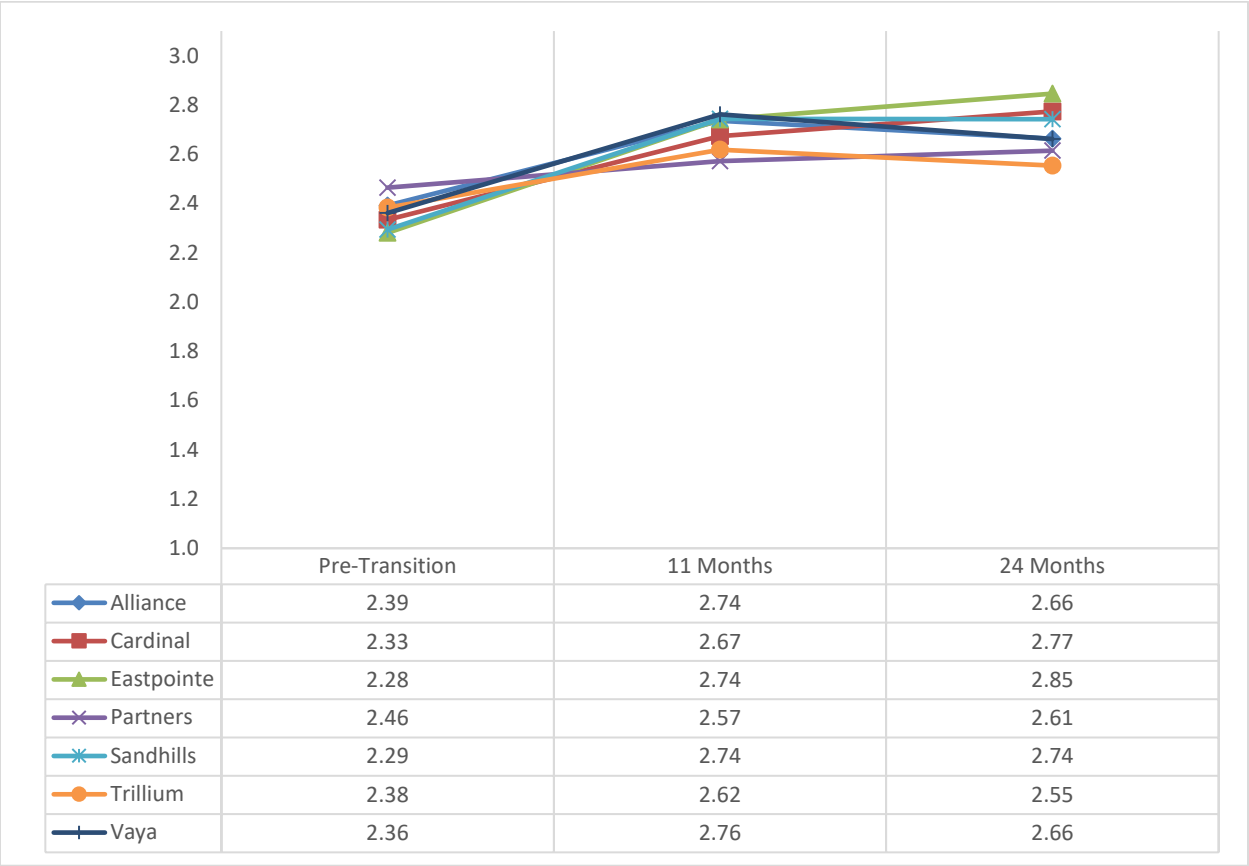
Figure 9: Quality of Life Index by Catchment Area, SFY 2019


| | Pre-Transition | 11-Month | 24-Month |
|---|---|---|---|
| Alliance | 2.71 | 2.89 | 2.87 |
| Cardinal | 2.72 | 2.84 | 2.88 |
| Eastpointe | 2.58 | 2.89 | 2.98 |
| Partners | 2.77 | 2.79 | 2.83 |
| Sandhills | 2.53 | 2.87 | 2.84 |
| Trillium | 2.72 | 2.81 | 2.81 |
| Vaya | 2.63 | 2.86 | 2.83 |

The QoL Index is calculated by converting question responses to numerical scores of 3, 2, and 1 indicating positive, neutral or middle, and negative experiences or perceptions and averaging across item scores. The possible score range is 1.0 to 3.0.

[7] For analyses reported by LME-MCO catchment area, each survey is assigned to the LME-MCO that submitted it or to the LME-MCO with which the submitting LME-MCO later merged. Participants may be housed in and/or subsequently move to different LME-MCO catchment areas.

Figure 10: Satisfaction Index by Catchment Area, SFY 2019



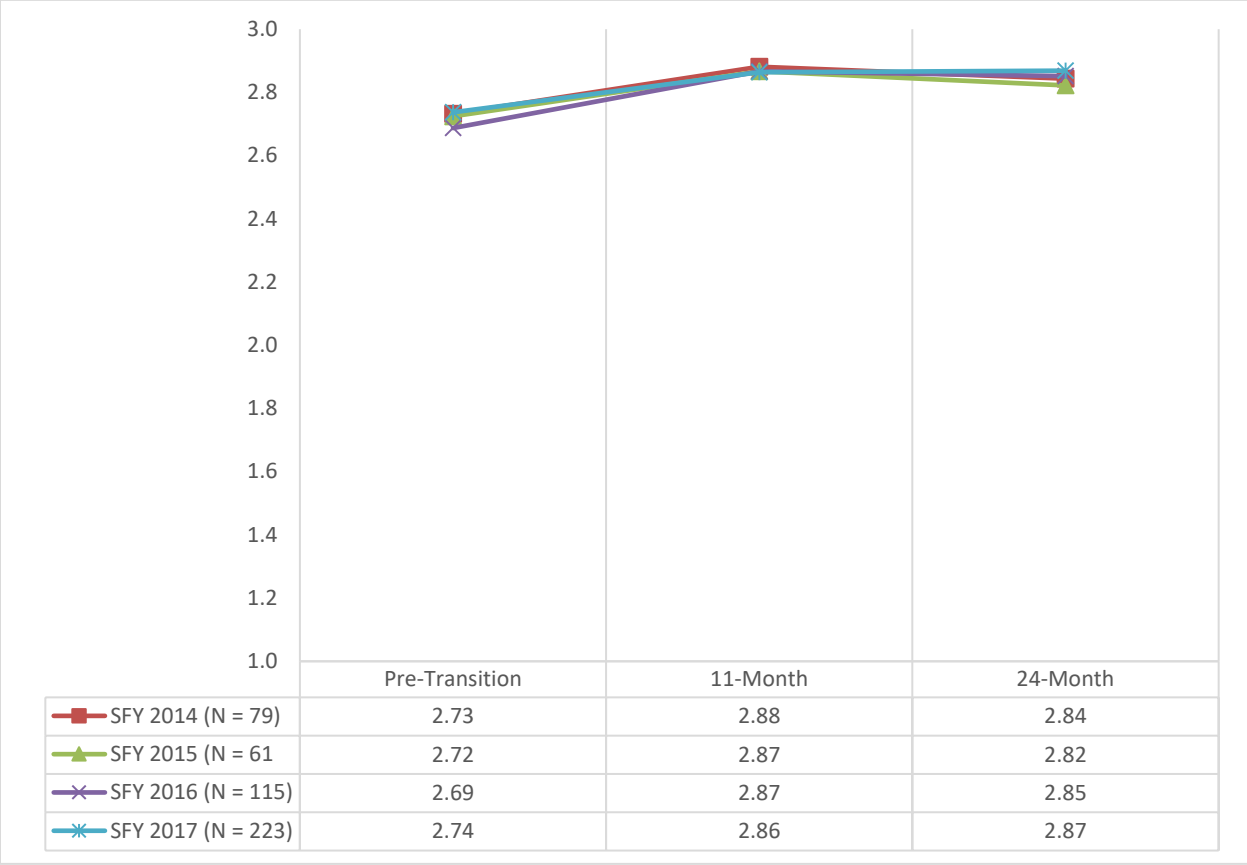

| | Pre-Transition | 11 Months | 24 Months |
|---|---|---|---|
| Alliance | 2.39 | 2.74 | 2.66 |
| Cardinal | 2.33 | 2.67 | 2.77 |
| Eastpointe | 2.28 | 2.74 | 2.85 |
| Partners | 2.46 | 2.57 | 2.61 |
| Sandhills | 2.29 | 2.74 | 2.74 |
| Trillium | 2.38 | 2.62 | 2.55 |
| Vaya | 2.36 | 2.76 | 2.66 |

The Satisfaction Index is computed as the re-coded (Satisfied = 3, No opinion = 2, Dissatisfied = 1) average of the ten housing and community satisfaction ratings for the areas shown in Figure 6. The possible score range is 1.0 to 3.0.

Figures 9 and 10 above suggest significant improvements in quality of life and satisfaction with home and community associated with the transition to supportive community housing. However, except for a small number of respondents who may have completed pre-transition and 11-month surveys both in SFY 2019, these analyses compare the responses of different groups of individuals who completed pre-transition, 11-month, and 24-month surveys during the same year. To assess individual changes over time, comparable analyses were conducted for approximately 500 individuals who transitioned between SFY 2014 and SFY 2017, and who had completed all three surveys by the end of SFY 2019.

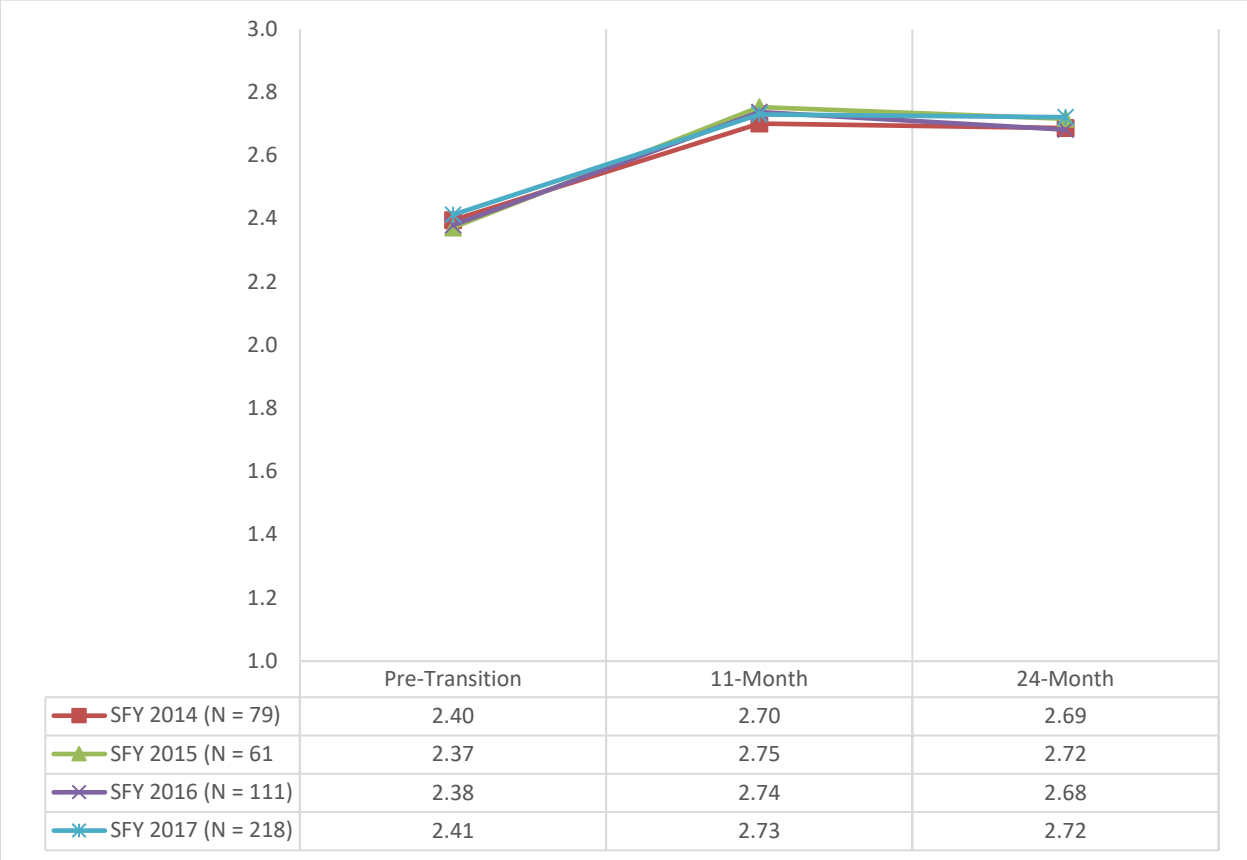
For a more controlled analysis of change over time, survey index scores for the same individuals over time were compared. These analyses confirmed the interpretation of increased quality of life and satisfaction after transitioning to supportive community housing. For both measures, the same individuals' scores were higher at the 11-month and 24-month follow-ups compared to pre-transition, and their 11-month and 24-month scores did not significantly differ. This same pattern was observed for individuals who transitioned in each state fiscal year. (See Figures 11 and 12.)

Figure 11: Individual Change in Quality of Life by Transition Year




| | Pre-Transition | 11-Month | 24-Month |
|---|---|---|---|
| SFY 2014 (N = 79) | 2.73 | 2.88 | 2.84 |
| SFY 2015 (N = 61 | 2.72 | 2.87 | 2.82 |
| SFY 2016 (N = 115) | 2.69 | 2.87 | 2.85 |
| SFY 2017 (N = 223) | 2.74 | 2.86 | 2.87 |

Figure 12: Individual Change in Satisfaction by Transition Year




| | Pre-Transition | 11-Month | 24-Month |
|---|---|---|---|
| SFY 2014 (N = 79) | 2.40 | 2.70 | 2.69 |
| SFY 2015 (N = 61 | 2.37 | 2.75 | 2.72 |
| SFY 2016 (N = 111) | 2.38 | 2.74 | 2.68 |
| SFY 2017 (N = 218) | 2.41 | 2.73 | 2.72 |

**Summary**

Responses to more than 5,000 participant surveys to date indicate that transition to supportive housing through the TCLI program is associated with improvements in individuals' self-reported satisfaction and quality of life. The vast majority of respondents housed through the program, and in many domains significantly larger percentages compared to their pre-transition peers, report positive choice and control in daily activities and satisfaction with staff, services, and housing.

While greater percentages of housed individuals reported positive experiences in virtually every domain queried, however, substantial numbers also reported obstacles to health and wellness, meaningful day, community integration, and natural supports. Responses of one quarter or more of housed individuals to survey questions in these domains indicated less than positive outcomes and challenges to quality of life.

Comparison of responses at 11 and 24 months did not suggest substantial incremental gains in quality of life during the second year in housing. However, results did indicate that individuals who remained in housing also maintained quality of life gains from the initial transition through the second year in housing.

**Appendix B to the Annual Report on North Carolina Supportive Housing Program: 2019 LME-MCO Network Adequacy and Accessibility Analysis Submissions, TCLI Excerpts**

The excerpts included in this Appendix are from 2019 Network Adequacy and Accessibility Analysis LME-MCO submissions. The Analysis is part of a process in which LMEs-MCOs assess service adequacy and accessibility, plan and implement strategies to address inadequacies and areas of inaccessibility, and evaluate progress and outcomes. The Analysis is an annual, joint initiative led by N.C. Medicaid and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS).

