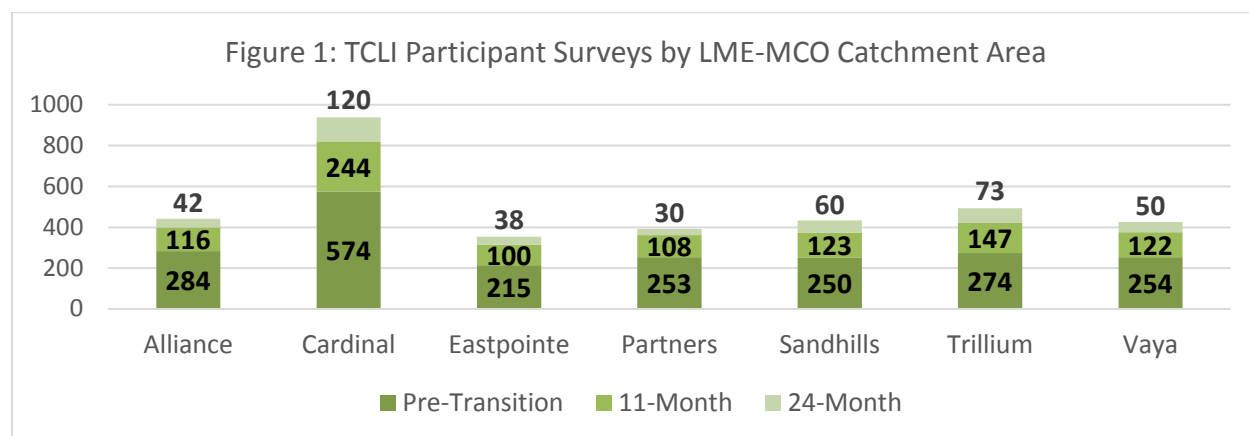


Appendix to the Annual Report on North Carolina Supportive Housing Program: Participant Quality of Life Survey Summary Report

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's transition to supportive housing. They then submit survey responses through the State's secure, web-based survey application.

This annual report summarizes 2,217 TCLI participants' responses to a total of 3,477 surveys submitted through June 30, 2018. The total number includes 2,104 pre-transition, 960 11-month, and 413 24-month surveys.¹ (See Figure 1.)

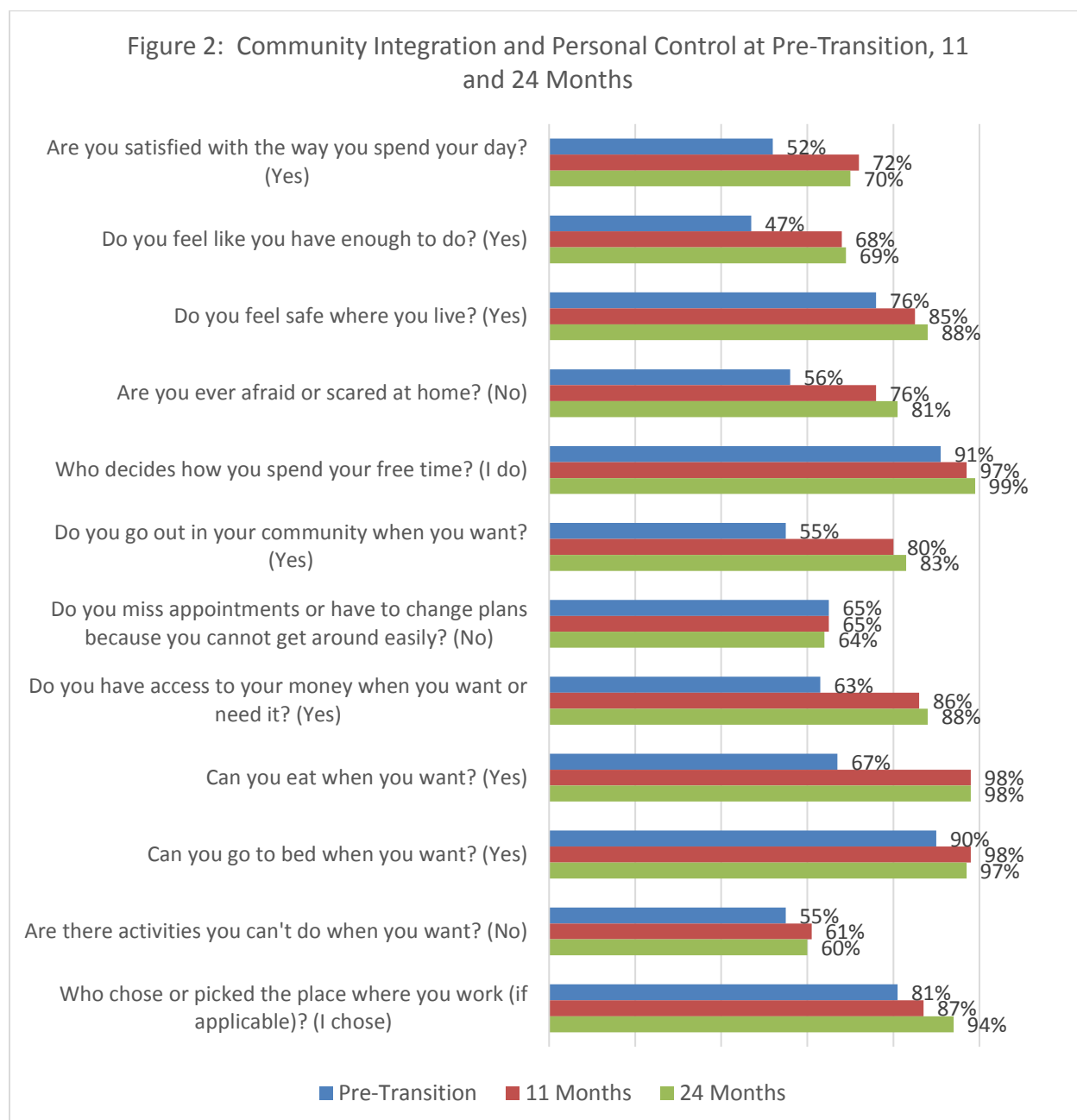


For all analyses by LME-MCO catchment area reported in this appendix, each survey is assigned to the LME-MCO that submitted it or to the LME-MCO with which the submitting LME-MCO later merged. Participants may be housed in and/or subsequently move to different LME-MCO catchment areas.

¹ 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 percent of all expected surveys have been submitted. This includes 90 percent of all Pre-transition Surveys for individuals housed through June 30, 2018, and 76 and 74 percent, respectively, of individuals housed for 11 and 24 months. During the 2017-18 State Fiscal Year, the overall submission rate was 89 percent, reflecting a 97 percent submission rate for pre-transition surveys and 82 percent submission rates for both follow-up surveys. Individual survey participation is voluntary, and participant refusals are counted toward LME-MCO submission rates if the reason the participant declined is documented and reported to the State team. Through June 30, 2018, 34 participant refusals, or one percent of all submissions, have been counted toward calculated submission rates.

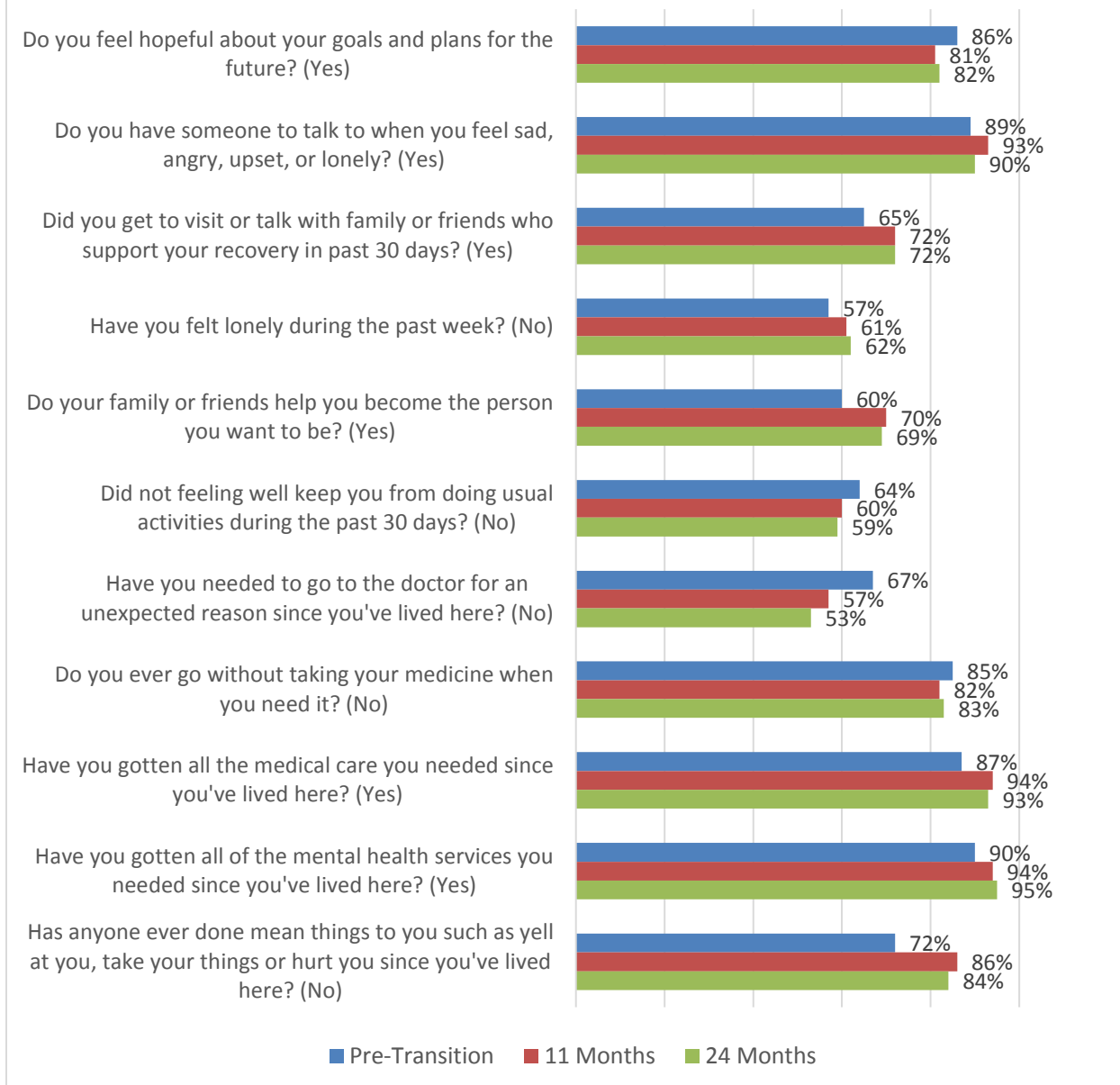
Quality of Life in Supportive Housing

Figures 2, 3, 4, and 5 show consistent patterns compared to previous years in participants' pre- and post-transition experiences of community integration and personal control; health and well-being; and satisfaction with services, supports, housing, and community. In most areas, participants were significantly more likely to report positive experiences at both follow-up surveys after transitioning to supportive housing.