**Table of Contents**

# Alliance Behavioral Healthcare

I. Transitions to Community Living Initiative (TCLI)

A. Community-Based Supportive Housing Slots

The following summarizes service gaps, obstacles, and recent activities and projects for the primary TCLI requirements for Community-Based Housing:

a. **Identification and engagement of eligible individuals:** We have experienced a large volume of individuals being referred for Diversion screenings since RSVP came online in November of 2018. At this time In-Reach Specialists caseloads are at capacity so there is barrier to assign individuals who have been identified eligible to In-Reach.

b. **Transition of individuals to community-based supported housing**: Housing availability is extremely limited in Wake/Durham counties. Access to "targeted units" is difficult due to the lack of a real-time inventory availability. While we have made tremendous strides in accessing private units through the TCL Voucher, we are at capacity with current vendors. In FY18 Alliance started a Landlord Incentive program that provided private landlords with incentive payments upon new leases and renewals for TCL participants. Funding was not approved to continue these incentives and it ended in FY19. Landlord risk- mitigation resources also assisted with the recruitment of new landlords. Our other challenge is the dual responsibilities of the transition coordination staff. They are faced with the challenge of balancing new moves and rehousing individuals who have separated from housing – especially those evicted from their units due to lease violations. Also, with the increased referrals due to RSVP implementation in November 2019, Transition Coordinator caseloads are also at capacity. This delays some individuals with getting connected to Transition Coordinators and moving into the community.

c. **Transition of individuals within 90 days of assignment:** Currently Transition Coordinators a backlog of individuals who are past the 90 day benchmark, each one housed will count towards the denominator, but not the numerator for this measure. Certain individuals have housing requirements that can take longer to accommodate, properties that meet such unique criteria may be more difficult to identify.

d. **Support of individuals' housing tenure and ability to maintain supportive community-based housing:** Alliance Transition/Care Coordination is required (per DMH/DMA contracts) for 90 days post-transition. The TCL & Care Coordination team steps back and the expectation is that ongoing support services are delivered by provider agencies. However, this presents many challenges and as of late we are experiencing an increase in the number of housing separations. The TCL Team needs staff capacity to provide ongoing support and monitoring of the contracted TCL providers as it relates to tenancy supports in housing, negotiating and

troubleshooting issues with landlords, and rehousing individuals. Alliance TCL staff also routinely have to check in with providers to get updates on members and there are usually tenancy issues that have been occurring unbeknownst to us. Ideally, Alliance TCL staff should be informed immediately when serious tenancy issues are occurring so we can assist the member or the provider, or intervene with the landlord. Just getting updates and concerns about members from providers has been a recurring challenge for Alliance TCL staff. Having a post transition team would create the staff capacity to do this kind of monitoring and provide better ongoing technical assistance to the providers.

B. IPS-Supported Employment

a. **Network capacity of IPS-SE services:** Alliance contracts with seven teams through five IPS-SE Supported Employment providers, including three providers located in Wake County and one provider each in Cumberland and Johnston counties. Teams are distributed to cover all Alliance counties, and several teams cover multiple counties. Of the seven teams, three cover Wake, two cover Johnston, two cover Cumberland, and two cover Durham. There is a sufficient number of providers for current service need. Our ability to continue to increase the number of individuals served will be dependent on both the ability to add teams as well as increasing funding of services. Of the seven current teams, only one has a waitlist, so the remaining six teams are open to new referrals. Additional gaps or barriers continue to revolve around insufficient rates or reimbursement for licensed clinicians to attend meetings, availability of benefits counselors and the availability of funding to increase rates to support adding benefits counselors to IPS teams, inability for IPS to bill for outreach in adult care homes, and high turn-over rates on IPS Teams. Due to state funding limitations for this service, we have limited new authorization of services to only those individuals meeting the in/at-risk priority population. We were able to convert some non-UCR allocations towards this service and have requested to reallocate some additional funds. This will support the provision of the service for the remainder of FY 19. It will not support the higher recommended rates that accompanied the new service definition and team requirements or opening eligibility back to include non-in/at risk individuals. Due to the uncertainty of the FY20 allocation, there is a concern about the sustainability of increasing rates and expanding eligibility.

| IPS Providers | Community Partnerships (CPI) | Johnston County Industries | Easter Seals UCP Wake | Easter Seals UCP Durham | Easter Seals UCP Cumberland/ Johnston | Service Source | Monarch |
|---|---|---|---|---|---|---|---|
| Counties Served | Wake Durham | Johnston | Wake | Durham | Cumberland Johnston | Cumberland | Wake |
| Team Composition | 1 FTE Team Lead<br>1 FTE EPM<br>2 FTE ESP's | 1 FTE Team Lead<br>2 FTE EPM's<br>1 PT EPM<br>3 FTE ESPs (Johnston County)<br>1 FT EPM (Harnett Co)<br>1 FT ESP (Harnett Co) | 1 FTE Team Lead 2 FTE EPMs 4 FTE ESP's | One FTE Team Lead<br>1 FTE EPM<br>One PT EPM<br>One FTE ESP's<br>1 PT ESP | Team Lead position is currently vacant & IPS Program Supervisor is standing in as TL<br>1 shared EPM on Wake Team 2 FTE ESP's | 1 FTE Team Lead<br>1 PT EPM<br>1 FTE ESP<br>1 PT IPS Administrator | 1 FTE Team Lead<br>1 FTE EPM<br>FTE ESPs |
| Waitlist | *Yes | No | No | No | No | No | No |
| Number of people served in 2018 | 36 | 69 | 58 | 36 | 32 | 22 | 37 |
| Fidelity | Fair | Fair | Fair | Fair | Fair | Good | Fair |

When we look at additional capacity of our IPS teams, we know that all of our teams except for CPI are continuing to take referrals. As noted in the IPS fidelity model as well as the service definition, Employment Support Professionals (ESP's) have the ability to carry a caseload of 25 people. We are also able to note that each team has grown beyond the minimum team size which confirms that our providers are willing to expand teams to meet referral numbers if necessary.

CPI was able to fill their IPS Team Lead position and add a staff member this fiscal year. Individuals on the waiting list/interest list are told approximate wait times and informed of other agencies that provide IPS-SE. Factors that contribute to having an interest list: needing all appropriate documentation for eligibility, training new staff, locating individuals who've been referred for services. They are also prioritizing any TCL referrals.

b. Engagement and referral of TCLI priority population: Alliance has increased the number of individuals newly enrolled in IPS-SE that meet the in/at risk of ACH over the past couple of years. Our primary focus this year has been increasing the number of TCLI eligible individuals (all phases – In-Reach, Transition, Post-Transition) among the number of in/at-risk individuals newly served. As mentioned previously, communications with DMH have resulted in the conversion of funds to apply to this service. It is also anticipated that our recent request for additional fund conversion will take place to sustain the services for completion of FY19. Additionally, information was shared about what would be required in order to increase rates and maintain sustainability moving forward.

As of 4/30/2019, it appears we had newly served 40 individuals who met in/at risk criteria; the goal set by DMH for this fiscal year is 60. If outreach to individuals were billable, that might assist with increasing the number of individuals meeting in/at risk criteria who receive the service.

We are hopeful that more of our IPS-SE providers will reach "good" fidelity. We only have one of seven teams in this category – the others are in the "fair" fidelity category (while several are close to 'good'). This increase in fidelity will result in a higher reimbursement rate for the providers which will make the service more sustainable for their agencies. With additional funding, the agencies may be able to reach a higher fidelity level. As mentioned above, if IPS teams were able to bill for meeting with individuals to discuss IPS prior to authorization, it would be beneficial. Recent, or ongoing, activities to increase referral of TCLI population include:

- Ongoing monthly IPS Collaborative. Members from the TCL Team continue to attend the collaborative and invitations are also extended to the TMS Providers to link more TCL individuals with IPS services and providers.
- Continued use of a TCL Referral form to identify TCL members as part of the priority population for providers.
- Additional trainings to In-Reach staff was provided on IPS-SE

- Monthly reminders to IPS-SE providers to update in/at risk checklists with additional or new information that might demonstrate an individual meets in/at risk of ACH criteria.

C. Community-Based Mental Health Services

The following summarizes the array, intensity and sufficiency of community-based mental health services provided to individuals living in supportive housing, as indicated by individuals' ability to obtain and maintain stable housing and by other personal outcomes indicative of greater integration in the community.

At the end of December 2018 there were 246 individuals living in supportive housing, while there are well over 1000 individuals in the In-Reach phase and about 80 in transition.

Not all of the requested information for individuals living in supportive housing is readily available or currently tracked or requested. TCLI follows the individual for the first 90 days the individual is in housing, but we do not have a "post-transition" team. The provider agencies are responsible for providing tenancy support and behavioral health services once the individual moves in to their own place. Please let us know if we should be collecting certain types of data.

- Hospital, adult care home, or inpatient psychiatric facility admissions: if an individual living in supportive housing enters an adult care home they would not be counted as being in housing. In addition, we do not track inpatient psychiatric and hospital admissions for this population. We could search paid claims but we do not have a modifier to identify which stage of TCLI a person is in.
- Use of crisis beds and community hospital admissions: While this is not something we track specifically to TCLI, however we were able to obtain a report and identified 71 individuals in housing who utilized mobile crisis and facility-based crisis from July 1, 2018-April 30, 2019. We do not have data readily available for community hospital admissions for this subset of individuals living in supportive housing.
- Emergency room visits: This report is not one that is currently generated as our identifier is TCLI for all individuals eligible for the settlement. If this is an area that should be compiled, we will start making arrangements with claims. Without post-transition coordination we have no ability to keep track of the information on a real-time basis.
- Incidents of harm: again, we do collect this information. There are many incidents of harm that occur with TCLI individuals in housing. We are only informed directly by the providers if there is an incident report that must be submitted to the LME-MCO.
- Time spent in congregate day programming: Based on our individual records, there are 11 individuals in housing who are receiving PSR. It should be noted that approximately half of TCLI individuals in housing receive ACT services and are ineligible to receive other behavioral health services. In addition, PSR should be focusing on psychosocial rehabilitation rather than day programming.
- Employment: Detailed information about IPS-SE at Alliance and our network providers is available as we track and report the information to DHHS monthly for the state's TCLI Dashboard. We have had 115 individuals newly enrolled in the IPS-

SE service from July 1, 2019-April 30, 2019. Of these, 34% (39) met the criteria for being in or at-risk of entry to an adult care home as outlined in the Settlement Agreement. Our efforts to connect TCLI individuals to IPS-SE continues to be a challenge. Based on claims data twenty five TCLI members received IPS-SE during this same timeframe.

- School attendance/ enrollment: Information is not reported or tracked by Alliance.
- Engagement in community life: We had experts from Temple University and UNC Center for Excellence provide a 1 ½ day training for ACT and TMS providers focused on Community Inclusion. The half day was for Provider Agency Leadership and Team Leads and the full day targeted the Team leads as well as other Team Members. This was to jump-start the Community Inclusion Initiative. This initiative includes the implementation of value based payments for providers increasing Community Inclusion with individuals living in the community who are identified as TCL. Another component of this Initiative includes opportunities for ongoing coaching and technical assistance from both Temple University and UNC Center for Excellence. More specific information about the outcome of this initiative will be available after May 2019.

This section also addresses service needs and gaps, obstacles and barriers, and actions taken to address identified gaps and barriers.

<u>Sufficiency of service array</u>:

- IPS-SE – there is a sufficient number of providers for current services need. Eligibility for state-funded IPS-SE has been limited to those who meet in/at risk criteria due to limited funding.
- ACT – there is a sufficient number of providers – however there is a need for an increased focus on tenancy and employment supports for individuals receiving service. Also, due to limited state funds there is a reduction in service capacity for members who do not receive Medicaid. Although there have been a high number of screenings completed through RSVP, it is still unclear with its recent implementation how capacity of the network will be impacted.
- Peer Support – Alliance has a robust provider network with plenty of capacity. However, we appear to be underutilizing this service with our TCLI population. TMS – Two agencies (Easter Seals/UCP & B&D) had one team each throughout FY18. In order to meet service definition requirements each agency expanded to two teams as of July 1, 2018. One provider is growing a 3rd team. Both providers are hiring new staff in order to accept our increasing number of referrals as well as due to turnover. With the uncertainty of this service due to the pending CST policy changes, the providers are very concerned about any new hiring/expansion. It was projected that the original allocation for FY19 TMS would not support the current utilization.

Service gaps, obstacles and actions taken to resolve them

The primary service gaps for the TCLI population are community engagement, natural supports development, and choice in daily living. While provision of behavioral health and tenancy focused services is essential, these services do not fully address all of the needs an individual has in order to be engaged in the community.

For this reason, we had experts from Temple University and UNC Center for Excellence provide a 1 ½ day training for ACT and TMS providers focused on Community Inclusion. The half day was for Provider Agency Leadership and Team Leads and the full day targeted the Team leads as well as other Team Members. This was to jump-start the Community Inclusion Initiative. This initiative includes the implementation of value based payments for providers increasing Community Inclusion with individuals living in the community who are identified as TCL. Another component of this Initiative includes opportunities for ongoing coaching and technical assistance from both Temple University and UNC Center for Excellence.

During the Community Inclusion Initiative, ACT and TMS teams also are able to apply for financial assistance from First in Families to aid individuals in their pursuit of community inclusion activities. We also continue to facilitate the ACT Collaborative monthly and have brought in subject matter experts to come in and present information to the teams, focusing on Whole Person Care as well as Medicaid Transformation. We continue to emphasize the importance of tenancy and employment and work with the teams to develop strategies to improve in these areas. When reviewing housing separations, the ACTT providers are included in this discussion to examine and identify contributing factors and areas of improvement.

Our challenges are two-fold – funding and provider engagement. Adequate funding is critical to support our providers in the delivery of services – primarily with TMS and IPS-SE. We plan to develop strategies to have performance based payment for providers who are supporting our TCLI individuals, and we also plan to increase provider accountability.

The expansion of TMS teams has not been extensive, in part due to the upcoming implementation of the revised CST service definition. Currently the TMS teams are continuing to grow. We now have 5 teams covering Alliance's catchment area. In order to be prepared for the increase of enrollment we requested a waiver for additional staff and members that can be served. The recent allocation that was received for TMS services will support the sustainability and level of service delivery required for the remainder of FY19.

We are hopeful that more of our IPS-SE providers will reach "good" fidelity. We only have one of seven teams in this category – the others are in the "fair" fidelity category (while several are close to good). This increase in fidelity will result in a higher reimbursement rate for the providers which will make the service more sustainable for their agencies. With additional funding the agencies may be able to reach a higher fidelity level.

In regard to Peer Support, the challenge will be making sure that providers are working collaboratively and have a clear understanding of roles. TMS has a peer support component and in many cases the peers are working most closely with individuals that are transitioning to or in supportive housing. The addition of the b3 Peer Support service can be duplicative without clarification – TMS peers focus

primarily on tenancy and b3 service peers focus primarily on recovery. The work often crosses over. By providing additional education for both providers we can reduce role confusion and hopefully offer b3 Peer Support to more TCLI individuals.

Additional steps taken to address service-specific gaps include:

- IPS-SE – As mentioned before, we limited eligibility for state-funded IPS-SE and converted non-UCR funds to UCR funds to help manage limited funding. It is understood that the IPS Teams will incur an increased expense with the new service definition and that it is difficult to meet the new staffing requirements without an increase in reimbursement. We have communicated with DMH about funding needs and issues related to sustainability.
- ACT –During FY19, we have continued to host monthly ACT Collaborative meetings and TCL staff members attend the meetings to continue educating providers about TCLI. We have emphasized the importance of tenancy and employment, and we work with the teams to develop strategies to improve in these areas. Alliance is working collaboratively with the ACTT Providers to determine the best way to report and monitor meaningful data regarding outcomes, natural supports, and engagement with members. To help with this, providers self-reported data on contacts with individuals, percentage of individuals who had natural supports involved, and employment for a few months as we have worked though the best way to collect data. For FY20, we are going to use data collected via NC TOPPS. Analyzing data will help us look at trends, consider alternative methods of payment, and evaluate the impact of increased Community Inclusion, especially as it relates to community tenure.
- Peer Support – We recently become aware of the underutilization of this service and plan to review service eligibility of individuals receiving TMS. In addition will be working with In-Reach staff to fully incorporate the discussion of this during visits.
- TMS – We had experts from Temple University and UNC Center for Excellence provide a 1 ½ day training for ACT and TMS providers focused on Community Inclusion. The half day was for Provider Agency Leadership and Team Leads and the full day targeted the Team leads as well as other Team Members. This was to jump-start the Community Inclusion Initiative. This initiative includes the implementation of value based payments for providers increasing Community Inclusion with individuals living in the community who are identified as TCL. Another component of this Initiative includes opportunities for ongoing coaching and technical assistance from both Temple University and UNC Center for Excellence.