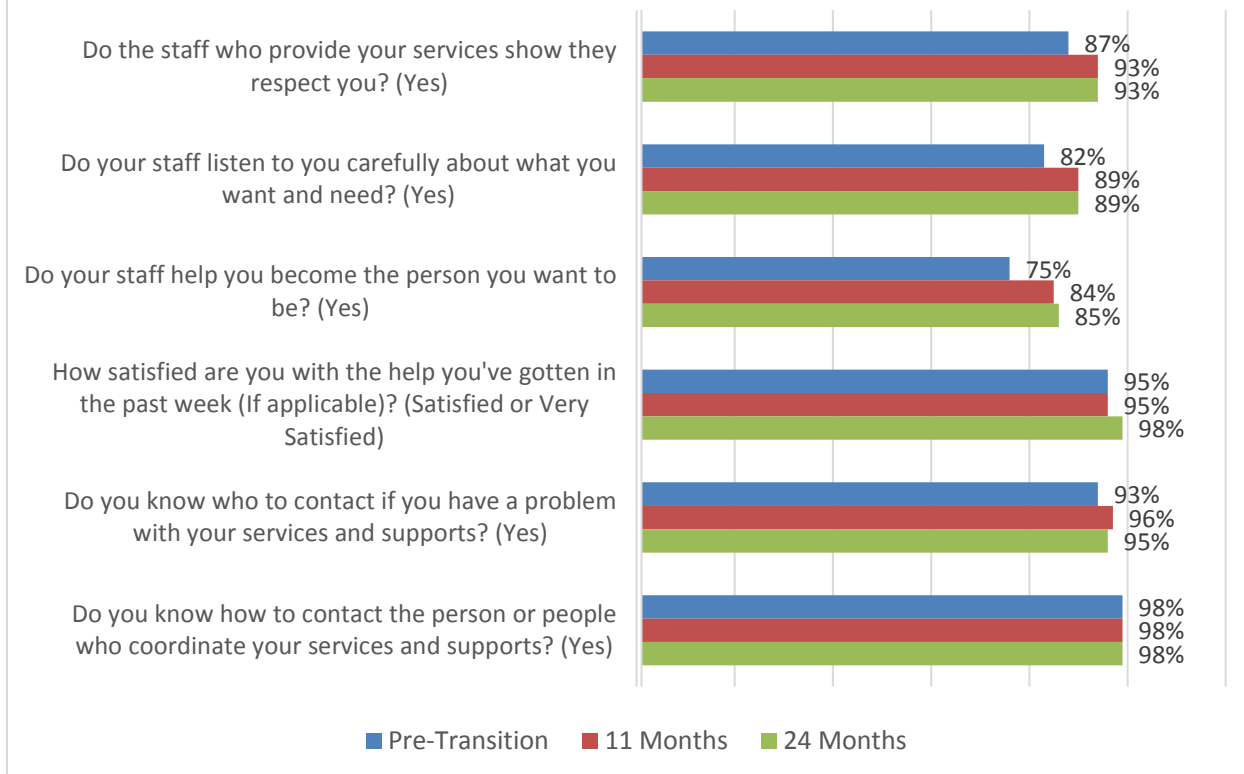
“No Response” and “Unsure” responses are excluded from percentage denominators.

Figure 3: Personal Well-Being at Pre-Transition, 11 and 24 Months



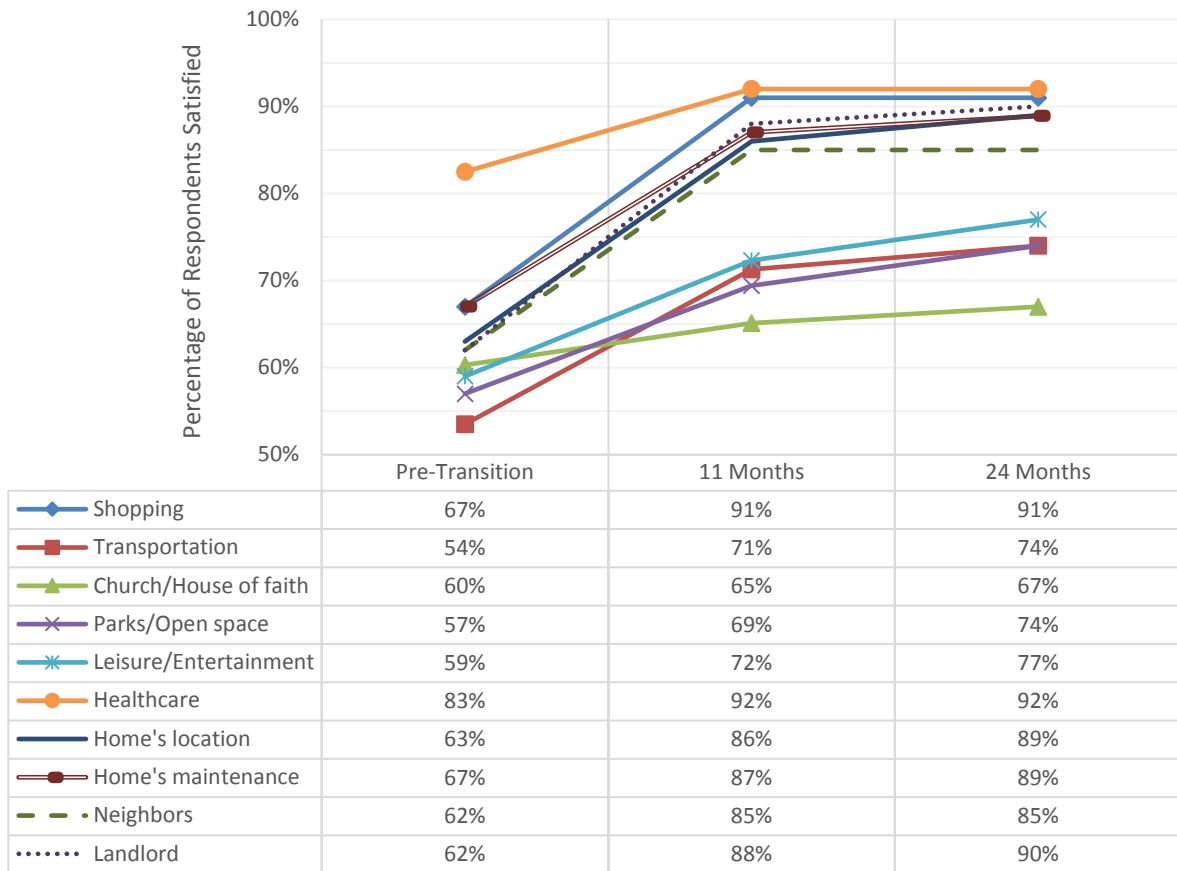
“No Response” and “Unsure” responses are excluded from percentage denominators.

Figure 4: Satisfaction With Services at Pre-Transition, 11 and 24 Months



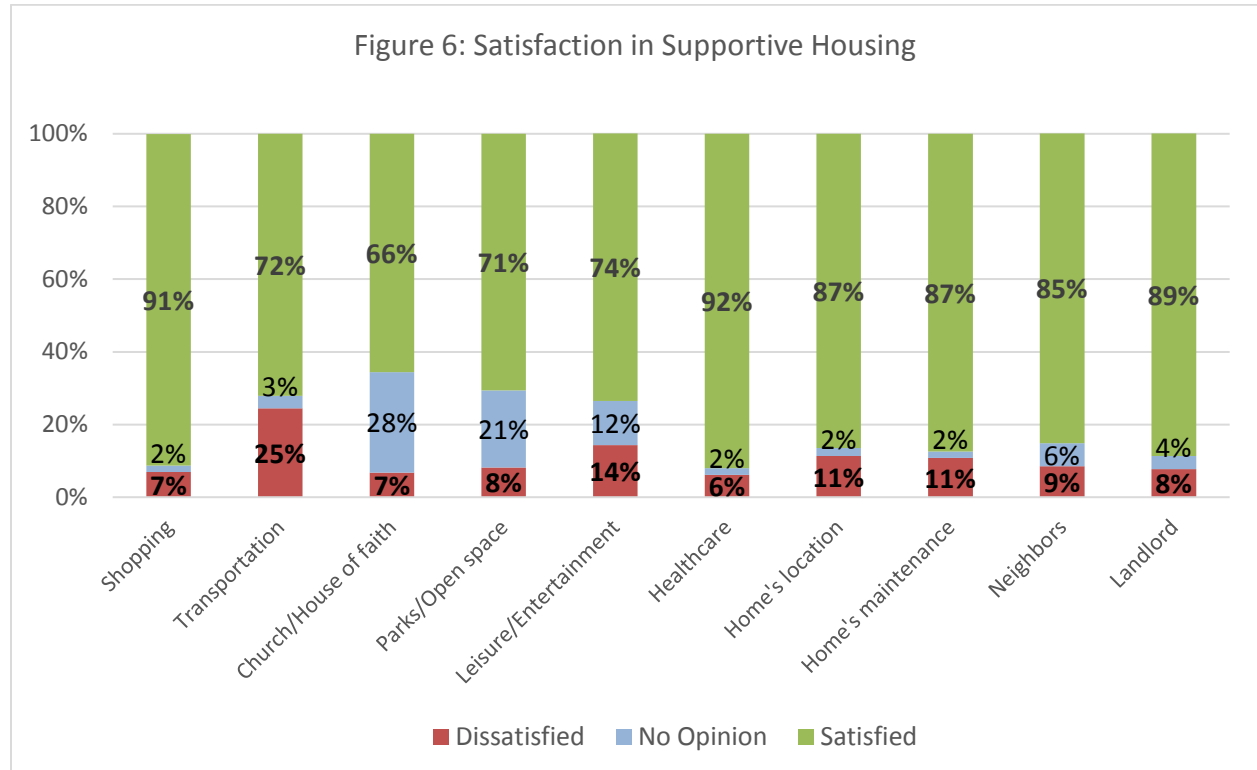
“No Response” and “Unsure” responses are excluded from percentage denominators.

Figure 5: Satisfaction with Housing and Community



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

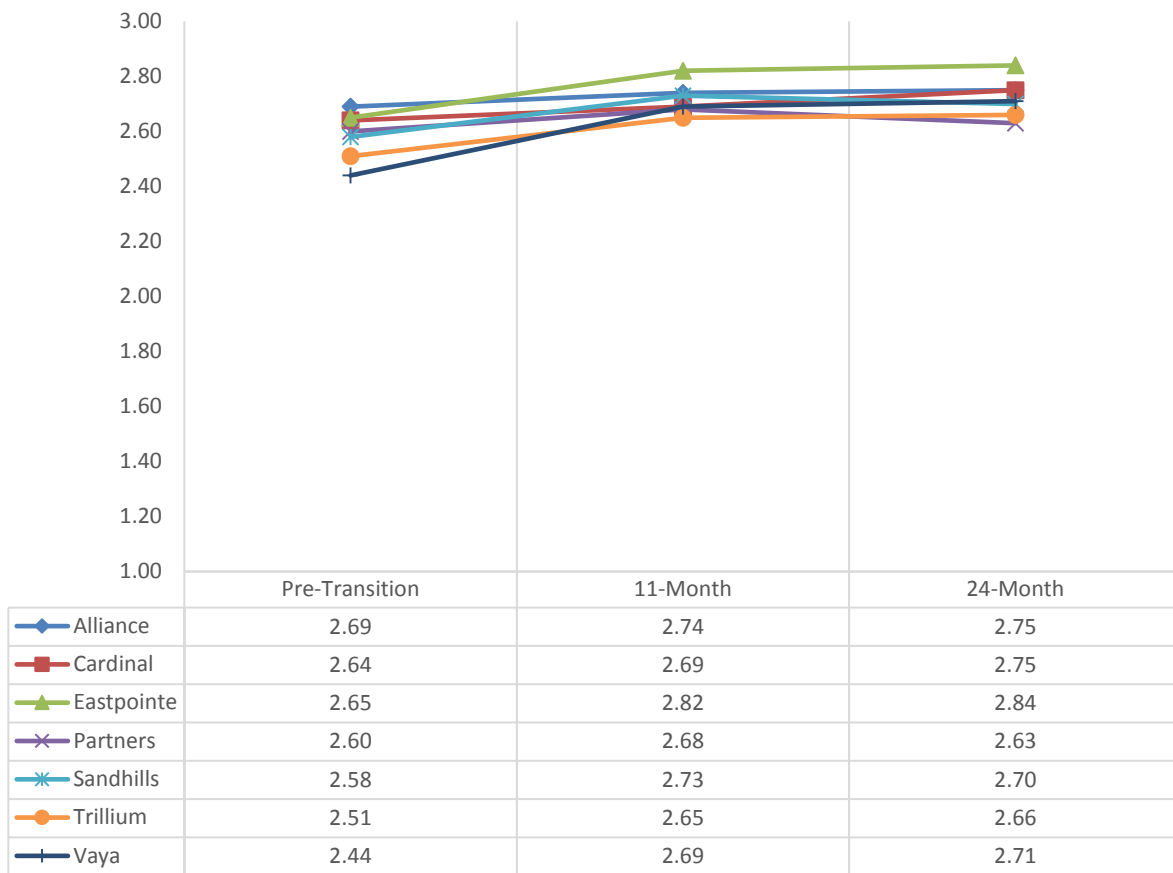
As illustrated in Figure 6, the relatively lower rates of reported satisfaction post-transition with some local resources such as Church and Parks reflect the larger percentages of participants who reported no opinion. Areas with the highest rates of post-transition dissatisfaction continue to be Transportation, Leisure, Home's location, and Home's maintenance.