D. Crisis Services

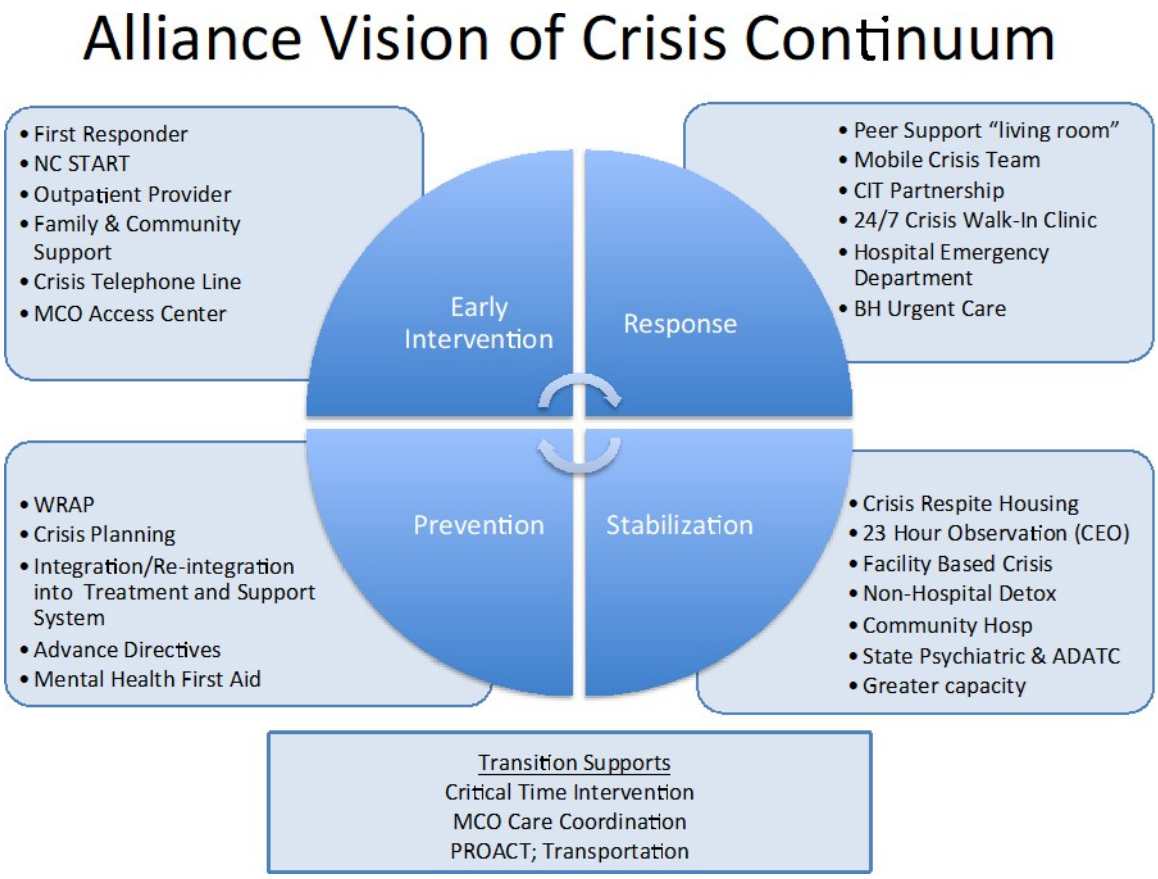
Alliance continues to invest significant resources to expanding the crisis continuum to avoid unnecessary hospital utilization, incarceration and institutionalization. Like most other communities, ours are challenged with maintaining enough services to meet the needs. In each of our four counties, there is an active crisis collaborative that consists of hospitals, community partners, law enforcement, and crisis facilities and service providers who regularly gather to discuss and address challenges in our crisis continuum. We work together to identify needs and how to meet those needs. The current crisis continuum is organized in such a way that it

provides services at the right place, right time, and with the right amount. The goal is to address crises in the least restrictive setting while ensuring that people receive the appropriate treatment to avoid future crises and/or unnecessary utilization of services that do not meet their needs. At each level, within each service, it is the expectation of the provider to consider the individual's crisis plan. As part of the contracting process, Alliance develops scopes of work for crisis services that provide detailed expectations for engagement, clinical treatment, and follow-up.

The following provides an update on the network adequacy of the LME/MCO crisis service system and its capacity to offer timely and accessible services and supports to individuals experiencing a behavioral health crisis. This scope of this summary applies both to the TCLI population as well as all individuals covered by the Alliance network. Additional information is provided about identified crisis continuum gaps and barriers, as well as actions taken to address identified gaps and barriers

Network adequacy of the Alliance crisis continuum

Alliance is committed to developing a comprehensive, accessible and effective crisis continuum within each of its communities and is working to develop a crisis continuum that includes service and support components in each of four levels of care: 1) Early Intervention, 2) Response, 3) Stabilization, and 4) Prevention. The services within each level are listed in the chart below, and a more detailed overview of the Alliance crisis continuum is included in **Appendix C**.




As the tables in **Appendix B**[1] show, there continue to be challenges with offering consistently timely response and stabilization services to all individuals experiencing a behavioral health crisis in each Alliance community. Areas of highest need include:

- Lack of inpatient psychiatric beds
- High volume at local crisis facilities
- Lack of state and county funding to expand walk-in crisis services in each county
- Frequent utilizers/familiar faces utilizing the ED for primary behavioral health care.

A continued key consideration as it relates to providing adequate and effective crisis services in the least restrictive setting is the availability of services at every point of the crisis continuum in each county. For example, individuals without insurance who face a crisis are generally able to access immediate crisis services, yet, the lack of funding for additional outpatient therapy capacity may keep them from accessing the appropriate follow-up care.

[1] Please note the Appendixes can be found in the complete Network Adequacy and Accessibility Analysis Submission

**Actions taken to address gaps and barriers**

During FY19, Alliance continued to develop the crisis continuum through the initiatives described below. These actions were priorities for the Alliance Network Development Plan, and additional information is available in **Section Five** below.

- Behavioral Health Urgent Care: this is an innovative model and increases community walk-in capacity and has expanded hours of operation. Services include brief assessments and on-site prescribers for the duration of operating hours. This service was added in Durham in FY18 and expanded to Wake County in FY19.
- Enhanced Mobile Crisis Pilot with Wake EMS: this model enhances the current Mobile Crisis Management model to improve timeliness of mobile crisis response. Licensed clinicians are embedded with Advanced Practice Paramedics to respond to individuals in the community in a timelier manner than is typically experienced with most mobile crisis responses. This project began early 2019.
- Cumberland County Crisis: After reviewing the effectiveness of MH/SUD services to individuals in crisis, Alliance decided to release a Request for Proposals to choose a new provider for the Cumberland crisis facility. Recovery Innovations was selected as the provider and will begin operations in the fall of 2019.

## Cardinal Innovations Healthcare

The TCL section explores recent activities and projects related to the community-based supportive housing slots, including the gaps and obstacles and experienced. In addition, Individual Placement and Support – Support Employment (IPS-SE), community-based mental health and crisis services are examined in relation to the TCL program, including gaps and barriers experienced.

No service gaps were identified for those in the TCL program but gaps were identified involving transportation, choice of ACTT providers meeting fidelity and providing ongoing tenancy support. For IPS-SE no service gaps were identified, but the following challenges were identified: staff turnover, lack of staff training in Benefits Counseling and inadequate state funding exist. While there are not any known gaps with community-based mental health services, such as outpatient therapy, medication management or crisis services, the following are noted as needs or barriers:

- Increase understanding of effective delivery of services (ACTT, IPS-SE, CST, PSS, TMS) specific to the TCL population
- Reduce transportation issues by educating members and group home providers
- Increase coordination of care across service providers
- Increase skills to minimize risk for eviction, and address social isolation as topics for the learning collaborative facilitated by Cardinal Innovations for providers (including ACTT and IPS-SE providers)

Most TCL members are supported within the community if they experience a crisis. This is reflected by mobile crisis services, emergency department visits and inpatient stays remaining low – 20% of members experienced a crisis event between April 2015 and October 2018.

As indicated in the Quality of Life surveys, there are significant increases in several of the community integration and personal outcomes data in the TCL program such as having enough to do, satisfaction with how the day is spent, doing things desired in the community, access to money when wanted and able to eat when wanted.

Activities are occurring across the network to close gaps such as:

- Increased nursing support
- Population health management
- Monitoring number of ACTT visits
- Training in Person Centered Planning and Crisis Plan development

Transitions to Community Living

### *(A) Community-based Supportive Housing Slots*

Cardinal Innovations serves those in the Transitions to Community Living (TCL) program in the most efficient and diligent manner possible. There are no identified service gaps, but obstacles

and barriers do exist for members in the TCL program. These include transportation, finding an ACTT provider who is accepting new members and providing ongoing tenancy support.

- Lack of transportation causes challenges in completing Comprehensive Clinical Assessments (CCA) to determine if those who choose to remain in Adult Care Homes (ACH) are eligible for Individual Placement and Support- Supported Employment (IPS-SE) and other services. Members often are unaware of transportation options and group home transportation is sometimes sparse. To address this need, group homes are being asked to improve their transportation capabilities. In addition, efforts are under way to teach members who have Medicaid about transportation options. Cardinal Innovations has added an online tool to its website at https://localresources.cardinalinnovations.org/. This tool can be used to search for local social services resources such as transportation and housing.
- Choice of ACTT providers becomes an obstacle when a member chooses a provider who has met the fidelity measure of admitting four to six members, but who cannot accept a new member. To address this issue, Cardinal Innovations facilitates a bi-monthly Learning Collaborative with providers.
- Better training on ongoing tenancy support is needed for ACTT providers to reduce separations due to evictions and abandonment. Through the Learning Collaborative, Cardinal Innovations is working with ACTT providers to improve tenancy support (e.g., landlord and navigations skills, mastering ADLs, utility use and management, community integration).

Cardinal Innovations also has engaged in several activities to improve the TCL program and help members maintain supportive community-based housing:

- Population Health Management: Population Health Management supports members after they move from ACHs to their own homes. Cardinal Innovations implemented new resources to better identify issues as early as possible in order to help the member maintain supportive community-based housing. Members are followed by TCL Care Coordinators and Population Health Specialists for the first six months after they move. At the beginning of the seventh month, members will be contacted by telephone every other month by our Population Health Specialists. The Specialists ask a few, brief questions to determine if the member is experiencing any difficulty with behavior health symptoms, tenancy issues, and/or medical concerns. If the member needs further face-to-face assistance, the Specialist contacts the TCL team.
- Increased Nursing Support: We have added Registered Nurses (RN) to the Diversion, Pre-Transition, and Post-Transition TCL teams to identify and address medical concerns.
- In addition, we are able to offer medical education to help members learn to better manage their medical conditions.

### *(B) Individual Placement and Support - Supported Employment*

Cardinal Innovations Healthcare has five contracted providers of IPS-SE, for a total of eight teams. All teams have met fidelity (achieved or exceeded expected benchmarks) on national standardized measures and all regions are served by one or two teams. Training led by the Department of Vocational Rehabilitation was held for IPS-SE providers to support teams in seeking vocational rehabilitation milestone payments as required in the new service definition. As of March 30, 2019, 370 members had received IPS-SE services in Fiscal Year 2019, and all teams had capacity to serve additional members pending no staff vacancies. Although there were no specific service gaps identified for IPS-SE, a second IPS-SE team was added in February for Mecklenburg County to meet the existing need and allow for choice. It was also believed a second team was necessary to meet the need of anticipated moves of TCL members and the onset of Referral Screening Verification Process (RSVP). The RSVP is an assessment process to determine if a member meets eligibility for TCL. Providers continue to report the same challenges to providing this service efficiently and effectively for members of the TCL priority population, including individuals with SMI living in community-based supportive housing and individuals living in or at risk of entry to adult care homes. Identified challenges include:

- Staff turnover which creates temporary access issues while new staff are being hired and trained
- Complications when the individual is receiving services from one provider and a combined Person-Centered Plan needs to be created/updated
- Locating viable employment options for members living in one region but who are moving to another
- Lack of staff being trained to provide Benefits Counseling
- Inadequate state funding to continue milestone payments to providers

### *(C) Community-based Mental Health Services*

It is important that individuals living in supportive housing have access to mental health services to ensure a successful transition. Outcomes show that access to these services are an indicator of the individual's ability to obtain and maintain stable housing, as well as integration to the community.

Members involved in TCL have access to an array of community-based behavioral health services (e.g., Assertive Community Treatment Team (ACTT), Transition Management Services (TMS), Community Support Team (CST), Peer Support, Psychosocial Rehabilitation (PSR) and Individual Placement and Support- Supported Employment (IPS-SE). The separation rate for Cardinal Innovations' TCL program averages 24%. While this includes reasons beyond the organization's ability to impact -
- death, moving in with family or friends, incarceration, long-term behavioral health or medical treatment – Cardinal Innovations recognizes the need to further reduce separation rates and address post-move needs. To address these needs, the organization has:

- Developed training for ACTT providers on how to help members maintain housing and housing specialists' duties
- Launched a Bridge Housing pilot program to help divert members from entering adult care homes while identifying and improving the member's independent living skills

A lookback of members that were in transition or Post-transition between April 2015 and October 2018, revealed the following service trends:

- Out of the 676 members in transition or that transitioned to the community, 586 (95%) members were engaged in a least one service
- Approximately 51% of members received ACTT services, while 49% received TMS
- Mobile Crisis services, emergency department visits and inpatient stays remained low – 20% of members experienced a crisis event during that time
- One hundred ninety-three (29%) of TCL members received Peer Support Services

Personal Outcomes and Community Integration

Personal outcomes and community integration data comes from the Quality Of Life (QOL) survey. Developed by DHHS, the QOL surveys assesses whether, to what extent, and in which areas individuals who transition to supportive housing in the community experience improvements in the quality of their daily lives. The surveys are designed to assess consumer perceptions and satisfaction related to housing and daily living, community supports and services, and personal well-being.

Surveys are administered in person during the transition planning period and again 11 and 24 months after the individual's transition to the community. LME-MCOs then submit survey responses through the State's secure, web-based survey tool.

The survey data reflects 1,343 surveys from April 2014 to February 2019 and includes the following:

- A total of 795 pre-transition surveys (member responses before they move)
- A total of 371 11-month surveys (member responses after being housed for 11 months)
- A total of 177 24-month surveys (member responses after being housed for 24 months)

As shown in the table below, there are significant increases in several of the community integration and personal outcomes data in the TCL program such as having enough to do, satisfaction with how the day is spent, doing things desired in the community, access to money when wanted and able to eat when wanted. Highlights for the 24 month surveys include:

| Question | Answer | Pre- Move | 11 Month | 24 Month | Change |
|---|---|---|---|---|---|
| Do you feel like you have enough to do? | Yes | 48% | 71% | 74% | 26% |
| Are you Satisfied with how you spend your day? | Yes | 50% | 75% | 76% | 26% |
| Do you feel safe where you live? | Yes | 74% | 86% | 89% | 15% |
| Do things in the community when you want? | Yes | 61% | 78% | 86% | 25% |
| Do you have Access to Money when you want it? | Yes | 63% | 88% | 89% | 26% |
| Can you eat when you want? | Yes | 68% | 98% | 98% | 30% |
| In past 30 days, have you talked/visited with family/friends who support your recovery? | Yes | 67% | 76% | 80% | 13% |
| Do your family and friends help you become the person you want to be? | Yes | 60% | 72% | 72% | 12% |

In regard to community inclusion, members reported the most significant changes in satisfaction with neighbors, landlords, and location of home:

| Question | Community Inclusion Domains | Answer | Pre-Move | 11 Month | 24 Month | Change |
|---|---|---|---|---|---|---|
| **Are you satisfied with the following:** | Shopping | Yes | 66% | 88% | 90% | 24% |
| | Transportation | Yes | 66% | 88% | 90% | 24% |
| | Church/House of Faith | Yes | 58% | 71% | 68% | 10% |
| | Parks and Open Spaces | Yes | 57% | 77% | 74% | 17% |
| | Recreation (bowling alley, movie theater) | Yes | 59% | 70% | 74% | 15% |
| | Healthcare Providers (doctor, pharmacy) | Yes | 86% | 90% | 90% | 4% |
| | Location of Home | Yes | 61% | 85% | 89% | 28% |
| | Homes Maintenance | Yes | 62% | 80% | 89% | 27% |
| | Neighbors | Yes | 55% | 85% | 84% | 29% |
| | Landlord | Yes | 54% | 85% | 82% | 28% |

***Gaps, Needs, Barriers and Obstacles in the Community-based Mental Health Services for Individuals in Community-based Supportive Housing***

While there are not any known gaps with outpatient therapy, medication management or crisis services, the following are noted as needs or barriers:

- Increase understanding of effective delivery of services (ACTT, IPS-SE, CST, PSS, TMS) specific to the TCL population
- Reduce transportation issues by educating members and group home providers
- Increase coordination of care across service providers
- Increase skills to minimize risk for eviction, and address social isolation as topics for the learning collaborative facilitated by Cardinal Innovations for providers (including ACTT and IPS-SE providers)

*Recent Activities*

Cardinal Innovations is monitoring the number of encounter visits provided by ACTT to assess frequency and intensity of service delivery for our members. Continuous monitoring occurs when the individual has any of the following services: ACTT, IPS-SE, CST, PSS and TMS. A training specific to ACTT providers was developed to further understanding of how to assist members in sustaining housing or with re-housing as needed.