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

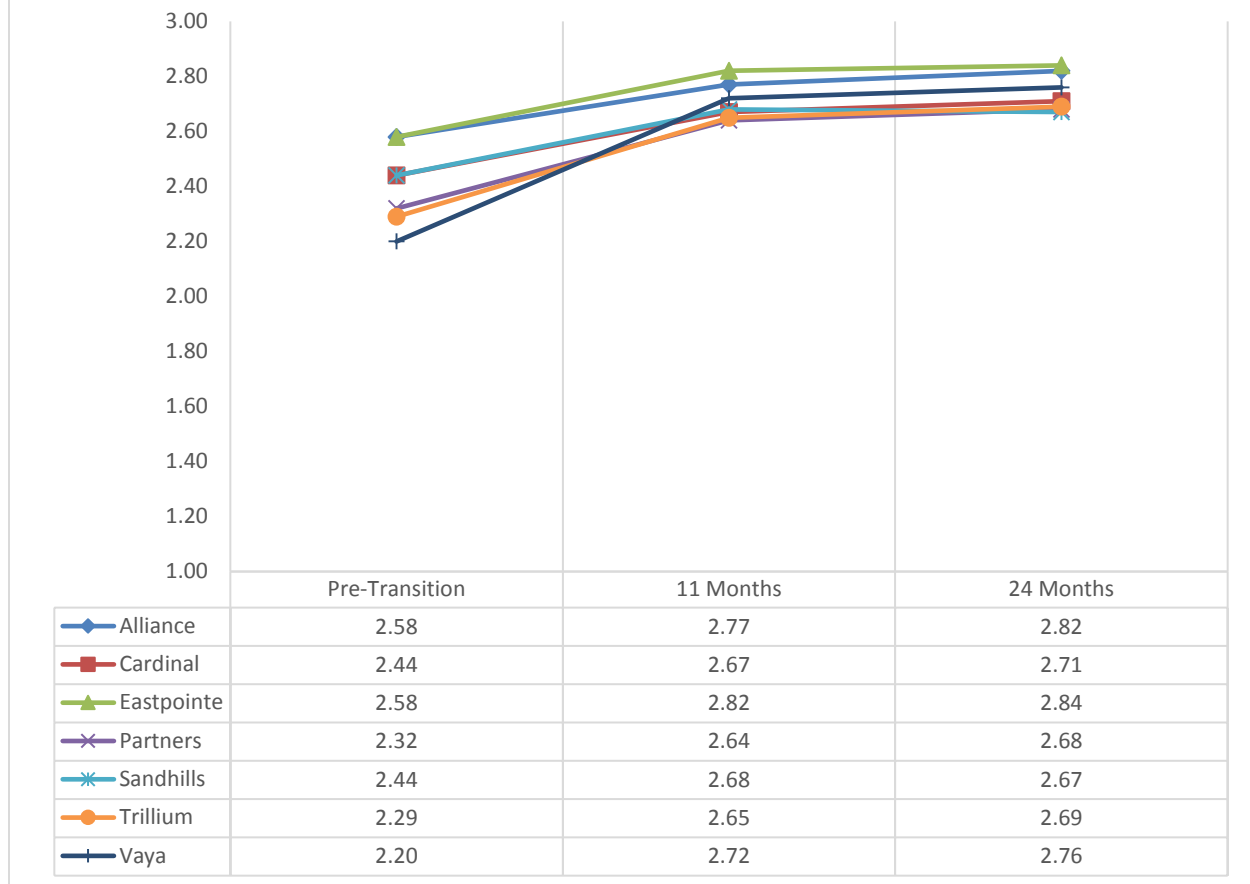
As illustrated in Figures 7 and 8, both the Quality of Life (QoL) Index based on the 29 survey questions listed in Figures 2, 3, and 4, and the aggregate Satisfaction Index based on the ten housing and community satisfaction ratings in Figure 5, showed virtually no change compared to the previous annual report. In general, scores were significantly higher at both follow-up points compared to pre-transition, and participants from all LME-MCO catchment areas reported comparable improvements in their experiences.

Figure 7: Quality of Life Index by Catchment Area



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.

Figure 8: Satisfaction Index by Catchment Area



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 5. The possible score range is 1.0 to 3.0.

Item responses to 1,094 surveys of individuals who maintained housing after the follow-up survey and throughout the report period were compared to responses from 279 follow-up surveys of individuals who later left housing. This analysis was used to identify a subset of 16 survey questions most predictive of housing stability, defined for this analysis in terms of the person's housing status at the end of the study period.

The survey questions are shown in Table 1 in descending order of the strength of their association with subsequent housing stability. An index computed as the average numerical score of the 16 items was strongly correlated with the QoL Index (correlation = .89) and with the Satisfaction Index (correlation = .73), which were also moderately associated (correlation = .59).

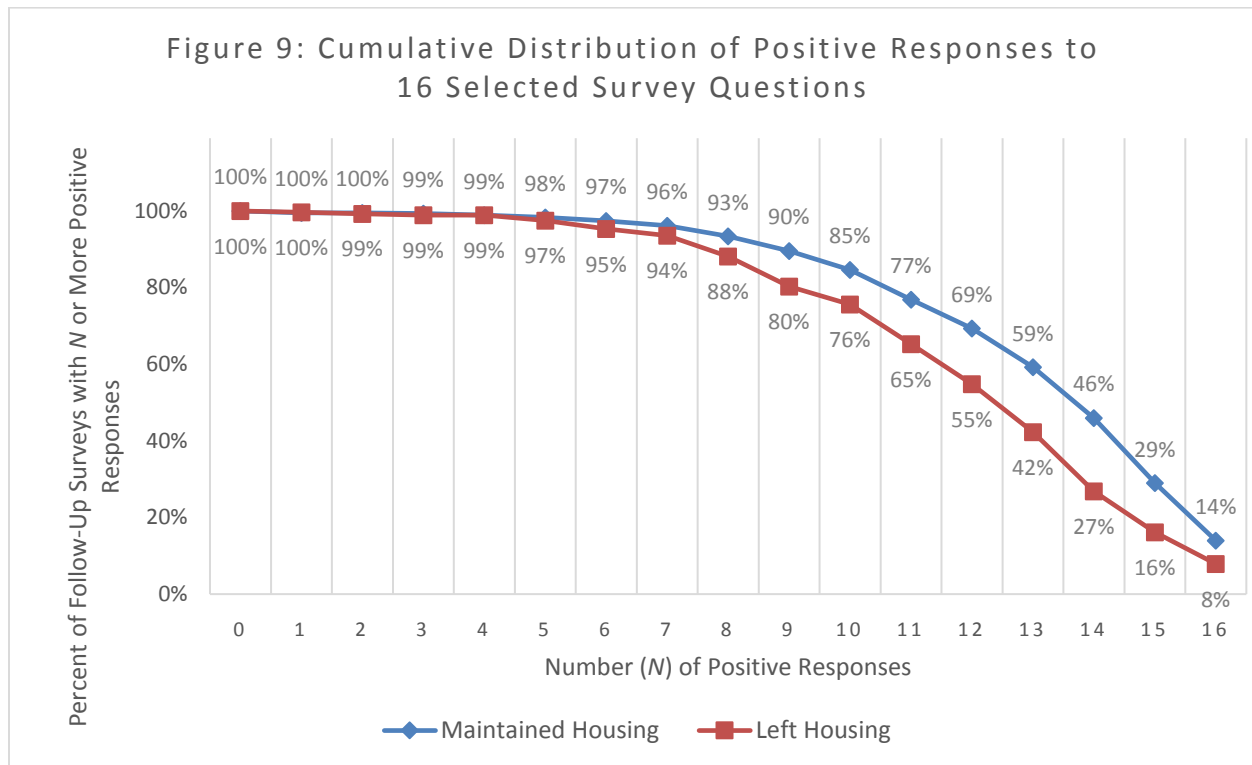
Table 1: Survey Items Most Predictive of Housing Status After Follow-Up Survey

Question Number	Question Content
21	Do your family or friends help you become the person you want to be? (Yes)
6	Do you feel safe where you live? (Yes)
15d	Satisfied with parks/open space
13	Can you eat when you want? (Yes)
31	Do your staff help you become the person you want to be? (Yes)
20	Did you get to visit or talk with family or friends who support your recovery in past 30 days? (Yes)
23	Have you needed to go to the doctor for an unexpected reason since you've lived here? (No)
14	Are there activities you can't do when you want? (No)
8	Do you go out in your community when you want? (Yes)
15g	Satisfied with home's location
11	Do you have access to your money when you want or need it? (Yes)
7	Are you ever afraid or scared at home? (No)
15j	Satisfaction with landlord
15h	Satisfaction with maintenance
3	Do you feel like you have enough to do? (Yes)
24	Do you ever go without taking your medicine when you need it? (No)

All three aggregate index indexes were statistically significant but weak predictors of the categorical housing stability variable. Housing status on June 30, 2018 was predicted by the QoL Index with a correlation of only $r = .09$, by the Satisfaction Index with a correlation of $r = .06$, and by the average score of Table 1 items with a correlation of $r = .15$.

On average, individuals who maintained housing selected the most positive response option to significantly more questions than individuals no longer in housing, but only by an average of one question (means = 11.4 and 12.5). As shown in Figure 10, the difference between groups

increases slightly with the total number of positive responses. Compared to those who maintained housing, individuals who later left housing were approximately 60 percent as likely to respond positively to 14 or more of the 16 questions.



“Positive responses” are the question response options that indicate more positive experiences and perceptions. Neutral or middle responses such as “sometimes” are not included in the count of positive responses. Refer to Table 1 for the list of survey questions. Follow-Up Surveys include 11- and 24-month surveys.

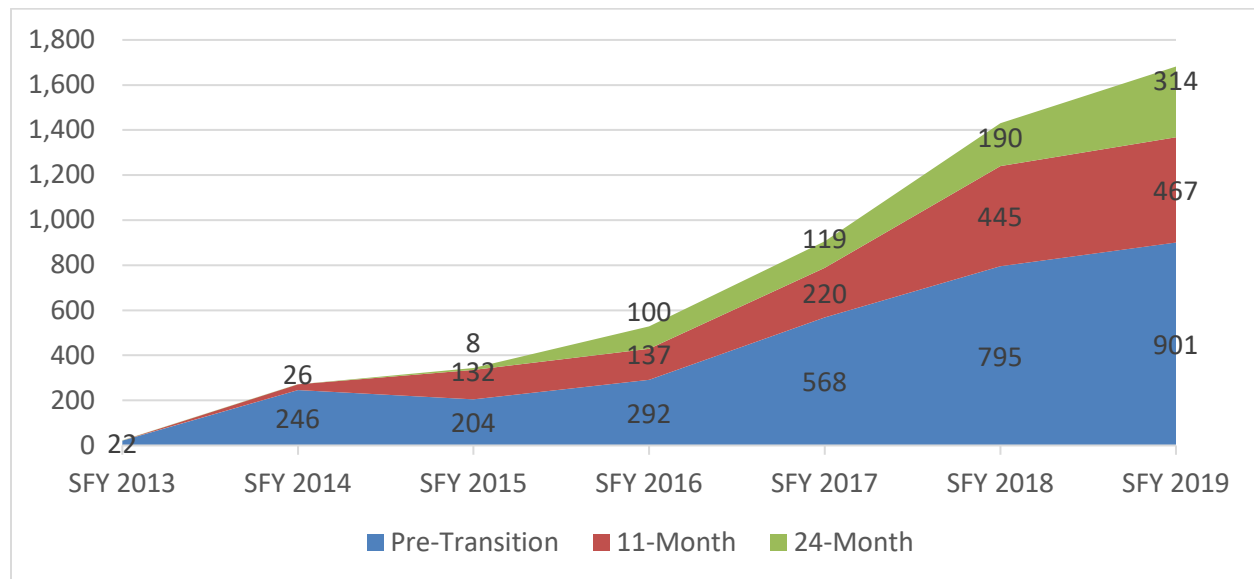
Appendix A to the Annual Report on North Carolina Supportive Housing Program: Participant Quality of Life Survey Summary Report

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.

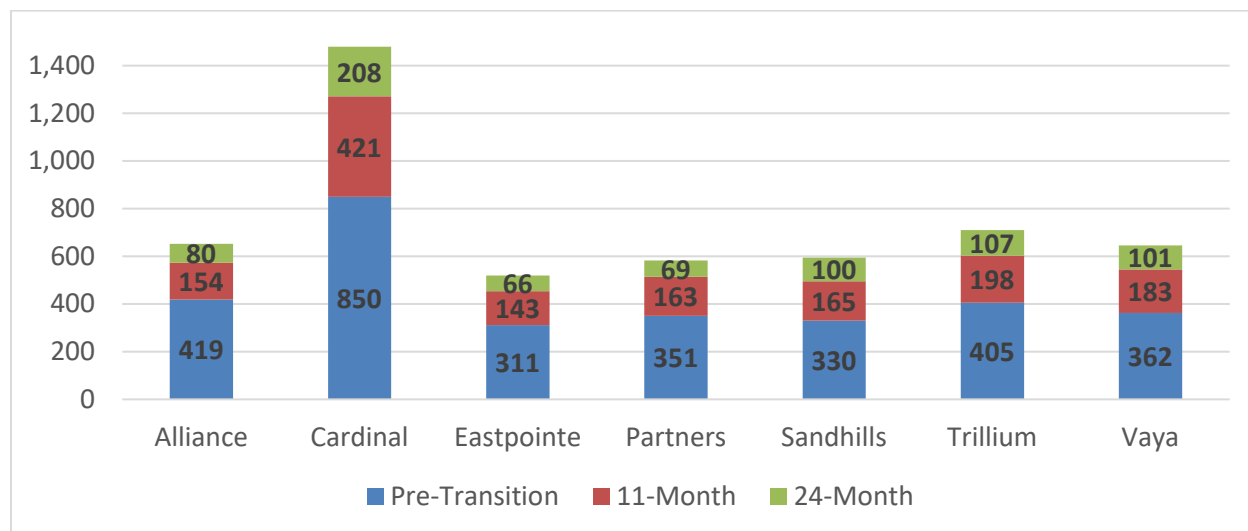
With this annual report, 3,159 individuals' responses to a total of 5,186 surveys submitted through approximately June 30, 2019 have been analyzed to date. The total number includes 3,028 pre-transition, 1,427 11-month, and 731 24-month surveys. (See Figures 1, 2 and 3.)

Figure 1: Completed Participant Surveys by State Fiscal Year



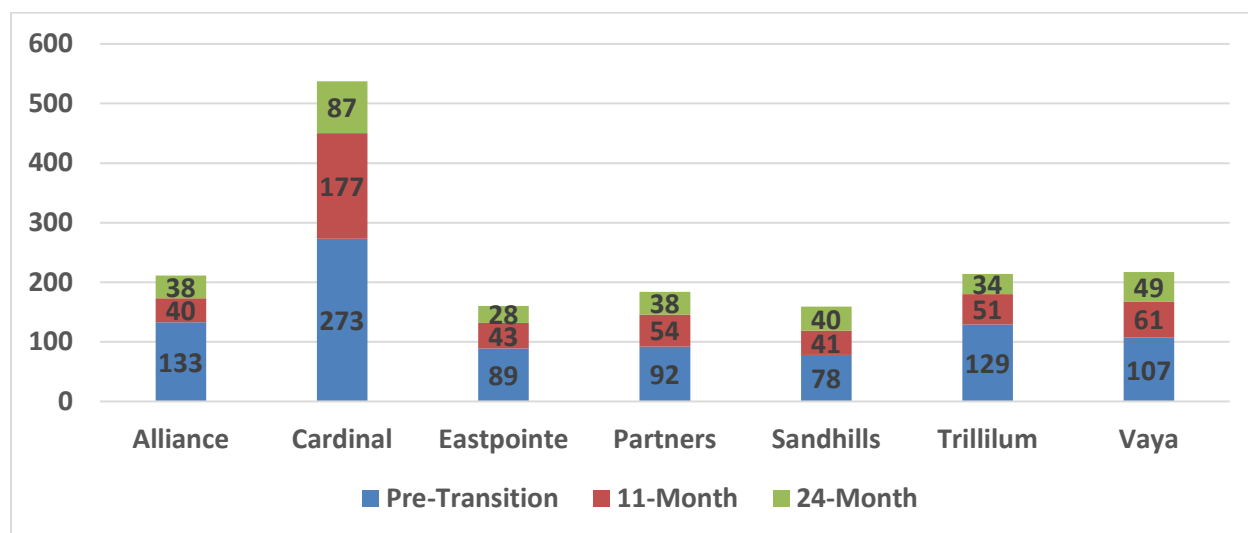
¹ Per Section III.G.5 of the State's Settlement Agreement (SA) with U.S. DOJ, the State implemented Quality of Life surveys in 2013. The SA requires the three surveys for individuals transitioning out of adult care homes or state psychiatric hospitals. The State extended the survey requirement for LMEs-MCOs 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 2013-2019²



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

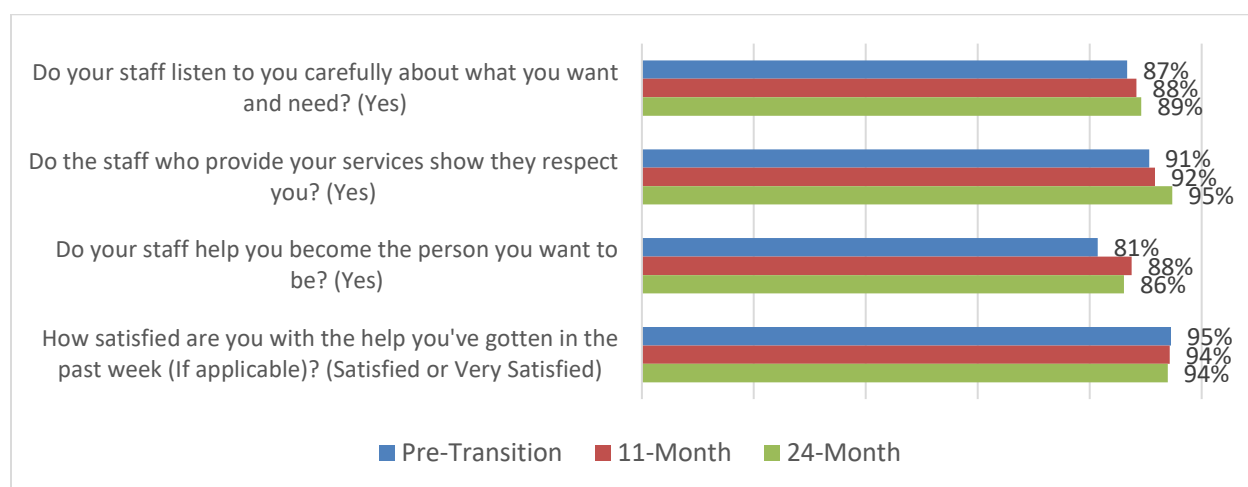
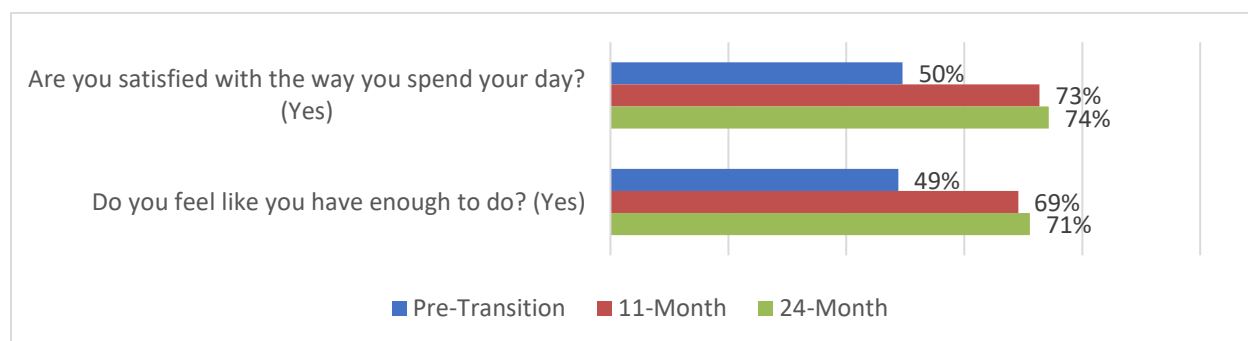