### *(D) Crisis Services*

Most TCL members are supported within the community if they experience a crisis. This is reflected by mobile crisis services, emergency department visits and inpatient stays remaining low – 20% of members experienced a crisis event between April 2015 and October 2018. Crisis plans are updated when a crisis occurs, and are reviewed by Utilization Management Care Managers.

Crisis services are provided in the least restrictive setting possible. The services are consistent with:

- An already developed individual community-based crisis plan, or
- In a manner that develops such a plan as a result of the crisis situation, and
- In a manner that prevents unnecessary hospitalization, incarceration or institutionalization through:
    - Open access/walk-in appointments with the Comprehensive Community Clinics within the network, and
    - ACTT providers remaining actively engaged with members using emergency department or inpatient services

*Recent Activities*

Person-Centered Plan training, including crisis plan development, is offered throughout the Cardinal Innovations service area. It is open to all providers. Providers that have routinely struggled to coordinate with other service providers on one plan for members were specifically invited to attend this training.

# Eastpointe

A. Community-Based Supportive Housing Slots

Implementation of the Transitions to Community Living Initiative (TCLI) presents multiple challenges. Obstacles and barriers exist that limit the TCLI population size, constrain program capacity, and hinder the transition process. Eastpointe engages with members, stakeholders, and its communities to understand root-causes and to address these obstacles and barriers.

The barriers that exist around identifying eligible individuals in the TCLI priority population stem from a lack of understanding around eligibility requirements, as criteria to identify eligibility is sometimes inaccurate. There is a quality improvement project in place to educate members and providers about TCLI eligibility requirements. A focal point for Eastpointe involves efforts to educate community stakeholders and assisted living facility providers on the eligibility requirements and benefits to members of TCLI.

Eastpointe's educational outreach programs are directed to staff and member residents of group living facilities such as adult care homes (ACH). Not all group living facility staff and ownership are aware of the eligibility requirements and the important benefits of TCLI. ACH providers in particular express concern over the loss member residents who transition into the community via TCLI. This lack of understanding of TCLI eligibility requirements and benefits may lead to a lack of cooperation by the ACH staff with Eastpointe staff. An ACH may, for example, decline to allow Eastpointe staff to enter the facility to meet with member residents. Eastpointe may require the assistance of a housing liaison. This approach helps to establish cooperation and critically leads to a more informed choice for the member.

Eastpointe additionally faces environmental obstacles and barriers. The Eastpointe catchment area suffered multiple hurricanes and other natural disasters during FY2018. The aftermath of these natural disasters presented a number of challenges for the TCLI population in terms of community-based supportive housing slots. Many rental properties in the Eastpointe catchment area were badly damaged or destroyed, forcing people out of their homes either permanently or temporarily while repairs were made. Due to the large number of homes in need of repair, the lack of developers and repair companies in the area, and difficulties in securing funding, many people were either unable to get the repairs they needed to be able to live in their homes or were forced to find housing elsewhere.

Other obstacles and behaviors may hinder providing access and transitioning individuals to community-based supported housing. Delays can be attributed to lengthy assessments completed by the providers and/or a lack of referral documentation. The North Carolina Department of Health and Human Services implemented the Referral Servicing Verification Process (RSVP) as of November 1, 2018. It includes new mandates on documentation required for referrals. With the new system, providers, family members, and members often fail to provide the accurate referral documentation needed. Adoption of the new referral system is slow as providers train and learn how to use RSVP. The lack of education and awareness on how to use the new referral system necessitates individual referral

guidance and follow-ups that impede transitions.

Finding housing to match member preferences presents another set of obstacles and barriers to the transition process. Eastpointe provides TCLI members choice in the housing selection process. Members can decline all housing options offered for any reason, including reasons not necessarily unrelated to the appropriateness and/or quality of the housing options.

Family members also influence member housing choices. This is an additional challenge to promptly transitioning members into community-based supported housing. Family members may disagree that it is in the best interests of the TCLI participant to rejoin the community. Family members dissuade the member from transitioning into the community by encouraging the member to decline housing options. This can occur if family doubt the capacity of the member to live independently in the community.

Of those members who do transition into community-based supported housing, stability is a persistent challenge. This challenge is greater for dual-diagnosed individuals, particularly those with a substance use disorder. These high-risk individuals have a difficult time maintaining stability and independence in a home. Behavioral issues stemming from the substance use disorder contribute to discord with neighbors and community members. These behaviors can lead to further isolation and relapse.

Additional obstacles and barriers exist in the management of the TCLI program. Fragmented data sourcing inhibits comprehensive, accurate, and timely data analysis. Currently, Eastpointe enters TCLI data into three disparate databases. The state-initiated development of system enhancements to reduce redundancies, streamline processes, and to centralize data sources. Implementation of the new system is pending.

Eastpointe identifies and engages TCLI-eligible individuals via multiple approaches. Eastpointe presents at provider forums. Provider forum presentations build awareness and help to educate the provider network about eligibility requirements.

Eastpointe additionally hosts housing presentations and housing collaborative meetings. The target audience is adult care homes. The housing presentations and housing collaborative meetings help improve communication and understanding. The goal of this approach is to improve collaboration to better identify and transition TCLI eligible individuals.

Eastpointe employs a focused task group to coordinate these efforts. The task group identifies and monitors implementation. Stakeholder engagement is a priority. Eastpointe aims to expedite the member transition once a provider is identified via a closer collaboration between all stakeholders. Efforts to develop more direct relationships and lines of communication with providers support this priority.

When transitioning individuals within 90 days of assignment to a transition team, Eastpointe takes multiple steps to give members choice and access. Staff help by physically showing members different properties as well as maintaining a dashboard to track activities and statuses.

Regarding supporting individuals' housing tenure and ability to maintain supportive community- based housing, Eastpointe has one of the lowest separation rates as found by a federal auditor. Staff follow up with members, even past the 90-day mark, with personal phone calls and hold routine meetings with providers to ensure proper service. This includes maintaining communication with providers to ensure they continuously check-in with members.

B. IPS-Supported Employment

Eastpointe delivers IPS-Supported Employment via four (4) teams in the Eastpointe network. Eastpointe enrolled 209 members, including 29 members from the TCLI population, into IPS- Supported Employment in FY18. Total monthly new member enrollment ranged between 0-42 members/month. TCLI monthly new member enrollment ranged between 0-10 members/month. The Eastpointe network avails adequate total IPS-Supported Employment service capacity. Total network IPS-Supported Employment concurrent capacity stands at
132 members. All teams accepted new referrals continuously

in FY18. IPS-Supported Employment Capacity:

| Team | Location | Member Capacity |
|---|---|---|
| Client First | Goldsboro | 25 |
| Family First | Mount Olive | 52 |
| Monarch | Lumberton | 30 |
| New Dimension | Rose Hill | 25 |

The IPS-Supported Employment fidelity scores for teams within the Eastpointe catchment area are all in compliance. As of the latest evaluations, Client First in Goldsboro scored 100, Family First in Mt. Olive scored 85, Monarch in Lumberton scored 97, and New Dimension in Rose Hill scored 86.

The barriers related to IPS-Supported Employment include a general lack of understanding of the service definition and eligibility requirements, as teams may not identify members that meet the criteria. There is a need for increased referrals to sustain the IPS-Supported Employment program.

Another barrier is the conflict of interest between employment and receipt of benefits as members are often choosing between being employed and fearing ineligibility to continue to receive benefits if they make more money than is allowed. All members are supposed to receive benefits counseling but sometimes the member does not receive the appropriate counseling services, and/or they fail to understand the work constraints to which they need to abide in order to continue receiving benefits. Employers of members should be aware of the constraints in which the members are under in order to continue to receive their benefits. However, sometimes the member's employer is not aware of or does not care about the time and salary constraints, so they allow the employee to work additional hours, thereby disqualifying them from receiving benefits.

Additionally, more jobs are needed in the community to fit the unique needs of members. Currently, there are not enough job opportunities that meet the unique needs of TCLI members. There are vocational and job training support programs but not enough of them exist in the catchment area. All employers need to be more aware and respectful of the unique job constraints that members face in order to continue to be eligible for benefits.

As the TCLI population can be a difficult population to serve, engaging providers is a priority. Quarterly TCLI meetings with the supported employment team and provider monitoring staff are held. The benefits counseling team works with this population to encourage stability during this time of major life transitions.

C. Community-Based Mental Health Services

Eastpointe delivered services to 268 TCLI members living supportive housing in FY18. Eastpointe deploys a service array that emphasizes development of natural supports, community engagement, evidenced-based treatment and support, and support for competitive employment. This service array is designed to help drive improvement in key personal outcomes for members, including:

- supportive housing tenure and maintenance of chosen living arrangement;
- hospital, adult care home, or inpatient psychiatric facility admissions;
- use of crisis beds and community hospital admissions;
- emergency room visits;
- incidents of harm;
- time spent in congregate day programming;
- employment;
- school attendance/ enrollment; and
- engagement in community life.

Eastpointe offers multiple wraparound services. Wraparound services directly support improvements in these personal outcomes. Wraparound services include: TMS (Transition Management Services), CST, ACTT, PSR, IPS-SE, and Peer Support. Eastpointe's service array is designed to comprehensively address key personal outcomes. Members in TCLI have access to any of the benefit plans for Eastpointe members, both IPRS and Medicaid. Eastpointe has a community inclusion pilot, which is currently the only one that exists in the state of North Carolina. Eastpointe has a contract with ADANC, which includes a specific allocation for TCLI members to find different community inclusion activities. For example, TCLI members are able to access freedom funds to do different community inclusion activities. In order to access these funds, TCLI members must submit a plan for how they plan to use the funds as it has to be used toward healthy integrative activities.

Eastpointe continues to excel in community retention for the TCLI population. Personal outcomes indicative of greater integration in the community for Eastpointe's TCLI population include a higher than average retention rate of 98.5 percent for FY18. Eastpointe closely monitors TCLI members who are admitted to the hospital, return to adult care homes, or are admitted to inpatient psychiatric facilities. Eastpointe works closely with

state hospitals to be notified faster when members are admitted to the hospital. In FY18, three people returned to adult care homes. Eastpointe takes a more collaborative approach to the member's care by increasing the numbers of face-to-face treatment team meetings with members and the hospital team.

With respect to the use of crisis beds and community hospital admissions, Eastpointe has an effort to identify TCLI members in authorized settings, including inpatient, facility-based, detox, and state facilities. An Eastpointe licensed care coordinator and a member of the QP staff go over to the facilities multiple times a week to work on engaging and discharge planning earlier. Eastpointe receives reports that list whether or not there is a TCLI member in the system and if they've been assigned to a care coordinator.

Eastpointe continues to make an effort to increase contact with community partners to increase education and awareness about TCLI. In general, the number of TCLI members re-entering high-level care settings is trending down. Eastpointe has increased referrals for Peer Support services due to an increased provider capacity and options for member's choice. ALL TCLI members are offered the following services: Peer Support, Transition Management Services, CST, ACTT, Supported Employment, and Community Inclusion. Other specialized services are offered such as trauma focused therapy. Eastpointe added a registered nurse to their staff. The nurse is addressing primary care, mental health, and substance use needs. The nurse is pivotal with assisting with linking the member to personal care services and service animals. TCLI members are enrolling in more services and the use of emergency/crisis services is trending down as well. In the past 4 years, the data has shown members to be more likely to leave housing due to deaths versus going back to an Adult Care home. Eastpointe had 8 inpatient admissions over the last fiscal year which is less than 10 percent of the Eastpointe total TCLI population.

Overall, there has been a reduction in instances of intentional self-harm among the TCLI population, with only two incidents of self-harm within FY18. Substance use is a root cause of the incidences of harm that Eastpointe sees among its members. In FY2018, for example, one member relapsed and reengaged in substance use and self-harm upon integration back into the community. Relapse and substance use issues contribute to the spread of communicable diseases so there is a new initiative in which Eastpointe is working with the local health department in Wayne County to offer screening and immunizations to TCLI members.

Eastpointe has seen an increase in the number of members involved with a supported employment provider. When Eastpointe conducts the initial assessment of a TCLI member, they offer supported employment opportunities. In FY 2018, there were 84 individuals in or at risk of Adult Care Home entry newly served by fidelity IPS-SE providers.

In FY 2018, there was one TCLI members enrolled in school. After researching the various community colleges, there is an office in student services to address the needs of members with disabilities. An example would be modification for longer testing time, wider testing areas for members with motorized wheelchairs and scooters for members who are non-ambulatory, and specialty assistance for members who are deaf and blind. However,

documentation of their disability is needed. Members are still afraid of the stigma that is still present in educational and employment settings.

Eastpointe continuously evaluates and works to address any service needs and gaps in the delivery of Community-based Mental Health services. Improving service delivery and outcomes for the TCLI population presents multiple challenges. Eastpointe prioritizes efforts to address key service needs and gaps and to improve overall service delivery.

Community-Based MH Service Needs/Gaps, Obstacles/Barriers, and Activities to Improve:

| Service Need/Gap | Obstacles/Barriers | Activities to Improve |
|---|---|---|
| Increasing TCLI eligible Member Referrals and Identifications | • Disparate information systems, communications, and workflow streams with hospitals<br>• Lack of awareness of TCLI-eligibility requirements and referrals for new enrollments<br>• Limited, developing community networks | • Expanding efforts to collaborate with community stakeholders, providers, and advocates (e.g. NC ADANC of NC for Community Inclusion)<br>• Developed In-Reach process to support use of the TCLD<br>• Prepared to support the RSVP referral process (implement 11/1/18 by DHHS to streamline the referral process for individuals being considered for admission to Adult Care homes and to screen TCLI targeted populations.<br>• Expanding interdepartmental education/ training curriculum to help educate staff on TCLI program<br>• Conducting external education/trainings of Eastpointe Provider Network Council, CFAC, and crisis collaborative<br>• DHHS implemented the quarterly collaborative meetings with state hospitals Cherry, Central Regional and Broughton to enhance information sharing and referrals of members hospitalized.<br>• Developing integrated workflows and communication mechanisms with DOJ, DSOHF, and the SOS to standardize referral identifications and member enrollment<br>• Enhancing provider and stakeholder linkages to: mobile crisis providers, physical providers, behavioral health providers, PCS providers, EMS, and law enforcement<br>• Collaborating with community hospitals and hospital transition care coordination teams to standardize identifications, referrals, and transition into TCLI |
| Enhancing community engagement | • Lack of awareness of TCLI-eligibility requirements<br>• Limited, developing community networks | • Piloting Community Inclusion project with DMH and ADANC of NC to enable member engagement in community life<br>• Enhancing wraparound services that support community integration, promoting utilization of Peer Support<br>• Piloting the Bridge Hotel program to expedite the transition into integrated supportive housing, prioritizing crisis placements and utilization of wraparound services with consistent support from TCLI staff and providers to increase housing retention and tenure<br>• Integrating community engagement content and techniques into provider training curriculum<br>• Collaborating with community stakeholders to build network and participation with natural supports (e.g. religious organizations, service animal organizations, community events organizers, and families/friends)<br>• Developing linkages with local community colleges to support education toward competitive employment |

| | | |
|---|---|---|
| | | • Expanding interdepartmental education/ training curriculum to help educate staff on TCLI program<br>• Conducting external education/trainings of Eastpointe Provider Network Council, CFAC, and crisis collaborative<br>• Participation on the IPS-SE provider steering committee to oversee and advise program goals and participate in the IPS Coalition training. |

Eastpointe services extend beyond evaluating and addressing service needs and gaps. Eastpointe staff continuously work to sustain quality and to deliver adequate and accessible services. It takes a different approach focused on member needs.

D. Crisis Services

Eastpointe delivers a continuum of crisis services across its catchment area. Accessibility is emphasized with crisis services. Crisis services are available to members via extensive identification and referral channels embedded in local communities. Eastpointe's approach to crisis service delivery promotes crisis intervention, stabilization, and support services to address triggers and to mitigate recurrence.