Figure 4B: Meaningful Day



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

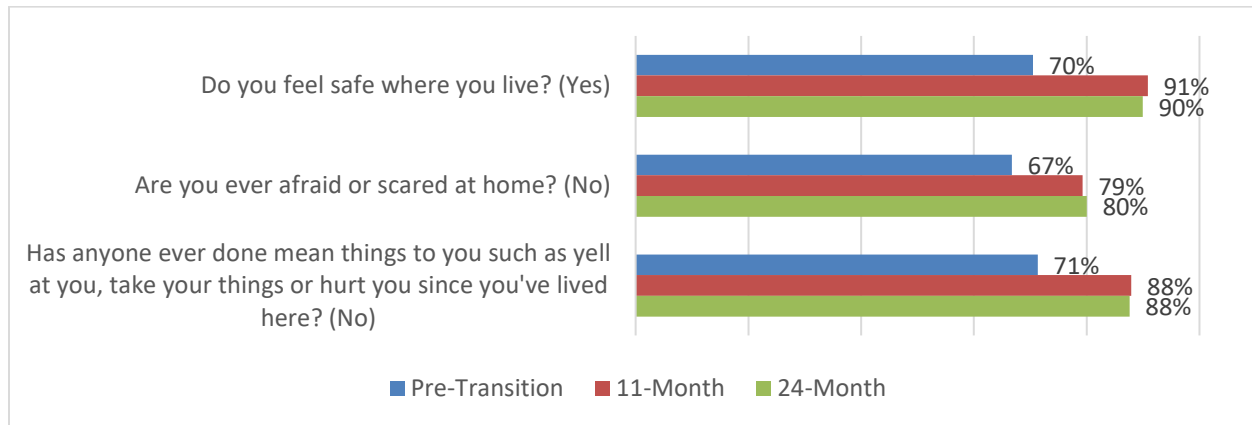


Figure 4D: Choice and Control

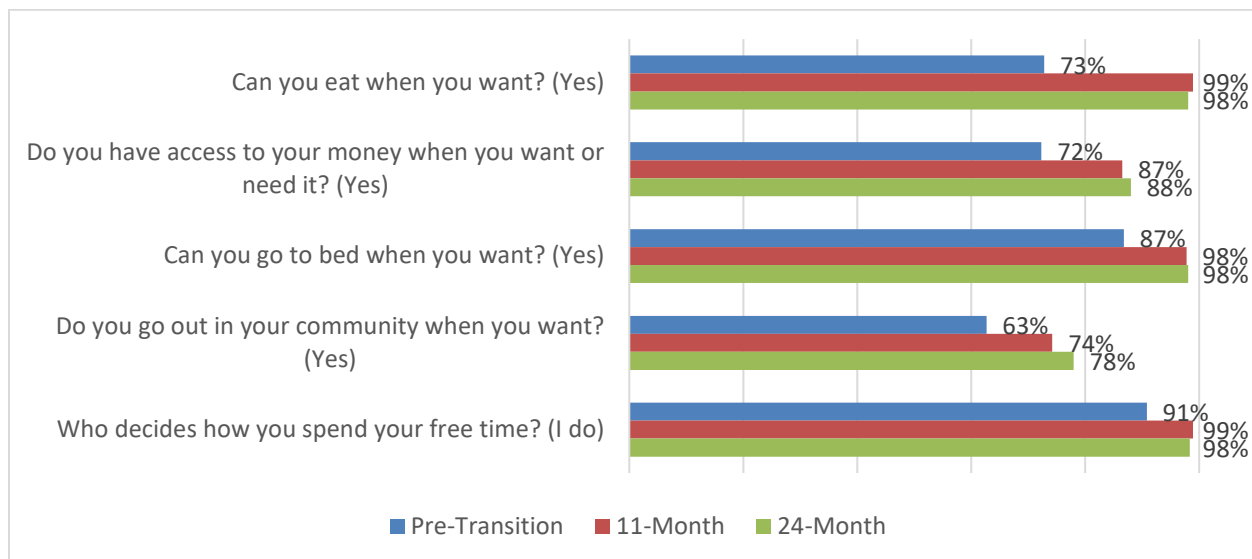


Figure 4E: Natural Supports

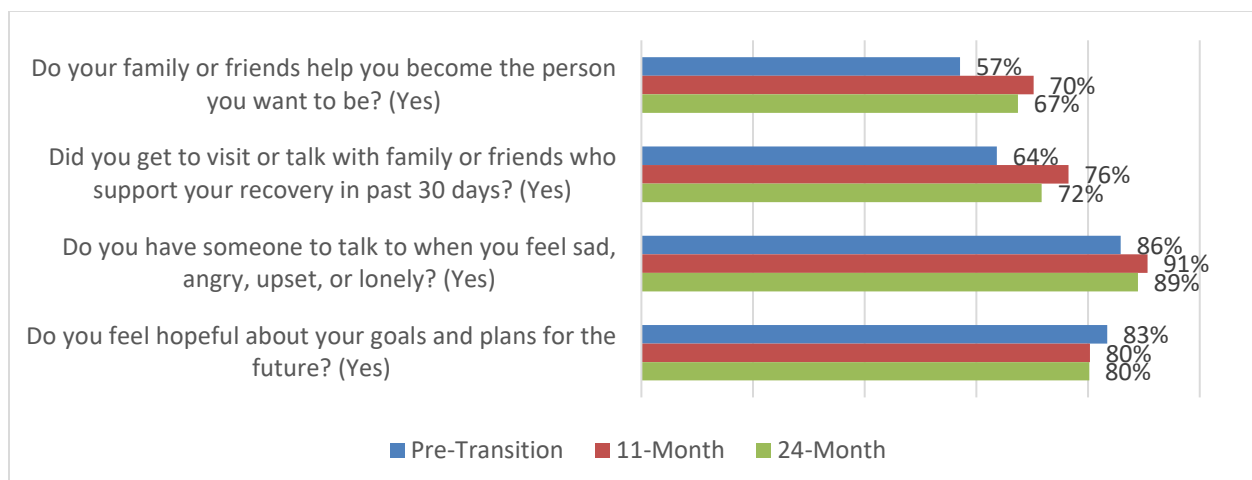


Figure 4F: Health and Wellness

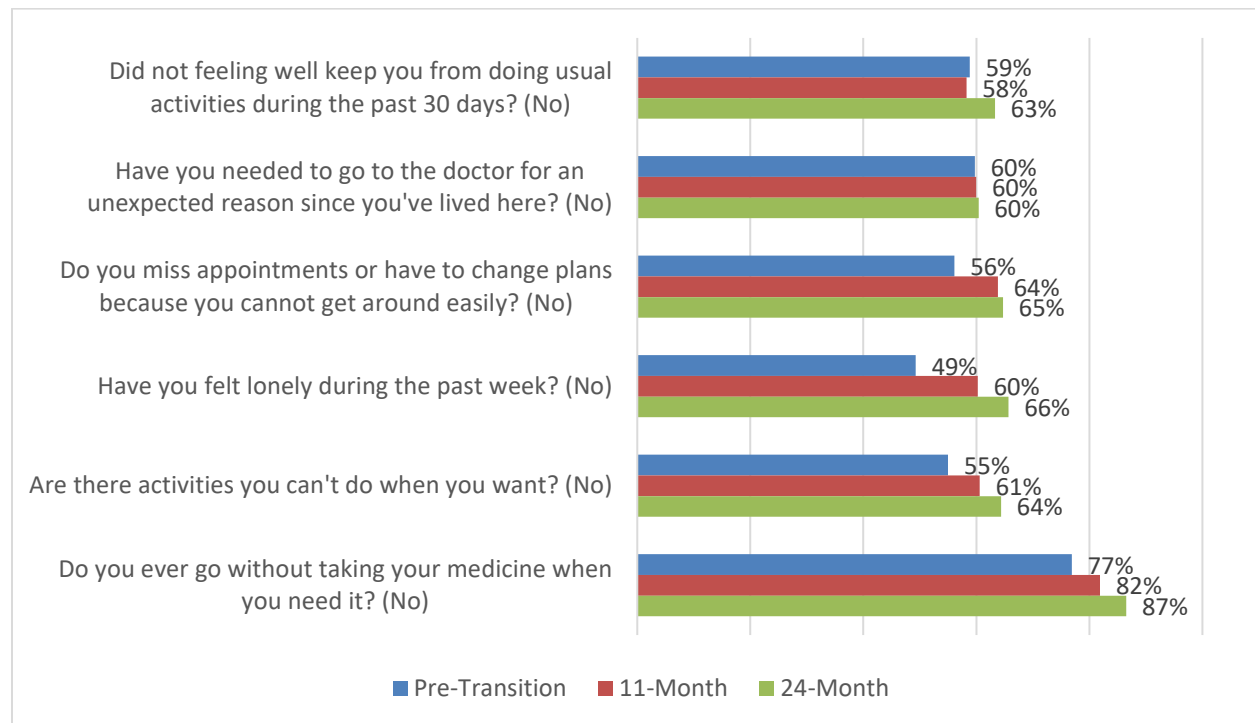


Figure 4G: Service Planning Contacts

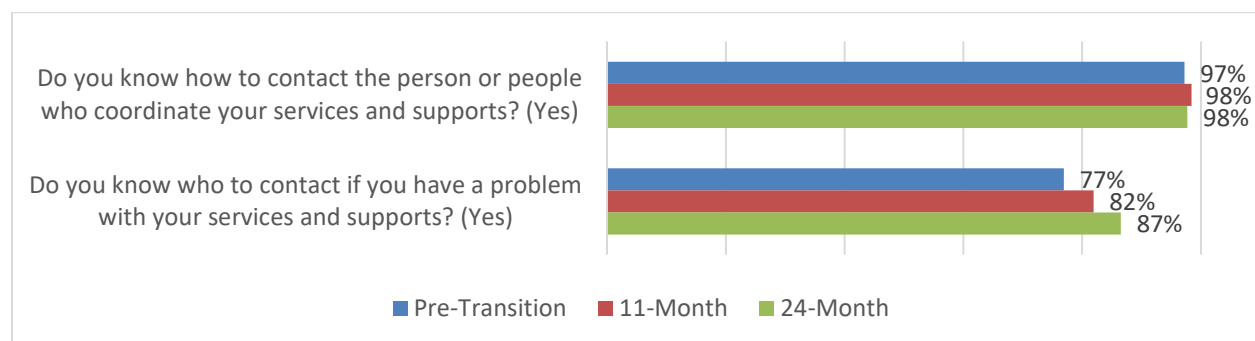


Figure 4H: Sufficiency of Services

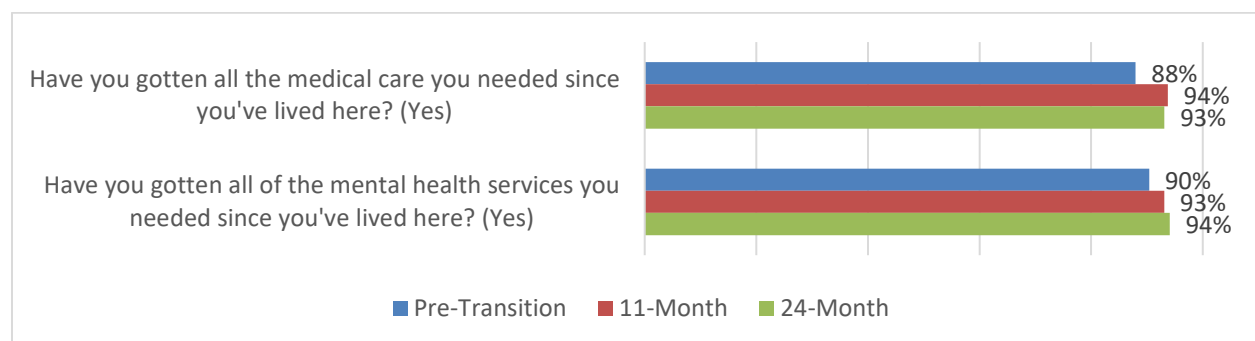
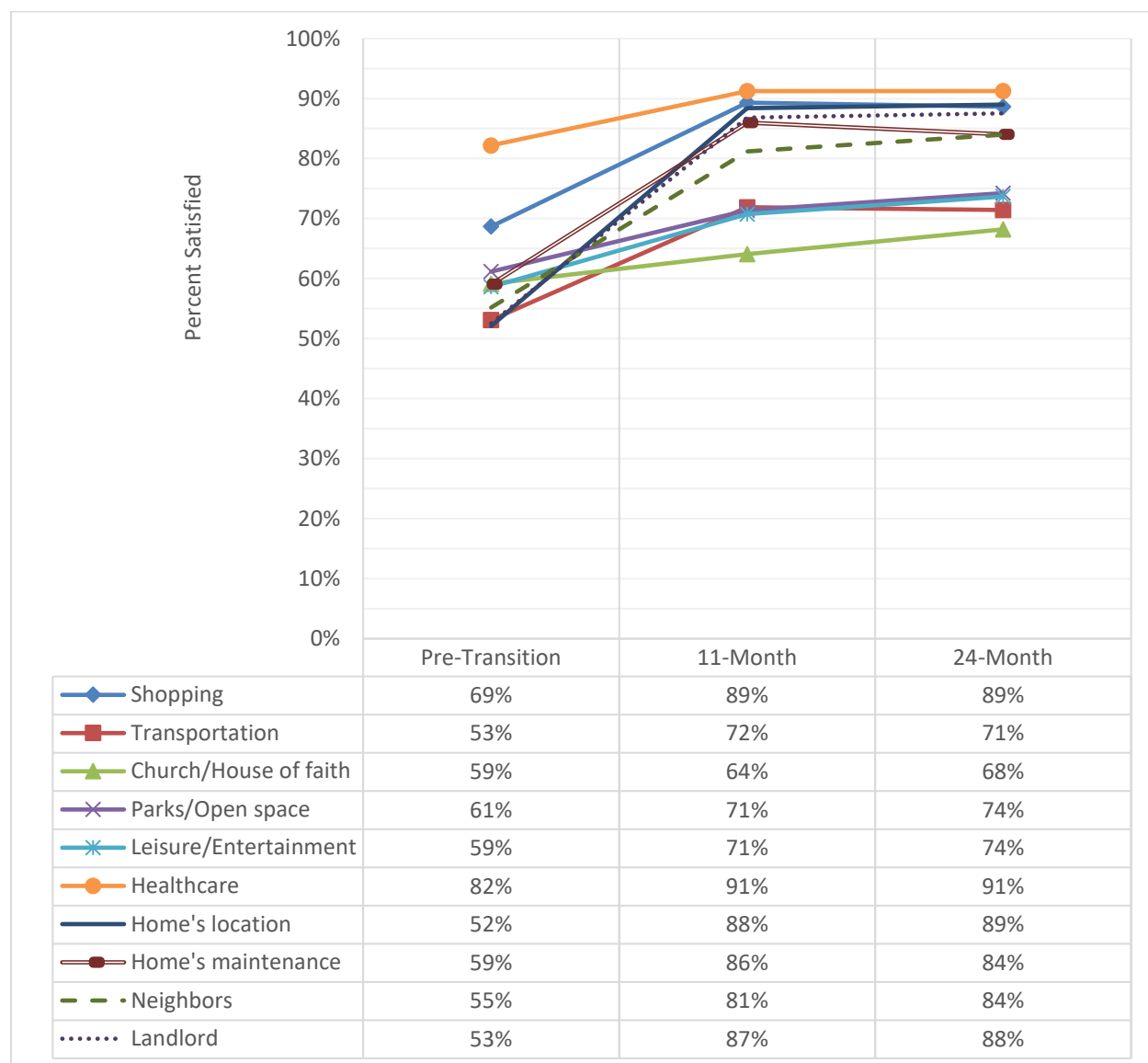


Figure 5A shows percentages of SFY 2019 survey respondents who reported being satisfied with various resources in their communities and with different aspects of their housing. As in previous years, significantly larger percentages of individuals in housing reported satisfaction in each of the ten areas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