Eastpointe crisis services are available in all Eastpointe catchment area counties. Many of the crisis services are designed to expand the reach and immediacy of services. Varying combinations of crisis services are available in each county, such as:

- Mobile crisis teams,
- 24/7 Walk-in Centers,
- MH First Aid,
- MCO office intake,
- law enforcement crisis trained response,
- facility-based crisis
- EMS crisis trained response, and
- 24/7 Member call center crisis response

These services are available to all Eastpointe members. Broad geographic access and a robust crisis service array enables timely and accessible services and supports. Locations for providers and crisis services' access sites vary by county. Geographic availability of services is presented in *Appendix A: Geo Maps.*[2]

Eastpointe staff develops a Community Inclusion Plan at the beginning of working with its members. This plan identifies triggers and outlines different contingencies. A crisis plan is included with contact information. Eastpointe provides crisis services in the least restrictive setting and crisis plans are implemented with the goal to prevent unnecessary hospitalization, incarceration or institutionalization. They utilize "mystery shoppers" to unexpectedly check up on service providers to make sure they are being responsive.

Eastpointe engages with different stakeholders to improve the quality of crisis services for members. Eastpointe meets with providers on a quarterly basis to talk about expectations regarding service definition. They also conduct monthly calls with community inclusion organizations including the Alliance of Disability Advocates of NC (ADANC) to discuss medication management, keeping appointments (medical or Mental Health), and transitions back into the community (integration or re-integration). They also discuss and identify new activities that the members are interested in doing and accordingly will provide transportation to those activities. Members are taken to various community

[2] Please note the Appendixes can be found in the complete Network Adequacy and Accessibility Analysis Submission

integration workshops that include information about an array of support services including supportive employment services, etc.

Additionally, Eastpointe conducts Mental Health first aid and other training programs with first responders. Eastpointe is also evaluating the START Program for implementation in the Eastpointe catchment area.

Eastpointe continuously evaluates and works to address any service needs and gaps in the delivery of crisis services. Improving service delivery and outcomes presents multiple challenges. Eastpointe

| Service Need/Gap | Obstacles/Barriers | Activities to Improve |
|---|---|---|
| Recidivism for Members with High Emergency Department (ED) Utilization | • Inconsistent coordination between ED's and Eastpointe<br>• Disparate information systems, communications, and workflow streams with hospitals/ED's<br>• Lack of awareness of TCLI eligibility requirements | • Conducting external education/trainings of Eastpointe Provider Network Council, CFAC, and crisis collaborative on importance of support services to prevent future crisis events<br>• Streamlining information sharing and workflows with community hospitals to improve collaboration with ED MH/SU care coordination teams, evaluating digital information sharing to expedite coordination<br>• Evaluating psychiatric telehealth service integration with ED's to introduce more acute, timely psychiatric support to stabilize members in the ED<br>• Enhancing provider and stakeholder linkages, including to: physical providers, behavioral health providers, PCS providers, EMS, and law Enforcement<br>•Training and working with hospitals to develop processes with consistent and timely reporting of ED admissions |
| Increase use of community-based supportive housing and natural supports | • Lack of community engagement and integration designed to prevent and mitigate crisis events<br>• Lack of community networks with natural supports<br>• Lack of awareness of TCLI-eligibility requirements and referrals for new enrollments | •Piloting Community Inclusion project with DHHS and a provider to enable member engagement in community life<br>•Enhancing wraparound services that support community integration, promoting increased utilization of Peer Support with emphasis on services designed to improve supportive housing retention and maintenance<br>•Piloting the Bridges Hotel program to expedite the transition into supportive housing, prioritizing crisis placements and emphasizing utilization of wraparound services with consistent support from TCLI staff and providers to increase housing retention and tenure<br>•Integrating community engagement content and techniques into provider training curriculum<br>•Collaborating with community stakeholders to build network and participation with natural supports (e.g. religious organizations, service animal organizations, community events organizers, and families/friends)<br>•Developing linkages with local community colleges to support educatin toward competitive employment<br>•Developed In-Reach process to support use of the TCLD<br>•Continue to support the RSVP referral process to centralize referrals to TCLI licensed staff<br>•Expanding interdepartmental education/ training curriculum to help educate staff on TCLI program<br>•Conducting external education/trainings of Eastpointe Provider Network Council, CFAC, and crisis collaborative |

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|---|---|---|
| | | •Participation on the IPS- SE provider steering committee to advise program goals for services that enable deeper community integration and promote self- sustainability needed to retain housing |

| Service Need/Gap | Obstacles/Barriers | Activities to Improve |
|---|---|---|
| Lack of substance use services | • Not enough providers<br>• Public stigma/perceptions may discourage members from seeking crisis services<br>• Awareness how/when to access services that are available<br>• Only long-term substance abuse providers in the catchment area are Walter B. Jones and Dart Cherry | • The state is working on the substance abuse waiver to cover all ASAM levels.<br>• Eastpointe's Mental Health Substance Use Care Coordination Team is in contact with Emergency Rooms so they are aware of when any Eastpointe members are in the Emergency Room so that they can assist with treatment planning and develop a coordinated discharge plan with MHSU Care Coordinator team, TCLI staff, IDD staff, and the Medical Director.<br>• Eastpointe has non-hospital detox programs and they are in the early stages of getting involved in the post-overdose rapid response team (PORRT) that operates in some of the counties in the Eastpointe catchment area. |
| Lack of funding | • Not enough funding for resources given the demand for services<br>• Lack of interagency coordination/operating in silos | • To cutdown on frequent utilizers of the ED, there is a QIP (Quality Improvement Plan) in place<br>• Encourage providers to use enhanced crisis services as is clinically indicated and use the other enhanced services initially |

| | | |
|---|---|---|
| Lack of resources/support for mobile crisis teams | • difficult business model to sustain when you're not embedded in a bigger agency<br>• Members must consent to mobile crisis services, may not fully appreciate/understand how mobile crisis can help, may lead to escalation into ED<br>• Public stigma/perceptions may discourage members from seeking crisis services Awareness how/when to access services that are available | • Continue with established bi-monthly meetings with EP Crisis Providers and MCC<br>• Resource sharing<br>• Dispatch concerns/opportunities<br>• Reporting concerns/opportunities<br>• Continue scheduling of aftercare appointments for all crisis service recipients where initiation of services originates via MCC<br>Continued monitoring and provision of feedback of the state effort to revise the existing service definition for MCC making it more restrictive and more difficult to utilize effectively across the network.<br>• Develop a collaborative group involving MCM Providers and key MCO staff to evaluate any existing barriers to service utilization<br>• Provide TA for MCM providers for any identified barriers including:<br>• Knowledge in accessing services<br>• Difficulty obtaining consent for services<br>• Community partnerships necessary for service initiation and utilization<br>• Explore topic of stigma associated with accessing crisis services<br>• Develop a collaborative across MCO's and key providers to explore variable successes in different regions and evaluate the viability of implementation within EP network |

For the first month following a crisis, staff maintain contact with members at least once a week. If there are concerns identified, staff connect with providers to assist or intervene directly to prevent a crisis. Eastpointe employs a team approach that comprehensively addresses member issues, allowing for teams such as Assertive Community Treatment Teams (ACTT) to make sure members are taken care of completely. Internal collaboration exists to outline upfront and post- crisis care. Eastpointe has 27 ACTT provider sites within the Eastpointe catchment area. Eastpointe delivered ACTT services to 572 members in FY2018.

The TCLI population has access to any services, such as hospitalization or facility-based crisis, that are in the network. Crisis Intervention Team (CIT) Training has been a priority as well, with many law enforcement officials trained for pre-crisis situations. Critical case conferences are held to address potential problems before they occur, and medication adherence monitoring, and multilingual services are in place to address needs. Eastpointe hosts CIT Trainings for law enforcement approximately quarterly each year.

Eastpointe works to provide wraparound support from beginning to end to mitigate population vulnerabilities. Peer Support services are available to anyone in the network to help with adjustment periods. In FY2018, Eastpointe delivered Peer Support Services to 115 members. There are currently 24 providers for Peer Support services in the Eastpointe catchment area and there is one provider with two sites that provides Peer Support Hospital Discharge Services. This is a new service that was added December 14, 2018. Lack of state funds limit availability of this service, and this service is not available via Medicaid. The service assists members with coordination and continuity of care – especially between 1 and 7 calendar days after discharge.

There is currently a peer support program at Southeastern Regional hospital that has peer support embedded in their programs. In addition, Eastpointe staff work to establish a relationship with members, typically becoming a first point of contact during times of crisis. Staff then can connect members with the proper providers as well as the member call center to respond to and prevent and/or mitigate crisis events.

To help with transportation issues after a crisis episode, Eastpointe launched a transportation pilot program in which they provide transportation to members after a crisis. There are crisis collaboratives within some of the communities in the Eastpointe catchment area that are made up of hospital representatives, EMS, staff from shelters, Eastpointe staff, and the police department.

The use of crisis services has decreased, as access to hospitals has improved with successful Eastpointe efforts to connect members with community-based supportive housing.

# Partners Behavioral Health Management

*Community-Based Supportive Housing Slots*

1. *Describe service gaps and needs, obstacles and barriers, and recent activities and projects in the LME/MCO to*:
   a. *Identify and engage eligible individuals in the TCLI priority population*: Partners TCLI In-Reach has not experienced problems with this. TCLI In-reach has been able to identify individuals in the priority population. This is achieved through working with the State hospital, visiting individuals at the Adult Care Home, and reaching out to individual through the diversion process.

   b. *Provide access and transition individuals to community-based supported housing*: As of December 2018, Partners TCLI In-Reach has successfully transitioned 344 individuals (over the life of the program) into the community with no problems. Grants were submitted for housing funds, and education and training opportunities have been provided to landlords. Improved access to Targeted Key units has been offered by the Department of Health and Human Services (DHHS) after Partners did an analysis and identified lack of vacancy information. This assists in increasing housing capacity more quickly. Partners TCLI In-Reach has also provided education and training for consumers, providers and employers on employment options available for individuals with mental health, intellectual/developmental disability and substance use disorder diagnoses. Lastly, benefit counseling for individuals with disabilities has been provided over the last year to encourage employment without losing benefits.

   c. *Transition individuals within 90 days of assignment to a transition team*: Barriers experienced by the Partners TCLI In-Reach team within the first 90 days include: criminal history, financial problems, medical problems, finding places to live in the individuals chosen area, and not enough handicapped accessible units. Partners hired an additional Housing Coordinator to assist TCLI staff in locating housing and making referrals, including reducing housing barriers, such as limited housing resources, inspections, and background checks. Recent activities and projects related to transitioning individuals within 90 days: (1) Partners is actively pursuing the Master Leasing option. The funding for Master Leasing was not available until November 2018. Without confirmation from DMH that Master Leasing funds will continue to be available at necessary rates for the next fiscal year, the agency who was interested in Master Leasing isn't comfortable signing one-year leases in March 2019 on a contract with Partners that expires June 30, 2019. Another alternative for diversion is being explored in Burke County rather than Master Leasing. In addition, Partners collaborated with Easter Seals CTI team and Davis Regional Hospital to pilot a Rapid Housing Project. The project would have emphasized diversion from Adult Care Homes and utilize hotel pilot funds. This project was ended due to the inability of the two community partners to reach an agreement. Partners will continue to focus the TCLI team on trouble-shooting moves and tracking the 90-day timeframe. Our goal was to increase available housing units by 30 through submission of building proposals in FY17-18 using TCLI Community Living Trust Funds at North Carolina Housing Finance

Agency (NCHFA). Sixteen units were approved by NCHFA out of the 30 requested due to lack of funding at the state level as well as priority funding being sent to eastern NC from hurricane damage. This will increase the availability of units for those that are more difficult to house since Partners will have sole referral option. TCLI team will ensure that individuals are placed on hold when criteria are met. The current follow-up at 30 days was adjusted from the previous 45 day follow up. After the 30-day mark, follow-up will take place every 14 days. TCLI staff will identify individuals currently in the transition process and establish timeframes for move-in dates within 90 days. We will focus the TCLI team lead functions on trouble-shooting moves and tracking the 90-day timeframe.

d. *Support individuals' housing tenure and ability to maintain supportive community-based housing*: Partners has identified contractual issues as a barrier to transitioning individuals into housing. The individual has care coordination for 90 days after transition then could be closed to care coordination. Unless TCLI staff is notified, TCLI staff do not know there are problems with the individuals housing tenure. We have tried to manage this by having weekly calls with the TMS to discuss each person.

IPS – Supported Employment

1. *Describe the network adequacy of IPS-Supported Employment services including*:
   a. *Number*: 2 – Partners currently has two approved fidelity IPS-SE providers; Monarch Inc. and Coastal Southeastern United Care. Both providers meet fidelity and are approved IPS-SE providers. A Caring Alterative (ACA) will meet fidelity this summer, therefore increasing the number to three.
   b. *locations of fidelity teams*: Monarch Inc. provides IPS-SE services in Cleveland, Lincoln and Gaston Counties. Coastal Southern United Care serves Gaston, Lincoln, and Cleveland counties.
   c. *capacity of fidelity teams*: Monarch hired two additional Employment Specialists and will have the capacity to serve at least 80 consumers once all training is completed. Prior to this, Monarch served 38 consumers with IPS-SE services. Coastal Southeastern United Care serves consumers in Gaston, Lincoln and Cleveland. Coastal currently has 30 consumers in IPS-SE services. Coastal has hired a new Employment Specialist, so they will be able to increase the number of IPS-SE consumers they serve once training is completed. A Caring Alternative (ACA) was awarded the RFP for 2018 IPS-SE from Partners. ACA will be the third team providing IPS-SE services once they complete fidelity requirements and are approved to provide the IPS-SE services. ACA will provide IPS-SE services for Burke and Catawba.
   d. *the LME-MCO's total service capacity requirements (including but not limited to the TCLI population)*: 220
   e. *service gaps and needs*: Partners has only two providers that meet fidelity and limits meeting this goal. Coastal Southeastern United serves consumers in Gaston, Lincoln, and Cleveland counties. Coastal served 30 consumers to date. Monarch provides this service in Cleveland, Lincoln and Gaston counties. Monarch served 38 consumers with IPS-SE services. ACA will provide services for Burke and Catawba counties once they complete fidelity requirements.

2. *Describe obstacles and barriers as well as recent activities and projects to engage and refer individuals in the TCLI priority population, including individuals with SMI living in*

*community-based supportive housing and individuals living in or at risk of entry to adult care homes*. Obstacles and barriers to sustainability of this service include concerns about the rates and how fidelity scoring is implemented. Providers express concerns about being able to maintain the service with the current payment structure and individuals are concerned about changes to the benefits they receive. We have focused on the recruitment of additional IPS-SE providers. Partners released a Request for Information (RFI) on Individual Placement and Support-Supported Employment (IPS-SE) for Burke and Catawba counties on May 23, 2018. Nine providers attended the Bidder's conference held on June 6, 2018. It appeared that several were interested in the RFI. However, only two responses were received. Partners initiated a Root Cause Analysis (RCA) involving our interdepartmental team, current IPS-SE providers and A Caring Alternative (ACA) Provider. TCLI staff will consult with and utilize technical assistance from the Supportive Employment/Enhanced Services Learning Collaborative on an ongoing basis. A Quality Improvement Project (QIP) was developed that included marketing IPS-SE to all individuals. We increased our focus on the referral management process for TCLI consumers at an individual level and increased consumer engagement with Supported Employment services. This resulted in reaching the total of 344 engaged consumers by end of December 2018. Partners will develop a script for TCLI and Care Coordination staff and will develop a strategic communication and marketing plan for IPS-SE. We are working internally to complete a cost analysis of the IPS-SE service. The report that we have created assesses IPS-SE effectiveness on an individual basis. Additionally, we have built into provider contracts IPS-SE incentives for adding members of the in/at risk population to increase IPS-SE service utilization. The feedback received from the providers who do deliver this service across the state and meet fidelity is this service needs to start at the good fidelity rate for baseline and then move up from there to be viable. This feedback is being assessed.

*Community-Based Mental Health Services*

*1. Describe the array and intensity of community-based mental health services provided to individuals living in supportive housing, as well as their sufficiency*: Individuals in supportive housing are linked with tenancy support and have access to the full-service array including but not limited to, mobile crisis, outpatient services, care coordination, Assertive Community Treatment Teams (ACTT), as well as respite. Tenancy support is a short-term service to transition individuals from a higher level of residential living to a community-based setting.