Figure 5A: Satisfaction with Community Resources and Housing

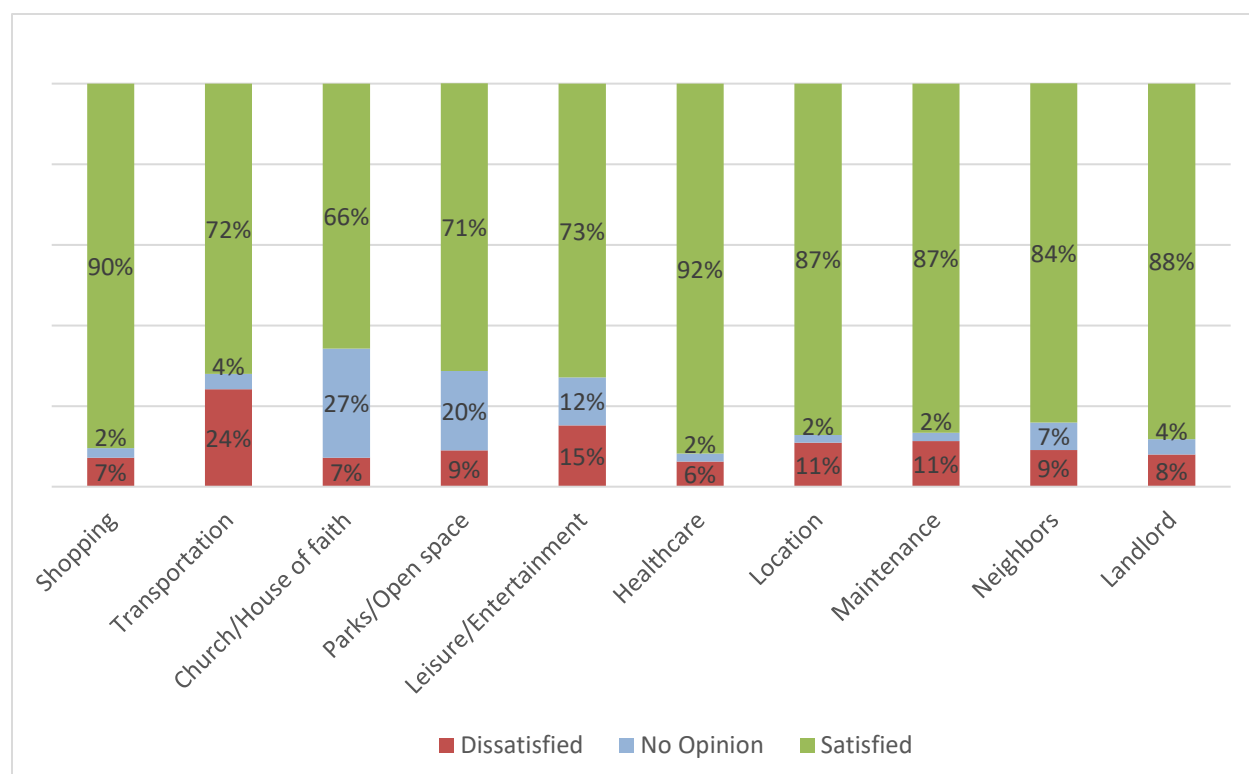


Cell values are percentages of respondents who selected “Satisfied” rather than “Dissatisfied” or “No opinion.” Non-responses are excluded from percentage denominators.

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 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.

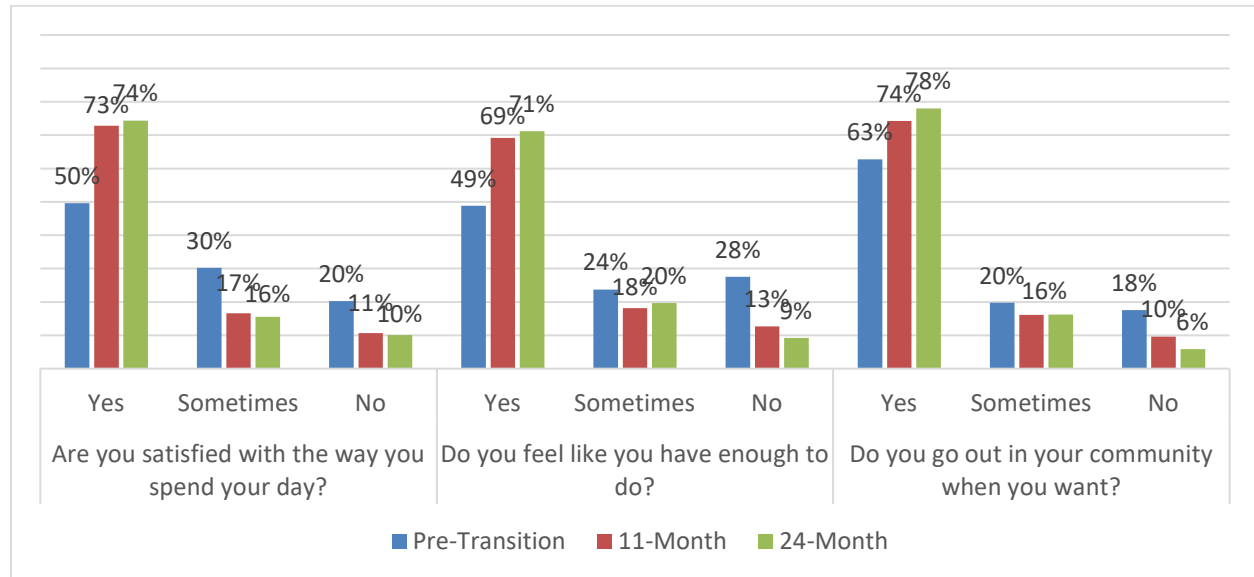
Figure 6 shows the response distributions to these three questions in greater detail. Pre-transition and post-transition respondents differed most in their reports of satisfaction with daily activities. At 24-month follow-up, 74 percent of housed individuals reported satisfaction, compared to 50 percent 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.

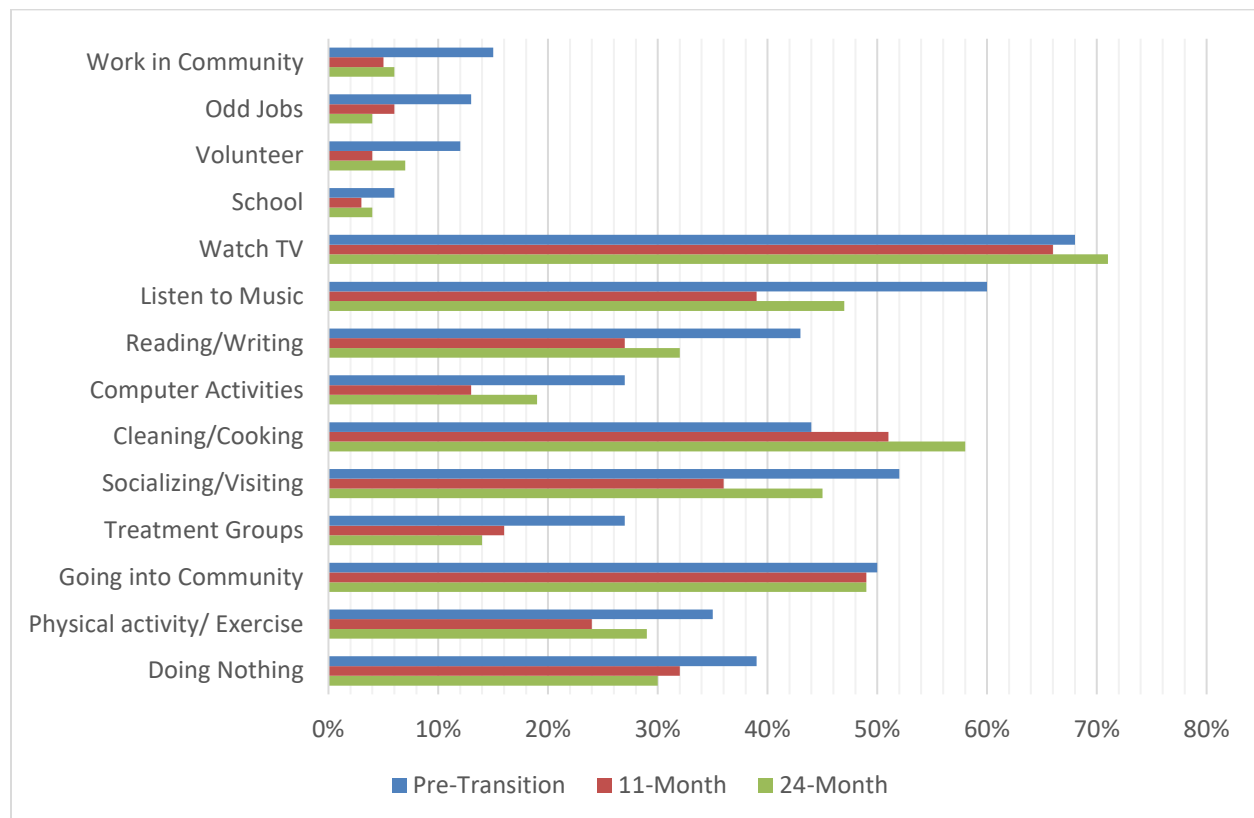
⁶ Activities are listed in descending order of the strength of their association with the 3-item CIE measure.

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?



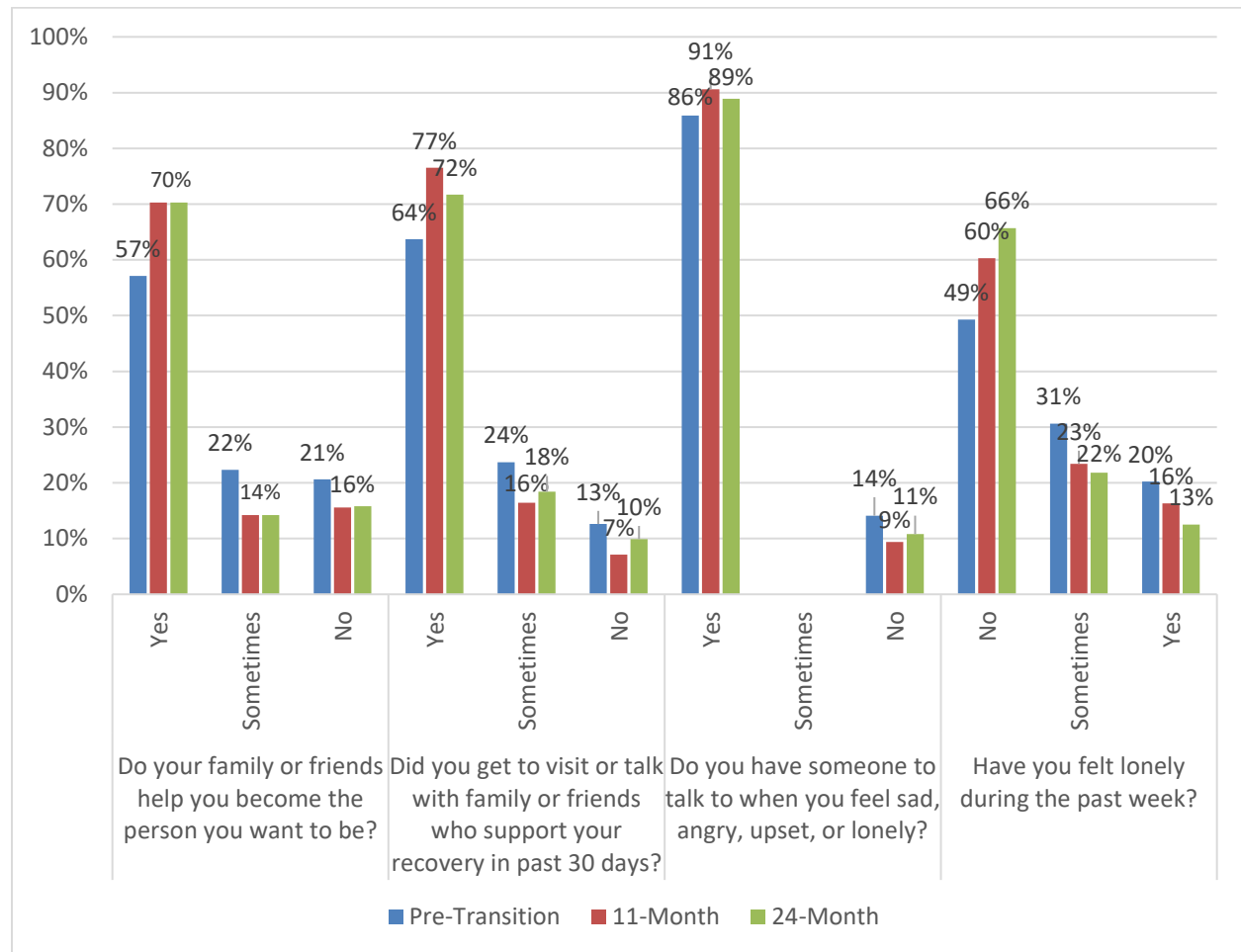
Participants in housing were more like to select Cooking/Cleaning, an activity that was positively associated with CIE, but they were less likely to select other activities associated with greater community integration, including Physical activity, Socializing, and Work. Percentages of housed individuals 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.

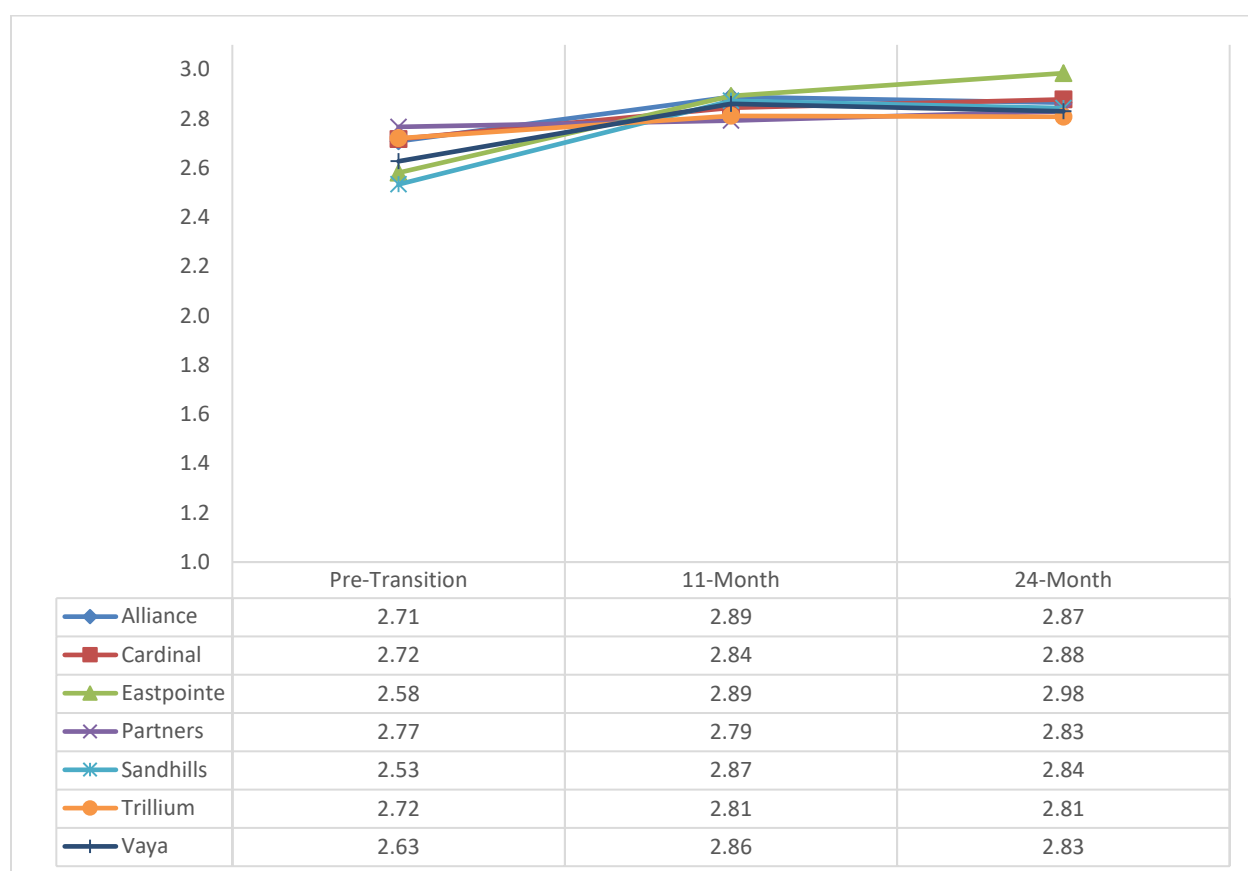
Figure 8: Indicators of Natural Supports Network Strength at Pre-Transition, 11 and 24 Months



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.)

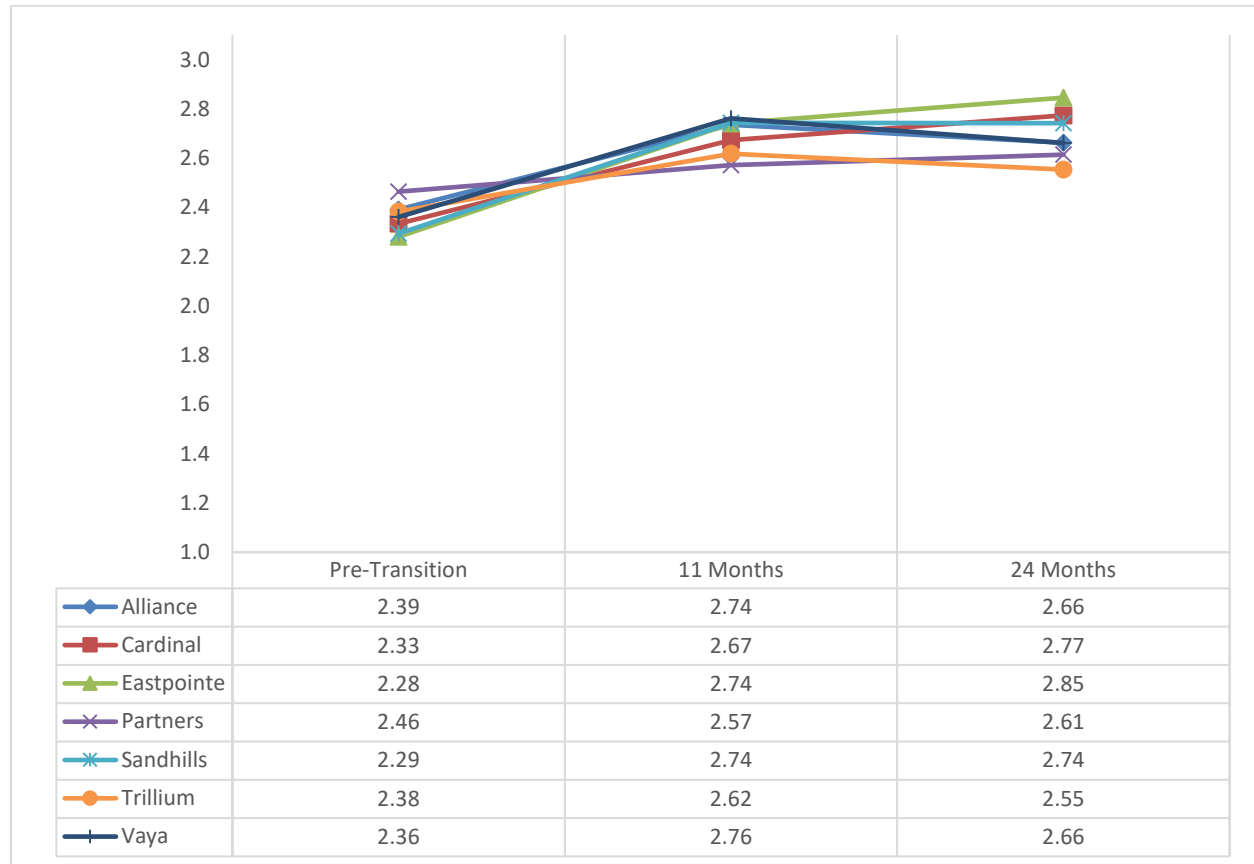
Figure 9: Quality of Life Index by Catchment Area, SFY 2019



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



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

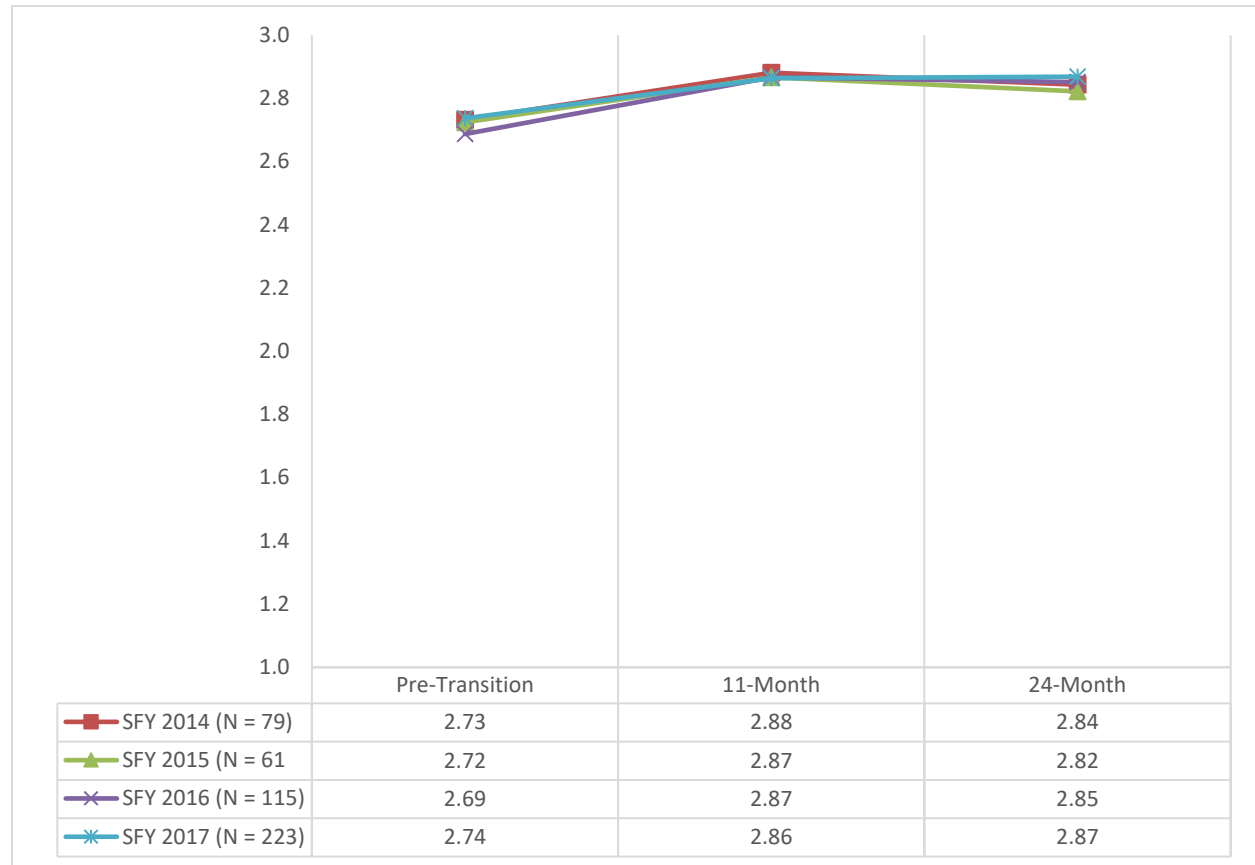
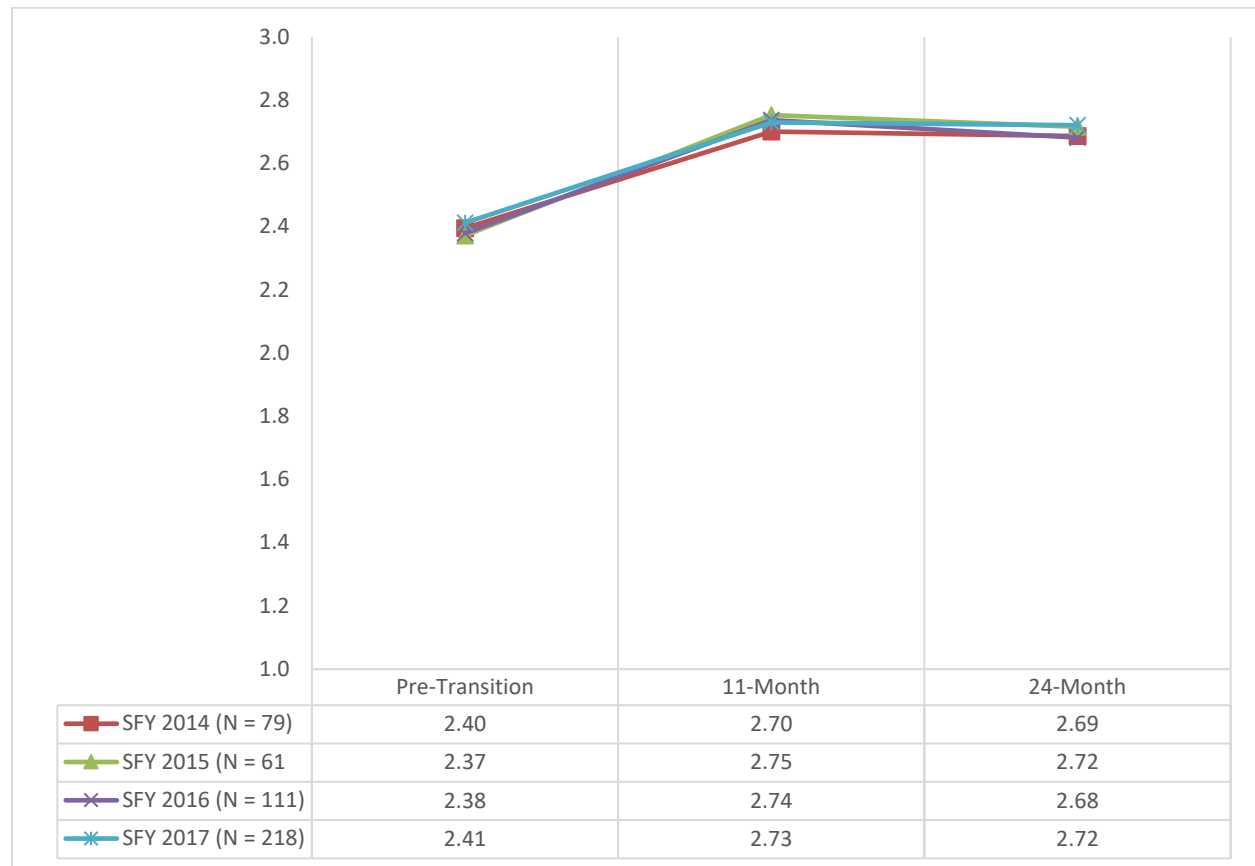