2. *Describe personal outcomes indicative of greater integration in the community. Personal outcomes addressed in response should include the following*: The numbers below were gathered two ways: (1) They are reflective of individuals that were participating in TCLI and Supported housing. The total number of surveyed individuals = 988. Personal Outcomes are not tracked specifically for the TCLI population after 90 days. Therefore, some of the items below do not reflect solely the TCLI population. (2) Claims FY18 data where an individual received a service with the DJ modifier. There were 188 individuals tracked this way during FY18.
    a. *supportive housing tenure and maintenance of chosen living arrangement*; 344 individuals have been successfully transitioned into their chosen living arrangement in the community. On the of barriers to tracking individuals is the individual has care coordination for 90 days after transition then could be closed

to Care coordination. Unless TCLI staff is notified, TCLI staff do not know there are problems with their housing tenure. We have tried to manage this by having weekly calls with the TMS to discuss each person.

b. *hospital, adult care home, or inpatient psychiatric facility admissions;* After completion of service: Out of 342 participants 14.9% reported a psychiatric inpatient episode. FY18 claims data shows, out of 188 individuals, 14.4% (n = 27) had a psychiatric inpatient episode and 19.1% (n = 36) had an initial hospital visit, subsequent hospital visit, or hospital discharge.
c. *use of crisis beds and community hospital admissions*; Out of 342 participants, 21.6% reported a crisis contact. Additionally, FY18 claims data shows out of 188 individuals, 4.3% (n = 8) had a crisis intervention – facility based; 2.7% (n = 5) had a crisis assessment & intervention; and 6.4% (n = 12) had a mobile crisis service.
d. *emergency room visits*; 22.5%; FY18 claims data shows out of 188 individuals, 21.3% (n=40) had an ER visit during the fiscal year.
e. *incidents of harm*; 5%
f. *time spent in congregate day programming*; .6%
g. *employment*; Out of 647 respondents, 39% were in the labor force, 17% were employed full time, and 23.9% were employed part time; FY18 claims data reports, of the 188 individuals 5.3% (n = 10) received supported employment services.
h. *school attendance/ enrollment*; out of 716 respondents, 92% were enrolled in an academic program
i. *engagement in community life*: out of 647 respondents, 13% participated in community/leisure events, and 7% in recovery related activities

3. *Describe gaps and needs in the community-based mental health services provided to individuals in TCLI supportive housing*. *Note that this item refers to gaps and needs related to the provision and outcomes of services for the TCLI population, and not solely to the access and choice standards.* In the past, individuals have reported difficulty in reaching providers when they needed service. There has been a focus to train peers to provide support in daily living skills, adherence to leases, and financial guidance.

4. *Describe obstacles and barriers as well as recent activities and projects to address gaps in the array, intensity, and sufficiency of community-based mental health services provided to individuals in supportive housing:* One of the obstacles is conflict between provider staff and TCLI individual. If there is a conflict between individuals and provider staff, individuals will not engage with the provider and disengage from services and ultimately could lead to eviction. In some cases, consumers engaged in services lose their housing due to firing their providers. Projects to address the gap includes (Assertive Community Treatment Team) ACTT and other high intensity service providers having a formal process to notify Partners Access when they have been terminated from providing services. However, for ACTT the team has a high intensity caseload with a large caseload, and sometimes they cannot respond as quickly as the TCLI member may need. Additionally, there are some geographic limits on certain service availability. For example, Surry, Yadkin and Iredell have only ACTT, PSR, Peer Support and TMS, so there is no continuum of services in that area. Another obstacle is medication adherence which can result in housing problems due to psychiatric instability. Projects to address this issue include solving transportation issues, psychoeducation on taking medications, improved treatment engagement, leasing

violations, and compliance with appointments to renew medications. Individuals are happy to let their buddies sleep on their couch or bring pets in without adding them to their lease. Improving daily living skills and more face to face visits by providers may also positively impact this issue. Treatment teams are built into the process and have occurred to address the issues. Lastly, B3 peer service funding is limited and therefore, limits peer engagement.

*Crisis Services*

** Note that this item refers to gaps and needs related to the provision and outcomes of services for the TCLI population, and not solely to the access and choice standards addressed in Section One.*

1. *Describe the network adequacy of the LME/MCO crisis service system including*:
   a. *the geographic availability*: There is no difference in the availability of services for TCLI consumers across the catchment area. The whole catchment area has access to the crisis service system. All consumers, including the TCLI population, have access to mobile crisis, integrated care centers, and behavioral health urgent care and access to care.
   b. *crisis service array and intensity of services*: The comprehensive crisis service array is available to all TCLI individuals. This includes, but is not limited to, mobile crisis, facility-based crisis, psychotherapy for crisis, Assertive Community Treatment Teams (ACTT), Facility based crisis, TMS, BHUC.
   c. *the sufficiency to offer timely and accessible services and supports to individuals experiencing a behavioral health crisis*: Consumers with Medicaid and those appearing to meet criteria for State Funded target populations are linked through Screening Triage & Refer (STR) to providers for an initial assessment/evaluation and treatment. This applies to TCLI consumers as well as individuals across the catchment area. Consumers who do not appear to qualify for any benefits under State Funds are linked to community resources. Standardized screening, triage and referral protocols focus on timely access to the most needed level of care. Triage is a brief process aimed at determining the intensity of the consumer's need and results in prioritizing their level of care into the following categories: Emergent Care Consumers will be seen face-to-face within 2 hours and 15 minutes or directly linked to 911 depending on severity due to medical needs. Consumers presenting with moderate risk or incapacitation in one or more area(s) of physical, cognitive, or behavioral functioning related to MH/IDD/SA problems. Urgent Care is provided within 48 hours of initial contact if the consumer is experiencing a more slowly evolving crisis and a catastrophic outcome is not imminent. Consumers presenting with mild risk or incapacitation in one or more area(s) of safety, or physical, cognitive, or behavioral functioning related to MH/IDD/SA problems. Routine Care will be provided to consumers within 14 calendar days of initial contact.
   d. *service gaps and needs*: The only concern here is Transition Management Services are not a clinical service and those providing the service do not have the training needed to conduct assessments in a crisis.

2. *Describe the extent to which crisis services are provided in the least restrictive setting and consistent with an already developed individual community-based crisis plan or in a manner that develops such a plan as a result of the crisis situation, and in a manner that prevents unnecessary hospitalization, incarceration or institutionalization*: A crisis plan is

developed prior to crisis episodes and assists with providing community supports that are helpful to each individual during a crisis to prevent hospitalization. These plans are made available to mobile crisis providers and/or ACTT team staff.

3. *Describe obstacles and barriers as well as recent activities and projects to address gaps related to crisis service availability, delivery, sufficiency, and outcomes:* Transition Management is not a clinical service and is often the first response for a TCLI consumer. Partners has offered some training with Transition Management Services (TMS) to assist with the crisis referral process and the state is looking to add TMS services to the Community Support Team service definition that will give clinical oversight. They are scheduled to release this definition July 1, 2019.

# Sandhills Center

A. Community-based Supportive Housing Slots*:*

*1. Describe service gaps and needs, obstacles and barriers, and recent activities and projects in the LME/MCO to:*

*a. Identify and engage eligible individuals in the TCLI priority population.*

On November 1, 2018, the diversion screening process, which previously involved PASRR screenings, transitioned to a new system called Referral Screening and Verification Process (RSVP). Since the implementation of RSVP on November 1, 2018 through April 30, 2019, Sandhills Center received 342 referrals, which averages 57 referrals per month. This has resulted in a much greater pool of candidates for participation in the TCLI program. Consequently, Sandhills Center has seen an increase in monthly transitions to the community.

*Obstacles and Barriers to engage eligible individuals*: Prior to 2013 and the TCLI Initiative, common thinking was that individuals with mental illness could not live independently in the community. Unfortunately, this perspective persists today. Individuals are oftentimes reluctant to participate in the program when the people in their lives, such as family members, guardians, providers, and doctors, continue to send the message that they are not capable of living on their own. In addition, there are individuals who are afraid of losing their benefits if they leave the facility that in many cases, took them years to acquire. Isolation also continues to be a significant concern as members frequently do not become fully acclimated in their community. In addition, members with extensive criminal and poor credit backgrounds present a barrier to transitioning as does the lack of available housing in the designated areas of members' choice. Sandhills Center has a DOJ Workgroup that meets once a month to stay abreast of changes and to discuss barriers regarding the TCLI Program. Sandhills Center also meets monthly with its' Transition Management Services (TMS) provider to discuss consumer issues and ways in which participants may be best supported in the community.

*Activities and Projects to engage eligible individuals*: Using the State-generated list, In-Reach staff identify names of individuals in adult care homes and state facilities to meet and talk with about the TCLI program and address questions or concerns expressed. The same process is completed by In-Reach staff for individuals referred via RSVP who have been determined eligible for participation. The staff follow up monthly with individuals who have previously declined to participate, to see if there are additional issues/concerns they can address for the individual. There are currently 2 staff members employed with RHA who are now tasked with the responsibility of performing community integration activities with the eligible individuals. These activities include assisting members in viewing available units, touring the Psychosocial Rehabilitation Programs, meeting with other members who have transitioned, and going to breakfast or lunch to establish therapeutic relationships.

*b. Provide access and transition individuals to community-based supported* housing.

*Obstacles and Barriers*: TCLI programs are encouraged to take advantage of "targeted key units," and these units have limited availability for our TCLI clients, making it more difficult to obtain affordable housing. Although the Targeted Key Vacancy Report is currently being sent out to the LME-MCOs, the process of identifying a targeted key unit continues to be so lengthy that very few TCLI participants are able to benefit from that specific program.

*Activities and Projects*: Sandhills Center employs two (2) Housing Specialists who work to maintain and build positive relationships with landlords and to increase the availability of supported housing in the community. Housing is also sought in locations that are within walking distance to grocery stores, etc. The Housing Specialists attempt to expand the landlord list by discussing the availability of landlords at the quarterly Resident Discharge Team Meetings with the Departments of Social Services in our nine county catchment area. The landlord list is not only made available to Sandhills staff but is also available to provider agencies and other outside entities as well. In addition, an annual landlord breakfast is held to recruit landlords who are interested in partnering with Sandhills Center.

*c. Transition individuals within 90 days of assignment to a transition team*:

*Obstacles and Barriers*: It is extremely difficult to find community-based housing for registered sex offenders and for individuals with a significant criminal record. It is also difficult to find affordable housing in some locations where the clients want to live, such as Wake County.

*Activities and Projects*: Sandhills Center is expanding the role of the housing specialist to develop relationships with landlords to increase the availability of affordable housing options for our clients.

d. *Support individuals, housing tenure and ability to maintain supportive community-based housing*.

*Obstacles and Barriers*: As noted earlier, the TCLI initiative requires a paradigm shift in thinking that individuals with mental illness cannot live independently in the community. This mind-set remains prevalent today. It is difficult to maintain housing tenure in community-based housing when those involved with the individual, such as their families and providers, are very quick to recommend that the individual move back into a facility when they enter difficult periods in their lives or struggle with their activities of daily living.

*Activities and Projects*: Sandhills Center's Medical Director and Associate Medical Director are conducting a retroactive review (of clients already placed in the community) and current review (of clients to be placed in the community) to develop recommendations on how best to meet the client's behavioral health and physical health needs in the community. This recommendation is based on a review of the client's CCA, PCP, and other relevant documents. Sandhills Center convenes clinical team meetings for TCLI members who may be struggling to maintain their living

arrangements for various reasons, to address the issues, develop additional interventions and strategies to support these members in maintaining their community- based housing.

B. IPS-Supported Employment:

*1. Describe the network adequacy of IPS-Supported Employment services, including a)* number, b) locations and c) capacity of fidelity teams; d) the LME-MCO's total service capacity requirements (including but not limited to the TCLI population); and e) service gaps and needs.

*Network Adequacy*: Currently Sandhills Center has 6 IPS-Supported Employment (IPS- SE) providers, all of which have met fidelity.[33] All six (6) IPS-SE providers report capacity to serve additional clients. Counties without coverage for IPS-SE are Anson and Montgomery[34]. For FY15-16, paid claims for IPS-SE individual was $277,415; this increased to $447,372 in FY17-18, an average of $37,281 per month. For FY18-19 through May 15, 2019, the average paid claims for IPS-SE individual is $40,459 per month.

*Gaps and Needs*: Paid claims reports are used to generate a monthly report that tracks patient counties without paid claims. This allows Sandhills Center Management to identify gaps. Recently one (1) IPS SE provider notified us that they would no longer be able to accept new clients in the southern counties due to fidelity model issues and co-location with a behavioral health entity. In an effort to resolve this identified gap, a Request for Proposal (RFP) process initiated in September 2018 to solicit additional IPS-SE providers in the southern counties. Through this RFP process, an IPS-SE provider was identified and is able to provide service coverage in several of the rural counties that were left without coverage.

*2. Describe obstacles and barriers as well as recent activities and projects to engage* and refer individuals in the TCLI priority population, including individuals with SMI living in community-based supportive housing and individuals living in or at risk of entry to adult care home.

Some eligible individuals are reluctant to engage in IPS-SE for fear of losing their benefits, which, in many cases, took many years for those individuals to acquire. As a result, family members/guardians tend to discourage members from returning to work. In addition, some members have been living in adult care homes for so long and not only have difficulty overcoming the stigma of having a mental illness, they have been led to believe that they are not capable of working.

Individuals currently receiving IPS-SE services must meet criteria for being at risk of entry to adult care home in order to be counted toward the TCLI IPS-SE quota, which each LME-MCO must meet in order to be in compliance with DOJ settlement requirements. As the in/at-risk criteria are being narrowed and LME-MCOs are having to provide more and more documentation to support the IPS-SE consumers identified

as being in/at-risk, it is becoming much more difficult process for providers and the LME-MCOs to identify consumers as being in/at-risk.

*Activities and Projects*: FY 18-19 credentialed Work Incentive Practitioners (CWIPs) or Certified Work Incentive Counselors (CWICs) has been added to the IPS-SE service definition, which allows the IPS-SE provider to receive a higher reimbursement rate for having these specialists on their team to provide the benefits counseling to their consumers. These Benefits Counselors work with potential IPS-SE participants to discuss employment and the impact it can have on individual benefits. As this has been a recent change to the IPS-SE service definition, IPS-SE providers are still in the process of adding the new staff indicated in the revised service definition and will inform the LME-MCO once they have added the positions indicated to their teams.

The DOJ Workgroup has approved a Supported Employment fact sheet to assist the TLCI staff in engaging members regarding Supported Employment. Both In-Reach staff as well as Transition Coordinators review the IPS-SE fact sheet (or script) with prospective participants as well as those who have agreed to participate in the TCLI program prior to transition and then on an ongoing basis.

*C. Community-Based Mental Health Services*

*1. Describe the array and intensity of community-based mental health services provided to individuals living in supportive housing, as well as their sufficiency.*

*2. Describe personal outcomes indicative of greater integration in the community. Personal outcomes addressed in the response should include the following:*

- ***a.*** *Supportive housing tenure and maintenance of chosen living arrangement*
- ***b.*** *Hospital, adult care home or inpatient psychiatric facility admissions*
- ***c.*** *Use of crisis beds and community hospital admissions*
- ***d.*** *Emergency room visits*
- ***e.*** *Incidents of harm*
- ***f.*** *Time spent in congregate day programming*
- ***g.*** *Employment*
- ***h.*** *School attendance/enrollment, and*
- ***i.*** *Engagement in community life*

During FY17-18, there were a total of 204 consumers[35] in housing or who transitioned to a supportive living arrangement during the fiscal year. Of these 204 consumers, 33 lost or exited housing due to death, eviction, jail, return to an adult care home, admission to mental health group home, admission to skilled nursing facility, or to live with a family member and were not rehoused via TCLI during the fiscal year.

Of the consumers participating in the TCLI program, approximately 50% of them were connected with Assertive Community Treatment Team (ACTT) services while the other 50% of consumers received Transition Management Services (TMS). Additional services, including crisis services, were accessed by these consumers as follows:

| Service | Number/Percentage of Consumers Accessed |
|---|---|
| Psychiatric Inpatient | 2 – < 1% |
| ED-Behavioral Health | 46 – 23% |
| Mobile Crisis Team | 5 – <1% |
| Facility-Based Crisis | 1 – <1% |
| Psychosocial Rehabilitation | 30 – 15% |
| IPS-SE 10 – <1% | |
| Incidents of Harm | 3 – <1% |
| School Enrollment/Attendance | 4– <1% |

The vast majority of TCLI consumers participate in community life. This includes going to the park, church, Walmart/grocery store, senior center, library, visiting friends/family members, as well as a variety of other community activities. During their transition meetings, the transition coordinators assist consumers in identifying their community interests and help to get them connected with these activities upon their transition. Ongoing engagement and participation in community life is directly attributable to the service providers with whom TCLI consumers are connected.

ACTT providers assist TCLI consumers by providing services at the intensity and frequency needed based on each consumer's level of need. This includes interaction with Peer Support Specialist, Substance Use Specialist, Vocational Specialist, Housing Specialist in the event of an eviction/housing loss, medication evaluations/reassessment, crisis intervention, teaching of Activities of Daily Living (ADL), integration into the community, making referrals to additional resources/services including physical health providers, and wellness management.

TMS and Peer Support workers assist in maintaining housing by teaching ADLs individually in the home environment, assisting with tenancy issues, connecting with additional services/resources including physical health providers, integration into the community, assisting with making and keeping behavioral and physical health appointments. Psychosocial Rehabilitation (PSR) providers assist members with social interaction and building social skills, wellness management, as well as teaching ADL skills in a group environment.

IPS-SE services assist TCLI consumers in maintaining their living arrangements in the community by assisting them to find competitive employment in the job of their choosing, which contributes to the consumers' recovery and their financial stability. Unfortunately, there was a gap in IPS-SE services in Sandhill Center's southern counties when one provider gave notice that they would no longer be able to serve members in the southern counties. In response to this gap, Sandhills Center conducted a Request for Proposal for IPS-SE. A provider was recently selected and joined the Sandhills Center network in April 2019. In addition, Sandhills Center is open to considering a single-case agreement for any consumer in our rural counties who expresses an interest in this service and cannot be served by a current network provider. Community Support Team (CST) is also a valuable service to our TCLI

members as they help consumers maintain their housing by teaching wellness skills, teaching/modeling behaviors such as appropriate social interactions, providing psychoeducation to members and their families, providing psychotherapy and substance abuse interventions, teaching relapse prevention strategies, connecting with other needed services and resources both for behavioral and physical health. At this time, there are 4 counties with limited coverage for CST services, including Anson, Montgomery, Richmond, and Moore. As we prepare for the revised CST service definition, we expect that the service will be expanded and available more widely to all Sandhills Center's consumers.

Assertive Community Treatment Team Services, Transition Management Services, Community Support Team, Psychosocial Rehabilitation Services, Peer Support Services, Individual Support Services, and Supported Employment Services are available services that TCLI eligible participants can choose from as they make plans to transition to the community. Depending on the needs and preferences of the member, one or more of the above services is offered to the member. The service definitions for this set of services are written to ensure that these services (if administered properly) will offer the members the support, assistance, and skills that they need to obtain and maintain stable housing and move forward to achieve an optimal level of community integration. Utilization of the appropriate supports would serve to mitigate inpatient psychiatric admissions, emergency room visits, incidents of harm, use of other psychiatric crisis interventions. It would also foster involvement in community life, school attendance, and employment in the targeted population. Gaps in the successful engagement in these services are apparent as providers of several services, which were created to provide the most intensive interventions, are too frequently opting to assist the members to return to a congregate living situation at the initial stages of adjusting to an independent living arrangement.

*3. Describe gaps and needs in the community-based mental health services provided to* individuals in TCLI supportive housing. Note that this item refers to gaps and needs related to the provision and outcomes of services, and not solely to the access and choice standards addressed in Section One.

50% of TCLI members are enrolled with an ACTT provider; those not enrolled with ACTT receive TMS services. Providers of different services, such as ACTT or TMS, may have differing views about whether or not adults with mental illness can be adequately served in the community, and their initial response to issues may be that the individual should be returned to the adult care home setting. Based on our experience, Peer Support providers are generally more likely to believe that individuals with mental illness can live in integrated settings in the community.

For the second fiscal year in a row, Sandhills Center has coordinated with the University of North Carolina Center for Excellence in Community Mental Health, to develop and provide a training series for our contracted ACTT providers to develop more advanced skills in direct line staff and improve the quality of service provided to TCLI participants. This training series has been offered throughout the

course of the fiscal year consisting of three 2-day training sessions and 10 technical assistance calls to the identified program staff each fiscal year. Sandhills Center has also invited TMS and CST staff to participate in the trainings to provide them with additional support as well. Topics have included CBT for psychosis, ACTT service definition, integrated care, psychopathology 101.

*4. Describe the obstacles and barriers as well as recent activities and projects to address* gaps in the array, intensity, and sufficiency of community-based mental health services provided to individuals in supportive housing.

*Obstacles and Barriers*: Based on member feedback, isolation and loneliness are the two biggest obstacles to remaining in the community. Members report that they missed the social and community aspects of living in an adult care home with others.

*Activities and Projects*: TCLI members are taught how to use Medicaid transportation and peer support specialists also provide transportation for members.

D. Crisis Services

*1. Describe the network adequacy of the LME/MCO crisis service system including:*

a. *Geographic Availability*: The majority of TCLI members have Medicaid funding, and as stated above, 50% of TCLI members receive ACTT services. Daymark Recovery Services, Inc. is contracted to provide ACTT coverage in Anson, Harnett, Hoke, Lee, Randolph, Richmond, Montgomery and Moore Counties. Easter Seals is operating out of Harnett County, and 3 other ACT Teams are operating out of Guilford County with coverage in Randolph County.

b. *Array and intensity of services*: In addition to the ACTT services referenced above, additional services available during crisis situations include:

- Transition Management Services that include personal crisis management and relapse prevention plans for TCLI members.
- Community Support Team services.
- Walk-In Crisis Units in all 9 counties of the catchment area.
- Mobile Crisis coverage across the catchment area.
- Emergency Department coverage, and
- Inpatient hospitalization

c. Sufficiency to offer timely and accessible services and supports to individuals experiencing a behavioral health crisis:

- ACTT services have "first responders" available 24/7, and this service includes crisis response and the development of a crisis management plan. Sandhills Center meets 100% access standard for ACTT services.
- Community Support Team (CST) services are available 24/7, and this service includes crisis management, crisis planning and

prevention. Sandhills Center meets 100% access standard for CST services.

- Walk-In Crisis Unit is open 24/7 in Guilford County and is available 8 am – 5pm in the remaining 8 counties of the catchment area.
- Mobile Crisis response to a crisis in community is 2 hours and the team will make referrals and will facilitate 911 transport to Emergency Departments and hospitals as needed, and
- Emergency Department and inpatient coverage in 24/7

d. Service gaps and needs:
We are not aware of gaps in the availability of timely crisis services to the TCLI population.

*2. Describe the extent to which crisis services are provided in the least restrictive* setting and consistent with an already developed individual community-based crisis plan or in a manner that develops such a plan as a result of the crisis situation, and in a manner that prevents unnecessary hospitalization, incarceration or institutionalization.

TCLI members receiving an enhanced service have a crisis plan to be followed when the member is experiencing a crisis situation. In addition, Daymark is contracted to provide Walk-In/Crisis Units in Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph and Richmond Counties. RHA and Monarch are contracted to provide Walk-In/Crisis Units in Guilford County. Therapeutic Alternatives provides Mobile Crisis services in all of Sandhills Center's 9 counties.

*3. Describe obstacles and barriers as well as recent activities and projects to address* gaps related to crisis service availability, delivery, sufficiency, and outcomes.

There are currently no obstacles or barriers related to crisis services available to TCLI consumers. In the Access and Availability section of this Report, 100% of Sandhills Center members (both Medicaid and IPRS funded) had access to at least 1 provider in catchment area for Facility-based Crisis Services for adults.

*Projects:* Following a competitive bid process, Sandhills Center awarded a contract to Daymark Recovery Services, Inc. for an adult Facility-based Crisis (FBC)/Comprehensive Care Center to be located in Randolph County, a central location in the catchment area. This facility will house 23-hour observations beds and 16 FBC beds. The facility is slated to open the summer of 2019. In addition, Sandhills Center is in the process of constructing a child Facility-based Crisis/Comprehensive Care Center in Richmond County at the southern border of our catchment area. This facility is slated to open early 2020.

# Trillium Health Resources

Community-Based Suportive Housing Slots

**Describe service gaps and needs, obstacles and barriers, and recent activities and projects in the LME/MCO to Identify and engage eligible individuals in the TCLI priority population.**

Trillium has offered continuous training to providers, community stakeholders and Members regarding the Olmstead Settlement and the TCLI program. The Preadmission Screening and Resident Review (PASARR) had previously been a barrier to engaging Members who were TCLI-eligible in the program. On November 1, 2018, the Referral Verification and Screening (RSVP) process was implemented, which allowed for each LME/MCO to determine TCLI eligibility at the LME/MCO level and to expedite personal care services via the new process. TCLI continues to work with state and community hospitals to receive information for Members in a more timely and efficient manner to assure a Member can be diverted from Adult Care Home entry upon discharge. Trillium has implemented revised contracts. TCLI, in conjunction with the Trillium Housing Department, is establishing bridge housing to assist Members in transitioning from a state hospital to independent living without entering an Adult Care Home. Significantly, in other TCLI areas, the MCO re- housed 24 Members displaced by Hurricane Florence; housed 121 new participants to the program; and had only two participants leave the program this year due to significant illness.

**Describe service gaps and needs, obstacles and barriers, and recent activities and projects in the LME/MCO to provide access and transition individuals to community-based supported housing.**

Transportation has been and will most likely continue to be an obstacle in the Trillium catchment area due to the high number of rural counties. Available and affordable housing is an obstacle. Housing for Members who have criminal backgrounds, extensive poor credit history, or are sex offenders continues to be difficult to identify. Trillium TCLI and Housing staff have diligently worked with private property owners to cultivate new housing opportunities.

**Describe service gaps and needs, obstacles and barriers, and recent activities and projects in the LME/MCO to transition individuals within 90 days of assignment to a transition team.**

Obstacles and barriers include a lack of affordable housing, extensive criminal records and poor credit history as well as a need for additional accessible or first floor apartments for older Members or Members with special needs.

**Describe service gaps and needs, obstacles and barriers, and recent activities and projects in the LME/MCO to support -based housing.**

Monthly follow-up by post-transition coordinators facilitates tenure in housing as well as scheduled meetings with staff to create a housing plan for Members. Access to Personal Care Service is limited and often difficult to establish in a timely manner, however, adding nursing staff to the TCLI program has assisted in streamlining the process.

IPS Supported Employment

**Describe the network adequacy of IPS-Supported Employment services, including numbers, locations and capacity of fidelity teams; the LME/ and service gaps and needs.**

Currently, there are eight teams operating in 24 counties within the Trillium 26-county catchment. The identified gap was the lack of a team to support all 26 counties in the catchment. An RFP has been completed and a new team will start serving the two remaining counties of Nash and Columbus this fiscal year.

The existing eight teams are serving 329 Members with the capacity to serve 476 Members. Per the new service definition released January 2019, a full IPS Team with eight ESPs and a Team Lead can serve 210 Members. Based on the current eight teams, the LME/MCO capacity would be 1680 if each team could get to full capacity. Once the additional team is operational in Nash and Columbus County, that number will rise to 1890 if all teams are fully staffed.

Presently, providers need more knowledge about the service to increase referrals to IPS teams. As the number of referrals increase, providers will have the incentive to hire more staff to fill the teams to full capacity in order to serve a full cohort of Members.

**Describe obstacles and barriers as well as recent activities and projects to engage and refer individuals in the TCLI priority population, including individuals with SMI living in community-based supportive housing and individuals living in or at risk of entry to adult care homes.**

In September 2018, Hurricane Florence created many obstacles for IPS Supported Employment, including IPS Team staff and Members being displaced out of the area due to damage to homes and lack of housing in the affected areas after the storms. Many providers have had to try to replace staff, therefore team staff numbers have dropped, which drops the number of Members who can be served.

Also, many teams have had to discharge Members as they have moved out of the area in order to find affordable housing. There is currently not a lot of knowledge about the service among providers. Trillium has formed a dedicated IPS Workgroup to work with IPS teams and providers to support initiatives, such as increasing knowledge of the service within the provider network. The workgroup has discussed things such as

highlighting the service in newsletters and other provider communications. Trillium has also assigned dedicated Contract Managers to work closely with IPS teams and to provide leadership and be a source of mediation between the provider and Trillium. Trillium reviews and reports to the State the addition of new Members who are In-/At-Risk based on In-/At-Risk checklists submitted by providers each month. Additional barriers include employer participation. Many of the teams are in rural areas with few employers and, in some cases, the number of employers has also dropped due to the storm.

In many rural communities, transportation is an issue with many areas not having a public system. In order to make employment sustainable, Members must have access to transportation as the services decrease and as they are discharged. Trillium and the IPS Team are currently participating in a Regional IPS Coalition with state fidelity reviewers, other LMEs/MCOs, and Vocational Rehabilitation Counselors. The coalition meets quarterly to discuss issues, barriers, solutions and successes of the service.

The misconception that participating in the service will result in the loss of benefits, i.e. SNAP, SI benefits, is another barrier. The new service definition addresses this in the optional addition of a Benefits Counselor to the IPS team. The person would be a Certified Work Incentives Counselor and would be able to address Member concerns about benefits. Trillium is encouraging IPS teams to add this position and some providers were allocated NON-UCR funds for benefits counseling for Members. Trillium also awarded Non-UCR funds to providers to help with the cost of behavioral team meetings for providers.

As stated above, Non-UCR funds were awarded to a provider to start an additional two counties in the area to ensure Trillium's full catchment is being served.

Community-Based MH Services

Describe the array and intensity of community-based mental health service provided to individuals living in supportive housing, as well as their sufficiency, as indicated by the individuals' ability to obtain and maintain a stable housing and by other personal outcomes indicative of greater integration in the community. Personal outcomes in response should include the following:

**Supportive housing tenure and maintenance of chosen living arrangement**

TMS, ACTT, Peer Support, CST, Medication Management, Outpatient Therapy

**Hospital, adult care home, or inpatient psychiatric facility admissions**

Nine TCLI Members served in inpatient; Trillium unable to run data on ACH services because it does not pay for these services.

**Use of crisis beds and community hospital admissions**

Four TCLI Members served in Crisis Beds

**Emergency room visits**

54 TCLI Members served via Levels 1-5 ED visits

**Incidents of harm**

15 incidents (source: IRIS reporting)

**Time spent in congregate day programming**

18 TCLI Members served in PSR

**Employment**

28 TCLI Members participate in IPS SE

**School attendance / Enrollment**

None known

Engagement in community life

Trillium reviewed TCLI Pre-transition, 11-month and 24-month Quality of Life Survey raw data. A review of survey responses revealed the most-identified barriers to engagement in community life were transportation and money/financial issues. This appears to coincide with the NC DHHS Transitions to Community Living Initiative Quality of Life Survey Summary Results - July 2017, which states transportation remains the most frequently cited challenge to and satisfaction.

The statewide data shows considerable variability across LME/MCO catchment areas. A total of one in five respondents in supportive housing reported lack of transportation has been an obstacle to going out into the community. Nearly one-third of participants cited transportation as an area of additional needed support. However, transportation was not among the indicators that most differentiated between individuals who maintained or subsequently left housing.

It went on to state transportation was a source of dissatisfaction for one of four individuals in supportive housing. One of seven were dissatisfied with options for leisure/recreation, church, parks/open space, and three areas.

Source: https://files.nc.gov/ncdhhs/documents/files/2016TCLIAnnualReportQoLAppendix.pdf

**Describe gaps and needs in the community-based mental health services provided to individuals in community-based supportive housing. Note that this item refers to gaps and needs related to the provision and outcomes of services, and not solely to the access and choice standards addressed in Section One.**

TCLI, in conjunction with the Trillium Housing Department, is establishing bridge housing to assist Members in transitioning from a state hospital to independent living without entering an Adult Care Home.

**Describe obstacles and barriers as well as recent activities and projects to address gaps in the array, intensity, and sufficiency of community based mental health services provided to individuals in supportive housing.**

TCLI and Housing staff have diligently worked with private property owners to cultivate new housing opportunities. Access to Personal Care Service is limited and often difficult to establish in a timely manner, however, adding nursing staff to the TCLI program has assisted in streamlining the process.

Crisis Services

**Describe the network adequacy of the LME/MCO crisis service system, including the geographic availability, array and intensity of services; the sufficiency to offer timely and accessible services and supports to individuals experiencing a behavioral health crisis; and service gaps and needs. Note that this item refers to gaps and needs related to the provision and outcomes of services, and not solely to the access and choice standards addressed in Section One.**

No barriers noted in crisis services.

Service in Trillium's Northern Region are identified as "ACT-like" (Assertive Community Treatment-like ) services. This means an unbundled array of services is provided 24/7 throughout the Trillium catchment to all Members regardless of diagnosis or payor source, including CST, Peer Support, Tenancy Management, Individual Therapy, Individual Supports, Supportive Employment, and Medication Management, Crisis services.