Figure 12: Individual Change in Satisfaction by Transition Year



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 Health	B-2
Cardinal Innovations Healthcare	B-13
Eastpointe	B-20
Partners Behavioral Health Management	B-34
Sandhills Center	B-40
Trillium Health Resources	B-48
Vaya Health	B-54

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
Countries Served	Wake Durham	Johnston	Wake	Durham	Cumberland Johnston	Cumberland	Wake
Team Composition	1 FTE Team Lead 1 FTE EPM 2 FTE ESP's	1 FTE Team Lead 2 FTE EPM's 1 PT EPM 3 FTE ESPs (Johnston County) 1 FT EPM (Harnett Co) 1 FT ESP (Harnett Co)	1 FTE Team Lead 2 FTE EPMs 4 FTE ESP's	One FTE Team Lead 1 FTE EPM One PT EPM One FTE ESP's 1 PT ESP	Team Lead position is currently vacant & IPS Program Supervisor is standing in as TL 1 shared EPM on Wake Team 2 FTE ESP's	1 FTE Team Lead 1 PT EPM 1 FTE ESP 1 PT IPS Administrator	1 FTE Team Lead 1 FTE EPM 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.

Sufficiency of service array:

- 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

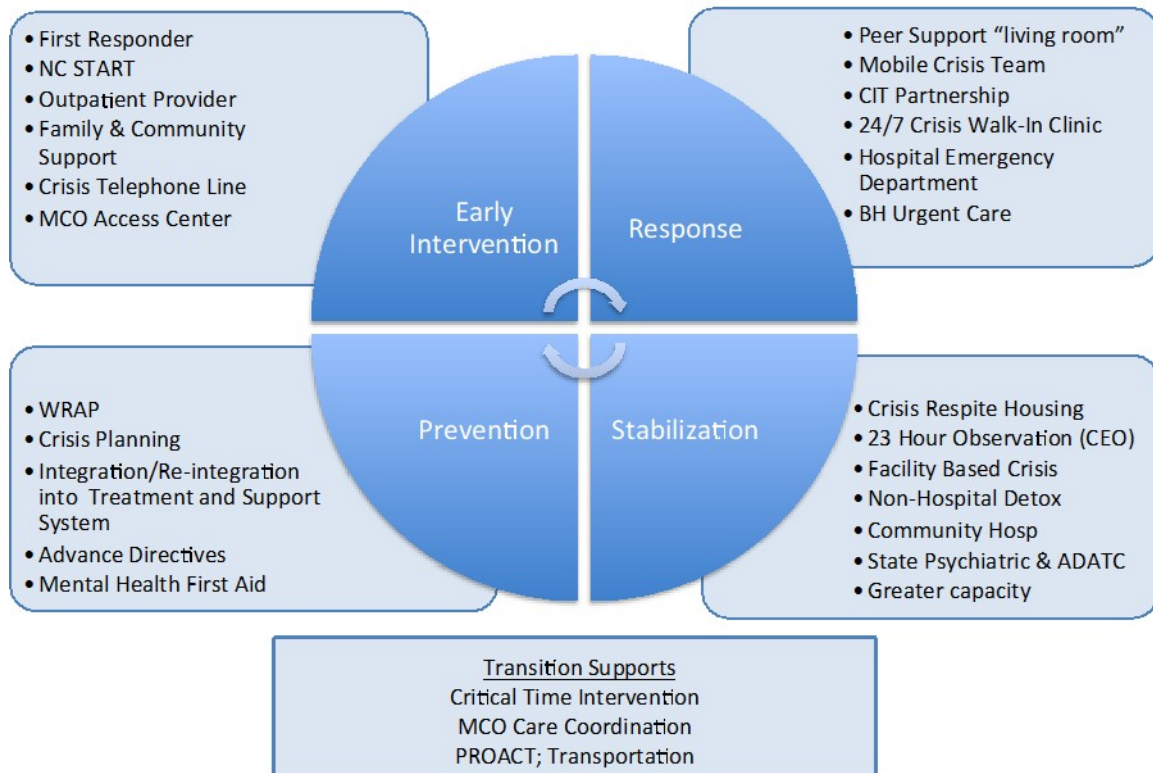
provides services at the right place, right time, and with the right amount. The goal is to address crises in the least restrictive setting while ensuring that people receive the appropriate treatment to avoid future crises and/or unnecessary utilization of services that do not meet their needs. At each 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**.

Alliance Vision of Crisis Continuum



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	<ul style="list-style-type: none"> • Disparate information systems, communications, and workflow streams with hospitals • Lack of awareness of TCLI-eligibility requirements and referrals for new enrollments • Limited, developing community networks 	<ul style="list-style-type: none"> • Expanding efforts to collaborate with community stakeholders, providers, and advocates (e.g. NC ADANC of NC for Community Inclusion) • Developed In-Reach process to support use of the TCLD • 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. • Expanding interdepartmental education/ training curriculum to help educate staff on TCLI program • Conducting external education/trainings of Eastpointe Provider Network Council, CFAC, and crisis collaborative • DHHS implemented the quarterly collaborative meetings with state hospitals Cherry, Central Regional and Broughton to enhance information sharing and referrals of members hospitalized. • Developing integrated workflows and communication mechanisms with DOJ, DSOHF, and the SOS to standardize referral identifications and member enrollment • Enhancing provider and stakeholder linkages to: mobile crisis providers, physical providers, behavioral health providers, PCS providers, EMS, and law enforcement • Collaborating with community hospitals and hospital transition care coordination teams to standardize identifications, referrals, and transition into TCLI
Enhancing community engagement	<ul style="list-style-type: none"> • Lack of awareness of TCLI-eligibility requirements • Limited, developing community networks 	<ul style="list-style-type: none"> • Piloting Community Inclusion project with DMH and ADANC of NC to enable member engagement in community life • Enhancing wraparound services that support community integration, promoting utilization of Peer Support • 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 • Integrating community engagement content and techniques into provider training curriculum • 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) • Developing linkages with local community colleges to support education toward competitive employment

		<ul style="list-style-type: none"> • Expanding interdepartmental education/ training curriculum to help educate staff on TCLI program • Conducting external education/trainings of Eastpointe Provider Network Council, CFAC, and crisis collaborative • 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	<ul style="list-style-type: none"> • Inconsistent coordination between ED's and Eastpointe • Disparate information systems, communications, and workflow streams with hospitals/ED's • Lack of awareness of TCLI eligibility requirements 	<ul style="list-style-type: none"> • Conducting external education/trainings of Eastpointe Provider Network Council, CFAC, and crisis collaborative on importance of support services to prevent future crisis events • 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 • Evaluating psychiatric telehealth service integration with ED's to introduce more acute, timely psychiatric support to stabilize members in the ED • Enhancing provider and stakeholder linkages, including to: physical providers, behavioral health providers, PCS providers, EMS, and law Enforcement • 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	<ul style="list-style-type: none"> • Lack of community engagement and integration designed to prevent and mitigate crisis events • Lack of community networks with natural supports • Lack of awareness of TCLI-eligibility requirements and referrals for new enrollments 	<ul style="list-style-type: none"> • Piloting Community Inclusion project with DHHS and a provider to enable member engagement in community life • 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 • 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 • Integrating community engagement content and techniques into provider training curriculum • 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) • Developing linkages with local community colleges to support education toward competitive employment • Developed In-Reach process to support use of the TCLD • Continue to support the RSVP referral process to centralize referrals to TCLI licensed staff • Expanding interdepartmental education/ training curriculum to help educate staff on TCLI program • Conducting external education/trainings of Eastpointe Provider Network Council, CFAC, and crisis collaborative

		<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Not enough providers Public stigma/perceptions may discourage members from seeking crisis services Awareness how/when to access services that are available Only long-term substance abuse providers in the catchment area are Walter B. Jones and Dart Cherry 	<ul style="list-style-type: none"> The state is working on the substance abuse waiver to cover all ASAM levels. 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. 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	<ul style="list-style-type: none"> Not enough funding for resources given the demand for services Lack of interagency coordination/operating in silos 	<ul style="list-style-type: none"> To cutdown on frequent utilizers of the ED, there is a QIP (Quality Improvement Plan) in place Encourage providers to use enhanced crisis services as is clinically indicated and use the other enhanced services initially

<p>Lack of resources/support for mobile crisis teams</p>	<ul style="list-style-type: none"> • difficult business model to sustain when you're not embedded in a bigger agency • Members must consent to mobile crisis services, may not fully appreciate/understand how mobile crisis can help, may lead to escalation into ED • Public stigma/perceptions may discourage members from seeking crisis services <p>Awareness how/when to access services that are available</p>	<ul style="list-style-type: none"> • Continue with established bi-monthly meetings with EP Crisis Providers and MCC <ul style="list-style-type: none"> • Resource sharing • Dispatch concerns/opportunities • Reporting concerns/opportunities • Continue scheduling of aftercare appointments for all crisis service recipients where initiation of services originates via MCC <p>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.</p> <ul style="list-style-type: none"> • Develop a collaborative group involving MCM Providers and key MCO staff to evaluate any existing barriers to service utilization • Provide TA for MCM providers for any identified barriers including: <ul style="list-style-type: none"> • Knowledge in accessing services • Difficulty obtaining consent for services • Community partnerships necessary for service initiation and utilization • Explore topic of stigma associated with accessing crisis services • 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 Alternative (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. One of the 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 Montgomery³⁴. 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 TCLI 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 consumers³⁵ 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:

<u>Service</u>	<u>Number/Percentage of Consumers Accessed</u>
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 Supportive 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/2016TCLIAAnnualReportQoLAppendix.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 participant's 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 individual's 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.