In addition, all TCLI Members receive Tenancy Management either through ACTT or as a stand-alone service. Tenancy Management is designed to assist Members with resolving issues that may arise while residing in an independent setting. Such issues may be related to housing and loneliness, communicating with the landlord, general maintenance of the home, cleaning and preparing food. Tenancy Management assists by being proactive with Members in honing and improving activities of daily living (ADL) and attempting to avoid crisis or separation from independent living.

**Describe the extent to which crisis services are provided in the least restrictive setting and consistent with an already developed individual community-based crisis plan or in a manner that develops such a plan as a result of the crisis, and in a manner that prevents unnecessary hospitalization, incarceration or institutionalization.**

Trillium offers Facility-Based Crisis and Respite throughout the 26-county catchment area to help prevent crisis and support Members avoid the need for a higher level of care. Trillium also collaborates with numerous Wellness Cities. A Wellness City is a community of individuals in recovery working together with a staff of well-trained peers. Each Wellness City typically offers outreach and peer support groups that teach Members self-management skills. As a preventive measure, these skills aid in avoiding a crisis.

All TCLI Members are linked to a provider upon contact with Mobile Crisis Services. Once linked to a provider agency, a Comprehensive Clinical Assessment is completed. A Person-Centered Plan (PCP) and Comprehensive Crisis Plan are developed and/or updated to address the most recent crisis episode. TCLI Members also are assigned to a Transition or Post Transition Coordinator. In the event of three crisis episodes, a root cause analysis, which includes consultations by Trillium's Chief Medical Officer, is conducted to assess the need for additional interventions.

**Describe obstacles and barriers as well as recent activities and projects to address gaps related to crisis service availability, delivery, sufficiency, and outcomes.**

Integrated Family Services (IFS) expanded Mobile Crisis into Columbus County, opening an office as well. Trillium hosted two Provider Fairs in Columbus County to engage providers delivering services to Columbus County recipients as a mechanism to avoid/prevent any lapses in services. Trillium accepted

and offered contracts to all providers from Eastpointe LME/MCO who had served Members in Columbus County during the past year.

# Vaya Health

Community Based Supported Housing Slots

**How does the TCLI team identify and engage eligible individuals in the Transitions to Community Living Initiative (TCLI) priority population?**

Vaya's TCLI team provides In Reach to eligible individuals in the community. This includes individuals that have been identified via; Referral, Screening, Verification Process (RSVP), the DHHS In Reach list, and Broughton State Hospital. Vaya now has a TCLI Community Liaison who works in the community, hospitals, Department of Social Services and other providers and stakeholders to provide education around TCLI and the RSVP process. The TCLI Community Liaison provides training/resources to community hospitals, legal guardians, ombudsman, service providers and county Departments of Social Services to assist with identifying individuals that may be eligible for TCLI. RSVP referrals are being screened by Vaya and TCLI eligible individuals are identified. These individuals are notified, and the Community Integration Plan is developed along with Options Counseling through the In Reach process.

**How does the TCLI team provide access and transition individuals to community-based supported housing?**

For FY 18-19, TCLI housed over 84 people in the community with tenancy supports. TCLI works in collaboration with Vaya's Housing, Member Services and Provider Network departments, as well as DHHS Regional Housing Coordinator's to assist with identifying the housing inventory available in each county. Each TCLI participant moving forward in transition planning, receives a Comprehensive Clinical Assessment (CCA) to assist with identifying necessary services to help the individual with maintaining supported housing in the community. Every TCLI participant transitions into supported independent living with a tenancy support service.

**How does the TCLI team ensure an individual is transitioned within 90 days of assignment to a transition team?**

During the In Reach process, barriers to housing are identified and addressed to help promote a smooth transition into housing within 90 days. TCLI works diligently to ensure that each individual transitions into the community within 90 days of a DHHS housing slot being assigned. In FY 18-19, 98% of individuals transitioned within 90 days.

**How does the TCLI team support individuals' housing tenure and ability to maintain supportive community-based housing?**

Our Transition Coordinators ensure that each participant is receiving a tenancy support service while in supported living through TCLI. Transition Coordinators are charged with managing each transition by requesting monthly updates from providers. TCLI collaborates with the Tenancy Support provider, and the rest of the transition team, to support an individualized approach when generating the person-centered plan and supporting the individual throughout their tenancy.

IPS-Supported Employment

**How does the TCLI team ensure network adequacy of IPS-Supported Employment services?**

Vaya has worked with our network of providers to develop IPS-Supported Employment across our region:

RHA Health Services – Contracted to serve Buncombe and McDowell counties. Currently FPS has one (1) team lead with three (3) Employment Support Professionals, (1) Employment Peer Mentors, and one (1) 0.5 FTE Program Assistant. This team's current capacity is eighty-five (85) individuals yet is RHA is serving forty-one (41) individuals as of 6/18/19. One ESP began work today (6/18/19) so is not currently carrying a caseload. RHA has the capacity/ability to serve forty-four (44) more individuals including but not limited to the TCLI population.

Family Preservation Services – Contracted to serve Buncombe, Henderson, Polk, and Rutherford counties. FPS has one team consisting of a team lead, one (1) Employment Support Professional, and one Employment Peer mentor. This team is currently serving fifty (50) individuals, including but not limited to the TCLI population, which is their maximum capacity. They are advertising for an additional ESP but have not yet secured the right candidate.

Meridian – Contracted to serve Haywood, Jackson, Macon, Graham, Cherokee, Clay, Transylvania and Swain counties. Currently, Meridian has one (1) team lead, one (1) ESP, and 1 EPM. Team is currently serving twenty-four (24) individuals with the capacity to serve thirty-five (35) in its current state.

Daymark – Contracted to serve Alleghany, Ashe, Avery, Watauga, and Wilkes counties. Their fidelity review was completed late November of 2018. Daymark has one (1)Team Lead, two (2) Employment Support Professionals, and one (1) Employment Peer Mentor. Daymark is currently serving thirty-one (31) individuals including but not limited to the TCLI population. Based on their current team structure they have the ability to serve an additional twenty-nine members.

If a waitlist occurs, priority populations (including TCLI participants) are placed at the top of the service waitlist for the team serving that county as well as the waitlist for teams serving adjoining counties. If referrals come from counties not listed, the IPS-SE team closest to that area will serve the referral.

**What are the obstacles and barriers that the TCLI team has encountered as well as recent activities and projects to engage and refer individuals in the TCLI priority population?**

Barriers include private and paid guardians understanding the TCLI process and being supportive of their ward exploring independent living opportunities. Other barriers include having available housing stock in desired counties and the lack of natural supports for individuals in communities.

Vaya now has a TCLI Community Liaison who works in the community, hospitals, Department of Social Services and other providers and stakeholders to provide education around TCLI and the RSVP process. The TCLI Community Liaison provides training/resources to community hospitals, legal guardians, ombudsman, service providers and county Departments of Social Services to assist with identifying individuals that may be eligible for TCLI.

Community-Based Mental Health Services

**What is the array and intensity of community-based mental health services provided to individuals living in supportive housing?**

After receiving a Comprehensive Clinical Assessment (CCA), TCLI participants could potentially take advantage of Assertive Community Treatment (ACT), Community Support Team (CST), Critical Time

Intervention (CTI), Transition Management Services (TMS), Peer Supports, Individual Therapy, Medication Management, Psychosocial Rehabilitation (PSR), Group Therapy, Substance Abuse Intensive Outpatient Program (SAIOP) and IPS-SE. The Crisis Service Continuum is also available 24/7. Services could be rendered as often as daily to monthly.

**How does the TCLI team provide supportive housing tenure and maintenance of chosen living arrangement?**

TCLI participants continue to receive Tenancy Supports during their tenure through TCLI. Tenancy Support providers communicate with Vaya monthly regarding each participants status and potential issues are addressed to promote continued housing. TCLI participants can access funds for housing related expenses, which if not resolved, will result in the individual being unable to maintain housing..

**How does the TCLI team support members after hospital, adult care home, or inpatient psychiatric facility admissions?**

When an event causes a TCLI participant to enter the hospital, an adult care home or an inpatient psychiatric facility, our team collaborates with the transition team to orchestrate the individuals return to supported living, if that is the desire of the participant. The transition team often consists of Care Management (Acute Response/MHSU), Tenancy Support provider, guardian, Transition Coordinator, as well as natural supports. If the participant is inpatient and desires to return to their home, the TCLI team works to maintain the home by ensuring that necessary bills are paid, and tenancy is maintained during the stabilization period. If the participant returns to a care home, then TCLI resumes In Reach.

**How does the TCLI team address the use of crisis beds and community hospital admissions?**

Because we encourage the least restrictive environment to meet the person's needs, TCLI encourages individuals to reach out to their behavioral health provider and follow their crisis plan instead of utilizing the services of the Emergency Department (ED) for quicker triage and stabilization.

**How does the TCLI team address emergency room visits?**

TCLI encourages individuals to follow their crisis plan and to directly reach out to their behavioral health service provider when they are having an MH/SU crisis instead of dialing 911 or walking into the ED. Once we learn that a participant has utilized the ED, we immediately reach out to the participant's provider to inform, as well as request that the TCLI participant connects with their medical home.

**How does the TCLI team address incidents of harm?**

If there are incidents of harm, TCLI encourages connection to the participant's behavioral health and medical providers as needed. If stabilization needs to occur outside of the home, TCLI coordinates maintaining the home and lease in conjunction with the tenancy support provider.

**How does the TCLI team address time spent in congregate day programming?**

TCLI promotes connecting or reconnecting a participant with natural and paid supports. Participants can take advantage of Psychosocial Rehabilitation, Peer Living Rooms, as well as other community resources. TCLI also works to identify and help pair the individual with community engagements that match their interests.

**How does the TCLI team address employment?**

Each TCLI participant is presented with information about IPS-SE and the value it may bring to their life. When an individual then expresses a desire to volunteer or work, TCLI connects them with the IPS-SE provider in their local community so that they can make an informed choice of whether to further explore the option of gaining meaningful employment at a job of their choice.

**How does the TCLI team address school enrollment and attendance?**

When TCLI participants express a desire to enroll in school, we communicate those wishes to their Tenancy Support provider so that the provider can support them in enrollment and attending school.

**How does the TCLI team address engagement in community life?**

TCLI encourages and assists the provider with linking the participant to community resources. TCLI promotes connecting or reconnecting a participant with natural and paid supports. Often, participants take advantage of Psychosocial Rehabilitation, Peer Living Rooms, as well as other community resources. TCLI also works to identify and help pair the individual with community engagements that match their interests.

**What gaps and needs exist in community-based mental health services provided to individuals in community-based supportive housing?**

There are continued gaps in services for our most rural counties which limit service choice. We are working in conjunction with Vaya's Provider Network team to strengthen service array in all counties. Other barriers include transportation and dentistry that will accept Medicaid.

There continues to be a need for TCLI to educate our tenancy support providers. One provider has invested in a dedicated TCLI specialist. This move has resulted in improvements in TCLI participants receiving efficient, appropriate and timely services. Vaya's Provider Network team also collaborates with the ACTT Coalition to assist with education around Tenancy Supports. An ACTT Learning Collaborative has also been developed and addresses tenancy supports, separation rates, and drivers of separation that can be improved upon.

**Describe the obstacles and barriers as well as recent activities and projects to address gaps in the array, intensity and sufficiency of services for the TCLI population.**

In the fall of 2018, TCLI identified that the current TMS teams were reaching capacity and would not be able to support additional TCLI participants, who would not qualify for other tenancy support services.

Vaya worked with our TMS provider to build an additional team to support the upcoming TCLI members. Vaya also developed a monthly meeting with the TMS provider to forecast capacity and to address any potential gaps or barriers.

This year, Vaya has started to identify the separation rates of ACTT providers. Vaya developed an ACTT Learning Collaborative and separation rates is a standing agenda item. The group discusses ways to better support TCLI participants regarding tenancy support issues, as well as separation rates, in order to improve outcomes.

Crisis Services

**Describe the availability and array of crisis service system.**

In coordination with RHA Health Services Inc. (RHA), Meridian Behavioral Health Services, Family Preservation Services, Daymark Recovery Services and Appalachian Community Services, we support twenty-six (26) Comprehensive Care Walk-In Centers. These Walk-In Centers provide crisis prevention, early intervention, response and stabilization services and supports as an alternative to emergency department visits or institutionalization. Services are provided based on triage protocols for emergent, urgent and routine needs. Comprehensive Care Center practices are based on a trauma informed recovery-oriented system of care and may include:

- Mobile Crisis Management (MCM), Assertive Community Treatment Team (ACTT) and Community Support Teams (CST) that dispatch for all ages, behavioral health and IDD needs. This service is available to any individual regardless of Medicaid status and is available 24/7. Vaya meets the 100% benchmark for MCM, ACTT, and CST by offering a choice of at least two provider agencies within the MCO catchment area.
- Facility Based Crisis (FBC) for adults and children with behavioral health, substance use, and intellectual and developmental disability needs. This service is available 24/7 to any Vaya beneficiary. There are four FBCs serving adults in the Vaya catchment: C3356 (Neil Dobbins Center) in Buncombe county (16 bed capacity), C3 Caldwell in Caldwell county (16 bed capacity), Balsam Center in Haywood county (16 bed capacity), and Synergy Recovery in Wilkes county (12 bed capacity). Vaya meets the 100% benchmark for FBC by offering a choice of at least one provider agency within the MCO catchment area.
- Outpatient Behavioral Health Services. These services are available throughout the week, with enhanced services (CST, ACTT, SAIOP, etc.) having 24/7 on call staff available for any crisis that may emerge.
- Assessment and diagnosis for mental health, substance abuse, and/or intellectual/developmental disability issues as well as crisis planning and referral for future treatment. Assessments are available Monday-Friday during normal business hours and members can walk in to any comprehensive provider to receive an assessment.
- Medication management is available Monday-Friday during normal business hours and can be accessed through enhanced services (ACTT, CST, etc.) for any crisis or PRN need 24/7.
- The Peer-led Living Room at C3356 in Buncombe county is open 7 days a week from 7 AM to 7PM. This living Room has a maximum capacity of 20 participants at any time.
- Recovery Education Centers are available Monday-Friday with centers available in Haywood, Jackson, Macon and Transylvania counties.
- 24/7 Behavioral Health Urgent Care (BHUC) for individuals with mental health, substance use, and intellectual and developmental disability (IDD) needs. This service is available 24/7 to any Vaya beneficiary. There are two BHUCs serving adults in Vaya's catchment area: C3356 in Buncombe county and Balsam Center in Haywood county.

**Describe least restrictive setting and consistency with individual crisis plans.**

Each TCLI participant has a comprehensive community-based crisis plan. The Vaya Health TCLI team works closely with the member and providers of tenancy supports to create these plans. The principles of recovery, housing first, employment first, person-centered practice, and full community inclusion, guide the implementation of the crisis plan. Each TCLI participant has a service or services that wraps the individual with supports (i.e. Individual Supports, IPS-SE, PSR, Peer Supports, ACTT, Critical Time Intervention, Transition Management Services, MCM, Home Health, Primary Care Physician, etc.). These services are in place to help prevent unnecessary hospitalizations, incarceration or institutionalization. Providers of these services follow the crisis plan to help ensure that the member can continue in the least restrictive setting. Providers strive to provide crisis response in the home or community. If a higher level of care is needed, the member can use a non-inpatient facility, such as Facility Based Crisis, to avoid unnecessary hospitalization, incarceration or institutionalization.

**What are the obstacles and barriers to crisis service availability and what are the recent activities and projects to address these gaps?**

At times, TCLI participants, as well as other Vaya beneficiaries go to Emergency Departments, when lower levels of care could be appropriate. Vaya is working to address this by providing education about our facility based crisis and behavioral health urgent care (BHUC) centers and encouraging providers to show members these facilities. Vaya is actively working to ensure that these facilities become designated IVC drop offs, which will also help members receive care in the least restrictive setting.

In January of 2017 Vaya Health was selected for a 3.5-million-dollar pilot project addressing Comprehensive Case Management (CCM) for Adults with Mental Health Treatment and Substance Use Disorder Treatment needs. Many of the nearly 600 individuals that present to the Mission Health's Emergency Department (ED) monthly with a primary behavioral health concern, are TCLI members. This unique partnership of Vaya, RHA, and Mission Hospital, provides 24/7/365 staff in the ED for immediate linkage to services, as well as case management services post discharge. CCM ensures individuals are successfully linked to community supports that can prevent future ED visits and potential institutional placements. The pilot has continued and anticipates funding through 2019/2020.